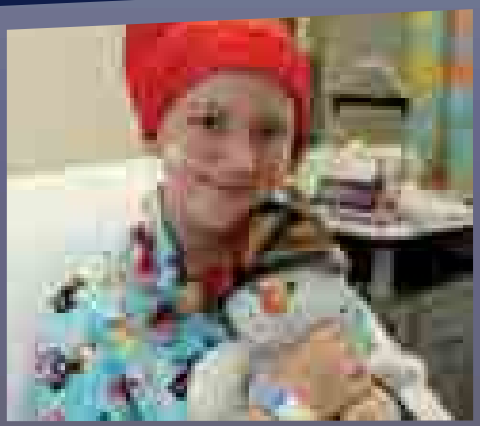
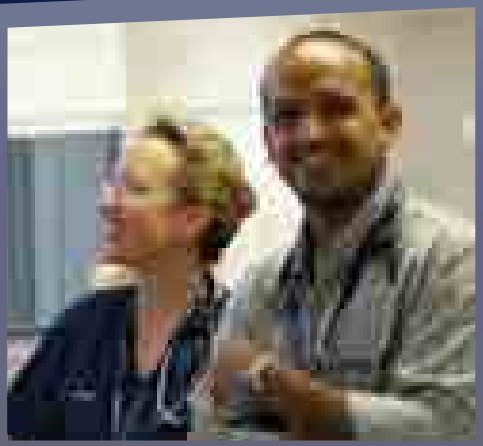
Annual Report 2009–2010

Queensland Health





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Toward 2 Tomorrow's Queensland | Queensland Government

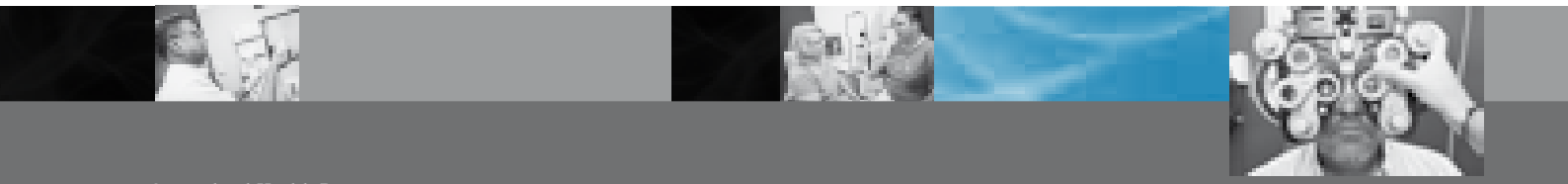
This annual report provides information about the Department of Health's financial and non-financial performance for 2009–2010. It has been prepared in accordance with the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2009*.

The report records significant achievements against strategies and outputs detailed in the department's Strategic Plan 2007–2012 (version 2) and the 2009–2010 Service Delivery Statement.

This report has been prepared for the Deputy Premier and Minister for Health to submit to Parliament and to meet the needs of stakeholders, including the Commonwealth and local governments, industry and business associations, community groups and staff.

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you need an interpreter, please contact the Translating and Interpreting Service (TIS National) on 131 450 and ask to be connected with Queensland Health on (07) 3234 1135.

Readers are invited to comment on this report through the department's website at www.health.qld.gov.au.



Queensland Health Report 2009–2010.

Published by the Queensland Government, September 2010.

147-163 Charlotte Street Brisbane.

Copies of this publication can be obtained at www.health.qld.gov.au, phone (07) 3234 1135, fax (07) 3234 1909.

ISNN 1838-4110

Letter of compliance

16 September 2010

The Honourable Paul Lucas MP
Deputy Premier and Minister for Health
Member for Lytton
GPO Box 48
Brisbane Qld 4000

Dear Minister

I am pleased to present the Annual Report 2009–2010 for the Department of Health.

I certify that this annual report complies with the:

- prescribed requirements of the Financial Accountability Act 2009 and the Financial and Performance Management Standard 2009
- 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 154 of this annual report or accessed at www.health.qld.gov.au/publications/corporate/annual_reports.

Yours sincerely

Michael Reid
Director-General
Queensland Health

Highlights

In 2009–2010, Queensland Health:

- reduced from 9,014 to two patients the number of elective surgery patients who were 'long waits' from September 2007
- reduced the number of 'long wait' patients to the lowest total since the statewide data collection began in 1996–1997
- increased clinical staff numbers by an additional 2,169 including:
  - 351 medical (including Visiting Medical Officers)
  - 1,369 nursing, including an additional 13 nurse practitioners
  - 449 allied health professionals
- provided 11,083,414 non-admitted patient services, including emergency services, in acute public hospitals
- provided 1,573,041 emergency services for non-admitted patients in acute public hospitals
- provided admitted care in acute public hospitals to 922,738 people, including 469,615 people who received same-day-admitted care
- provided 473,105 adult and 465,454 child dental appointments
- provided 6,450 Telehealth non-admitted occasions of service, an increase of 53 per cent
- installed 85 new Telehealth systems around Queensland, bringing the total to more than 800, the largest managed Telehealth system in Australia
- spent $9.552 billion on public health services, an average of $26.1 million per day
- screened 226,199 women for breast cancer
- delivered 43,136 babies in acute public hospitals
- established newborn and drop-in services in 18 communities
- provided more than 1,350 older Queenslanders with residential care in 20 aged care services
- helped about 4,000 older Queenslanders to regain their independence and be able to return to live in their own homes
- gave qualified and supportive advice to 257,838 callers through the health hotline, 13HEALTH
- administered more than 930,000 pandemic (H1N1) 2009 vaccines
- completed 17 significant infrastructure projects, including:
  - Cairns Medical Imaging Department and installation of a new Magnetic Resonance Imaging (MRI)
  - Cairns Hospital Emergency Department expansion
  - Ingham Hospital redevelopment final stage
  - The Townsville Hospital 30-bed expansion
  - Capricorn Coast Hospital and Health Service
  - Rockhampton Base Hospital expansion phase one
  - Bundaberg Base Hospital Mental Health building refurbishment
  - Nambour Residential Aged Care facility 45-bed refurbishment
  - The Prince Charles Hospital redevelopment final stage.

Contents

Year in review

Queensland Health made encouraging progress in 2009–2010 towards its long-term ambition of making Queenslanders Australia's healthiest people by 2020.

Queensland Health has responsibility for leading two health targets under the Queensland Government's vision for the state, *Toward Q2: Tomorrow's Queensland*. These targets are to:

- cut obesity, smoking, heavy drinking and unsafe sun exposure by one-third
- ensure Queensland has the shortest public hospital waiting times in Australia.

Promising figures have been recorded in strategies aimed at reducing the rates of obesity, smoking, heavy drinking and sun exposure among Queenslanders. Targeted programs include a better choice of healthy foods available in Queensland Health facilities, boosting consumption of fruit and vegetables, and lifestyle activities to increase community physical activity.

Queensland Health also made significant progress in addressing the issue of the number of Queenslanders waiting too long for elective surgery. In addition to providing extra operating theatres in public hospitals, the Surgery Connect Program, which provides alternative treatment options for 'long wait' elective surgery patients, has enabled the treatment of more than 19,000 Queenslanders, in both private and public hospitals, since 2007.

The Queensland Health Patient Flow Strategy, refined in the past 12 months, has prioritised efficient use of emergency department resources with the aim of ensuring emergency department stay should be less than six hours for admitted patients and even less for non-admitted patients. Ultimate goals of the strategy are to improve patients' journey, reduce delays and increase access to services.

Queensland Health has continued statewide expansion of the Telehealth network. Telehealth is an extension of the way we can communicate with patients and nurses, doctors and other specialists by using audio and visual technologies. Telehealth can be used to remove physical and social distances between health professionals and their patients.

In total, Queensland Health invested $9.552 billion during the year, at an average of $26.1 million per day. The $7.33 billion health infrastructure program, the largest ever undertaken in the nation, will deliver more than 200 new and expanded hospital and health services projects across the state. The program includes planning and design for the new Gold Coast University Hospital, Sunshine Coast University Hospital and the Queensland Children's Hospital.

Statewide Clinical Networks, Health Community Councils and the Clinical Senate are ongoing Queensland Health initiatives which engage clinicians and consumers in decisions addressing problems in quality and/or efficiency of health care, clinical services planning and implementation, clinical practice improvement and quality and safety enhancements.

Implementation of the Auditor-General's recommendations will deliver a new, local payroll model with strong links between payroll hubs and local hospitals and builds on our delivery of a new payroll system. I would like to apologise once again to Queensland Health staff and their families who experienced any inconvenience or hardship resulting from the implementation of this new system.

The commitment, dedication and professionalism of Queensland Health staff across the state during a difficult year for some has enabled us to continue to provide the best health care possible for all Queenslanders.

I look forward to the continued support of our valued staff in future years as we strive to make Queenslanders Australia's healthiest people.

Michael Reid
Director-General

1 our organisation

Four strategic priorities are the keynote of Queensland Health's continuing commitment to meeting the healthcare needs of all Queenslanders.

Our mandate

The Queensland Department of Health was established in 1901. Queensland Health is responsible for management, administration and delivery of public sector health services in Queensland.

The *Health Services Act 1991* prescribes the objectives as protecting and promoting health, helping to prevent and control disease and injury, and providing for the treatment of the sick.

This responsibility is discharged through a network of 15 health service districts, a range of statewide support services, such as radiology and pathology, and supporting corporate functions.

Our mission, values and operating principles

Our mission

Creating dependable health care and better health for all Queenslanders.

Our values

- caring for people
- leadership
- integrity
- respect.

Our operating principles

- responding justly and fairly
- working in partnership
- enabling and supporting change in the healthcare system
- being accountable for our resources and actions.

Our strategic direction

To achieve our mission, the Queensland Health Strategic Plan 2007–2012 outlines four strategic priorities that confirm our continuing commitment to meeting the Toward Q2: Tomorrow's Queensland ambition of making Queenslanders Australia's healthiest people and to address the challenges articulated in Advancing Health Action (2008).

Queensland Health's strategic priorities are:

- making Queenslanders healthier, with a focus on promotion and protection of the health of all Queenslanders and prevention of ill health, by supporting healthy behaviour and lifestyle choices, improving access to cancer-screening programs, managing preventable environmental health hazards, preventing and controlling communicable diseases and maintaining vaccination rates
- meeting Queenslanders' healthcare needs safely and sustainably by addressing the challenge of meeting the healthcare needs of Queenslanders across the spectrum of care, including expanding services in the primary care setting, expanding hospital and related services to meet the needs of a growing population, and improving patient care, safety and patient outcomes
- reducing health service inequities across Queensland through greater access to health services for specific population groups most at risk, including closing the gap on health outcomes for rural and remote and Indigenous Queenslanders and improving access to mental health services across Queensland
- developing our staff and enhancing organisational performance by valuing the role of people and resources in the organisation, and implementing performance management, governance and accountability systems to best achieve the department's strategic priorities.

Future challenges for Queensland Health include:

- changing the community's focus to prevention of illness and maintenance of good health
- managing complex care delivery by ensuring the right services are provided in the right place
- building public confidence in the healthcare system
- providing a seamless transition for patients as they move across healthcare providers and settings
- attracting and retaining skilled professionals in rural and remote areas and specialist services
- managing the growing demand for services within the economic and financial environment.

To address these challenges and ensure we meet key responsibilities within the Queensland Government's Toward Q2 and National Healthcare Agreements, we have 18 objectives under our four strategic priorities.

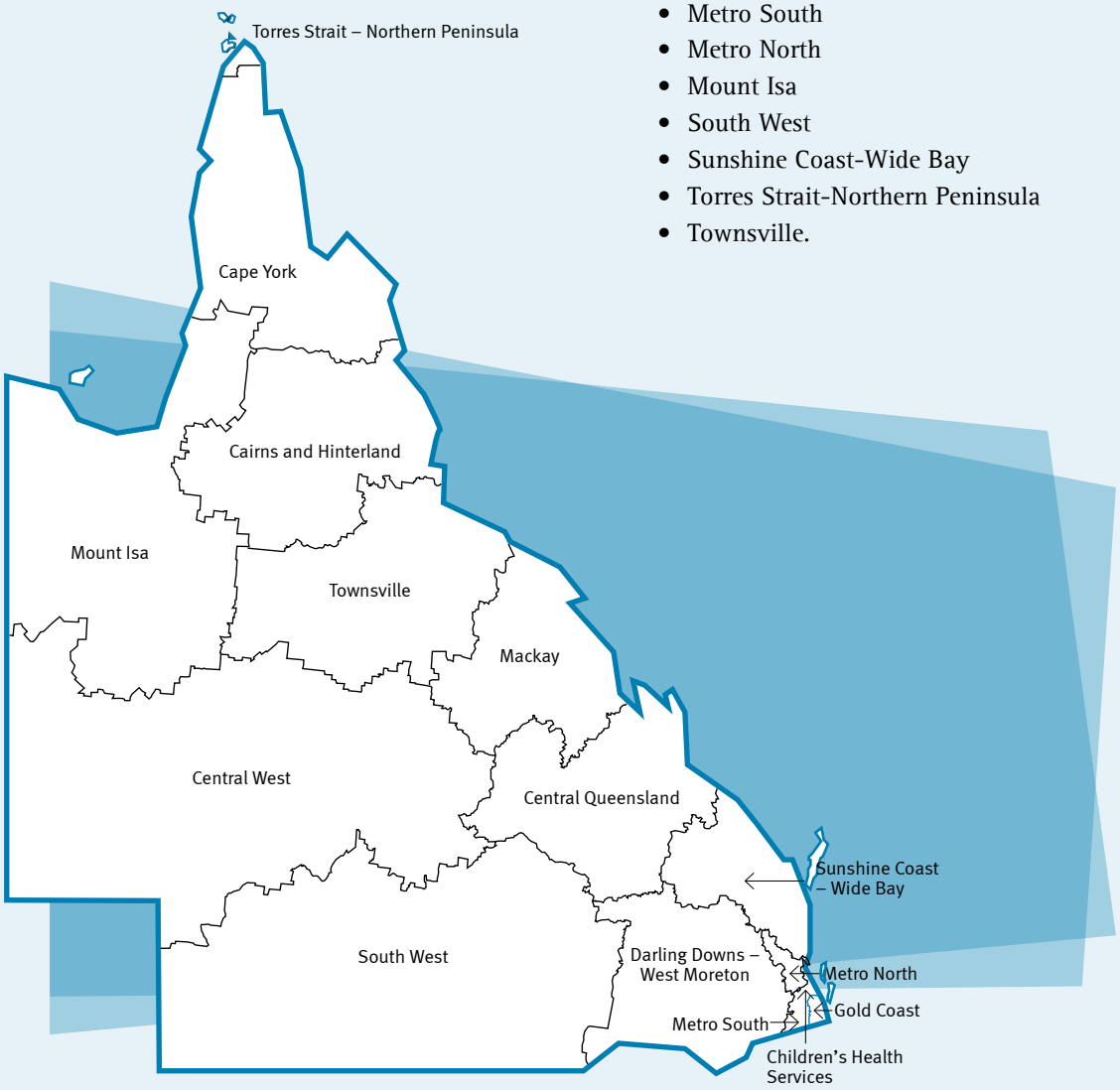
For information about the objectives and our performance against the objectives, refer to the 'Our performance' section.

Our structure

Queensland Health operates from several district and corporate offices throughout the state.

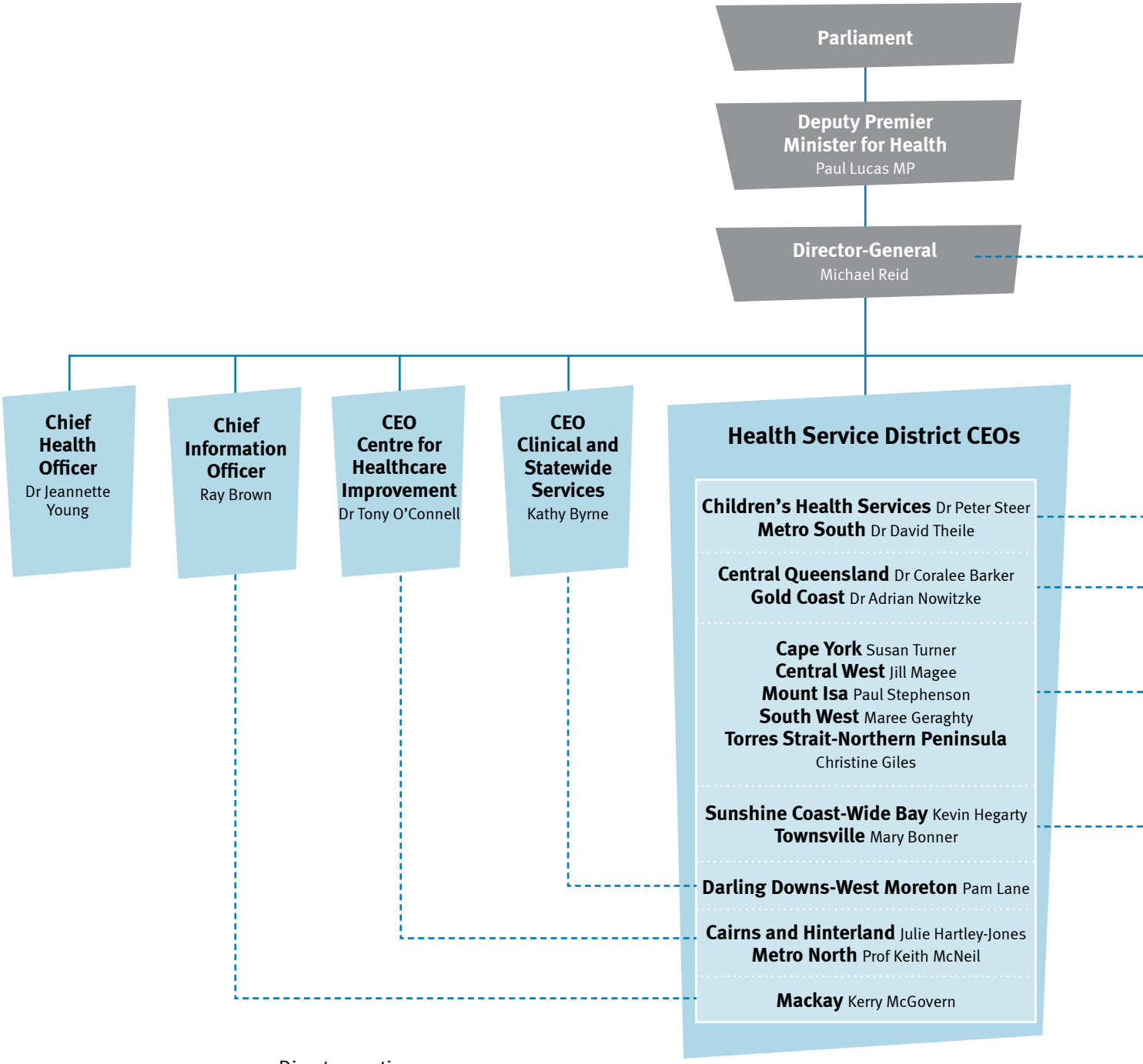
Services are provided through a network of 15 health service districts:

- Cairns and Hinterland
- Cape York
- Central West
- Children's Health Services
- Central Queensland
- Darling Downs-West Moreton
- Gold Coast
- Mackay
- Metro South
- Metro North
- Mount Isa
- South West
- Sunshine Coast-Wide Bay
- Torres Strait-Northern Peninsula
- Townsville.



Queensland Health's organisational structure

June 2010



Direct reporting

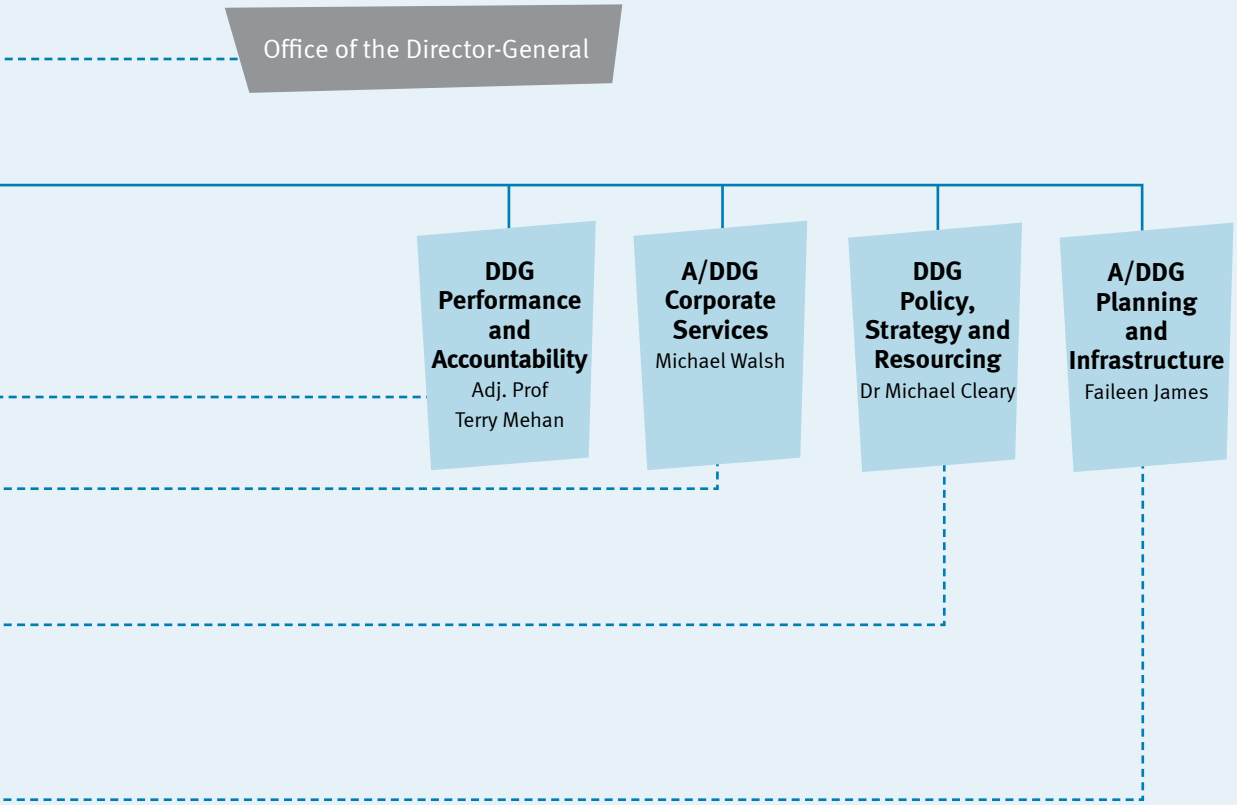
Performance reporting/coordination

DDG Deputy Director-General

CEO Chief Executive Officer

Districts are supported by the Office of the Director-General and eight corporate divisions:

- Clinical and Statewide Services
- Office of the Chief Health Officer
- Policy, Strategy and Resourcing
- Centre for Healthcare Improvement
- Performance and Accountability
- Corporate Services
- Health Planning and Infrastructure
- Chief Information Officer.



Office of the Director-General

The Office of the Director-General is committed to driving high-quality health care and continuous improvement.

As the main provider of public health services, the challenge is safe provision of quality services across Queensland and across the diversity of needs within the annual budget.

The Office of the Director-General has a strong commitment and focus on performance, accountability, openness and transparency.

The Office of the Director-General incorporates the following branches/units:

- Office of the Director-General
- Assurance and Risk Advisory Services, including the statutory governance functions of internal audit, risk management and internal witness support
- Ethical Standards Unit
- Health Community Council Coordination
- Health Consumers Queensland Secretariat.

Clinical and Statewide Services

Clinical and Statewide Services brings together:

- Biomedical Technology Services
- Forensic and Scientific Services
- Medication Services Queensland
- Pathology Queensland
- Queensland Blood Management Program
- Radiology Support
- Statewide Health Services, including Telehealth, Healthy Hearing Program and Health Contact Centre (13HEALTH).

These seven branches are supported by the corporate services branches of Finance, Business Services and Information Communication and Technology.

The division has supported health service districts to manage their priorities of efficiency, patient flow, access and patient safety through a range of programs.

The division is innovative and outcome-driven with an emphasis on quality management systems and creating a learning environment.

Chief Health Officer

The Chief Health Officer is committed to the goal of Queenslanders becoming Australia's healthiest people, in alignment with the Queensland Government's 2020 vision of Toward Q2: Tomorrow's Queensland.

The purpose of the division is to help prevent disease and illness, as well as actively promote good health and wellbeing across the state.

The Chief Health Officer is Dr Jeannette Young, who provides the leadership of the division and performs the regulatory functions of her role as the Chief Health Officer.

The division operates as a statewide service consisting of six directorates:

- Health Coordination Services
- Health Protection
- Preventative Health
- Mental Health
- Offender Health Services
- Governance and Capability.

The 2009–2010 recurrent budget was about $250 million, including $90 million of vaccines.

Policy, Strategy and Resourcing

The main focus of Policy, Strategy and Resourcing (PSR) is on integrating health policy, strategic planning and resourcing. This is essential for ensuring health service delivery and available resources are aligned to changing needs.

This allows consolidation of policy development functions across a range of areas, including strategic planning, intergovernmental relations, resource allocation, legislation and workforce.

The division also plays a crucial role in the national health agenda, such as maternity, child health and safety, Aboriginal and Torres Strait Islander health national registration, accreditation and national partnership agreements, and sustainable service models for rural and remote Queensland.

It also takes a lead role in implementing recommendations from the National Health and Hospitals Network Agreement.

Policy, Strategy and Resourcing comprises the following branches/units:

- Aboriginal and Torres Strait Islander Health Branch
- Clinical Workforce Planning and Development Branch
- Office of the Chief Dental Officer
- Office of the Deputy Director-General PSR
- Office of the Chief Nursing Officer
- Office of Rural and Remote Health
- Primary, Community and Extended Care Branch
- Strategic Policy, Funding and Intergovernmental Relations Branch.

Centre for Healthcare Improvement

The Centre for Healthcare Improvement leads quality improvement in Queensland Health through all aspects of quality care and safety, access to services, patient experience, appropriate therapy, efficiency and effectiveness. This also includes improving organisational culture and staff skills, and promoting innovation and research.

The centre was realigned in March 2010 and now includes the Patient Safety and Quality Improvement Service, Access Improvement Service, Clinical Skills Development Service, Office of Health and Medical Research and Healthcare Culture and Leadership Service.

This has enabled the best arrangement of core activities and alignment of 'safety' and 'quality' to focus on high-quality clinical outcomes, as reflected in other federal and state health jurisdictions.

Performance and Accountability

The Performance and Accountability Division has developed a suite of frameworks (governance, strategic planning and performance management) to set clear and consistent objectives that:

- align to the department's strategic objectives
- measure and improve performance against valid and reliable key performance indicators
- embed accountability for our decisions and actions in performance agreements and individual performance appraisal and development plans
- ensure sound governance arrangements across the organisation to drive effective performance management and decision-making.

Queensland Health is committed to strengthening the use of performance information to improve:

- service delivery and outcomes
- quality and consistency of performance information and monitoring practices.

The performance and accountability function consolidates and aligns external and internal performance monitoring and reporting for improved decision-making at all levels.

To further support Queensland Health's commitment to strengthening its performance and accountability, the Health Statistics Centre was realigned to Performance and Accountability Division in October 2009.

The Health Statistics Centre collects, processes, analyses and disseminates statistics on the health of Queenslanders and their use of health services.

The centre plays an important role in developing a culture of accountability across the organisation with trusted information that supports decision-making and public reporting, contributes to improved openness and transparency and informs improved planning, monitoring and evaluation of health services.

Performance and Accountability Division comprises three branches:

- Performance Analysis and Accountability
- Strategic and Business Alignment
- Health Statistics Centre.

Corporate Services

Corporate Services Division provides quality corporate governance and support services for Queensland Health and its customers to improve and support health services.

The division's services include strategic human resource management, finance, purchasing, legal, and occupational health and safety management.

Corporate Services provides principal advice to the department on human resource management and development, and the monitoring of Queensland Health's financial management framework, including implementation of appropriate taxation, accounting, financial policy and financial systems.

Corporate Services Division consists of 11 units and branches:

- Business Capability Team
- Business Performance and Improvement Unit
- Business Services
- Divisional Property and Facilities Management
- Finance Branch
- Health Services Purchasing and Logistics
- Legal Unit
- People and Culture Strategic Services
- Performance and Policy Services
- Queensland Health Enterprise Solution Transition
- Queensland Health Shared Service Partner.

In 2009–2010, relationships with key stakeholders were a significant component of the division's work, with a focus on continued support of health service districts.

Health Planning and Infrastructure

Health Planning and Infrastructure Division was established in September 2009 to combine Planning and Coordination Branch (previously part of the then Policy, Planning and Resourcing Division) with the existing Health Infrastructure and Projects Division.

The creation of the Health Planning and Infrastructure Division aimed to:

- facilitate greater collaboration and integration between health service planning and infrastructure planning, delivery and whole-of-life management
- significantly improve discipline and consistency of service planning, and the integration and coordination of service and enabling planning, and local planning with statewide strategies.

Health Planning and Infrastructure Division leads future health services and infrastructure planning and significant infrastructure committed to by government and the department, as well as overseeing management of future infrastructure assets.

Queensland has some of Australia's fastest-growing regions, and the need for health infrastructure is essential to grow existing and new services, sustaining service levels over the coming years.

The division aims to deliver more than 300 projects worth in excess of $1 billion per year over the next few years.

The portfolio is extremely varied, including construction of three new specialty hospitals, redevelopment of several critical regional hospitals and numerous smaller yet important construction projects, ranging from standalone community centres, ward redevelopments and critical non-clinical support services infrastructure.

A key outcome from the program will be to deliver more than 1,700 new hospital beds over the next seven years.

Chief Information Officer

Queensland Health's Information Division is one of the largest information communication and technology (ICT) operations in the state.

It is responsible for ensuring smooth operation of information systems and technologies so Queensland Health employees and health providers have access to information to support health care.

The smart use of data, information and communication is essential for improved quality, safety and efficiency of health care. Access to good information is also vital to measuring and monitoring the health of our population.

Queensland Health manages information and data according to the Queensland Health Data Management Policy, which states that data will be accurate, accessible, comprehensive, current, consistent, precise, relevant and timely.

Queensland Health also values the privacy and integrity of patient data, collecting and managing personal information in accordance with Information Standard 42A Information Privacy for the Queensland Department of Health.

The focus on information and information management will increase as the e-Health agenda is transformed.

Information Division provides:

- reliable access to Queensland Health's major information systems through a wide variety of desktop computers, laptops, personal computing devices and telephones
- leadership and guidance in identifying and resolving the information and technology implications of changes in health care
- leadership in development and implementation of information management and ICT strategies, policies and standards
- ease of governance to ensure the greatest healthcare value from investments that influence information and ICT.

In 2009–2010, Queensland Health delivered services classified to six departmental services within the limits of its total available revenue.

Financial highlights

How the money was spent

The services provided by Queensland Health are reported in six major services. The department's major services and their relative share are shown in Chart 1.

Queensland Health achieved an operating surplus of $0.832 million while still delivering on agreed major services. The surplus is attributed to increased own-sourced revenue and share of profit in associates.

Income

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

- the state contributions
- the Commonwealth contributions and grants
- own-sourced revenue generated from user charges, grants and other revenue.

Chart 2 details the extent of these funding sources for 2009-2010.

Queensland Health's total income from continuing operations and share of profit in associates for 2009-2010 was $9.552 billion. Of this, the state contribution was $6.231 billion (65.2 per cent), Commonwealth contribution was $2.477 billion (25.9 per cent), other revenue was $0.830 billion (8.7 per cent) and share of profit in associates was $0.0146 billion (0.2 per cent).

Expenses

Total expenses were $9.552 billion, averaging at $26.1 million a day to provide public health services, an increase of $0.973 million or 11 per cent from last year. Most of the increase in expenses has been incurred in:

- employee expenses – which reflects the impact of increased staffing and salary increases under the current enterprise bargaining agreement
- supplies and services – following trends over previous years
- grants and subsidies – reflecting increased funding to other organisations for the delivery of health services.

Capital investment

Total acquisitions of $1.019 billion were made on rebuilding and maintaining the level of health infrastructure – averaging $2.793 million per day.

Chart 1: Expense by major services

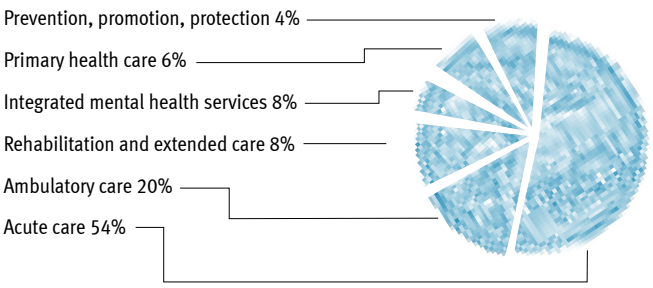
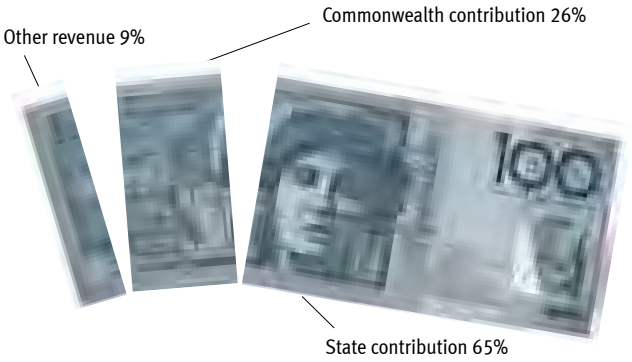
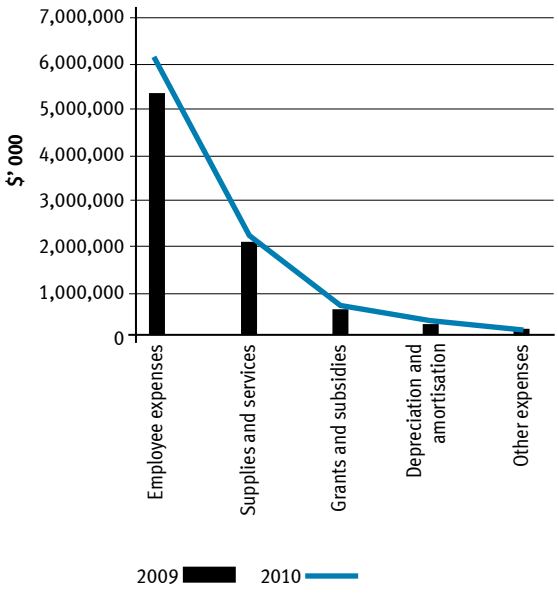


Chart 2: Revenue by funding source



Graph 1: Expense two-year comparison



2

managing our business

Sound and effective governance practices, coordinated through an executive committee framework, are an integral part of achieving strategic goals and objectives.

Executive Management Team

Standing, left to right
Ray Brown, Dr Tony O'Connell, Faileen James, Dr Michael Cleary.

Seated, left to right
Michael Walsh, Dr Jeannette Young, Michael Reid, Adj. Prof Terry Mehan, Kathy Byrne.

Governance

Queensland Health manages the achievement of our strategic goals and operational objectives through sound governance practices.

The Queensland Health Governance Framework is based on the elements of effective governance detailed in the *Financial and Performance Management Standard 2009* and other prescribed requirements, such as our risk management framework, internal and external audit results, and policies.

Executive committees are an integral part of our governance structure. Each committee performs an annual self-assessment of their performance and reports their progress against their forward working plan. Any significant issues are escalated to the Executive Management Team (EMT).

Statement from the Chief Finance Officer

Section 77 (2)(b) of the *Financial Accountability Act 2009* (FA Act), which took effect on 1 July 2009, requires the Chief Finance Officer of Queensland Health to provide the accountable officer with a statement as to whether the department's financial internal controls are operating efficiently, effectively and economically.

For the financial year ended 30 June 2010, a statement assessing Queensland Health's financial internal controls has been provided by the Chief Finance Officer to the Director-General.

This statement was prepared in conformance with Section 57 of the *Financial and Performance Management Standard 2009*. This statement was provided to the Queensland Health Audit Committee before submission to the Director-General.

Executive Management Team

- supports the Director-General to meet responsibilities outlined in the *Health Services Act 1991* and other relevant legislation
- makes recommendations on the strategic direction, priorities and objectives of the organisation and endorses plans and actions to achieve the objectives
- sets an example for the corporate culture throughout the organisation.

The Executive Management Team's functions are to:

- endorse and review annually, or as required, the Queensland Health Strategic Plan and the Statewide Health Services Plan
- lead preparation of an annual operational plan as cascaded from the strategic and other enabling plans, in accordance with *Financial and Performance Management Standard 2009*, Section 17
- make recommendations to the Director-General about approval of the annual budget, ensuring alignment to the Queensland Health Strategic Plan, Asset Strategic Plan, Information Management Strategic Plan, Statewide Health Services Plan and other plans
- review regular performance and quality reports to ensure Queensland Health achieves its objectives
- ensure a comprehensive risk-evaluation program, monitor organisational risks and ensure effective implementation of risk mitigation/tolerance strategies
- advise the Director-General on recommendations and escalations from executive committees
- advise the Director-General on executive committee governance structure and ensure organisational policies and terms of reference for governance committees give clear delineation of roles, responsibilities, authority and accountability
- advise the Director-General on delegations and how they can be structured to support improved accountability
- develop an annual EMT work plan, linked to the strategic plan and key performance indicators, and undertake regular review of EMT performance, including independent external review.

As at 30 June 2010, EMT memberships comprised:

- Director-General (Chair)
- Chief Executive Officer, Clinical and Statewide Services
- Chief Executive Officer, Centre for Healthcare Improvement
- Chief Health Officer
- Chief Information Officer
- Deputy Director-General, Corporate Services
- Deputy Director-General, Health Planning and Infrastructure
- Deputy Director-General, Performance and Accountability
- Deputy Director-General, Policy, Strategy and Resourcing.

Key achievements for 2009–2010 included:

- endorsed the revised Queensland Health Strategic Plan
- led preparation of an annual operational plan which cascaded from the strategic and enabling plans, in accordance with the *Financial and Performance Management Standard 2009*
- made recommendations to the Director-General on approval of the annual budget which aligned to the strategic plan
- endorsement of the Governance, Strategic Planning and Performance Management frameworks.

EMT met 36 times.

EMT member profiles

Michael Reid
Director-General

Michael Reid has many years of experience in the public and private sectors. He has held senior public service positions in the health, science and medical research sectors in most states in Australia, including five years as New South Wales Health Director-General (1996–2002). Mr Reid became Queensland Health Director-General in June 2008.

Mr Reid's private sector experience includes managing director of a consulting company, with numerous projects in Australia, for governments in the Asia and Pacific regions and with United Nations' organisations. Principal areas of consulting have included health system design, clinical service planning and organisational reform.

Ray Brown
Chief Information Officer

Ray Brown has worked in information communication and technology for 35 years. After a brief time in the private sector, Mr Brown joined the Department of Corrective Services as Information Management Director in 2001.

He became the Queensland Police Service, Information Systems Branch Manager in 2003, and the Information Management Division Acting Director in 2006. Mr Brown was involved in the successful implementation of the Queensland Police Records and Information Management Exchange project.

In June 2008, Mr Brown started as Queensland Health's Executive Director Information Division. He relieved as Chief Information Officer from January 2009 and was permanently appointed in August 2009.

Adj. Prof Terry Mehan
Acting Deputy Director-General, Performance and Accountability

Terry Mehan has more than 30 years experience in senior executive positions in health and aged care. Mr Mehan has specialist expertise in health service management, delivery and planning. He is an experienced chief executive of small rural hospitals, major regional hospitals and large metropolitan teaching hospitals. He is also an advisor to Papua New Guinea's National Department of Health.

Before Mr Mehan's current appointment, he held the positions of Central Area Health Service General Manager, Southern Area Health Service General Manager, and Queensland Health Zonal Manager (Northern Zone).

As Deputy Director-General, Performance and Accountability, Mr Mehan is responsible for strengthening governance and accountability across Queensland Health.

Dr Tony O'Connell
Chief Executive Officer, Centre for Healthcare Improvement

Dr Tony O'Connell commenced as Chief Executive Officer, Centre for Healthcare Improvement in August 2009. He had previously worked with the New South Wales Department of Health as Deputy Director-General Health System Performance and directed the Clinical Services Redesign Program.

Dr O'Connell was a clinician for 28 years, as an intensive care specialist and anaesthetist. In 2004, he moved from heading the Paediatric Intensive Care Unit at the Children's Hospital at Westmead to work full-time in the NSW Department of Health. Dr O'Connell has been involved in statewide system change for more than a decade.

Kathy Byrne
Chief Executive Officer, Clinical and Statewide Services

Kathy Byrne's career in the public and private health sectors spans more than 25 years. She was previously a health service chief executive and has a significant track record in strategic and operational leadership and achievement in five states and territories in Australia.

As a member of the Queensland Health Executive Management Team, Ms Byrne has leadership of the development of the statewide services response in the National Health Reform.

Ms Byrne provides executive leadership to the Clinical and Statewide Services Division, which aims to deliver safe, sustainable and appropriate forensic, scientific, diagnostic and therapeutic services across the state to enhance health care.

Dr Jeannette Young
Chief Health Officer

Dr Jeannette Young is the Chief Health Officer for Queensland. Before starting this role in August 2005, she held the position of the Medical Services Executive Director at the Princess Alexandra Hospital, as well as other senior administration roles.

Her responsibilities include disaster planning and response, patient retrieval services, licensing of private hospitals, organ and tissue donation services, offender health services, population health services and mental health policy.

Dr Young served on the Medical Board of Queensland and is a member of numerous state and national committees, including the National Health and Medical Research Council, the Clinical, Technical and Ethical Principal Committee and the Australian Health Protection Committee. She also serves as a council member of the Queensland Institute of Medical Research.

Michael Walsh
Acting Deputy Director-General, Corporate Services Division

Michael Walsh was appointed Acting Deputy Director-General Corporate Services in June 2010 to lead the restructure of Queensland Health's Corporate Services Division. Mr Walsh previously led the Payroll Stabilisation Project in response to significant issues from implementing a new payroll system within the organisation.

Mr Walsh started as Queensland Health's Deputy Director-General Health Planning and Infrastructure in September 2009 and established the new division, combining the former Major Hospitals Projects Office, Capital Works and Asset Management Branch, and the Planning and Coordination Branch.

Mr Walsh has previously worked as the Department of Infrastructure and Planning Deputy Director-General, and Department of Education, Training and the Arts Deputy Director-General.

Dr Michael Cleary
Deputy Director-General, Policy, Stategy and Resourcing

Dr Michael Cleary is an Australian-trained emergency physician who has been with Queensland Health for the past 25 years.

Dr Cleary has held a range of executive roles in Queensland Health and is a Queensland Health pre-eminent staff specialist. He is also Professor at the School of Public Health at the Queensland University of Technology.

He was previously executive director and director of Medical Services for Logan and Beaudesert Hospitals, Metro South Health Service District. Dr Cleary was appointed to lead the Policy, Strategy and Resourcing Division of Queensland Health in April 2010.

Faileen James
Acting Deputy Director-General, Health Planning and Infrastructure Division

Faileen James is currently the Acting Deputy-Director General, Health Planning and Infrastructure Division of Queensland Health.

Ms James' permanent role is the Health Planning and Infrastructure Division, Policy, Planning and Asset Services, Executive Director. She has had a varied career, starting work as a registered nurse before studying law and business.

Ms James practised as a lawyer for several years, mainly in health law. She then moved into a senior management role in one of Australia's largest not-for-profit organisations, before joining Queensland Health three years ago.

Chief Executive Officer and Deputy Director-General Forum

The Chief Executive Officer and Deputy Director-General Forum is an opportunity for district chief executive officers and EMT members to collaboratively work in partnership with other areas of Queensland Health and influence policy direction by:

- engaging in high-level strategic discussion
- having input into strategic decision-making
- strategically overseeing service performance
- ensuring alignment of strategic objectives and the supporting and enabling functions required to ensure organisational achievement of goals
- providing a point of coordination for system-wide performance improvement strategy development and monitoring.

The Chief Executive Officer and Deputy Director-General Forum was held 10 times.

Executive committees

Patient Safety and Quality Executive Committee

The Patient Safety and Quality Executive Committee sets policy direction in patient safety and quality of service delivery, in accordance with the *Health Services Act 1991* and the Queensland Health Strategic Plan 2007–2012.

To contribute to the management and delivery of Queensland Health services and the achievement of Queensland Health's strategic objectives, the Patient Safety and Quality Executive Committee undertakes the following:

- oversees the Queensland Health Clinical Governance Framework
- endorses strategy, policies and implementation standards for patient safety and quality issues
- advises the executive management team on all matters about patient safety and quality
- develops and monitors a Patient Safety and Quality Plan for Queensland Health
- directs action to promote improvement in patient safety and quality of health care and consider relevant information as appropriate
- assesses Queensland Health responses to safety and quality issues
- reviews and monitors patient safety and quality risks and performance indicators
- collaborates with other Queensland Health executive committees/committees when decisions/issues may impact on respective parts of the organisation.

The Patient Safety and Quality Executive Committee met 10 times. There are external members on this committee.

Table 1: Patient Safety and Quality Executive Committee Membership and Remuneration 2009–2010

Name	Membership	Dates
Dr Tony O'Connell	Chair	September 2009–June 2010
Adj. Prof Terry Mehan	Ex-officio member	July 2009–June 2010
Dr Jeannette Young/ Dr Alun Richards	Ex-officio member Delegated for CHO	September 2009–June 2010
Pauline Ross	Ex-officio member	July 2009–June 2010
Dr Peter Steer	Ex-officio member	April 2009–June 2010
Dr Coralee Barker	Ex-officio member	April 2009–June 2010
Jill Magee	Ex-officio member	April 2009–June 2010
Dr Maarten Kamp	Ex-officio member	M'ship ceased March 2010
Dr John Wakefield	Ex-officio member	July 2009–June 2010
Dr Don Martin	Ex-officio member	July 2009–June 2010
Dr Jill Newland	Ex-officio member	July 2009–June 2010
Barbara Kent	DG-appointed member (consumer rep)	July 2009–June 2010
Gary Rebgetz	DG-appointed member (consumer rep)	July 2009–June 2010
Marie Pietsch	DG-appointed member (consumer rep)	July 2009–June 2010
Judy Graves	DG-appointed member	July 2009–June 2010
Ian Scott	DG-appointed member	July 2009–June 2010
Kathy Byrne	DG-appointed member	July 2009–June 2010
Kym Volp	DG-appointed member	Membership ceased December 09
Prof Sue Tett	DG-appointed member (external)	Membership ceased December 09
Sue Boisen	DG-appointed member (external)	April 2009–June 2010
Prof Glenn Gardiner	DG-appointed member (external)	April 2009–June 2010

The external members on this committee are remunerated for their time in attendance and related expenses. The total amount paid during 2009–2010 to external members was $17,336.

Integrated Policy and Planning Executive Committee

The Integrated Policy and Planning Executive Committee aims to integrate, coordinate and endorse statewide policy development and implementation, and health service planning within Queensland Health to:

- improve access to safe and sustainable health services
- better meet people's needs across the health continuum
- enhance organisational work processes and systems to support service delivery and business effectiveness
- help Queensland Health to achieve its strategic objectives.

To contribute to management and delivery of statewide and district health services, the Integrated Policy and Planning Executive Committee:

- gives executive overview of strategic and statewide policy and health service planning
- develops, coordinates and integrates within Queensland Health, in collaboration with relevant stakeholders, including health service districts
- gives direction on developing and establishing planning systems to improve integration of policy development, health service planning and other key planning activity across health service districts, the department and government
- considers contributions of policy development and planning activities to achieving Queensland Health's strategic objectives

- considers identified issues, risks and opportunities from strategic policy development, health service planning and other planning processes, including budget and performance management processes
- considers strategic and statewide policy and planning implications at a statewide and district level in Queensland Health
- gives direction on priority Queensland Health planning and policy projects and how these will be progressed
- engages effectively with internal and external Queensland Health policy and planning stakeholders to seek input for policy and planning decisions – this includes relevant consultation with health service districts and other key stakeholders before discussion of agenda items and/or finalisation of decisions where appropriate
- promotes organisation-wide integration when undertaking policy and planning activities, including:
  - communicating and advocating for integration of processes and systems
  - leading integration practices within their areas of responsibility
- endorses statewide policy development and planning activities at key project stages ensuring they:
  - are consistent with Queensland Health endorsed processes
  - promote effective implementation planning as a key element
- monitors consistency between statewide and health service district (where there may be statewide or cross-district implications) policy development and planning
- endorses development of systems that support integrated policy and planning development
- leads development, implementation and review of the Statewide Health Services Plan, a legislative requirement (*Health Services Act 1991*, s3, s7).

The Integrated Policy and Planning Executive Committee met 15 times. There are no external members on this committee.

Human Resources Executive Committee

The Human Resources Executive Committee aims to:

- give strategic context and direction for development of the Queensland Health People Plan and related plans, namely:
  - workforce planning
  - workplace culture and leadership
  - human resources, including organisational design
  - occupational health and safety
- ensure all associated strategies are coordinated, integrated and aligned to the broader Queensland Health strategic objectives
- create a forum for advice on strategic policy and critical issues.

To contribute to management and delivery of health services, the Human Resources Executive Committee:

- facilitates development of the Queensland Health People Plan and its periodic review, in collaboration with relevant stakeholders, including health service districts
- ensures clear linkages between the Queensland Health People Plan and the Queensland Health Strategic Plan and between related plans and the People Plan
- monitors implementation of the People Plan and related plans, and consider identified issues, risks and opportunities
- ensures matters referred for strategic advice are well researched and allow the delegates to make well-informed decisions.

The Human Resources Executive Committee met 10 times. There are no external members on this committee.

Resource Executive Committee

The Resource Executive Committee aims to:

- review the financial position and performance of Queensland Health in the current and future years
- give strategic advice and recommendations to the executive management team on development, implementation and management of Queensland Health's financial management strategy
- ensure all financial and organisational performance improvement processes are coordinated and effective, and lead to the achievement of Queensland Health's strategic objectives
- oversee progress against critical objectives and ensure appropriate action to support improvements where necessary
- promote development of effective team-working across Queensland Health, and the most effective division of responsibilities for financial strategy and organisational performance improvement.

To contribute to management and delivery of health services, the Resource Executive Committee:

- develops Queensland Health's financial strategy, in accordance with the strategic direction as determined by the executive
- oversees implementation of the approved financial strategy, including annual development of the Queensland Health budget for executive approval
- promotes development of an effective organisational performance monitoring and improvement framework
- oversees and gives focused direction in development of coordinated performance and financial information and decision-support systems to underpin performance monitoring, analysis and reporting of Queensland Health
- monitors variances to outcomes of the financial strategy implementation, including review of significant variances to approved annual budgets, and making decisions to rectify variances to the financial strategy
- analyses any material request for alteration to the approved budget and decides on their financial viability.

The Resource Executive Committee met nine times. There are no external members on this committee.

Health Infrastructure and Projects Executive Committee

The Health Infrastructure and Projects Executive Committee aims to:

- ensure capital works and infrastructure aligns with strategic and endorsed service planning directions of Queensland Health
- give strategic advice and recommendations to ensure optimal investments in physical infrastructure and assets to achieve Queensland Health's health service delivery outcomes
- give strategic advice and recommendations to ensure long-term sustainability of the department's asset base
- endorse strategies, policies and work programs in physical infrastructure and assets
- ensure all strategies and planning (including enabling planning) are coordinated, integrated and aligned, and lead to achievement of Queensland Health's strategic objectives
- monitor progress and outcomes of the strategies and give direction and guidance as required.

To contribute to the management and delivery of health services, The Health Infrastructure and Projects Executive Committee:

- reviews, monitors, prioritises and manages Capital Acquisition Plan performance, including reviewing specific project delivery methodologies, reviewing project and program risk assessments and related mitigation strategies, and financial performance
- engages with departmental planning units (including other enabling planning units), health service districts and external stakeholders on infrastructure planning, capital works and assets
- obtains approval of the departmental Capital Acquisition Plan
- oversees development and implementation of the departmental Capital and Asset Planning Framework, and recommends approval
- obtains approval of the annual departmental Asset Strategic Plan
- oversees development of the department's Capital Investment Plan and recommends which proposed capital projects proceed to further planning and/or future budget submissions

- oversees outcomes of infrastructure planning activities and recommends further activities
- oversees development of design guidelines and recommends approval
- executive overview of asset management strategy and policy, and recommends policy approvals
- reviews and monitors asset performance and infrastructure risks.

The Health Infrastructure and Projects Executive Committee met 10 times. There are no external members on this committee.

Information and Communication Technology Executive Committee

The Information and Communication Technology Executive Committee aims to:

- provide a forum for setting strategic Information and Communication Technology (ICT) direction, priorities and objectives and endorsing plans and actions to achieve the organisation's objectives
- optimise returns on ICT investment
- help Queensland Health achieve its strategic objectives.

To contribute to management and delivery of health services and achievement of Queensland Health's strategic objectives, the Information and Communication Technology Executive Committee:

- approves the ICT Capital and Asset Planning Framework
- approves the departmental ICT Plan, as specified by the *Financial and Performance Management Standard 2009*
- approves the annual departmental ICT Asset Strategic Plan
- approves the departmental ICT Capital Acquisition Plan (ICT CAP)
- approves the departmental ICT capital policy, including ICT architecture guidelines
- oversees the portfolio of projects funded by ICT CAP. Review, monitor and manage ICT CAP performance (risks, delivery performance, financial performance)
- approves ICT asset management strategy and policy
- monitors lifecycle ICT asset management frameworks, strategies and policies consistent with best practice asset management
- reviews and monitors ICT asset performance and ICT infrastructure risks
- reviews and monitors ICT service performance across Queensland Health
- evaluates new ICT Investment initiatives proposed for resource allocation
- ensures whole-of-government issues are considered and reporting requirements are satisfied.

The Information and Communication Technology Executive Committee met five times. There are no external members on this committee.

Audit and Risk Management Committees

Audit Committee

The Audit Committee provides independent assurance and assistance to Queensland Health's Director-General on the department's:

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

To contribute to management and delivery of health services, the Audit Committee's responsibilities cover:

- financial statements
- internal control
- internal audit
- external audit
- compliance
- reporting.

Financial statements

- reviews appropriateness of accounting policies
- reviews appropriateness of significant management assumptions in preparing financial statements
- reviews financial statements for compliance with prescribed accounting and other requirements
- reviews, with management and the internal and external auditors, results of the external audit and any significant issues identified
- ensures a proper explanation for any unusual transactions or trends or material variations from budget
- ensures that assurance is given by management on the accuracy and completeness of the financial statements.

Internal control

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

Internal audit

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

External audit

- consults with external audit on the function's proposed audit strategy, audit plan and audit fees for the year
- reviews findings and recommendations of external audit and management's response to them
- assesses if there is a material overlap between the internal and external audit plans
- assesses the extent of reliance by the external auditor on internal audit work and monitoring external audit reports and the department's response to those reports.

Compliance

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

Reporting

- submits reports as required to the Queensland Health Director-General, outlining relevant matters it considers need to be brought to his attention
- prepares an annual report to the Queensland Health Director-General, summarising the performance for the previous year – an interim program of the planned activities for the coming year is also provided
- submits a summary of its activities for inclusion in Queensland Health's Annual Report.

During 2009–2010, the Audit Committee Charter was reviewed in line with the Queensland Treasury's Audit Committee Guidelines: Improving Accountability and Performance and was endorsed by the Director-General in May 2010.

The Audit Committee observed the terms of its charter and had due regard to Queensland Treasury's Audit Committee Guidelines.

The Audit and Risk Management Committee met three times between July and October 2009. The restructured Audit Committee met six times between December 2009 and June 2010.

Table 2: Audit and Risk Management Committee Membership and Remuneration 2009–2010 (Note: Committee dissolved in September 2009)

Name	Membership	Dates
Bob Shed	Chair	July–August 2009
Dr Coralee Barker	Member	July–September 2009
Dr Jeannette Young	Member	July–September 2009
Adj. Prof Terry Mehan	Member	July–September 2009
Julie Hartley-Jones	Member	July–September 2009
Ken Brown	Member (Health Community Councils representative)	July–September 2009
Andrew McCloud	Member (external audit specialist)	July–September 2009
Adrian Savage	Member (external risk management advisor)	July–September 2009

External members on the Audit and Risk Management Committee and the Audit Committee are remunerated for their time in attendance. The total amount paid during 2009–2010 to external members was $25,014.

Table 3: Audit Committee Membership and Remuneration 2009–2010 (Note: Committee established in December 2009)

Name	Membership	Dates
Len Scanlan	Chair	December 2009–June 2010
Dr Jeannette Young	Member	December 2009–June 2010
Adj. Prof Terry Mehan	Member	December 2009–June 2010
Julie Hartley-Jones	Member	December 2009–June 2010
Ken Brown	Health Community Councils representative	December 2009–June 2010

External members on the Audit and Risk Management Committee and the Audit Committee are remunerated for their time in attendance. The total amount paid during 2009–2010 to external members was $25,014.

Risk Management Advisory Committee

In recognition of the potential to strengthen risk management across the department, a dedicated Risk Management Advisory Committee was established in February 2010 specifically to:

- direct development and integration of a strategic approach to managing risk and recommend strategies for effective risk management are embedded in routine governance and management practice
- advise the Director-General and delegates of their statutory obligations on risk management.

The committee met three times.

Table 4: Risk Management Advisory Committee Membership and Remuneration 2009–2010 (Note: Committee established in February 2010)

Name	Membership	Dates
Adj. Prof Terry Mehan	Chair	February–June 2010
Dr Tony O'Connell	Member	February–June 2010
Dr Michael Cleary	Member	April–June 2010
Michael Kalimnios	Member	February–June 2010
Kevin Hegarty	Member	February–June 2010
Paul Stephenson	Member	February–June 2010
Mary Bonner	Member	February–June 2010
Adrian Savage	External Risk Management Advisor	February–June 2010

External committee members on the Risk Management Advisory Committee are remunerated for their time in attendance. The total amount paid during 2009–2010 to external members was $2,350.

Assurance and Risk Advisory Services

Assurance and Risk Advisory Services performs a key role in the effective corporate governance of Queensland Health, reporting directly to the Director-General.

The Assurance and Risk Advisory Services role includes the statutory governance functions of internal audit, risk management and internal witness support.

Key functions of the Assurance and Risk Advisory Services include advice and counsel to the Director-General and senior executives on a wide range of financial, compliance, operational, information and risk management matters affecting Queensland Health.

It also assesses disclosures under the *Whistleblowers Protection Act 1994* and supports whistleblowers.

Assurance and Risk Advisory Services functions are quality-assured under a Quality Management System, based on A*ustralian Standard AS/NZS ISO 9001:2000*, and regularly certified by an independent external assessor.

The Audit and Operational Review Unit is subjected to ongoing quality assessments that are independently validated by the Institute of Internal Auditors every five years. The Institute of Internal Auditors' 2010 validation confirmed that the Audit and Operational Review Unit meets the 'International Standards for the Professional Practice of Internal Auditing (Standards)'.

Other activities:

- Assurance and Risk Advisory Services made presentations to the Chinese, Filipino, Papua New Guinean and Nepalese delegations during their respective visits to Queensland during 2009–2010
- Four staff members completed a Diploma of Financial Services – Risk Management in 2009–2010.

Audit

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

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

The purpose, authority and responsibility of the Audit and Operational Review Unit are formally defined in its charter which, under Section 30 of the *Financial and Performance Management Standard 2009*, is approved by the Director-General.

The charter is consistent with the *International Standards for the Professional Practice of Internal Auditing* as set by the Institute of Internal Auditors. All members of the Audit and Operational Review Unit are bound by the principles of integrity, objectivity, confidentiality and competency under the institute's code of ethics.

The operations of the Audit and Operational Review Unit are governed by a strategic audit plan, based on identified corporate risks and an annual audit plan of audit activities (as required by Section 31 of the *Financial and Performance Management Standard 2009*).

An annual audit plan, approved by the Director-General, is developed in consultation with key stakeholders (senior management) and takes into account the strategic risks identified by management.

All Audit and Operational Review Unit activities and processes observe the principles of the Queensland Treasury's Audit Committee Guidelines.

Table 5: Audit coverage during 2009–2010:

Stream	Coverage
Operational and efficiency audits	25%
Financial and compliance audits	54%
Information systems audits	21%

Risk management

Queensland Health's risk management framework is consistent with the *Australian and New Zealand Standard AS/NZS ISO 31000:2009 Risk Management*.

Risk management is an integral part of the department's corporate governance framework. Risks are controlled within the financial and management accountabilities of each position.

The Director-General, as the department's accountable officer, is supported by the executive management of each corporate division and health service district. The Director-General and individual executives manage risks, with support from management structures within their areas of responsibility and from local and departmental executive/governance committees.

The Risk Management Unit is responsible for:

- maintaining the department's Integrated Risk Management Policy Framework
- risk management training and education
- coordinating the panel arrangement for risk advisory services
- administration of the department's risk management information system (QHRisk).

The unit's services are designed to help health service districts and corporate divisions achieve their objectives, meet their statutory risk management obligations and comply with government policies and better practice principles.

Table 6: During 2009–2010, risk management achievements were:

Activity	Number of sessions	Training hours	Number of staff completed	Location
Risk management online learning module (ELMO) Introduction and overview of the Queensland Health Integrated Risk Management Policy Framework for managers and staff	714	357	668	E-learning
Risk-in-focus session Advanced risk management training, focusing on key aspects of advanced risk management and its application to management decision-making	14	28	162	Brisbane Roma Mackay Rockhampton Townsville Cairns
QHRisk training System training in the use of the QHRisk risk information system	14	42	91	
SAI global risk and compliance management In-house two-day course with a focus on effective risk and compliance management	2	32	23	Brisbane (Attendees from 12 districts and four divisions)
Total	744	459	944	

External audits

To improve service delivery and internal operations, Queensland Health participates in external reviews and audits. Those of significance during 2009–2010 included:

- Auditor-General of Queensland Report to Parliament No.2 for 2009 — Health Service Planning for the Future: A Performance Management Systems Audit
- Auditor-General of Queensland Report to Parliament No.5 for 2009 — Management of patient flow through Queensland Hospitals
- Auditor-General of Queensland Report to Parliament No.7 for 2010 — Information systems governance and control, including the Queensland Health Implementation of Continuity Project.

Auditor-General of Queensland Report to Parliament No.2 for 2009 — Health Service Planning for the Future: A Performance Management Systems Audit

The Auditor-General's report on Queensland Health's service planning gave four recommendations to improve health service planning. In summary these were:

- integrated service planning process be implemented with appropriate governance arrangements and clear linkages between all service plans
- adequate support be provided to districts to build service planning capacity and ensure effective plans are produced of a consistent quality
- ensure all endorsed service plans are adequately supported by resources and funding
- a framework and guidance material for implementing, measuring progress and evaluating the success of strategies within service plans be developed and implemented.

Queensland Health addressed the recommendations by:

- strengthening the Integrated Policy and Planning Executive Committee's role as the key governance body to oversee and integrate service planning
- establishing mandatory frameworks and processes for health services planning, including the Guide to Health Service Planning, and helping health service districts use the new resources
- establishing a panel of pre-qualified health service planning consultants

- collaborating to establish postgraduate university courses specific to health service planning and developing a scholarship program for staff to build internal capability for health service planning
- increasing internal planning education and skills development to increase the ability of planners to expertly analyse data underpinning rigorous service planning
- developing service planning tools that help inform decisions on the most necessary and urgent services, and how to best deliver them
- allocating endorsed statewide service plans to an accountable executive management team 'owner'
- developing the Performance Management Framework, in line with whole-of-government framework, to use performance agreements and indicators, ongoing performance measures, and regular reporting and management to 'drive' performance
- ensuring all service plans with significant new resource requirements will be presented to government for consideration under the Queensland Government's Project Assurance Framework, which sets a rigorous standard for planning to inform investment decisions, or through the government's usual budgetary processes.

The Queensland Audit Office started re-auditing Queensland Health's Service Planning Framework in May 2010.

Auditor-General of Queensland Report to Parliament No.5 for 2009 — Management of patient flow through Queensland Hospitals

In July 2009, the Auditor-General of Queensland released a report on the current status of patient flow in Queensland public hospitals.

The report found that while improvement was evident at the system level and pockets of excellence existed across the state, there was still considerable variation with the patient flow improvement initiatives across health service districts.

In response to the report, the *Queensland Health Patient Flow Strategy 2010* was developed to define a statewide approach to better manage the entire journey for patients, including standardised goals and successful models of care for sustained improvement in access to services across Queensland.

The strategy aims to challenge the way we think and to reshape Queensland Health processes to enable the system to cope with additional pressures.

The Auditor-General's recommendations relate to key areas for improved patient flows, that is the need to:

- improve direction, coordination and support for patient flow, including development of frameworks, policies and procedures
- increase identification and communication of better practice in patient flow to achieve broader, more sustainable outcomes at a statewide level
- improve patient flow systems to reduce bottlenecks and delays within the hospital setting
- develop performance indicators for all aspects of patient flow that are reported against consistently by all hospitals and actively monitored by an identified corporate area.

The strategy is supported by a patient flow website and patient flow resource team that provide ongoing information and guidance on the necessary tools for improved patient flow.

Auditor-General of Queensland Report to Parliament No.7 for 2010 — Information systems governance and control, including the Queensland Health Implementation of Continuity Project

The Auditor-General's report on Queensland Health's Implementation of Continuity Project examined the information technology program management, as part of a broader audit examining three whole-of-government information and communication technology programs.

Implementation of Continuity Project

The Auditor-General made two specific recommendations to Queensland Health about the Implementation of Continuity Project. In summary, these were:

- the action to stabilise the payroll project continue
- Queensland Health to reconsider its business model to deliver payroll services. This included consideration of re-engineering the payroll process to include an appropriate mix of local decision-making with efficiencies of centralised processing.

To address recommendations, a new payroll model was developed as a result of a large consultation process, inclusive of staff and unions, conducted by KPMG.

The new payroll operating model allows for complete end-to-end payroll processing at local payroll hubs, supported centrally with technical payroll leadership, policies and procedures and whole-of-payroll systems performance.

Implementation of the new payroll model will be through the Payroll Improvement Program.

Patient Information Security

The Auditor-General of Queensland's report also examined the security of patient information within Queensland Health to determine if there were suitable systems and frameworks to ensure effective safeguarding of patient information.

The scope of the audit was limited to security of patient information within the information technology environment at corporate office in Brisbane and the emergency departments at Princess Alexandra and Redland hospitals.

Major implications of the review include:

- While adequate information security measures are in place, additional interim information security measures will be put in place for paper records until electronic medical records are deployed across Queensland Health.
- Better governance of local ICT investment is required and Information Division will take a lead in gaining visibility of all ICT investments and working with districts and divisions to implement adequate local governance processes.
- Disaster recovery and business continuity planning for ICT needs to be improved and work is under way to ensure requirements are met.
- Increased focus on implementing 'Managing Successful Programs' methodology across Information Division to improve program delivery.

Future outlook

In 2010–2011, Queensland Health's budget will grow to $9.99 billion, an increase of 10.5 per cent on 2009–2010.

Continuing infrastructure projects

The Queensland Government is committed to making Queenslanders Australia's healthiest people, investing unprecedented levels of expenditure on capital infrastructure to meet the ever-increasing demands of Queensland's growing population.

In 2010–2011, Queensland Health will invest $1.634 billion in new infrastructure projects, including:

- $636.9 million to continue the planning and development of three new tertiary hospitals – Gold Coast University Hospital, Sunshine Coast University Hospital and the Queensland Children's Hospital, at a total cost of $5.132 billion
- $252.8 million to continue redevelopments at Cairns, Mackay, Townsville, Rockhampton and Mount Isa hospitals, at a total cost of $1.403 billion
- $41.1 million to continue upgrades to emergency departments at Logan, Redland and QEII hospitals, under the $140.4 million Faster Emergency Care in our Hospitals initiative. Under this initiative, emergency departments at Ipswich, Caboolture and Toowoomba hospitals will also be upgraded, as well as a dedicated paediatric emergency department at The Prince Charles Hospital.

A range of health infrastructure initiatives will be continued in 2010–2011, including:

- Robina Hospital expansion ($274.3 million)
- Sunshine Coast Health Service District additional bed capacity ($191 million)
- Ipswich Hospital additional bed capacity ($122 million)
- Princess Alexandra Hospital emergency department additional bed capacity ($52 million)
- Bundaberg Hospital expansion ($41.9 million)
- Thursday Island Chronic Disease Centre ($39 million)
- Regional Accommodation Program ($88.7 million).

National reform

Queensland Health supported the Queensland Government to reach an historic agreement on health and hospitals reform at the Council of Australian Governments meeting in April 2010.

These reforms will build on the strengths of the current health system, such as access to primary health care through Medicare and the free public hospital system, and will ensure these elements of the Australian healthcare system remain sustainable into the future.

Most importantly, they build on the skills and dedication of Australia's hard-working doctors, nurses and other health professionals.

Over the next four years, Queensland will receive an extra $741.9 million for improvements in three priority areas for Queensland – better emergency departments, faster elective surgery and more hospital beds including:

- $150.5 million to meet a new service delivery target of four-hour treatment in emergency departments over the next four years
- $160.5 million to ensure more Queenslanders get surgery within clinically recommended times
- $327 million for 270 new sub-acute care hospital beds – for more appropriate care for patients transitioning out of hospital (rehabilitation) and to free up acute care beds for acute patients sooner
- an extra $37.7 million over three years to be used where needed in emergency departments, elective surgery or to provide sub-acute beds to meet the reform targets
- $47.3 million for longer-stay older patients
- $16.1 million over four years to expand multi-purpose services.

The Commonwealth has guaranteed Queensland will receive a minimum of $3 billion in growth funds from 2014–2020 when the Commonwealth reforms take effect.

Other future highlights

Regional cancer centres

$194.5 million operational and $179.3 million capital funding over four years will be invested by the Queensland Government and Australian Government for new or upgraded cancer centres throughout Queensland, including:

- enhancement to cancer services in north Queensland with 26 additional chemotherapy chairs, two additional linear accelerators and a positron emission tomography scanner at Townsville and enhanced tele-oncology and chemotherapy treatment services at Mount Isa
- expansion of medical oncology services in southern Queensland through recruitment of more medical, nursing and allied health staff, more treatment spaces and inpatient beds at Toowoomba, with outreach services provided by the Princess Alexandra Hospital
- enhancement of regional cancer services to central Queensland by increasing staff numbers, beds and day treatment spaces at Rockhampton, Bundaberg and Hervey Bay, with outreach services by the Royal Brisbane and Women's Hospital.

Children's hearing services

$5.5 million additional funding in 2010–2011 ($16.5 million over four years) to deliver:

- an increased number of cochlear implants to children in public hospitals
- expanded early intervention services to Queensland children with each child to receive appropriate and timely follow-up therapy to ensure their optimal speech and language outcomes
- community development programs in northern Queensland for Indigenous children to receive enhanced access to therapy services
- additional auditory-verbal therapy services through the private sector and funding to support the expansion of clinical space to the Hear and Say Centre.

Sunshine Coast interim service enhancements

Total funding of $111.6 million operational over four years and $26.1 million capital over two years to enhance services on the Sunshine Coast, including:

- a new cardiac catheterisation laboratory, endoscopy and vascular surgery suites and improvements to neurosurgery services at the Nambour General Hospital (capital funding by the Australian Government under the National Health and Hospitals Network Agreement)
- Caloundra Hospital emergency department will increase clinical capability and capacity to meet rising demand until the opening of the Sunshine Coast University Hospital
- enhanced access to radiation oncology services for public patients
- increased access to a dedicated aero-medical retrieval service.

Persistent pain strategy

$39.1 million operational funding over four years to implement the Statewide Persistent Pain Health Services Strategy 2010–2015, with four pilot sites to start over two years from 2010–2011 at the Gold Coast, Townsville, Princess Alexandra and Nambour General hospitals.

Mental Health Stigma Campaign

$8.5 million operational funding over four years to launch a mental health social marketing campaign with statewide mass advertising, community engagement and education activities to raise awareness of mental health issues.

James Cook University Dental School Training Facilities

$25 million additional funding contribution in 2010–2011 ($45 million total funding over four years) towards building and operating dental clinic training facilities at the James Cook University Cairns and Townsville campuses.

Queensland Institute of Medical Research

$7.8 million additional funding in 2010–2011 ($31.2 million total funding over four years) to support the Queensland Institute of Medical Research.

Compliance information

Public interest disclosures

Queensland Health aspires to an organisational climate in which all employees feel confident and comfortable about reporting wrongdoing.

The Internal Witness Support Unit is responsible for an internal reporting system for the disclosure of wrongdoing, pursuant to the provisions of the *Whistleblowers Protection Act 1994* (the Act).

The Act encourages and helps disclosures of improper conduct, also known as public interest disclosures (PIDs) and promotes a system for disclosures to be investigated and reviewed.

The unit facilitates a support network for people who make disclosures about unlawful, negligent and improper public sector conduct or disclosures about danger to public health or safety, danger to a person with a disability or danger to the environment, while acknowledging a balancing of interest for the person(s) subject of a disclosure.

On receipt of a potential public interest disclosure, the unit conducts its assessment in accordance with the provisions of the *Whistleblowers Protection Act 1994* and helps establish a support network for the discloser.

The unit monitors subsequent investigation and/or review of issues raised and gives feedback to disclosers upon completion of the investigation and/or review.

In 2009–2010, a total of 260 individual disclosures were made to Queensland Health. Of those, 149 were assessed as amounting to public interest disclosures, 93 were assessed as not constituting public interest disclosures, and 18 are pending assessment.

Table 7: The following table gives a breakdown of the work undertaken by the unit during 2009–2010.

Section of the *Whistleblowers Protection Act*		Assessed as PID in 2009–2010	PIDs substantiated in 2009–2010	PIDs not substantiated in 2009–2010
s15	disclosures of official misconduct	143	60	38
s16	disclosures of maladministration	2	4	4
s17	disclosures of negligent or improper management affecting public funds	0	2	1
s18	disclosures of danger to public health or safety or the environment	17	27	10
s19	disclosures of danger to person with disability or to environment	6	5	0
s20	disclosures about reprisal	12	3	7

Note: Of the disclosures determined to be PIDs, one or more sections of the Act may apply to a disclosure. An outcome from disclosures received during previous years may be determined as substantiated or unsubstantiated in 2009–2010 and is included in this reporting year's figures. Outcomes of PIDs assessed in 2009–2010 may be determined as substantiated or unsubstantiated in future reporting years.

The number of disclosures made to the department has increased since the unit's establishment – demonstrating a clear commitment to improved promotion of a culture of reporting and transparency within Queensland Health. The following table illustrates the increase.

Table 8: Audit coverage during 2009–2010:

Year	PIPs received
2005–06	15
2006–07	29
2007–08	116
2008–09	180
2009–10	260

Achievements for 2009–2010 include:

Queensland Health delivered training across the state to raise awareness of public interest disclosures and the *Whistleblowers Protection Act 1994*.

- In May 2010, it became compulsory for Queensland Health staff to complete the public interest disclosure online training. In 2009–2010, 1,138 Queensland Health staff completed the online training tool.
- In keeping with better practice principles, Queensland Health finalised assessments of incoming disclosures, on average, within two business days of receiving sufficient information.
- Queensland Health gave feedback to the Queensland Public Service Commission on the Queensland Government's Integrity Reforms, including drafting of the proposed Public Interest Disclosure Bill.
- Queensland Health's progress in implementing strategies for whistleblowers was recognised at the Australian Public Sector Anti-Corruption Conference in July 2009.

Ethical standards

The Ethical Standards Unit performs a key role in ensuring compliance with the Director-General's statutory obligation to report allegations of suspected official misconduct to the Crime and Misconduct Commission and dealing with allegations that the Crime and Misconduct Commission refers back to the department.

The Ethical Standards Unit is the department's central point for receiving, reporting and investigating allegations of suspected official misconduct under the *Crime and Misconduct Act 2001*.

The unit manages instances of internet misuse and advises the Director-General, senior management and health service districts about new allegations of suspected official misconduct, code of conduct and other issues of ethical behaviour.

Investigations

The unit assesses new allegations of suspected official misconduct through a collaborative assessment committee, including:

- Ethical Standards Unit director and investigators
- corporate office human resource managers
- Queensland Police liaison officer
- other specialist stakeholders relevant to the allegations, such as the Environmental Health Unit or Drugs of Dependency Unit.

The department's internal investigations team includes a seconded Queensland Police Service acting inspector, who gives specialist advice on criminal matters, acts as a liaison point with local police and investigates allegations of criminal activity.

During 2009–2010, the Ethical Standards Unit managed 577 complaints about suspected official misconduct and advised Queensland Health work units on another 286 ethical issues that did not involve suspected official misconduct. This compared with 411 cases of suspected official misconduct in 2008–2009 and 344 cases in 2007–2008.

The increase in reporting of suspected official misconduct is due largely to increased ethical awareness, as result of a successful statewide awareness program conducted by the unit, in partnership with the Crime and Misconduct Commission.

The Crime and Misconduct Commission remains satisfied that this trend is positive in terms of public confidence in the department's transparency and accountability, and increased staff awareness of the need to report suspected official misconduct.

Joint project

In January 2009, approval was given to partner with the Crime and Misconduct Commission to develop a framework for improved management of complaints of suspected official misconduct in Queensland Health.

Major outcomes of the partnership project include:

- empowerment of health service districts to manage and resolve less serious official misconduct complaints with improved timeframes
- a monitoring and support function to increase districts' capacity to deal with such complaints
- concentration of investigative resources in dealing with the most serious cases of suspected official misconduct, subject to monitoring by the Crime and Misconduct Commission
- Crime and Misconduct Commission COMPASS database and case-management system to improve management of complaints and provide high-level reports so senior management can identify and address complaint trends.

Workplace investigations

Queensland Health employees are entitled to work in an environment free from bullying and harassment. Accordingly, we have a zero-tolerance policy to workplace harassment.

Following the recommendations of the Relationship Interest Based Bargaining (RIBB) group strategic paper – Workplace Bullying and Harassment, November 2005 – the Director-General established the Workplace Investigations Unit.

In October 2009, following a recommendation of the McHugh report, the Workplace Investigations Unit merged with the Complex Case Management Unit to form Workplace Services, within People and Culture Strategic Services.

Workplace Services' role on workplace harassment is to:

- develop and promote strategies to ensure Queensland Health is harassment-free
- help managers and staff to resolve conflict at the local level in an informal and timely way
- manage formal grievances about workplace harassment that cannot be resolved at the local level.

Table 9: Grievances 2009–2010

Type of grievance	2009–2010	
Description	Total	%
Administrative decision	29	26.1%
Employee conduct	54	48.6%
Sexual harassment	5	4.5%
Bullying/harassment	23	20.7%
TOTAL	111	99.9%

Resolution strategy	2009–2010	
Description	Total	%
Investigation and decision by delegate	58	52.3%
OPSME appeal	13	11.7%
Mediation	7	6.3%
Other (for example, informal options, retraction of grievance, resignation of respondent/complainant etc)	33	29.7%
TOTAL	111	100%

Source: Public Service Commission Grievance Statistics

The Workplace Equity and Harassment Officer Network includes more than 250 employees – workplace equity and harassment officers (WEHO) – who give staff confidential information to help address issues of equity, harassment and discrimination in the workplace.

From 2005 to 2010, formal grievances have reduced by 28.4 per cent. Workplace harassment grievances have reduced by 64.1 per cent.

Queensland Health continues to implement strategies to proactively address workplace harassment including:

- ensuring staff can obtain information, advice and support on workplace harassment issues and complaints processes from several sources, including workplace equity and harassment officers, workplace harassment hotline, Staff Complaints Liaison Office, People and Culture (HR) units and the Employee Assistance Service
- managing a panel of external providers who can provide quality, innovative strategies to resolve workplace conflict, improve employee relations and workplace culture or identify and resolve other workplace issues
- managing a panel of external investigators to ensure transparency and prevent perceptions of bias in workplace harassment investigations
- helping districts and divisions to build capacity and expertise to address workplace issues by developing tools, such as templates, guidelines, information sheets, contemporary case management/industrial advice.

Reconciliation Action Plan

Under the Queensland Government Reconciliation Action Plan 2009–2012 (RAP), all departments are required to report on their progress on implementing their action plan.

Table 10: Queensland Government Reconciliation Action Plan (RAP) — implementation progress

Initiative	National Aboriginal and Torres Strait Islander reforms
Action	The Queensland Government will work actively with Aboriginal and Torres Strait Islander people to achieve the Council of Australian Governments' national Closing the Gap targets and strategies, including in the key areas of early childhood, schooling, housing, health and economic participation.
Queensland Health's Implementation Progress in 2009–2010	• package of anti-smoking reforms • regulatory efforts to encourage reduction/cessation in smoking • start the establishment of a Southern Queensland Centre of Excellence for Indigenous Primary Health Care at Inala, Brisbane, to provide best-practice health services, training of health professionals and service delivery research • statewide rollout of the Audit and Best Practice Chronic Disease program in more than 60 sites in Queensland • three-year cardiac outreach program for specialist cardiac diagnostic and treatment services, including primary, secondary and tertiary prevention strategies • new and expanded Indigenous hospital liaison services • Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033 • four-year Indigenous care connect pilot project at Royal Brisbane and Women's Hospital undertaking targeted interventions to support Aboriginal and Torres Strait Islander patients undergoing renal treatment • new and expanded services to support young Aboriginal and Torres Strait Islander people aged eight to 18 years to avert the uptake of risky behaviour and to improve their emotional and social wellbeing
Action	All Queensland Government agencies will incorporate relevant reconciliation actions in their annual business plans and report on the progress of the implementation of the Queensland Government Reconciliation Action Plan 2009–2012 as part of their annual reports.
Queensland Health's Implementation Progress in 2009–2010	• Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033 • development of the new Queensland Health Statement of Commitment to Reconciliation 2010 (co-signed Queensland Health Director-General, and Reconciliation Australia, co-acting CEO) • review of Aboriginal and Torres Strait Islander Cultural Orientation on-Line (COOL) program • start of review of Aboriginal and Torres Strait Islander Cultural Awareness Program (continues to be run across Queensland Health) • purchase of 70 sets of internal flags and 30 sets of external flags (Australian, Aboriginal and Torres Strait Islander) for distribution across Queensland Health • commissioning of artwork representing Aboriginal and Torres Strait Islander health and purchase of 36 canvases of the artwork for distribution across Queensland Health • intranet site as a platform for information and resources for Aboriginal and Torres Strait Islander cultural guidance and health information

Record-keeping

Queensland Health has a strong commitment to improving record-keeping practices and complying with the *Public Records Act 2002 and Information Standard 40 – Recordkeeping*.

In 2009–2010, the Director-General approved the Queensland Health Strategic Record-keeping Implementation Plan.

Queensland Health collaborated with the Strategic Records Management team on the launch of the Queensland Health Records Management Policy for Administrative, Clinical and Functional Records.

The Queensland State Archives' Record-keeping Awareness Program recognised Queensland Health as leading the way to better record-keeping in a November 2009 article about the policy launch.

Key achievements and activities in 2009–2010 included:

- ongoing development of clinical interactive forms to ensure access to patient information at the point of care, and support and automate workflows and processes for eHealth rollout
- collaboration with corporate business areas on innovative solutions to reduce forms development timeframes by at least 50 per cent for significant efficiencies
- review of record-keeping requirements for H1N1 vaccination
- ongoing quarterly meetings of the statewide Health Information Management Reference Group, with discussion and advice on clinical information management initiatives and issues.

Electronic solution

The electronic Document and Records Management System Project (eDRMS Project) was established for a Queensland Health enterprise-wide eDRMS solution to manage physical and electronic non-clinical documents and records.

An enterprise-wide eDRMS will enable Queensland Health to maximise the value of administrative documents and records with consistent and timely capture and compliance management. It will improve accessibility, reduce duplication and promote information-sharing across Queensland Health.

The eDRMS solution will also enhance life-cycle management of Queensland Health non-clinical records by automating controls governing information security and disposal.

In late-2009, an evaluation of products on the whole-of-government electronic Document and Records Management System Standing Offer Arrangement resulted in HP TRIM software being selected for Queensland Health's eDRMS solution.

HP TRIM software will be introduced into Queensland Health in a phased approach to manage non-clinical documents and records and provide:

- a single, standardised information system, accessible to Queensland Health staff statewide, to support consistent enterprise-wide business processes
- improved access and secure management of documents and records for less duplication and more opportunities for information-sharing and collaboration
- increased compliance with government and regulatory obligations to reduce operational, financial and legal risks of legal discovery, litigation and audit
- improved capability to support evidence-based decision-making and transparency of processes.

Right to information

On 1 July 2009, both the *Right to Information Act 2009* (the RTI Act) and *Information Privacy Act 2009* (the IP Act) came into effect, replacing the *Freedom of Information Act 1992*.

Access and amendment provisions are now in the RTI Act (for non-personal information) and the IP Act (for personal information).

For more information on access and amendment to documents held by Queensland Health, visit the RTI and IP website at www.health.qld.gov.au/foi/rti.asp.

Publication scheme

Underpinning the new legislation is the commitment to provide information as a matter of course, without the need to resort to formal application under the Act – the 'push model'.

There had already been a significant change to the information publicly available from Queensland Health due to health reform following the Davies' Commission of Inquiry and the Forster Review.

In September 2008, the New South Wales Independent Privacy and Regulatory Tribunal (IPART) in its review of performance improvement in health in New South Wales, referred to Queensland Health as an exemplar. One of its recommendations specifically suggested that NSW Health review its reporting in light of the Queensland Health Quarterly Public Hospitals Performance Report.

With the impetus from the Right to Information legislation, Queensland Health undertook a further scan to identify other material that could be publicly released. As a result, the department published several documents at the launch of the RTI Publication Scheme on 1 July 2009.

Since then, more information has been released publicly. There has been an increase in the frequency of reporting on emergency department performance with new monthly reports. These reports now also include additional measures.

Since the September 2009 quarter, access block information has been included in the Quarterly Public Hospitals Performance Report and off-stretcher time has been included since the December 2009 quarter.

Disclosure log

Agencies must make non-personal documents released as a result of RTI applications available to the broader community.

There is 24-hour exclusive access to the material released from an RTI application. At the end of this time, the agency must make the documents available to the public through publication on the disclosure log within five days of release of the material.

The Queensland Health disclosure log comprises a list of available documents – summarised according to the scope of each RTI application. The disclosure log is available at the department's RTI/IP internet site at www.health.qld.gov.au/foi/rti.asp.

Interested parties may access copies of the documents listed in the disclosure log (in hard copy or by CD) by contacting the Administrative Law Team.

Privacy

Queensland Health is committed to protecting the privacy of its patients, business partners and staff.

On 1 July 2009, in addition to existing confidentiality provisions, the department became subject to the *Information Privacy Act 2009*. Under this legislation, Queensland Health is subject to a modified version of the National Privacy Principles (found at Schedule 2 of the IP Act).

Detailed information on the department's information privacy scheme is available at www.health.qld.gov.au/foi/rti.asp.

Complaints about breaches of privacy are dealt with in accordance with the department's complaints management system and can be raised directly with the complaints coordinator at the point of service in the first instance.

A list of complaints coordinators is available on the Queensland Health website at www.health.qld.gov.au/quality/consumer_complaints/complaints.asp.

General enquiries can be made to the department's privacy contact officer at RTI-Privacy@health.qld.gov.au.

RTI/IP activity

Queensland Health is the only agency which administers the access and amendment provisions of the RTI and IP Acts through decision-makers throughout the state.

Most RTI/IP applications within the health service districts concern personal information (health records, staff-related information). RTI/IP applications processed centrally commonly relate to departmental decision-making and corporate issues.

Under the former FOI regime, Queensland Health consistently received the highest number of FOI applications of any Queensland Government agency each year, with increased numbers every year. In 2009–2010, Queensland Health again had an increase in the number of RTI/IP applications, in comparison with the number of FOI applications received in the 2008–2009 reporting period.

Waste management

Queensland Health Waste Management Strategic Plan 2005–2010 identifies areas to ensure compliance with legislative requirements.

Legal and other requirements

Queensland Health has obligations under the following legislation:

- *Environmental Protection Act 1994*
- *Water Supply (Safety and Reliability) Act 2008*
- *Radiation Safety Act 1999*
- relevant subordinate legislation.

These obligations are met through a variety of actions, including:

- relevant safety and management plans
- risk assessments to monitor for regulatory compliance
- training and induction programs
- facility-initiated self-audits.

Governance

Queensland Health has strengthened its governance of waste management practices within its facilities by the Waste Management Committee through:

- overseeing implementation of the external technical audit's recommendations on the handling, storage and disposal of hazardous liquid waste
- proposing to establish a comprehensive management system for waste that allows for an integrated waste management approach to deal with all waste streams
- developing resources to ensure consistency in clinical and related waste and trade waste management practices.

Resource management

Waste avoidance, reduction and management strategies are implemented as appropriate.

Carbon emissions

The following table and summary outlines the Queensland Health carbon emissions during 2009–2010, covering the period 1 April 2009 to 31 March 2010.

Table 11: Carbon emissions summary for reporting year 2009–2010

Emission source	Tonnes of CO2 emissions		
	Gross emissions	Less offsets	Net omissions
Vehicles (QFleet)	11,253	1,722	9,531
Avis car rental	459	459	-
Airline travel	11,238	11,238	-
Electricity			
• directly purchased by the department	387,275	12,970	374,305
• third party (leased premises)	7,278	244	7,034
Electricity total	394,553	13,214	381,339

Source: Electricity: Carbon Management Unit, Queensland Health. Vehicles: QFleet, Department of Public Works. Airline: Travel Hub, Queensland Health.

Vehicle usage

The emissions data has been aggregated using the National Greenhouse Emissions Reporting (NGER) guidelines and represents emissions for four primary fuel types – unleaded petrol, diesel, liquefied petroleum gas (LPG) and E10.

Emissions shown are estimates based on actual kilometres travelled and available fuel consumption records. The emission offsets figure relates to purchased national Greenhouse Friendly™ certified carbon offsets.

The hire car vehicle emissions attributable to Avis Australia vehicles booked under the standing offer arrangement managed by the Queensland Government Chief Procurement Office have been calculated by Avis Australia.

The emission offsets figure relates to purchased national Greenhouse Friendly™ certified carbon offsets.

Airline travel

Air travel includes all flights recorded by the Queensland Government Chief Procurement Office (QGCPO) during the period 1 April 2009 to 31 March 2010, specifically:

- international air travel on commercial airlines
- domestic air travel on commercial airlines.

For all air travel, the following methodology is used. QGCPO calculates the kilometres flown from data provided. The kilometre figure is divided by 100 and multiplied by an industry average number of litres of fuel burnt per passenger per 100 kilometres. A factor of five has been used for all air travel (sourced from the International Civil Aviation Organisation).

The use of this method gives the average litres of fuel burnt for a flight, per passenger. This figure is subsequently converted from litres into kilograms, and then from kilograms into tonnes, before being multiplied by 3.157 (which represents the amount of CO2 tonnes produced by burning one tonne of aviation fuel sourced from the International Civil Aviation Organisation).

The emission offsets figure for air travel relates to purchased national Greenhouse Friendly™ certified carbon offsets.

Queensland Health is committed to the Queensland Government's strategies – Environmental Protection (Waste Management) Policy 2000 and ClimateSmart 2050, which aim to reduce the government's carbon footprint.

Six gases – carbon dioxide, hydrofluorocarbons, methane, nitrous oxides, perfluorocarbons and sulphur hexafluoride – have been identified under the Kyoto Protocol as the main gases that need to be accounted for. As part of standard emission accounting practices, these gases are reported as carbon dioxide equivalent emissions (CO2 – e).

Electricity usage

The electricity consumption information has been converted to carbon emissions using the combined Scope 2 and Scope 3 conversion factor of 1.01 kg CO2-e/kWh as published in the Australian Government's National Greenhouse Accounts Factors Workbook (June 2009).

The emission offsets figure includes GreenPower-accredited renewable energy procured through EcoFund by the Department of Public Works on behalf of each department.

The process involved the centralised bulk purchase of Queensland-based GreenPower Renewable Energy Certificates (RECs), and subsequently surrendering them to the Australian Government's Office of the Renewable Energy Regulator.

The emissions offset figure has been calculated from the department's allocation of the whole-of-government centralised bulk purchase of renewable energy undertaken by the Department of Public Works on behalf of the Queensland Government and its departments.

Directly purchased

For these records, the emissions reported are limited to those linked to electricity purchased directly from an energy retailer for the relevant department's own buildings and any space it leases. Where electricity accounts have not been received for the full 12-month period, data has been apportioned/extrapolated to provide an estimate of usage for the full period.

Third-party leased DPW Buildings

This emissions figure is based on emissions associated with electricity use in leased spaces where the electricity is not directly purchased by the tenant department from an energy retailer, for example, where the electricity costs form part

of lease charges. This figure includes estimated consumption (where specific details aren't available) and actual electricity records received from government and private sector landlords.

Incomplete electricity consumption records have been apportioned and/or extrapolated where necessary.

For example, in those major government office buildings owned by the Department of Public Works and that do not have separate electricity sub-metering for tenants, the electricity consumption and associated emissions have been apportioned 45 per cent to the landlord, and 55 per cent to the tenants – in line with industry practice and historical benchmarking.

Where leases are less than 12 months old, the data relates to the actual period the lease was in place. The data has been validated where possible, however, a full and comprehensive validation of data has not been undertaken.

Table 12: Queensland Health Statewide Eco Efficiency Program annual guaranteed statewide utility savings

Facility name	CO2 tonnes	Electricity (kWh)	Gas (Gj)	Water (Kls)
Beaudesert Hospital	248	238,600	–	–
Biomedical Technology Services	54	60,117	–	–
Caboolture Hospital	2,173	2,086,388	–	8,096
Cairns Hospital	1,251	1,181,830	871	62,780
Eventide Nursing Home	1,133	1,251,111	–	9,370
Gladstone Hospital	857	843,333	–	4,974
Hervey Bay Hospital	1,625	1,534,014	1,721	–
Ipswich Hospital	4,154	4,103,055	–	23,400
Kirwin Health Facility	483	543,480	–	–
Logan Hospital	2,253	2,125,482	2,400	32,248
Mackay Hospital	1,300	1,214,252	2,947	16,303
Maryborough Hospital	1,105	1,104,878	105	1,078
Nambour Hospital	3,455	4,392,777	–	23,500
Northward Health Facility	187	210,442	–	–
Pine Rivers and Redcliffe Community Health Centres	91	87,222	–	–
Redcliffe Hospital	1,504	1,431,586	–	6,102
Rockhampton Hospital	1,442	1,363,833	1,492	23,406
RBH Mental Health Building	771	741,896	–	636
RBH Block 7	1,765	1,680,833	–	5,955
Herston Campus Water Project	891	1,035,833	–	133,739
RBWH – Mayne and Tweddell Buildings	555	524,520	–	–
Royal Children's Hospital	547	473,930	–	–
Scientific Services Complex	1,205	139,835	–	3,086
Townsville Distribution Centre	295	331,657	–	–
The Prince Charles Hospital	7,707	12,119,787	82,834	–
TOTAL	**37,051**	**40,820,691**	**92,370**	**354,673**

Source: Carbon Management Unit, Queensland Health

Supporting our services

A range of statewide services and corporate functions support the delivery of health services across Queensland.

Clinical and Statewide Services

Forensic, scientific, diagnostic and therapeutic services are provided through the Clinical and Statewide Services Division. These statewide services are:

- Biomedical Technology Services
- Forensic and Scientific Services
- Medication Services Queensland
- Pathology Queensland
- Queensland Blood Management Program
- Radiology Support.

During 2009–2010, Queensland Health performed:

- 1,453 coronial autopsies by forensic pathologists (about half of Queensland autopsies in 2009–2010)
- 2,310 postmortem toxicology analyses to help in the Coroner's determination of cause and circumstance of death
- 2,140 air-quality sample tests
- 1,574 food-safety analyses
- 728 purified recycled water tests, each for up to 421 different compounds
- 890 drinking water, food, environmental water and soil analyses
- 2,400 pesticide and herbicide residue analyses
- 1,240 water supply analyses for toxic blue-green algae in Queensland
- 2,417 illicit drug analyses for the presence of drugs of abuse
- 12,207 urine sample analyses for the presence of drugs of abuse
- 1,119 blood sample analyses from drivers for alcohol content from the Queensland Police Service
- 944 blood sample analyses from drivers for drug content from the Queensland Police Service
- 376 roadside saliva tests for drug presence from the Queensland Police Service
- more than 900 CT scans.

Achievements of 2009–2010 included:

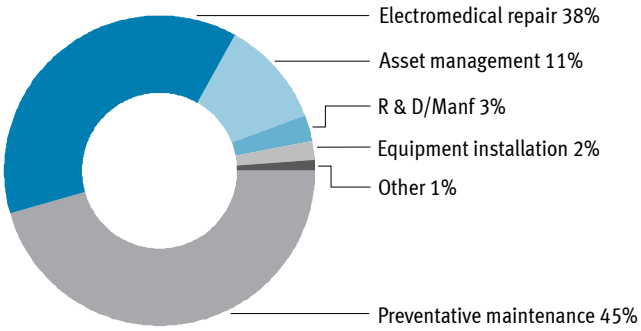
- delivery of a $6.6 million capital program, including constructing a new pathology laboratory at Charleville and buying scientific equipment for Pathology Queensland and Forensic and Scientific Services
- continued development of a new DNA laboratory and central pharmacy with enhanced manufacturing capability
- continued funding to deliver an enterprise picture archive and communication system, which stores, retrieves, distributes and presents medical images on local screens.

Biomedical Technology Services

Biomedical Technology Services deliver essential statewide biomedical engineering and radiology medical physics services, supporting district clinical services across Queensland.

Biomedical Technology Services delivered improvements in product-recall management, contract feasibility assessment, risk-centred maintenance planning, and increasing collaboration with other departments and agencies (Chart 3).

Chart 3: BTS activity 2009–2010



Forensic and Scientific Services

Queensland Health Forensic and Scientific Services is a leading provider of public health and forensic laboratories and delivers high-quality science within timeframes agreed with clients.

Achievements of 2009–2010 included meeting the increasing demands for communicable disease analysis, including testing for the 2009 H1N1 pandemic influenza, testing of water quality and supporting public health investigations into food-borne outbreaks.

In the last two financial years (refer to Graph 2) more than 15,000 PCR tests for influenza were performed (a 20-fold increase on usual annual testing numbers) due to the Public Health Laboratory response for the H1N1 pandemic influenza 2009.

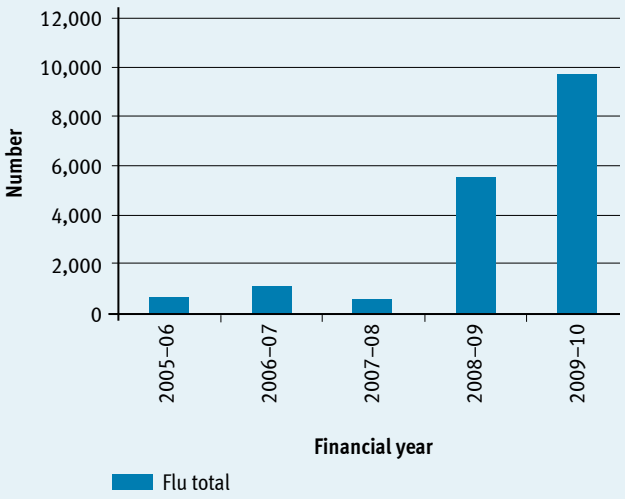
Radioanalytical services were increased by 62 per cent in 2009–2010 as the lead scientific consultancy role characterising radiological properties of wastewater from major medical facilities and water recycling plants in Queensland.

These projects support Queensland Health and other major government water reuse and infrastructure projects.

Queensland Health monitors the microbiological safety of foods available to Queenslanders by analysing routine sample submissions.

In 2009–2010, there was a large statewide survey on fresh eggs because eggs continue to be the leading cause of food poisoning outbreaks due to salmonella sp.

Graph 2: Flu total PCR testing



Entomology services

- developed new methods for surveillance and monitoring of the public health threat posed by mosquito species in the transmission of arboviruses.

Forensic pathologist services

- collaborated with the DNA Analysis Unit and the Queensland Police Service to decrease the time to provide DNA results from crime scene exhibits to the courts
- appointing four regional specialist forensic pathologists for strengthened forensic pathology services to Queenslanders living in regional, rural and remote communities.

Criminal forensic medical services

During 2009–2010, Queensland Health provided the following services:

- examined victims of crime and alleged offenders to obtain, document and interpret medical evidence
- examined adult sexual assault victims
- gave toxicological advice to the coroner and courts on suspicious deaths and driving matters
- appeared in court to give objective, impartial expert evidence
- examined and treated police detainees.

Queensland Health collaborated with the International Atomic Energy Agency and other international partners, showcasing cutting-edge skills and knowledge developed locally within Queensland Health and emphasising the vital contribution of science to protecting Queenslanders.

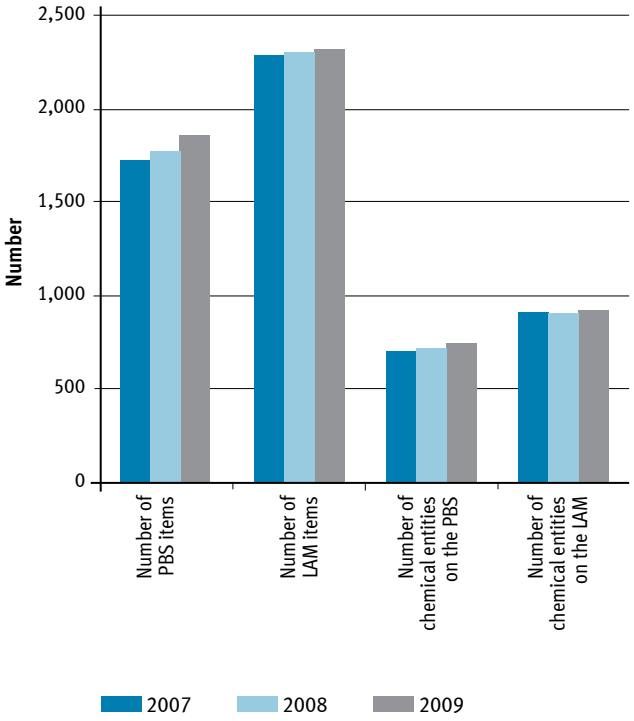
Medication Services Queensland

Medication Services Queensland collaborates with health service districts to support accessible and sustainable medication management for patients for better patient safety outcomes and more effective access to medicines and related services.

Achievements in 2009–2010 included:

- support medication management in rural and remote areas by:
  - developing a mentoring strategy for junior sole pharmacists
  - Pharmacist Relief Team for service continuity in rural and remote hospitals
  - targeting medication management issues, such as venous thromboembolism prophylaxis through face-to-face visits to 79 sites
  - an action plan to 'Close the Gap' in medication management for Aboriginal and Torres Strait Islanders in remote Queensland
  - supporting nurses in rural and remote hospitals to produce discharge medication records for patients with training and access to incentives under the Clinical Practice Improvement Payment Scheme
- medication risk reduction through ongoing introduction of tools for more effective prescribing and monitoring of high-risk medications and guidelines, and computer support for prescribing high-risk medicines
- more effective medication management tools and systems through:
  - statewide implementation and user support of iPharmacy and ScripTraker
  - revising prescription charts of patients in hospital to prompt staff to provide treatments to minimise risk of blood clots (preventing venous thromboembolism)
  - developing and trialling medication management key performance indicators for performance measurement and benchmarking across Queensland Health hospitals
  - successfully trialling the ward-based role for pharmacy assistants, enabling pharmacists to have more clinical input into patient care at the bedside, as well as improving inventory management in the wards
- improved access to medications by:
  - management of Pharmaceutical Benefits Scheme and Highly Specialised Drugs programs, giving Queensland Health hospitals access to annual federal funding of $50 million and $91 million respectively
  - recommendations to Queensland Health List of Approved Medicines through the Queensland Health Medicines Advisory Committee to ensure equity of access to medicines for all Queensland Health clients and encourage evidence-based prescribing practices and cost-effective, safe use of medicine (see Graph 3).

Graph 3: PBS and LAM comparision over time



In 2009–2010, Queensland Health's Central Pharmacy:

- distributed more than $275 million of medications (7 per cent increase in turnover compared with 2008–2009)
- provided pharmaceutical manufacturing services to all Queensland Health district health services
- improved distribution of medications to assure medications supplied to Queensland Health patients are of the highest quality.

Pathology Queensland

Pathology Queensland consists of 33 laboratories at public hospitals throughout the state. Pathology services contribute to 70 per cent of all medical diagnoses and 100 per cent of all cancer diagnoses. It plays an essential role in the majority of preventative health programs and is crucial for the diagnosis and management of many chronic diseases, such as cancer, diabetes, arthritis, hepatitis and HIV.

Pathology testing in Queensland public hospitals has continued to increase in the past seven years.

Achievements in 2009–2010 include:

- 11 million pathology tests in 2009, an average annual growth of 11.9 per cent since its inception 2002 – the number of pathology tests is expected to almost double in the next seven years (18 million tests by 2015–2016)
- initiating the Pathology Utilisation Medical Project to help districts develop a locally designed but coordinated approach to pathology use, including reducing unnecessary pathology use, improving patient care and achieve best use of pathology resources
- expanding the Point of Care Testing service, with 26 new iSTAT devices commissioned
- an online iSTAT training and learning tool with more than 4,000 registered users
- the first specific test for the 2009 H1N1 (swine) flu in Australia by the Queensland Paediatric Infectious Diseases Laboratory and Pathology Queensland
- expanding the hours of operation at Redcliffe, Robina, Redland and QEII laboratories
- pathology training programs for scientific and operational staff, in conjunction with universities and technology institutes.

Diagnostic Results and Information Management systems:

- More than 11 million diagnostic tests are done every year in 33 Pathology Queensland laboratories across the state. Patient diagnostic results are available in real-time, to clinicians anywhere in Queensland from the AUSLAB™ Laboratory Information system.

In 2009–2010:

- Queensland led the way in efficient management of swine flu cases and resources, with updated diagnostic results for the state available as soon as tests were done via AUSLAB™
- AUSCARE™ has been implemented in all facilities across Cairns and Hinterland, Torres Strait and Northern Peninsula, Cape York and Gold Coast, Central West, Central Queensland and Mackay districts to improve monitoring and reporting of patients' results. Statewide implementation will be completed by mid-2011, including integration of radiology and clinical measurement (cardiology, respiratory investigations) results.

Queensland Blood Management Program

The Queensland Blood Management Program is responsible for ensuring a safe, sufficient and cost-effective blood supply for Queensland under the terms of the National Blood Agreement.

In 2009–2010 projects included:

- Ordering and Receipting Blood System project team further developed the system to support a 'Proof of Concept' trial in South Australia and Tasmania. The Ordering and Receipting Blood System has improved the flow and management of blood components and products.
- Hospital participation in Queensland's Haemovigilance system (Queensland Incidents in Transfusion) has grown since statewide rollout started in January 2009. Data from this system supports initiatives to enhance the safety and quality of transfusion practice in Queensland hospitals.
- The Queensland Blood Management Program Transfusion Laboratory Workshop in May included participants from all private and public pathology providers in Queensland, the National Blood Authority and the Australian Red Cross Blood Service.

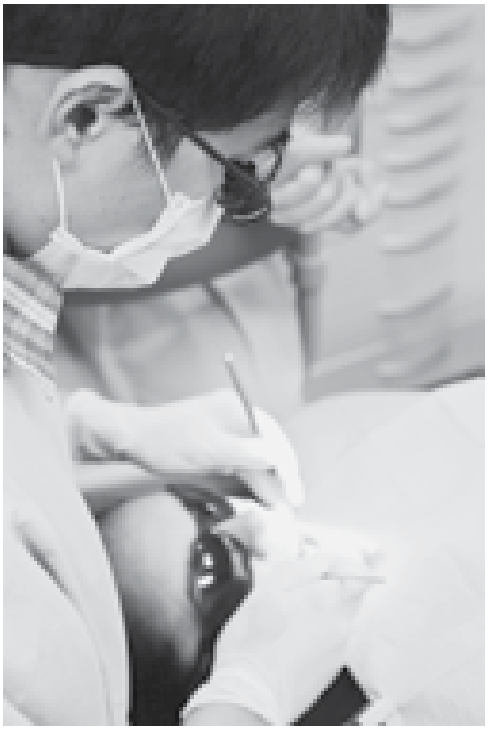
- The Queensland Blood Management Program supported the safe provision of emergency donor panels and provides a quarterly report back to the Queensland Blood Board.

Radiology Support

The Radiology Support Service supports a statewide radiology service network and provides radiology coverage across Queensland Health.

In 2009–2010 achievements include:

- being on track to meet the Department of Health and Ageing's Diagnostic Imaging Accreditation Scheme Stage II requirements by all Queensland Health hospitals
- locum radiographic services to support rural and remote facilities in the state's far-north and west
- sponsoring the Radiology Informatics Program to deliver the teleradiology network to allow viewing of radiology reports and diagnostic medical images statewide.



Oral health

About 45.3 per cent of the Queensland population, or 1.9 million people, are eligible for public dental treatment. In 2009–2010:

- adult dental services included:
  - 473,105 occasions of service
  - 42,971 general courses of care
  - 182,375 emergency courses of care
  - 21,237 dentures
  - 342,711 preventive treatments
- waiting times for services to adults for routine dental check-ups:
  - 96,281 patients waiting
  - average waiting time of 2.9 years
  - 45,477 patients (47 per cent) waiting more than the two years recommended waiting time
  - patients are generally seen within 24 hours for acute dental emergencies
- 456,454 occasions of dental services delivered to children and adolescents (aged 15 years and less).

Initiatives for 2009–2010 include:

- continuing a replacement and refurbishment program for mobile dental clinics – 53 mobile dental clinics refurbished and 38 mobile dental clinics replaced
- Information System for Oral Health into 355 school clinics (158 fixed dental clinics and 197 mobile school clinics) covering about 2,000 state, independent and Catholic schools across Queensland. This project has facilitated:
  - electronic access to schoool dental records statewide
  - electronic capture of performance reporting rather than via a manual paper-based system
  - improved timeliness and accuracy of data collection
  - staff acccess to information sources, such as Queensland Health Electronic Publishing Service (QHEPS) and email for professional support
- expanding the mobile dental clinic fleet to include:
  - six double-surgery mobile dental clinics
  - three additional self-drive (Drover) mobile dental clinics
- starting a research study to determine the oral health status of five–14-year-olds across the state to inform policy and service delivery priorities.

Private hospitals

The function of the Private Health Regulatory Unit is to assess the suitability of applicants and submissions for development of private health care services and facilities, in accordance with the legislative framework.

This involves issuing of licences, monitoring and enforcement of compliance with the *Private Health Facilities Act 1999*, regulations, standards and guidelines, and to provide expert advice to the private health care sector, professional bodies, project developers and consumers.

Of Queensland's 104 licensed private health facilities, one private hospital and one day hospital closed and 33 amendments were made to existing licenses. A total of 163 applications were lodged and processed, and 213 audits were conducted.

Healthcare-associated infections

Prevention, monitoring and reporting of healthcare-associated infections (HAI) is part of a program of work to reduce preventable harm in Queensland Health hospitals.

The Centre for Healthcare-Related Infection Surveillance and Prevention (CHRISP) provides clinical governance, leadership, expert advice and statewide systems and processes that underpin quality improvement and patient/staff safety.

CHRISP is committed to providing a safe and healthy environment for patients, visitors and healthcare workers by minimising the spread of preventable infections within healthcare settings and the broader community.

Key achievements:

- strategies to reduce healthcare workers' exposure to vaccine preventable diseases in the workplace – in 2009–2010, 59 per cent of staff were vaccinated against influenza as part of this program
- coordinated the reporting of HAI surveillance data from 23 participating sites and facilitated signal infection surveillance for all other sites
- a hand hygiene program to improve healthcare workers' practices, resulting in a 30 per cent improvement in hand hygiene compliance
- workforce training and development opportunities, resulting in 65 central sterilising department staff participating in a Certificate III in Sterilising Services and another 34 enrolled to complete a Certificate IV in Training and Assessment
- an online learning program, in partnership with the Cancer Council Queensland, to raise awareness of the infection risks of cancer and related treatment and promote ways of preventing infections
- Medical Leadership Initiative, including curriculum changes in medical schools, interventions for doctors to increase hand hygiene compliance of their peers, recruitment of doctors to be voices for infection prevention (VIP) and creation of resources to help infection control practitioners recruit medical leadership
- hollow-bore needle safety program, consisting of an online survey tool, recommended practices and processes for product evaluation.

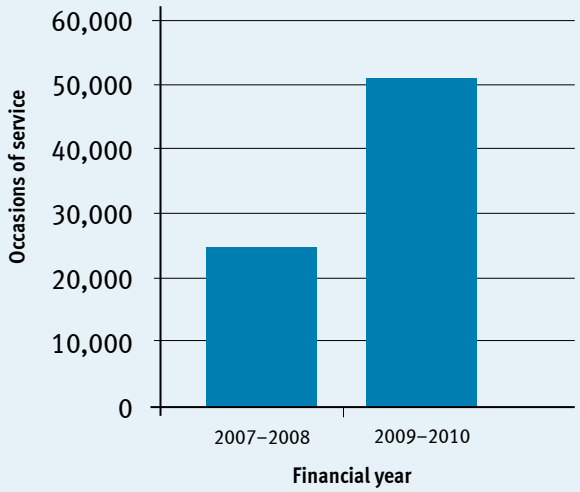
Multicultural health

In 2009, the Queensland Health Interpreter Service received an award of excellence from the Australian Institute of Interpreters and Translators Incorporated for its system-level service model and, in particular, training strategy to improve the quality of health interpreting.

Key achievements in 2009–2010:

- expanded the interpreter services activity from 24,504 in 2008–2009 to 51,653 in 2009–2010 (see Graph 4)

Graph 4: Provision of interpreter services since the establishment of the Queensland Health Interpreter Service



- culturally tailored healthy eating and physical activity modules were developed for targeted culturally and linguistically diverse (CALD) communities as a part of the Living Well program
- multicultural health workers delivered the national Measure Up campaign to targeted CALD communities and information on swine flu to Pacific Islander communities
- more than 2,700 people participated in the Queensland Transcultural Mental Health Centre's training, including more than 1,900 clinicians
- statewide refugee health assessment service, Refugee Health Queensland, assessed more than 1,600 consumers up to December 2009
- successful trial of the video remote interpreting pilot in 2009–2010, the first of its kind in Australia.

Shared services

The Shared Service Initiative is a whole-of-government approach to corporate services delivery. The vision is to provide high-quality, cost-effective corporate support services across the Queensland Government.

Shared services are underpinned by standardising business processes, consolidating technology, pooling resources and expertise.

The Queensland Health Shared Service Partner aims to provide efficient, high-quality and innovative corporate transactional services that support the delivery of health services and promote organisational effectiveness for Queensland Health.

The Queensland Health Shared Service Partner delivers the following services:

- finance transaction processing
- supply and distribution
- payroll and establishment
- recruitment administration
- linen services.

Recent achievements include:

- expansion of linen services to encompass facilities servicing Toowoomba and the Fraser Coast
- commissioning of a new 12,742m^2 distribution centre at Richlands to progressively support delivery of clinical consumables to health service districts from the Gold Coast to Rockhampton
- continued implementation of a balanced scorecard that links to Queensland Health's broader priorities and directly correlates with organisational and workforce performance.

Future developments include:

- implementation of a localised payroll model to better support the department's delivery of health services
- ongoing implementation of the Supply Chain Management Integration Strategy to design, develop and implement a model of service delivery that supports a lean, high-performance supply chain capable of achieving best practice.

3 our performance

Protecting the health and wellbeing of all Queenslanders is the vital target which helps Queensland Health promote healthy behaviour and lifestyle choices.

Managing our performance

The Queensland Health Strategic Plan outlines the objectives and outcomes for Queensland Health to ensure a consistent focus on performance against the Government's Toward Q2 targets, other government commitments and the department's priorities.

The links between the Queensland Health Strategic Plan, Toward Q2 and the Service Delivery Statements are shown in Table 13.

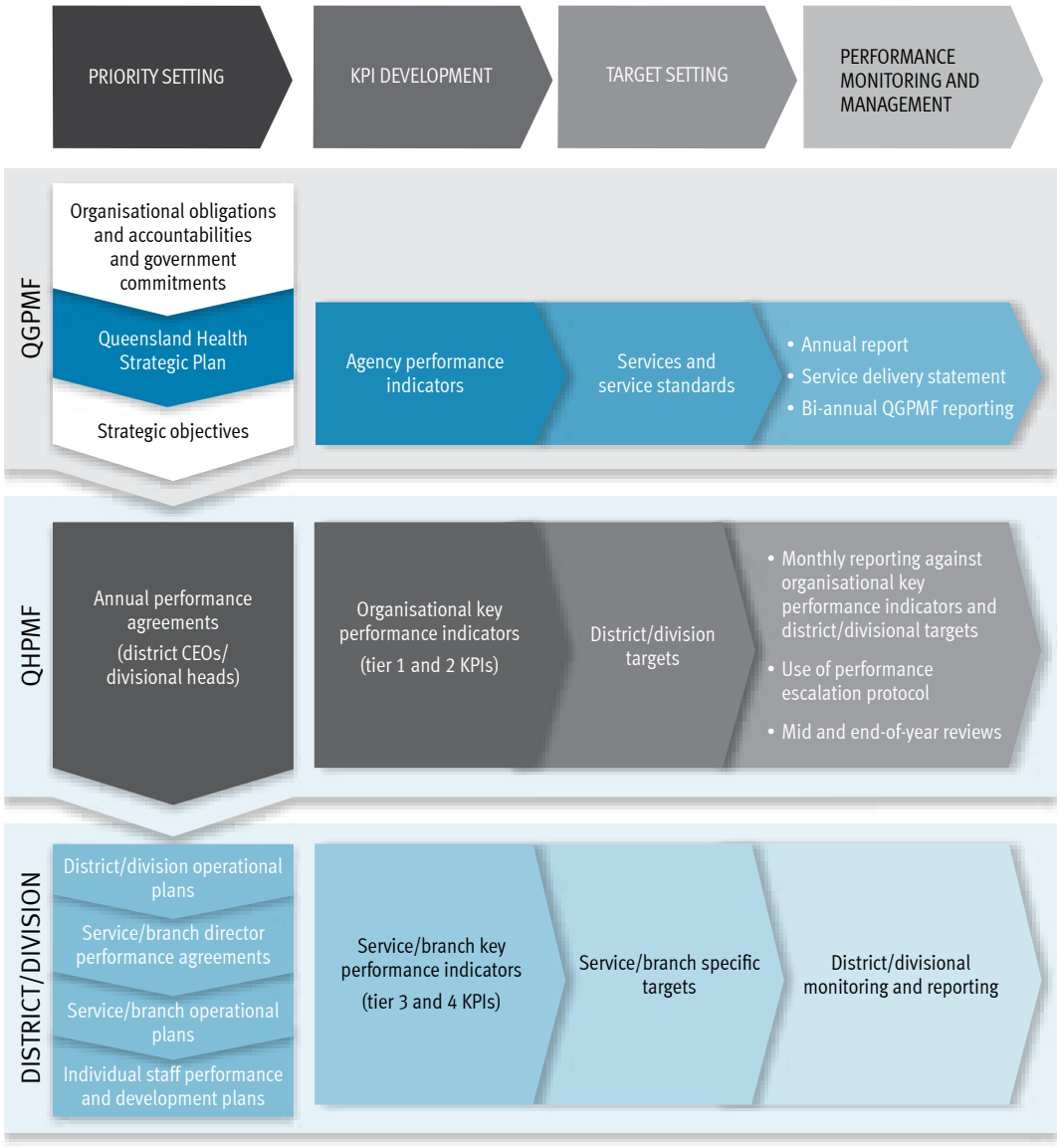
Table 13

Toward Q2: Tomorrow's Queensland				
Q2 ambition	Healthy	Healthy		
Q2 target	Making Queenslanders Australia's healthiest people • cut by one-third obesity, smoking, heavy drinking and unsafe sun exposure	Making Queenslanders Australia's healthiest people • Queensland will have the shortest public waiting times in Australia		
Queensland Health Strategic Plan				
Strategic priority	Making Queenslanders healthier	Meeting Queenslanders' healthcare needs safely and sustainably	Reducing health service inequities across Queensland	Developing our staff and enhancing organisational performance
Objective	• support healthy behaviour and lifestyle choices • protect the health of Queenslanders	• support an expanded range of services in a primary care setting • give mothers and babies the best start • expand hospital and related services to meet the needs of a growing population • expand access to subacute care services in hospital and community settings • improve older Queenslander assessment services and access to high-quality appropriate aged care services • improve patient care, safety and patient outcomes	• Close the Gap in health outcomes for Indigenous Queenslanders • Close the Gap in health outcomes for rural and remote Queenslanders • improve access to mental health services across Queensland	• develop and value the workforce • manage infrastructure and assets to ensure safe, efficient and effective services • distribute healthcare resources efficiently and effectively • invest in information and communication technology • work in partnership to effectively influence health and wellbeing outcomes • invest in research that promotes evidence-based practice and innovation • strengthen performance management, governance and accountability to ensure openness and transparency
Service delivery statement				
Queensland Health services	Prevention, promotion and protection	• ambulatory care • acute care • rehabilitation and extended care	• primary health care • integrated mental health services	

Table 14 illustrates how accountability for performance is cascaded throughout Queensland Health. The key elements of performance management in Queensland Health are:

- **Executive performance agreements:** Agreements are in place between the Director-General and all district chief executive officers and divisional heads. These agreements outline performance expectations against whole-of-government, departmental and district/division priorities and compliance with legislation and policy responsibilities.
- **Key performance indicators and targets:** A suite of indicators and targets measure performance against the strategic plan. These indicators and targets are included in executive performance agreements and reported against throughout the year. The indicators and targets are consistent with the service standards in the service delivery statement.
- **Performance management:** Formal reviews of performance against the accountabilities in performance agreements occur throughout the year. The relevant functional division head also provides direct support and additional monitoring where performance against the key performance indicators and targets is not at acceptable levels.

Table 14: Queensland Health Performance Management Framework



Achievements against our strategic objectives

Queensland Health's direction is articulated through the departmental strategic plan, which is shaped by a range of obligations and commitments set at both the state (for example, through *Toward Q2: Tomorrow's Queensland*) and national (for example, through the National Healthcare Agreement) level. The stategic plan communicates the mission, values and longer-term strategic objectives of the department.

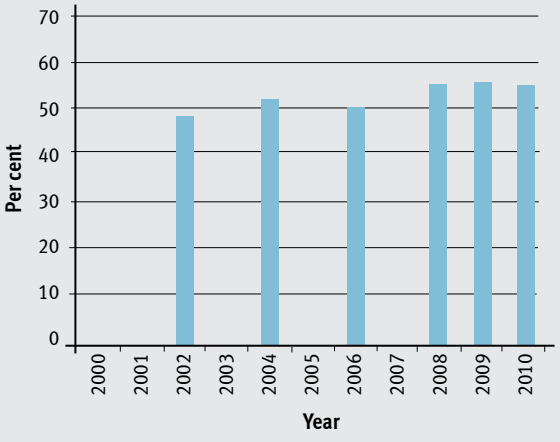
The following pages record our achievements against our strategic objectives over the 2009–2010 year.

Strategic objective

Support healthy behaviour and lifestyle choices to reduce the population rates of obesity, smoking, heavy drinking and sun exposure.

Activities	Achievements
• Queensland Health Strategy for Chronic Disease 2005–2015 to prevent or reduce lifestyle and behavioural risk factors and support better care for people with chronic disease	• shortlisted A Better Choice Healthy Food Strategy for Queensland Health facilities as a finalist in the Queensland Health Awards for Excellence • implemented a fruit and vegetable promotion program for Indigenous Queenslanders
• self-reported health status surveillance system to show prevalence of key chronic disease prevention indicators	• prevalence of Queenslanders self-reported as overweight and obese increased by 1.8 per cent per year between 2002 and 2010 • 8.4 per cent of Queensland adults consume the recommended amounts of fruit and vegetables – consumption of the recommended two or more serves of fruit per day increased in Queensland from 49 per cent in 2001 to 57 per cent in 2010 • 54 per cent of adult Queenslanders engage in levels of physical activity for health benefit • number of adults doing sufficient physical activity for health benefit increased by 6 per cent per year between 2004 and 2010 • more than 2,500 Lighten Up to a Healthy Lifestyle participant manuals have been sold and distributed – Lighten Up facilitator training delivered through the network of healthy lifestyle coordinators in health service districts and non-government organisations • published a series of reports on adult prevalence figures for 17 chronic disease and wellbeing risk factors • launched the Supportive Environments for Physical Activity and Healthy Eating resources for use with local governments • launched the Active, Healthy Communities resource to promote integration of physical activity infrastructure into land use plans

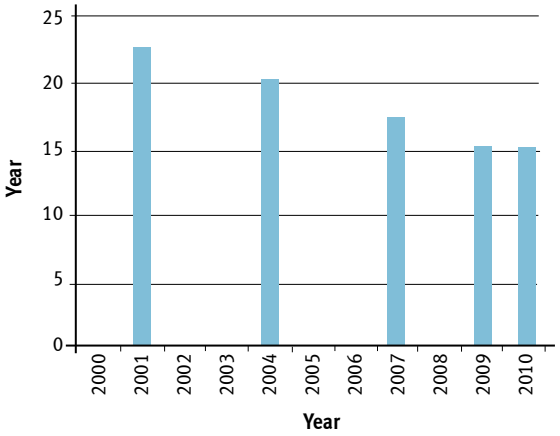
Graph 5: Percentage overweight and obese



Source: Queensland Health Self-Reported Health Status Surveillance System. 2010 data is preliminary, subject to change

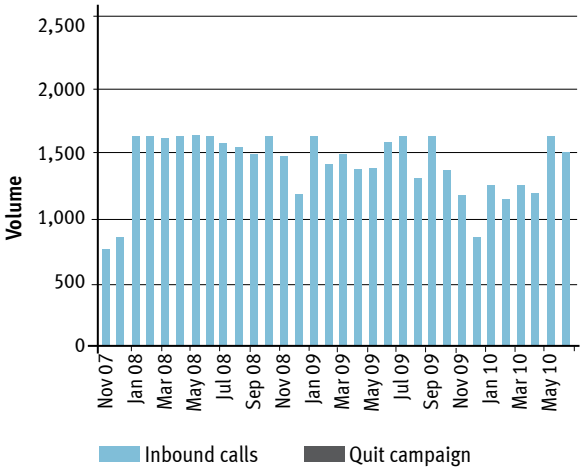
Activities	Achievements
• regular Quitline campaigning and promotion to support smoking cessation by Queenslanders	• smoking among adult Queenslanders has decreased by 30 per cent between 2001 and 2010 • Quitline service received an average of 500 calls per week and helped 24,072 people to stop smoking

Graph 6: Percentage daily smoking

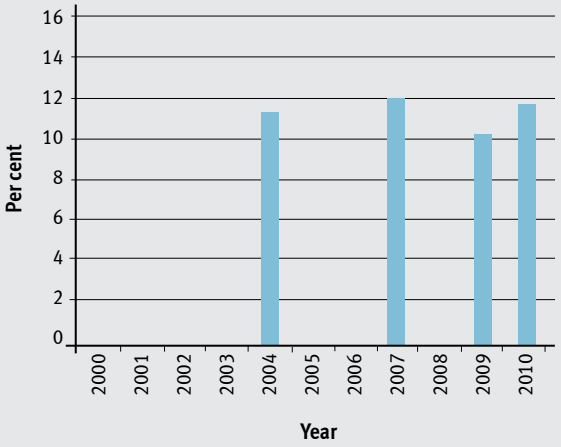
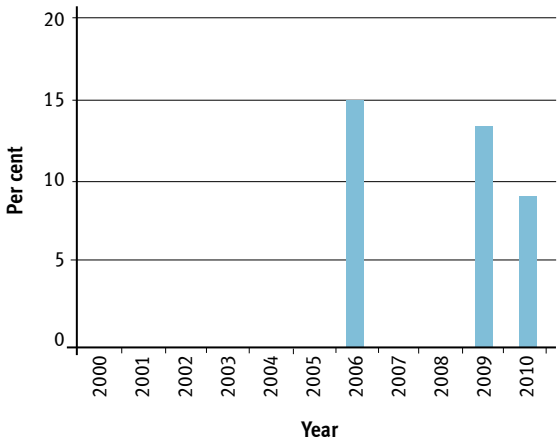


Source: Queensland Health Self-Reported Health Status Surveillance System. 2010 data is preliminary, subject to change

Graph 7 : Quitline call volume — inbound calls only (caller initiated)



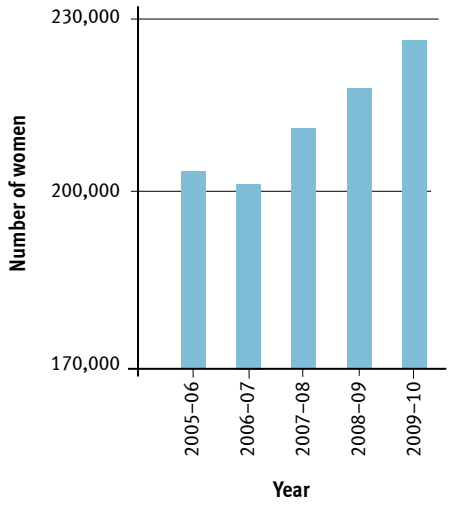
Source: Health Contact Centre, Queensland Health

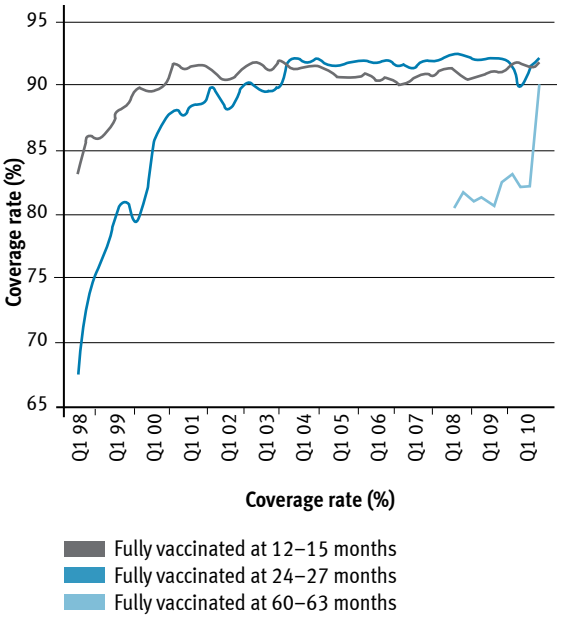
Activities	Achievements
• supported and participated in alcohol partnerships and liquor industry action groups (LIAGs) • implemented the Safer Venues program in 15 localities to address alcohol-related harm in liquor-licensed venues	• 11.4 per cent of Queensland adults consume alcohol at risky and high-risk levels for long-term harm – similar to national rates • Queensland Alcohol Diversion Program had 151 participants, of whom 60 graduated **Graph 8: Percentage risky/high-risk long-term alcohol consumption**  *Source: Queensland Health Self-Reported Health Status Surveillance System. 2010 data is preliminary, subject to change*
• promoting The Dark Side of Tanning campaign to encourage healthy sun safety **Graph 9: Percentage sunburnt on previous weekend**  *Source: Queensland Health Self-reported Health Status Surveillance System. 2010 data is preliminary, subject to change*	• 96.5 per cent of Queenslanders adopt at least one sun-protective behaviour in summer • 56.5 per cent of Queensland adults practise at least three sun-protective behaviours in summer and 33.8 per cent do so in winter • 80 per cent prompted recall within the targeted population for The Dark Side of Tanning campaign • gave 4,500 workplaces sun-protection posters, messages and information for outdoor workers

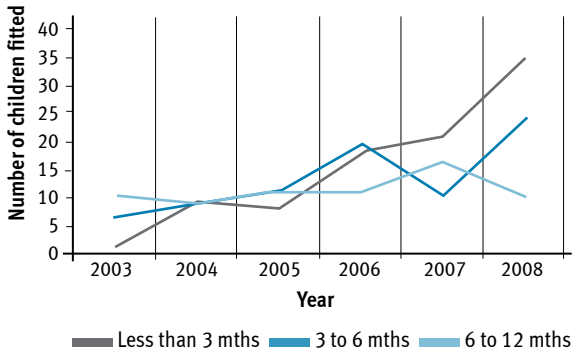
Strategic objective

Protect the health of Queenslanders by:

- **improving access to and participation rates in cancer screening programs**
- **managing preventable environmental health hazards**
- **preventing and controlling communicable diseases and maintaining vaccination rates.**

Activities	Achievements
• BreastScreen Queensland provides state-of-the-art digital mammography through 37 digital mammography facilities **Graph 10: BreastScreen Queensland — number of women screened**  *Source: BreastScreen Queensland*	• early detection of breast cancer through the BreastScreen Queensland Program contributed to an overall decrease in the mortality rate from breast cancer of 28 per cent in Queensland from 1994–2006, and an increase in five-year survival rates to an all-time high of 89 per cent from 2001–2006 • all 11 BreastScreen Queensland Screening and Assessment Services have been transitioned to digital mammography, including the 20 satellites, six mobiles and two relocatables. Implementation of the Picture Archiving Communications System (PACS) has started • BreastScreen Queensland screened 226,199 women in 2009–2010, an increase of 4 per cent more women than screened in the previous period • digital mammography technology for BreastScreen Queensland was completed on 30 June 2010
• expanding the Healthy Women's Initiative across Queensland with the recruitment of another three Indigenous women's health workers in Cairns, Charters Towers and Brisbane • development of resources for promoting cervical screening among Aboriginal and Torres Strait Islander women	• Mobile Women's Health Service received a Queensland Health Award for Excellence for 'developing beneficial partnerships' that recognised equitable access to cervical screening for women in rural and remote areas of the state
• started implementing the Pit Stop program in 2009 to enhance the participation of men in bowel cancer screening • implemented the Endoscopy Services Information System Solution (ESISS) project in Queensland Health endoscopy units in 2009. ESISS is a point-of-care information system that will significantly enhance Queensland Health's ability to monitor and report on endoscopy services	• National Bowel Cancer Screening Program in Queensland achieved a participation rate of 41.4 per cent in the 2008 calendar year (latest available figures) – significantly higher than New South Wales 31 per cent and Victoria 32 per cent • of 1,764 participants who had a colonoscopy in a Queensland Health facility during Phase 1 of the program, 49.5 per cent had a precancerous adenoma detected
• upgraded the Queensland Cancer Registry, which is a population-based cancer registry of all cases of cancer diagnosed in Queensland	• upgraded the Queensland Cancer Registry ($1 million) to enable a business process review to be conducted and to address the collection of routine cancer staging information

Activities	Achievements
• continuation of the Queensland Health Immunisation Program which aims to minimise incidence of major vaccine preventable diseases in Queensland by maintaining and, where possible, increasing immunisation coverage for vulnerable groups **Graph 11: Queensland immunisation program vaccination coverage rate**  *Source: Australian Childhood Immunisation Register*	• vaccination coverage data at 30 June 2010 indicated 90 per cent coverage had been achieved for all cohorts reported – the first time this had been achieved • implemented a free pertussis (whooping cough) vaccination program for parents of babies born on or after 1 May 2010 and about 90,600 doses of pertussis-containing vaccine have been distributed to support this program • successfully implemented the seasonal influenza program with more than 600,000 influenza vaccines distributed for people over 65, Indigenous people over 15, pregnant women and all individuals over six months with medical risk factors
• Vaccination Program for the Pandemic (H1N1) 2009 (human swine influenza)	• more than 930,000 Pandemic (H1N1) 2009 vaccines were reported as administered in Queensland as at 30 June 2010, including about 127,000 at more than 400 weekend school clinics between February and May 2010
• Fluoridation of Queensland Water Supplies project aims to increase access to fluoridated water to more than 90 per cent of the Queensland population by 2012	• installed 31 fluoride dosing plants • about 82 per cent of the Queensland population are receiving fluoridated reticulated water

Activities	Achievements
• continuation of the Healthy Hearing Program • Queensland's birthing hospitals now offer screening of newborn hearing **Graph 12: Hearing aid fitting — age of child**  *Source: Report on Demographics of Persons under the age of 21 years with Hearing Aids, 2010, Australian Hearing Publication, March 2010*	• in the five years from 2003 to 2008 in which the Healthy Hearing Program has operated, the number of children under three months of age fitted with a hearing aid increased from one in 2003 to 34 in 2008 (most recent data available). Another 34 were fitted with a hearing aid by 12 months in 2008 • 60,793 eligible infants (99.2 per cent) were screened, of which 512 babies (0.8 per cent) were referred to audiology for diagnostic assessment • 1,507 infants (2.44 per cent) passed screening, but had risk factors for late onset or progressive hearing loss and were referred for follow-up by an audiologist in the first year of life • 78 infants (0.12 per cent) were identified as having a moderate or greater degree of permanent hearing loss in one or both ears – this is within national benchmarks for screening programs
• a mosquito-borne disease prevention and control program has been established to expand Queensland Health's capacity to implement mosquito-borne disease prevention and control programs, in collaboration with local governments	• conducted a dedicated dengue public awareness campaign in north Queensland from December 2009 to March 2010 • container-breeding mosquito surveillance undertaken in 30 towns in central and southern Queensland to detect incursion of the dengue mosquito (Aedes aegypti). It was detected in 15 central Queensland towns, including five towns where it has not previously been detected
• ongoing overview and advice on impacts of health risks associated with environmental hazards	• 1,048 high-risk environmental hazard complaints/issues were investigated and managed • 10,658 *Radiation Act 1999* instruments were issued, comprising 1,385 (12.99 per cent) possession licences, 8,441 (79.20 per cent) use licences, 118 (1.11 per cent) transport licences, 620 (5.82 per cent) radiation safety officer certificates and 94 (0.88 per cent) accreditation certificates • 3,410 *Pest Management Act 2001* instruments were issued, comprising 3,180 (93.26 per cent) pest management technician licences and 230 (6.74 per cent) fumigation licences • 1,780 poisons licences were issued under the Health (Drugs and Poisons) Regulation 1996 • all food safety programs submitted by the 132 eligible Queensland Health facilities were assessed and audits are being conducted to ensure their implementation • four of the 51 food recalls actioned were initiated by Queensland Health • 24 environmental impact statements were considered by Queensland Health to ensure health risks and monitoring and compliance requirements are considered before the development starts

Activities	Achievements
• provided ongoing emergency response activities	Emergency Management Unit response activities for 2009–2010 included: • pandemic (H1N1) 2009 • tropical cyclone Ului • south-western Queensland floods • Hendra virus outbreaks • medical assistance team deployment to Samoa • Chilean tsunami warning
The Sexual Health and Blood-borne Virus program addresses public health issues associated with human immunodeficiency virus (HIV), other sexually transmissible infections (STIs) and viral hepatitis.	
• Respect Inc, a service to deliver the HIV/AIDS, Hepatitis C and Sexual Health program targeting sex workers in Queensland, started operation in January 2010 • continued to dedicate funding ($1.6 million per annum) to support increased access to treatment for people with hepatitis C • contact tracing support officer positions are located within five sexual health services – networks have been established and resources developed for target groups, including young Indigenous Queenslanders	• to date, the service has established offices in Brisbane, Townsville and Cairns, developed a range of specialist resources, including a website and started outreach with relevant service providers and sex workers across Queensland • an independent evaluation of the Hepatitis C Shared Care Initiative was completed by Latrobe University, Victoria – it concluded that Queensland Health's investment had improved access to services across the state for people with hepatitis C • this project helps general practitioners and other service providers to contact the sexual partners of clients presenting with sexually transmissible infections (STIs) to stop onward transmission of STIs, reducing the probability of re-infection and reducing the overall burden of disease caused by STIs

Strategic objective

Support an expanded range of services available in a primary setting.

Activities	Achievements
• established 15 local Partnership Councils through the Connecting Healthcare in Communities (CHIC) initiatives	• developed and delivered programs for chronic and complex care, integrated health promotion and illness prevention, early childhood health, community mental health and drug and alcohol services
• entered into a three-year service agreement for a Healthy Communities Project with the Local Government Association of Queensland	• helped local governments with resources to establish environments that support physical activity and healthy eating
• engagement with General Practice Queensland • actively participated in the General Practice Advisory Council	• formalised commitment to future collaborative action with General Practice Queensland in improving health outcomes for individuals and communities
• redeveloped Ingham Hospital	• completed construction of an integrated facility to house both acute and community based health services with close linkages with a general practitioner clinic
• supported the statewide health hotlines 13HEALTH and 13QUIT through the Health Contact Centre	• provided significant statewide primary health care services through the 13 HEALTH hotline on a 24-hour, seven-days-a-week basis

In 2009–2010 the Health Contact Centre:

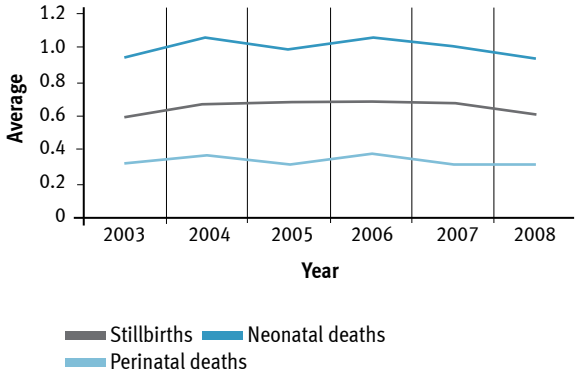
- answered 82 per cent of all calls within 20 seconds against the target of 80 per cent
- answered 257,838 calls against the target of 230,000 calls
- provided phone health advice to 199,932 Queenslanders
- advised 2,237 rural and remote Queenslanders how to manage signs and symptoms
- educated 42,462 Queenslanders on various health conditions
- provided coaching to 725 patients suffering chronic disease, helping them to better manage their diabetes or heart conditions
- helped 24,072 people to stop smoking.

Strategic objective

Provide mothers and babies with the best start.

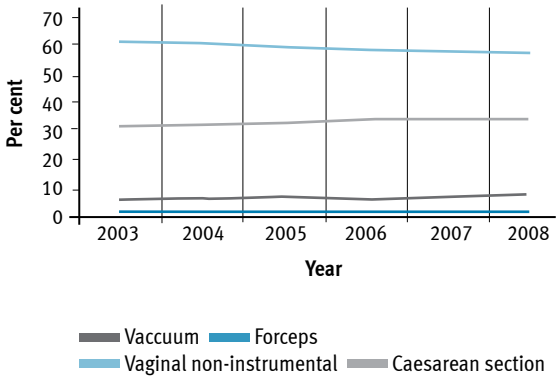
- delivered 43,136 babies in acute public hospitals
- Queensland's perinatal mortality rate declined slightly between 2005 and 2008, due largely to a small decrease in the number of stillbirths
- proportion of babies born before 37 weeks gestation or with low/very low birth weight remained largely unchanged for the same time period, at about 8.7 per cent of births and 7 per cent of births respectively
- over this same period, the proportion of caesarean sections increased from 31 to 34 per cent of all births; while the rate of vaginal non-instrumental birth declined from 61 to 57 per cent

Graph 13: Perinatal deaths



Source: Queensland Perinatal Data Collection

Graph 14: Method of birth



Source: Queensland Perinatal Data Collection

Activities

- invested in infrastructure and service delivery to address key priorities for maternity care

Achievements

- established new birth centres in Townsville, Toowoomba and started planning for a birth centre in Cairns
- invested $29.7 million over four years (2007–2011) in the Universal Postnatal Contact Services initiative, to ensure mothers receive follow-up care after the birth of a baby
- provided $9 million over four years (2008–2012) for the Maternity Services Enhancement Program, including $5 million for the Rural Maternity Initiative, to increase access to continuity and midwifery-led maternity care for rural women
- re-established the Queensland Maternal Perinatal Quality Council
- introduced seven new midwife and Indigenous health worker outreach teams and 10 Indigenous maternity liaison positions

Activities	Achievements
• implemented initiatives aimed at: – improving consumer involvement in their care – making informed choices with respect to their care	• offered midwifery group practice or team models of care in 14 maternity services, providing 4,000 women with a choice of care • provided some primary antenatal care in community-based settings in 51 per cent of maternity services, an increase of 75 per cent since 2008 • involved consumers in maternity service planning in 61 per cent of services (up from 44 per cent in 2008) • contributed a chapter on Cultural Dimensions of Pregnancy, Birth and Postnatal Care in the Queensland Health Multicultural Clinical Support Resource folder, to improve the care of women from culturally and linguistically diverse backgrounds
• implemented and/or continued initiatives which enhance the quality and safety of maternity care provision	• started screening of pregnant women for key risk factors that affect the health of both mother and baby (tobacco smoking, alcohol and drug use, depression, psychosocial wellbeing and domestic violence) in 25 maternity services, to improve identification and referral to appropriate support services • continued to report on rates of episiotomy, instrumental delivery, rates of caesarean section, induction of labour and perineal tears, to monitor maternal and neonatal clinical outcomes and compare results across hospitals • developed and published 12 statewide maternity and neonatal clinical guidelines, to guide best practice in Queensland public hospitals • conducted a 20-year review of perinatal data to report on trends in Queensland maternal and perinatal outcomes • provided maternity crisis resource management training to 163 midwives and medical staff through the Skills Development Centre
• Newborn and Family Drop-in services were established in 18 communities across Queensland	• specialist advice to new parents on a range of issues, such as infant feeding and settling, infant development and bonding and parenting concerns
• rollout of key initiatives to improve outcomes for Aboriginal and Torres Strait Islander women and their babies under the $30 million over five years (2008–2013) Council of Australian Governments' Indigenous Early Childhood Development National Partnership Agreement	• enabled increased access to culturally appropriate maternity care, enhanced the Aboriginal and Torres Strait Islander health workforce, and provided more support for young Aboriginal and Torres Strait Islander parents

Activities	Achievements
• funded a range of initiatives aimed at sustaining and enhancing the maternity care workforce	• developed an emergency birthing training program for rural registered nurses and general practitioners who work in facilities that do not provide birthing services • provided financial support for five Indigenous health workers to undertake a Certificate IV Maternal and Child Health (Aboriginal and Torres Strait Islander) course • established funding and pathways for midwives wishing to re-enter the workforce • started a Queensland rural general practitioner obstetrician training scheme, to increase the number of rural generalists with advanced skills in obstetrics

Strategic objective

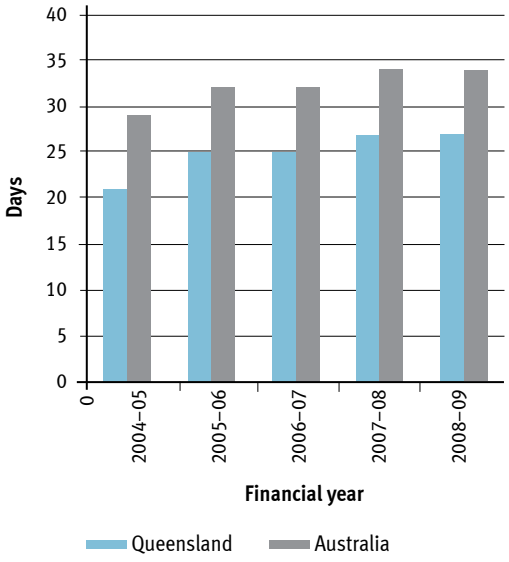
Expand hospital and related services to meet the needs of a growing population.

Activities

Elective surgery

- introduced the Queensland Health Statewide Surgical Services Program to ensure that Queenslanders who waited the longest for their elective surgery were treated as a priority
- continued to fund Queensland Health's successful Surgery Connect program, which aims to provide alternative treatments options for 'long wait' elective surgery patients, either in the private sector or by using available capacity in the public sector outside of normal operating hours

Graph 15: Median waiting time for elective surgery (days)

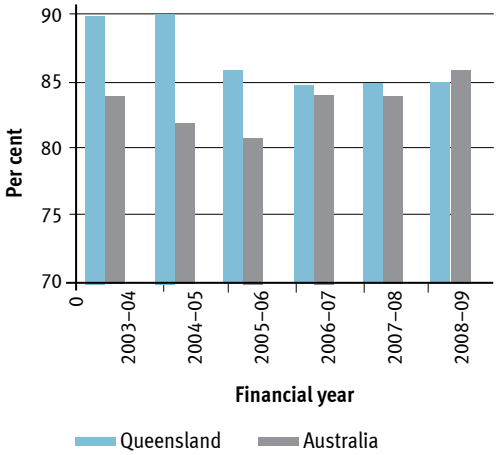


Source: State of Our Public Hospitals – June 2010, Australian Department of Health and Ageing

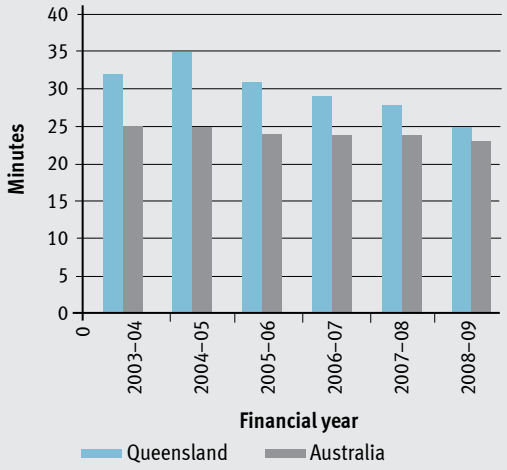
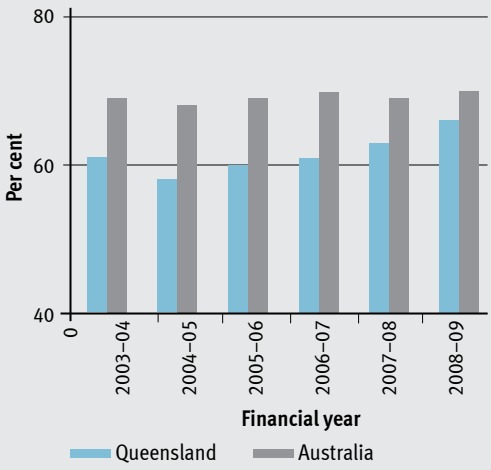
Achievements

- maintained (in 2008–2009) the shortest national median wait time for elective surgery (27 days compared with 34 days nationally)
- treated 85 per cent of elective surgery patients within the clinically recommended time for their category (in 2008–2009), compared with 86 per cent nationally
- reduced from 9,014 to two patients during 2009–2010 the number of elective surgery patients who were 'long waits' from September 2007
- reduced the number of 'long wait' patients to the lowest total since the statewide data collection began in 1996–1997 and an 11.6 per cent decrease from 1 July 2009
- reduced from 2,618 at the beginning of January 2010 to 216 patients at 30 June 2010 the total elective surgery patients who were waiting for more than 365 days
- facilitated the treatment of about 19,000 patients, either internally or through outsourcing to the private sector, through the Surgery Connect program, which started in 1997
- treated 4,553 patients in the private sector through Surgery Connect in 2009–2010
- provided $28.9 million through Surgery Connect to facilitate the treatment of 'long wait' elective surgery patients internally in Queensland public hospitals

Graph 16: Elective surgery patients seen within recommended time (percentage)



Source: State of Our Public Hospitals – June 2010, Australian Department of Health and Ageing

Activities	Achievements
Emergency departments • implemented the 'Model Business Rules for Management of Hospital Emergency Care Escalation' to provide consistent guidelines for the management of demand on emergency department services • published emergency department performance monthly, enabling the public to view emergency department waiting times for individual facilities	• achieved (in 2008–2009) a median waiting time for emergency department treatment of 25 minutes, the third-shortest median waiting time in Australia (national median 23 minutes) • treated 66 per cent of emergency department patients within the clinically recommended time for their category (in 2008–2009), compared with 70 per cent nationally
Graph 17: Median waiting time for emergency department treatment (minutes)  *Source: State of Our Public Hospitals – June 2010, Australian Department of Health and Ageing*	**Graph 18: Emergency department patients seen within recommended time (percentage)**  *Source: State of Our Public Hospitals – June 2010, Australian Department of Health and Ageing*
Patient flow • implemented the Queensland Health Patient Flow Strategy	• developed a Queensland Health Patient Flow website that provides information and toolkits for staff on: – system redesign processes and methodologies – effective service delivery models across the acute, ambulatory and sub acute settings – access to a range of performance measurement tools and data for districts • introduced the Criteria Led Discharge initiative into 10 pilot sites across the state • engaged with key clinicians to discuss current patient flow issues and identify local solutions currently in place, which may be transferable across other Queensland Health sites • developed and launched the web-based diagnostic tools and patient flow data reports to help districts in identifying and improving patient flow problems

Activities	Achievements
• implementing discharge protocols through the Criteria Led Discharge (CLD) project. Intended outcomes associated with the implementation of CLD are a reduction in length of stay, and increase in discharges earlier in the day and on weekends and an increase in patient and staff satisfaction	• piloted Criteria Led Discharge across 10 Queensland Health hospitals, including Cairns, Townsville, Mackay, Rockhampton, Bundaberg, The Prince Charles, Princess Alexandra, Gold Coast, Toowoomba and Roma hospitals • developing discharge criteria with major involvement from the relevant clinical networks to ensure endorsement by peers at a statewide level
• increased access to cancer treatment services	• 35 per cent increase in the total number of patients who accessed effective high-cost medication for the treatment of many cancers under the $5.3 million Limited Indicated Medication Scheme • allocated $15 million grant funding over three years (2009–2012) to build or enhance accommodation for patients travelling to receive treatment away from home • enhanced outreach and Telehealth cancer services from metropolitan centres to regional centres • allocated $3.2 million operational funding in north Queensland to increase chemotherapy services and inpatients beds • relocated the Cairns Base Hospital Cancer Care Services Day Oncology Unit, enabling expansion of clinical treatment areas from seven to 12
• increased the capacity of Queensland Health facilities by investing unprecedented levels of expenditure on capital infrastructure to meet the ever-increasing demands of Queensland's growing population	• significant capital infrastructure projects are outlined in Table 15

Table 15: Significant infrastructure investments

Queensland Children's Hospital (QCH)	Early works has started on the Queensland Children's Hospital. When completed, QCH will provide 359 public beds, 71 more beds than the Mater and Royal Children's Hospitals combined.
Gold Coast University Hospital (GCUH)	The Gold Coast University Hospital is on budget and on track for completion in December 2012. A total of 750 overnight beds will be available by 2015–2016.
Sunshine Coast University Hospital (SCUH)	Development is progressing on the Sunshine Coast, including the new Sunshine Coast University Hospital to be opened with 450 beds in 2016, increasing to 738 beds by 2021 at a total cost of $1.972 billion and a co-located private hospital on the SCUH site to open in 2013.
Cairns Base Hospital	The Cairns Base Hospital redevelopment will provide an additional 168 overnight and same day beds by the end of 2014. A staged expansion of the adult emergency department at Cairns for more treatment capacity is also under way.
The Townsville Hospital	The expansion of The Townsville Hospital is continuing. The original scope has been expanded by additional Commonwealth funds for both general expansion and a major expansion of the regional cancer centre. Due for completion in mid-2014.
Mackay Base Hospital	The Mackay Base Hospital redevelopment will provide an additional 158 overnight and same day beds by the end of 2013.
Rockhampton Hospital	The expansion of the Rockhampton Hospital is continuing. The original scope has been expanded by additional Commonwealth funds for both general expansion and a new regional cancer centre. Due for completion in mid-2013.
Bundaberg Hospital	The Bundaberg Hospital expansion will provide 42 additional beds at a cost of $41.35 million and a further $4 million for enhancements to the emergency department. This will deliver a total of 182 beds up from the current 140 beds.
Robina Hospital	The Robina Hospital expansion will deliver an additional 154 beds by mid-2011 and refurbishment of existing buildings is due for completion mid-2012.
The Prince Charles Hospital	The Prince Charles Hospital expansion, with an emergency department and expansion of the hospital's capacity with additional beds, operating theatres and support facilities, was completed in March 2010. Early works have started on the new paediatric emergency department, which is a $45.6 million project.
Mount Isa Hospital	Mount Isa Hospital is undergoing a $65.19 million redevelopment scheduled for completion early-2012.
Yeppoon Hospital	Construction of a replacement hospital providing 22 beds, four oral health chairs plus a community health wing was completed on 31 October 2009.

Hospital activity

The following table and graphs show acute public hospital data for the previous three financial years for each of our health service districts.

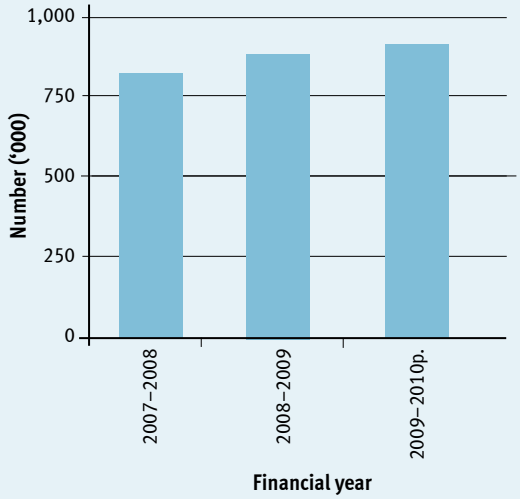
In 2009–2010, there were 922,738 patient episodes of care (admissions) to Queensland public hospitals – a 4.5 per cent increase from 882,933 in 2008–2009. There was also a 1.6 per cent increase across the state in the number of accrued days in hospital for admitted patients.

Table 16: Hospital activity statistics, public acute hospitals, Queensland

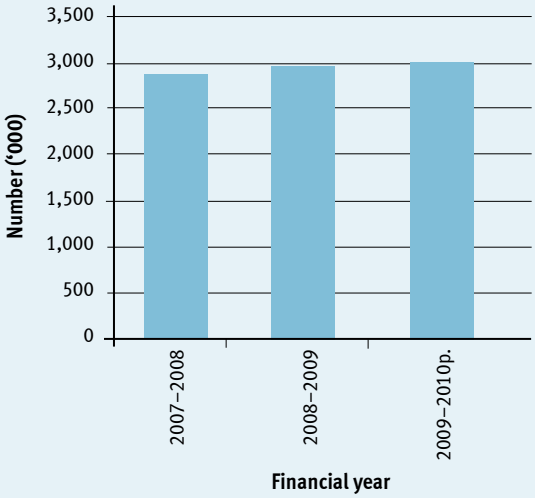
	Patient episodes of care			Accrued patient days		
District	2007–2008	2008–2009	2009–2010p.	2007–2008	2008–2009	2009–2010p.
Cairns and Hinterland	62,091	64,097	63,601	213,375	219,309	218,421
Cape York	3,044	2,669	3,051	6,283	6,446	6,306
Central Queensland	38,935	38,805	40,775	118,985	117,316	116,108
Central West	3,321	2,757	2,364	10,283	9,560	8,061
Children's Health Services	20,316	21,936	22,537	53,724	56,510	56,877
Darling Downs-West Moreton	85,258	86,774	89,836	278,141	279,407	288,158
Gold Coast	66,467	78,118	82,600	241,001	259,682	266,030
Mackay	34,841	35,523	33,027	85,202	85,397	78,957
Mater Public Hospitals	42,520	46,575	48,949	112,380	132,818	135,748
Metro North	151,622	159,241	169,718	658,381	673,703	688,551
Metro South	147,676	159,553	166,775	516,402	522,837	531,425
Mount Isa	8,447	8,342	8,883	30,011	25,899	26,695
South West	6,568	6,697	6,725	26,736	27,218	24,582
Sunshine Coast-Wide Bay	102,894	112,889	121,695	300,667	326,727	340,869
Torres Strait-Northern Peninsula	1,771	1,763	1,832	11,358	14,238	11,202
Townsville	55,777	57,194	60,370	197,038	206,607	213,802
Queensland	831,548	882,933	922,738	2,859,967	2,963,674	3,011,792

Notes: p. preliminary data, subject to change. Excludes unqualified newborns, posthumous organ procurement and boarders
Source: Queensland Hospital Admitted Patient Data Collection (QHAPDC), Queensland Health. Monthly Activity Collection (MAC), Queensland Health (extracted 6 September 2010).

Graph 19: Episodes of care, public acute hospitals, Queensland



Graph 20: Accrued patient days, public acute hospitals, Queensland



Source: Queensland Hospital Admitted Patient Data Collection (QHAPDC), Queensland Health. Monthly Activity Collection (MAC), Queensland Health (extracted 6 September 2010). Excludes unqualified newborns, posthumous organ procurement and boarders. Notes: 'p' 2009–2010 data are preliminary, subject to change.

Strategic objective

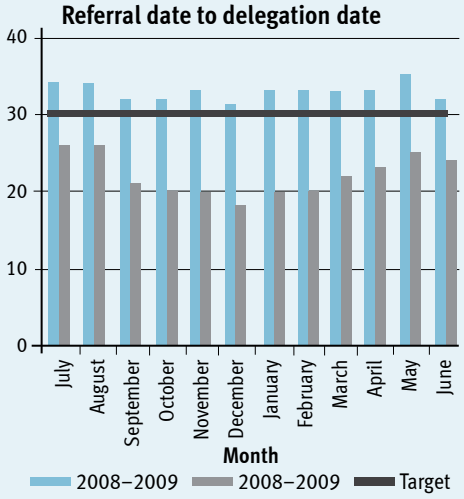
Expand access to subacute care services in both hospital and community settings.

Activities	Achievements
• funded and implemented a range of initiatives to increase the range and usage of subacute care services	• construction completed in August 2009 of the Rockhampton Hospital Rehabilitation Facility • completed construction of the Nambour Residential Aged Care Facility • implemented an occupancy-based funding system for the Transition Care Program • funded an extensive study into the provision of subacute care services in Queensland to inform the planning and delivery of these services into the future • established quality improvement and benchmarking systems for the provision of inpatient rehabilitation services • continued to develop a range of services aimed at avoiding unnecessary hospital admissions such as Hospital in the Home, Hospital in the Nursing Home • implemented interim care programs through the Long Stay Older Patients Program at sites across Queensland

Number of sub and non-acute patient days in 2009–2010 was 489,301, compared with 467,167 in 2008–2009.

Strategic objective

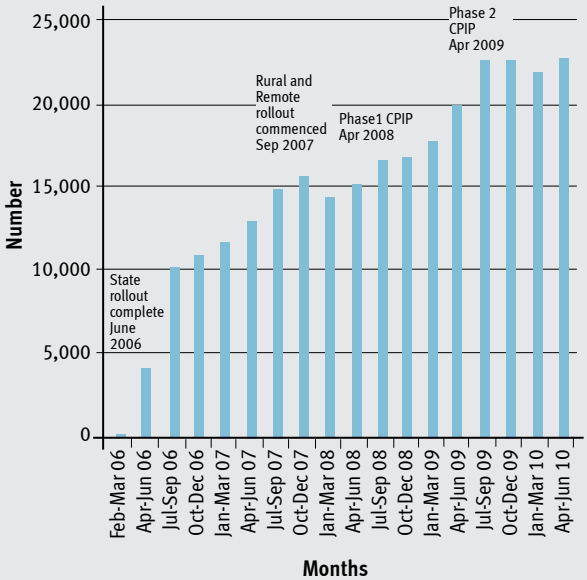
Improve older Queenslanders assessment services and access to high-quality appropriate aged care services.

Activities	Achievements
• the Commonwealth Government has overall responsibility for the provision of residential aged care. As at 30 June 2009, there were more than 31,300 operational residential aged care places and more than 7,500 operational community care places in Queensland	• Queensland Health operated 20 residential aged care facilities providing care to more than 1,350 older Queenslanders in 2009–2010 • maintained the accreditation status of all Queensland Health facilities • a project is under way to improve the standardisation of quality systems across all Queensland Health residential aged care services
• Queensland Health managed 17 Aged Care Assessment Teams (ACAT) who determine eligibility to receive aged care services such as nursing home care or a package of care in the community **Graph 21: Statewide ACAT Referral date to delegation date**  *Source: Queensland Aged Care Assesssment Program Data Collection (2008–2009 and 2009–2010)*	• performed more than 33,000 assessments of older people. Referrals for community care services continue to rise (currently more than 40 per cent of referrals) as the range of service options has continued to increase and older people want to remain in their own homes • reduced the number of days between referral to and approval by an Aged Care Assessment Team from an average of 34 days in 2008–2009 to an average of 22 days in 2009–2010 – improving patient flow and access to the available aged care places • aged care assessment teams benefited from the Council of Australian Governments' collaborative, receiving $622,000 in 2009–2010 in funding for initiatives such as: – improved assessment of older Aboriginal and Torres Strait Islander peoples through the development, modification and implementation of appropriate assessment tools and the introduction of an ACAT 'buddy' model – assessment of the ACAT education officer model
• increased the number of transition care places it operated from 389 to 480. By 30 June 2012, there will be total of 733 places operating across the state. The Transition Care Program provides a time-limited period of restorative care at the conclusion of an older person's admission to hospital	• helped about 4,000 older people to regain their independence and being able to return to live in their own home
• Queensland Health received $6.75 million in 2009–2010 to implement a wide range of projects under the Commonwealth-funded Long Stay Older Patients Program in both rural and urban settings	• funded rural projects included upgrading hospitals to either make them more aged-person friendly or to become a multipurpose health service • funded urban initiatives focused on interim care, Hospital in the Home, Hospital in the Nursing Home, and admission avoidance

Strategic objective

Improve patient care, safety and patient outcomes.

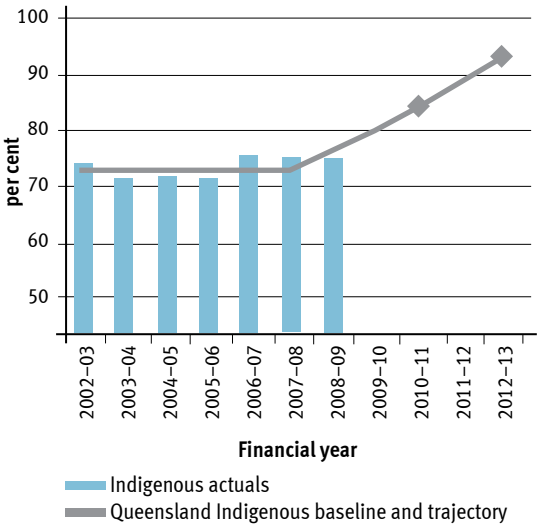
Activities	Achievements
• continued the Open Disclosure Program	• trained more than 400 senior clinicians and executives as open disclosure consultants • integrated formal open disclosure into the Clinical Incidents Management Implementation Standard • developed a new Clinician Disclosure curriculum – a clinician disclosure pilot was undertaken involving university health science students
• reviewed patient safety notification process	• developed an implementation standard for the governance of patient safety notifications (patient safety alerts, patient safety notices and patient safety communiqués), including Therapeutic Goods Administration recalls • patient safety notifications are being processed at a central location ensuring ease of access for all Queensland Health staff
• continued the Recognition and Management of the Deteriorating Patient project	• designed early warning and response systems (EWARS), according to human factors engineering principles, including rapid response systems to effectively detect and manage physiological deterioration of patients • completed the evaluation on the Children's Early Warning Tool, which was piloted in 2009 • developed Adult Deterioration Detection System using human factors design principles in collaboration with University of Queensland, Australian Commission on Safety and Health Care and Patient Safety and Quality Improvement Service
• informed consent documents were reviewed/ developed	• 100 consent documents have been developed for medical imaging • nine consent documents developed or reviewed for nuclear medicine • one consent document developed for patients having procedures with radiation • 33 consent documents reviewed for neurosurgery • nine medical imaging patient information documents translated into 10 languages other than English

Activities	Achievements
• reducing falls and injuries project undertaken	• developed, analysed and compiled an extensive falls baseline data report, including ambulance attendance, emergency department presentations, hospital admissions, inpatient falls and fall-related deaths • increased membership of the Queensland Falls Injury Prevention Collaborative (FIPC) to more than 900 professionals
• implementation and development of clinical pathways to provide standardised clinical processes	• developed clinical pathways to reduce variation in areas such as the: – pregnancy hand-held record – acute coronary syndrome non-interventional clinical pathway – statewide peri-operative documentation tool
• implemented the Acute Resuscitation Plan in all Queensland Health hospitals in response to Coronial recommendations about end-of-life decision-making and Not For Resuscitation (NFR) orders	• implemented Acute Resuscitation Plan after consultation and endorsement from relevant clinical networks, universities and consumers • worked collaboratively with Health Consumers Queensland on Advance Care Planning and Advance Health Directives
• progressed the implementation of the Queensland Medication Management Plan **Graph 22: Number of Discharge Medication Records (DMRs) from eLMS by quarter for all sites 2006–2010**  *Source: Electronic Liaison Medication System (eLMS)*	• established Medicines Collaborative to link the Queensland Health Medicines Advisory Committee with local medication governance groups in districts • delivered a new version of the national inpatient medication chart that prompts for venous thromboembolism prevention • completed an expanded trial of Telepharmacy services (new model of pharmacy practice using electronic information and communication technologies for remote pharmaceutical review) • completed a successful trial of pharmacist prescribing in pre-admission clinics • completed the pharmacy assistant/pharmacy technician models of care trial – its findings supported increased access to clinical pharmacy services through greater use of support staff • delivered the Medication History Training and Competency Assessment Module Version 2, which trains nursing and other clinical staff on how to take the best available medication history when patients are admitted to hospital • increased the percentage of non-same-day separations that received a discharge medication record from eLMS when leaving hospital from 15 per cent of patients in 2007–2008 to 19 per cent in 2008–2009 to 22 per cent in 2009–2010

Strategic objective

Close the Gap in health outcomes for Indigenous Queenslanders.

Activities	Achievements
• continued implementation of the Indigenous Health Outcomes National Partnership Agreement	• endorsed and initiated the Queensland Implementation Plan for the Council of Australian Governments' Indigenous Health Outcomes National Partnership Agreement • finalised Making Tracks towards Closing the Gap in health outcomes for Indigenous Queenslanders by 2033 Policy and Accountability Framework and Implementation Plan 2009–2012 • finalised the Queensland Health's Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033 • started establishment of the Southern Queensland Centre of Excellence for Indigenous Primary Health Care at Inala • established a three-year cardiac outreach program to provide specialist cardiac diagnostic and treatment services, including primary, secondary and tertiary prevention strategies • started a four-year Indigenous care connect pilot project at Royal Brisbane and Women's Hospital undertaking targeted interventions to support Aboriginal and Torres Strait Islander patients undergoing renal treatment • implemented a package of Indigenous-specific smoking cessation and support services, including: – strategies to improve delivery of cessation services, such as nicotine replacement therapy – a range of targeted social marketing anti-smoking campaigns • developed new and expanded services to support young Aboriginal and Torres Strait Islander people aged eight-18 years to avert the uptake of risky behaviour and to improve their emotional and social wellbeing

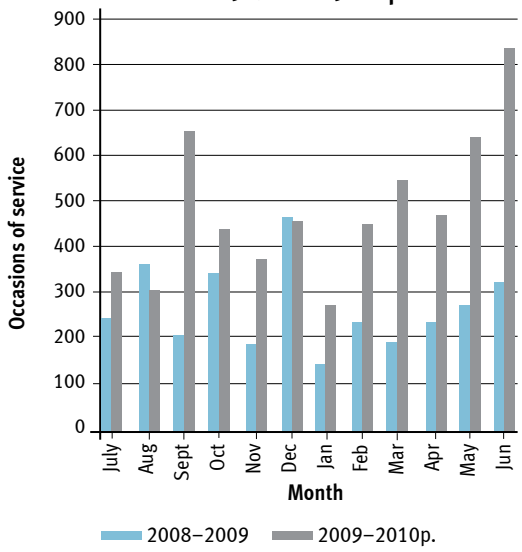
Activities	Achievements
• implementation of Indigenous Early Childhood National Partnership Agreement strategies to improve pre-pregnancy health, increase antenatal attendance and to provide greater access to sexual and reproductive health services for young people **Graph 23: Proportion of Indigenous women who attend 5 or more antenatal visits during pregnancy — Trajectory to Close the Gap**  *This trajectory to Close the Gap is based on 2008–2009 actual data pending the availability of actual 2009–2010. Source: Perinatal Data Collection, Queensland Health*	• preliminary data for 2009–2010 indicates that about 76.9 per cent of Aboriginal and Torres Strait Islander women who gave birth had five or more antenatal visits • continued expansion of initiatives in Cape York to enhance child and maternal health services, including increased access to specialist services and a Baby Basket initiative • increased access to culturally appropriate services in rural maternity units for Aboriginal and Torres Strait Islander women and their families • five scholarships for Indigenous child health workers to undertake a Certificate IV course in Child and Youth Health
• delivered new and existing healthy lifestyle programs specific to the health issues of Aboriginal and Torres Strait Islander communities	• created six Indigenous sexual health worker positions to service prisons and youth detention centres across the state • conducted breastfeeding health promotion for Aboriginal and Torres Strait Islander people to support mothers to breastfeed for longer. More than 8,000 antenatal breastfeeding guides and 1,000 breastfeeding posters have been distributed through maternity and child health services statewide • implemented Indigenous alcohol diversion programs in three areas – Rockhampton/ Woorabinda, Cairns/Yarrabah and Townsville/ Palm Island. Of the 161 participants commencing the program, 60 graduated
• social marketing campaigns to reduce smoking-related harms among Aboriginal and Torres Strait Islander people	• trained and supported more than 1,550 workers in the SmokeCheck program to help Indigenous people to quit smoking • in 2009–2010, SmokeCheck Brief Intervention training program delivered to 560 health workers in 44 communities • supported 90 sporting and cultural events through community grants and smoke-free promotional materials

Strategic objective

Close the Gap in health outcomes for rural and remote Queenslanders.

Activities	Achievements
• expanded Telehealth Program to provide services to more people	• Preliminary data indicates a: – 53 per cent increase in the number of Telehealth non-admitted occasions of service – 66 per cent increase for the number of clinicians participating in a Clinical Mental Health Service using Telehealth (5,978 in January 2009 to June 2010 compared with 3,604 reported in January 2008 to June 2009) – 55 per cent increase in consumers receiving a mental health service by Telehealth (1,820 compared with 1,174 for the same period in 2008–2009) • 85 new Telehealth systems were installed around the state, bringing the total to more than 800, the largest managed Telehealth system in Australia
• The Telehealth Expansion Program spent $11.5 million to fund about 50 initiatives, providing services to more people in more locations	• upgraded bandwidth (WAN) to 113 regional, rural and remote sites across Queensland • linked 18 remote emergency departments to tertiary hospitals and Retrieval Services Queensland (RSQ) • upgraded equipment to support telegeriatrics in the Sunshine Coast-Wide Bay Health Service District • extended medical and radiation oncology services from Townsville to Cloncurry, Hughenden, Bowen and Proserpine • new teleobstetric and adolescent gynaecology services linked specialists at RBWH to high-risk patients in Mackay, Bundaberg and Nambour and patients in Townsville to Mount Isa, Hervey Bay and Rockhampton • increased teleradiology support at Townsville and Rockhampton hospitals • implemented foetal monitoring (foetal maternal ultrasound) from Cairns to the Mater Mothers' Hospital

Graph 24: Telehealth non-admitted patient occasions of service by month public acute hospitals, Queensland, 2008–09 and 2009–10p.



Source: Monthly Activity Collection, Queensland Health 2009–2010 July 16 2010; 2008-2009 extracted July 20, 2010.
Note: 'p' = preliminary data

Activities	Achievements
• expanded the Medical Specialist Outreach Assistance Program	• increased the number of patients seen by the Medical Specialist Outreach Assistance Program from 12,598 in 2008–2009 to 14,111 in 2009–2010 • increased the number of Indigenous patients treated under the program from 6,586 in 2008–2009 to 7,772 in 2009–2010 • expanded the Medical Specialist Outreach Assistance Program to include Indigenous chronic disease
• continued implementation of health components of Blueprint for the Bush	• expanded multipurpose health services from 22 to 26 sites – new sites include Augathella, Childers, Mitchell and Mungindi • established the rural sustainability principles and guidelines for sustainable health services for rural Queensland • started an allied health relief pool service which provided 224 weeks of relief for rural and remote allied health practitioners
• enhanced rural maternity care and child health services	• funded nine rural sites to establish or improve midwifery care models • established a rural and remote maternity collaborative to develop a range of sustainable maternity models of service delivery for rural and remote communities • enhanced the Flying Obstetrician and Gynaecologist Service • reactivated the Queensland Maternal and Perinatal Quality Council
• patient transport and accommodation	• progressed stage two of the $15 million commitment for Patient Accommodation Grants with five organisations to build or enhance patient accommodation facilities in Cairns (2), Townsville (2) and Toowoomba (1) – two projects focus on Aboriginal and Torres Strait Islander patients • provided a grant to Cancer Council Queensland towards the construction of the new Central Queensland Cancer Education Support and Accommodation Centre in Rockhampton
• Patient Travel Subsidy Scheme Review	• administrative review of the Patient Travel Subsidy Scheme (PTSS) will develop and implement a statewide PTSS framework to enable a simpler application process for patients, medical practitioners and staff; reduced reimbursement times, and more consistent use of the scheme across the state • progressing to develop a standardised PTSS information system that will enhance the operation and effectiveness of the scheme

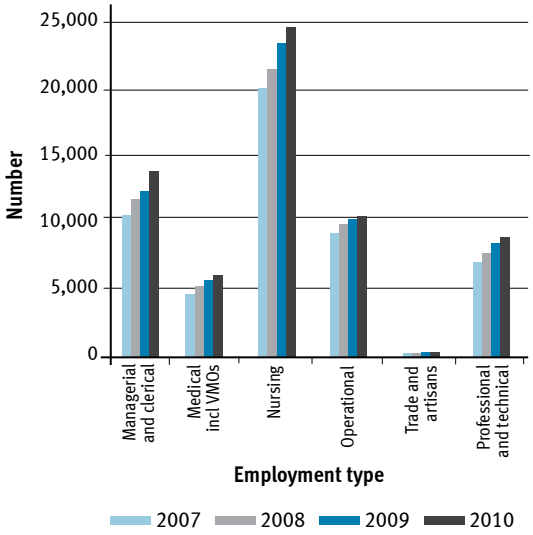
Strategic objective

Improve access to mental health services across Queensland.

Activities	Achievements
Improved mental health services through the Queensland Plan for Mental Health 2007–2017 priority areas:	
• Priority 1: Promotion, prevention and early intervention	• ongoing policy development, research, and implementation of promotion, prevention and early intervention programs through the Queensland Centre for Mental Health Promotion, Prevention and Early Intervention • more than 13,500 people in Queensland and 66 accredited Queensland Health mental health first-aid trainers trained in mental health first-aid
• Priority 2: Integrating and improving the care system	• expanded mental health services with 514 new doctors, nurses, allied health and support positions in public community mental health services, a 23 per cent increase in clinical staff working in community settings since 2006–2007 • ongoing work on 17 capital works projects across the state to deliver 146 additional beds by 2011–2012
• Priority 3: Participation in the community	• developed a plan in partnership with the Department of Communities (Disability Services) to guide ongoing service development and investment in the non-government sector
• Priority 4: Coordinating care	• established 20 service integration coordinators across 15 health service districts to support coordination of mental health service delivery across government, non-government and private sector services
• Priority 5: Workforce, quality, information and safety	• continued implementation of workforce recruitment and retention strategies that have enabled the recruitment of more than 500 additional staff • implemented a new integrated mental health information system for direct care clinicians for improved timely access to consumer clinical information

Strategic objective

Develop and value the workforce.

Activities	Achievements
• increased clinical recruitment through a range of initiatives including re-entry programs, scholarships and targeted recruitment marketing	• during 2009–2010, clinical staff numbers increased by an additional 2,169 • implemented an allied health re-entry framework • processed 550 applications from international medical graduates for special purpose registration • offered 556 medical internships to medical graduates **Graph 25: MOHRI occupied FTE by employment stream**  *Source: Minimum Obligatory Human Resource Information (MOHRI)*
• improved staff retention *The retention rate is the number of permanent staff who were employed by the organisation at the start of the financial year and who remain employed at the end of the financial year, expressed as a percentage of total staff employed **The separation rate represents the separations for the year against the start of the year headcount	• Queensland Health retention rate* is 91.2 per cent • Queensland Health separation rate** for 2009–2010 was 6.9 per cent compared with a separation rate of 7 per cent in 2008–2009
• increased support and training for nurses and midwives	• awarded more than 30 midwifery scholarships and 70 nursing scholarships
• increased support and training for interns	• developed and implemented the More Learning for Interns in Emergency program
• improved recruitment and training for intensive care registrars	• implemented a statewide intensive care registrar training and recruitment process

Activities	Achievements
• increased nurse practitioner positions in priority areas, such as emergency, aged care, paediatric, mental health, rural and remote and chronic disease	• employed an additional 13 nurse practitioners in 2009–2010 in emergency departments at Logan, Redlands, Redcliffe, Ipswich and Cairns Base hospitals • sponsored 24 registered nurses to start a Master of Nurse Practitioner program in 2010
• Developed a model for a statewide internal nursing locum service – NurseOnQ	• developed the model for NurseOnQ and implementation is scheduled for late-2010
• implemented an allied health rural and remote relief program	• started the allied health relief pool service, which provided 224 weeks of relief in rural and remote facilities
• increased leadership skills	• leadership development workshops to 200 Queensland Health staff • provided 360-degree feedback summary reports for Queensland Health executives continue to show improvement in key leadership qualities
• increased allied health research	• provided $700,000 for allied health research grants, including $200,000 specifically for clinical education and training research
• provided suitable staff accommodation in rural and remote areas	• completed six new staff accommodation projects at Aurukun, Cooktown, Kowanyama, Mount Perry, Mount Isa and Palm Island

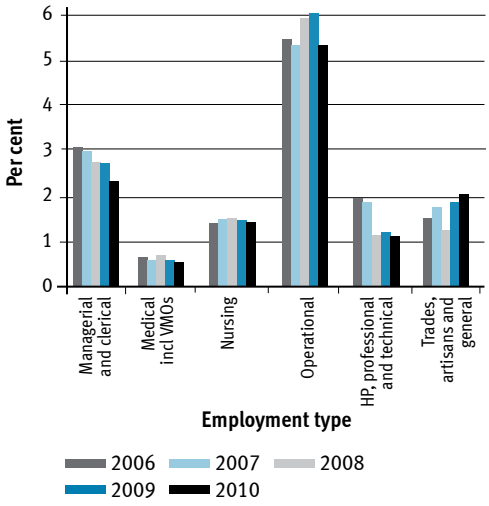
Activities	Achievements
• Queensland Aboriginal and Torres Strait Islander Workforce Strategy 2009–2012 was developed to increase Aboriginal and Torres Strait Islander representation in the workforce	• Aboriginal and Torres Strait Islander representation in the Queensland Health workforce in June 2010 was 2.16 per cent – 1.25 per cent of the clinical workforce identified as Aboriginal and Torres Strait Islander, and 3.7 per cent of the non-clinical workforce identified as Aboriginal and Torres Strait Islander **Graph 26: Percentage Aboriginal and Torres Strait Islander workforce**  *Source: Monthly Workforce Profile, Queensland Health*
• continued to implement the Occupational Health and Safety Strategic Plan 2007–2012	• compliance with the essential criteria of the Safer and Healthier Workplaces was confirmed in an external audit conducted by The Brief Group in May 2010 • developed the Occupational Health and Safety Management system and the staged statewide implementation commenced in 2009–2010 • Table 17 demonstrates a slight increase in the number of injuries reported to WorkCover (3,000 compared with 2,982 in 2008–2009), but the average number of days lost was reduced from 15 to 14 days

Table 17: Staff injuries	2008–2009	2009–2010
Number of incidents/near-miss reported	20,274	21,530
Number of injury workers' compensation claims*	2,982	3,000
Total days lost	45,784	42,065
Average days lost	15.4	14.0
Total claims cost	$11,493,006	$10,602,164
Average claims cost	$3,854	$3,534

** All workers' compensation claims lodged regardless of acceptance by WorkCover Queensland*
Source: Incident Management System, Queensland Health and WorkCover, Queensland

Strategic objective

Manage infrastructure and assets to ensure safe, efficient and effective services evident by delivering major infrastructure developments on time and within budget.

Activities	Achievements
• established a minimum funding benchmark for building asset maintenance	• expended $141.35 million on asset maintenance, which is slightly more than the minimum funding benchmark of $134.92 million • developed strategic maintenance plans to reflect maintenance needs of Queensland Health's building portfolio
• provided a $7.33 billion investment over four years (2010–2014) in new and improved infrastructure	• completed the following projects in 2009–2010: – $26.38 million Capricorn Coast Hospital and Health Service – $41.44 million Ingham Hospital redevelopment final stage – $139.57 million Prince Charles Hospital redevelopment final stage – $1.30 million relocation and expansion of Cairns Base Hospital Cancer Care Centre – $8.30 million expansion of Cairns Medical Imaging Department and installation of a new MRI – $11.1 million expansion of the Cairns Hospital Emergency Department – $13.40 million refurbishment of 45-bed Nambour residential aged care facility – $149.08 million new rehabilitation building at Rockhampton Base Hospital – part of stage 1 hospital expansion project – $7 million renovations to Eventide Nursing Home at Sandgate – $1.82 million new staff accommodation and $840,000 new dialysis patient accommodation in Mount Isa – five additional psycho-geriatric extended treatment beds as part of the $13.40 million new Nambour residential aged care facility – refurbishments to Bundaberg Base Hospital mental health building to increase ward capacity as part of a $4.28 million extension and refurbishment project

Strategic objective

Distribute healthcare resources efficiently and effectively.

Activities	Achievements
• optimised own-source revenue	• focused on improving own-source revenue generation throughout 2009–2010 with a range of strategies that achieved overall growth in this area, including health service districts' optimising own source revenue capability profiling and recommendations
• continued to develop and implement a casemix funding model	• initiated and developed a number of programs within the casemix funding model with a continued focus on the development and veracity of Queensland Health's activity-based funding model, with a view to align with the National Health Reform processes underway • state activity-based funding implementation plan was endorsed by the Deputy Premier in November 2009 in response to the national implementation of activity-based funding • implemented a number of initiatives to consolidate and advance towards full implementation of activity-based funding
• improved organisational capacity in effective financial management	• formalised an alliance with the Institute of Chartered Accountants to promote excellence in technical and professional skills and knowledge • implemented a competency-based training framework for finance and accounting professionals • expanded the finance graduate program to eight graduates who completed various rotations throughout the department while completing their professional studies • launched online training modules in core accounting skills • developed training modules to help all staff, including clinicians, to understand and work with a new activity-based funding model

Strategic objective

Invest in information and communication technology.

Activities	Achievements
• invested in information and communication technology to support the electronic medical record (eMR)	• completed establishment and discovery phase of the eHealth project, including: – extensive consultation with stakeholders – identification of existing projects/programs – investigation of tactical and strategic eMR options – established governance arrangements for implementation – started implementation planning
• ensured ongoing replacement and management of technological devices and investment in new health technologies	• ICT Management Program included: – replaced 9,095 workstations – managed 65,000 email accounts – blocked an average of 204,000 spam messages every day
• implemented an electronic messaging system to connect Queensland Health with General Practitioners – GP Connect	• GP Connect is being used by more than 6,000 healthcare providers in 1,300 practices – there are currently 3,500 messages sent per day to GPs, Australian Defence Force clinicians, Royal Flying Doctor Service, Family Planning Queensland and the University of Papua New Guinea and Tabubil Hospital in Papua New Guinea
• continued to roll out the Queensland Radiology Information System The Queensland Radiology Information System won the Premier's Award for Excellence in Public Service Delivery	• in 2009–2010, the Queensland Radiology Information System (QRiS) was implemented in another 25 sites, bringing the total number of sites to 36, leading to: – 20,500 tele-reported images taken in 30 rural, remote and Indigenous hospitals by specialists in Townsville, Rockhampton and Brisbane, compared with 11,700 during 2008–2009 – 191,790 radiologist image reports completed in QRiS, compared with 103,930 in 2008–2009 • in 2009–2010, QRiS implementation resulted in: – 62,701 validated radiology reports completed at The Prince Charles Hospital – 89,788 validated radiology reports completed at The Townsville Hospital – 7,484 validated radiology reports completed at Mackay Base Hospital (since March 2010) – 9,763 validated radiology reports completed at Gold Coast and Robina hospitals (since April 2010)

Activities	Achievements
	– 22,054 validated radiology reports completed at Rockhampton hospital (since December 2009) • 74 of the 130 Queensland Health medical imaging facilities now have electronic access to radiology reports • deployment of QRiS to continue in 2010–2011
• expanded the Picture Archiving and Communication Systems (PACS)	• in 2009–2010 Enterprise PACS were implemented at five facilities • 66 facilities have access to images online • 85 facilities have the ability to transfer images electronically to another Queensland Health facility • deployment of enterprise PACS to continue in 2010–2011
• continued to roll out the statewide enterprise discharge summary system to support the continuum of patient care	• enterprise discharge summary system is live in 108 public hospitals in Queensland, with 69 systems delivered during 2009–2010 • 136,426 discharge summaries were sent to general practitioners in 2009–2010
• continued implementation of the information system for School of Oral Health	• Information System for Oral Health (ISOH) is live in 355 sites (158 school dental clinics and 197 mobile vans) that cover about 2,000 state, independent and Catholic schools across Queensland • more than 524,000 school dental records are available electronically statewide • all occasions of service have been recorded in the ISOH, increasing the availability and quality of service information. Previously 80 per cent of occasions of service were recorded • 98.9 per cent of treatment information is available in the ISOH • all clinics now have access to information sources, such as Queensland Health Electronic Publishing Service (QHEPS) and email for professional support and increased service efficiency, as well as remote professional supervision

Strategic objective

Work in partnership to effectively influence health and wellbeing outcomes.

Activities	Achievements
• established a Queensland Clinical Senate as a multidisciplinary forum of practising clinicians and consumers, to provide recommendations to Queensland Health on how to deliver the best health care to Queenslanders	• inaugural meeting of the Queensland Clinical Senate was held on 22 May 2009 • Clinical Senate made 59 Senate recommendations on clinical workforce education and training, patient care and patient flow. Queensland Health has endorsed, or endorsed in principle, 57 of these recommendations
• continued to use the clinical networks to give direction and advice to Queensland Health in areas, such as clinical standards, planning, workforce, quality, research and clinical information systems	• increased the number of consumers, general practitioners and NGOs participating in clinical networks – eight of the nine clinical networks have consumer representation • key achievements for clinical networks in 2009–2010 included: – development of a midwifery-led mother and baby discharge implementation guide – guidelines for the management of insulin pumps – framework for the care of patients with dementia in the acute care setting – guidelines for the transition of adolescents with chronic/complex care needs to adult services and established advisory groups into paediatric mortality and morbidity – completed the ABO-incompatible renal transplant pilot and helped establish five dialysis chairs in the Kingaroy Dialysis Unit – developed a statewide database of pulmonary rehabilitation programs and developed the spirometry training program – implemented an automated anaesthetic record-keeping information system to 11 healthcare facilities – established a protocol for the endorsement of clinical guidelines

Strategic objective

Invest in research that promotes evidence-based practice and innovation.

Activities	Achievements
• streamline administrative and regulatory processes impacting on health and medical research	• streamlined ethical reviews and research governance administrative processes for multicentre research • provided guidance, support and opportunities for collaboration across the statewide health and medical research sector through the Office of Health and Medical Research • continued implementation of the Health and Medical Research Strategy • awarded $15.5 million in funding for the Health Research Fellowship Program resulting in 261 more hours of research per week • provided another $9 million towards operational support and other research funding programs • Queensland Health Human Research Ethic Committees reviewed 927 research studies during 2009–2010

Strategic objective

Strengthen performance management, governance and accountability to ensure openness and transparency.

Activities	Achievements
• developed the Queensland Health Performance Management Framework	• developed the Queensland Health Performance Management Framework and toolkit to help health service districts and corporate divisions apply the framework locally • ongoing engagement with health service districts and corporate divisions regarding performance management
• coordinated and executed executive performance agreements	• The 2009–2010 Queensland Health Executive Performance Agreements were developed and are operational for all district chief executive officers and executive management team members
• regular reporting and review of performance against schedules in the executive performance agreements	• completed mid and end-of-year reviews for district chief executive officers, chief executives and deputy directors-general • monthly reporting of Tier 1 key performance indicators to the executive management team and district chief executive officers • authoritative source of statistical data and services to help performance measurement, forecasting and public reporting

Service delivery statement

Departmental services

Each year Queensland Government agencies are required to report on their service delivery within the State Budget Service Delivery Statement papers.

Queensland Health reports service delivery under six services that reflect the department's planning priorities and supports investment decision-making across the health continuum, including delivery of Toward Q2 targets – cut by one-third obesity, smoking, heavy drinking and unsafe sun exposure and Queensland will have the shortest public hospital waiting times in Australia.

Prevention, promotion and protection

Prevention, promotion and protection aims to prevent illness and injury, actively promote and protect the good health and wellbeing for Queenslanders and reduce the health status gap between the most and least advantaged in the community.

The service is directed at the entire well population or specific sub-populations, rather than individual treatment and care. It uses a range of strategies, such as disease control, regulation, social marketing, community development and screening.

Primary health care

Primary health care addresses health problems or established risk factors of individuals and small targeted groups with curative, promotive, preventative and rehabilitative services.

Primary health care services are largely provided by general practitioners or other non-government healthcare providers. However, through multidisciplinary teams of healthcare professionals, Queensland Health provides a range of primary health care services, including early detection and intervention services and risk factor management programs through community health facilities, child health centres and dental clinics.

Ambulatory care

Ambulatory care aims to give equitable access to quality emergency medical services in public hospital emergency departments and Queensland's public hospital outpatient departments. These include pre-admission, post-acute and other specialist medical, allied health, nursing and ancillary outpatient services.

Acute care

Acute care aims to increase equity of access to high-quality acute hospital services statewide. It includes medical, surgical and obstetric services to people treated as acute admitted patients in Queensland's public acute hospitals.

Rehabilitation and extended care

Rehabilitation and extended care predominantly targets the needs of people with prolonged conditions and chronic consequences. The goal is to improve the functional status of a patient with an impairment or disability, slow the progression and help them maintain and better manage their health condition.

It includes rehabilitation, palliative care, respite, psychogeriatric, geriatric evaluation and management, residential aged care services, residential services for young people with physical and intellectual disabilities, as well as extended care services that focus on maintaining a person's health and current functional status.

Integrated mental health services

Integrated mental health services span the health continuum through mental health promotion and prevention activities (including suicide-prevention strategies), community-based services, acute inpatient services and extended treatment services.

Mental health reform is guided by the Fourth National Mental Health Plan and the Queensland Plan for Mental Health 2007–2017. Mental health services aim to promote the community's mental health, prevent development of mental health problems where possible, and give timely access to assessment and treatment services.

Departmental statements

The Queensland Government's Performance Management Framework is being progressively implemented.

The concepts of 'outputs' and 'performance measures', previously used in service delivery statements, have been replaced with 'services' and 'service standards'. These terms are defined in the Budget Readers' Guide and show how efficiently and effectively agencies deliver services within their approved budget.

Table 18: Service delivery statement

Service standards	Notes	2009–2010 target/est.	2009–2010 est. actual (a)	2009–2010 actual (b)
Service: Prevention, Promotion and Protection				
Percentage of the Queensland population who:				
• consume recommended amounts of fruit and vegetables		9%	8.45%	8.41%
• engage in levels of physical activity for health benefit		56%	54%	54%
• consume alcohol at risky and high-risk levels		11%	11.4%	11.4%
• smoke tobacco		15%	15.5%	15.5%
• adopt ultraviolet (UV) protective behaviour		95%	96%	96%
Percentage of target population screened for:				
• breast cancer		57.5%	57.4%	57.4%
• cervical cancer		59.5%	59.8%	59.8%
• bowel cancer	2	42.5%	41.4%	40.9%
Vaccination rates at designated milestones for:				
• all children aged 2 years		92%	90.8%	91.34%
• Aboriginal and Torres Strait Islander children aged 2 years	3	92%	90.5%	91.39%
• Year 8 female students for Human Papilloma Virus (HPV)	4	75%	65%	65%
New notifications of HIV infection		185	185	202
Percentage of Queensland population, meeting the requirements of the *Water Fluoridation Act 2008*, that receive fluoridated water from reticulated water supplies		80%	80%	82%
Percentage and number of fall-related hospitalisations for older people (aged over 65 years) in Queensland	5	4.3% 21,546	2.7% 13,584	2.7% 13,584
Percentage of invasive cancers detected through BreastScreen Queensland that are small (<15mm) in diameter		New measure	60.8%	61.8%
Number of high-risk complaints investigated and the risk controlled	6	New measure	865	1,048
State contribution ($000)	7,8	357,396	279,333	202,774
Other revenue ($000)		165,081	196,570	196,518
Total cost ($000)		522,477	475,903	399,292

Service standards	Notes	2009–2010 target/est.	2009–2010 est. actual (a)	2009–2010 actual (b)
Service: Primary health care				
Number of calls to 13 HEALTH (information and teletriage service)		230,000	251,000	257,838
Percentage of calls to 13 HEALTH (information and teletriage service) answered within 20 seconds		80%	83.16%	82%
Number of children and adolescents oral health occasions of service (0-15 years)	9	560,000–580,000	460,000	456,454
Number of adult oral health weighted occasions of service (ages 16+)		1,900,000–2,100,000	1,900,000	1,916,393
Number and age standardised rate of potentially preventable admitted patient episodes of care:	1			
• non-Aboriginal and Torres Strait Islander patients		No: 124,000 Rate: 30	No: 120,488 Rate: 27.9	No: 118,839 Rate: 27.5
• Aboriginal and Torres Strait Islander patients		No: 7,750 Rate: 83.4	No: 8,330 Rate: 85.7	No: 8,104 Rate: 84.2
Percentage of women who, during their pregnancy were smoking after 20 weeks:	1			
• non-Aboriginal and Torres Strait Islander women		14%	13.1%	12.4%
• Aboriginal and Torres Strait Islander women		48.2%	46.8%	46.5%
State contribution ($000)	7,8	375,266	449,784	499,910
Other revenue ($000)		60,861	71,508	74,965
Total cost ($000)		436,127	521,292	574,875

Service: Ambulatory care				
Total number of non-admitted occasions of service (including emergency services):	1,12	11,000,000 –11,500,000	10,872,652	11,083,414
• emergency services			1,562,613	1,573,041
• speciality clinics			3,408,080	3,544,242
• diagnostic and outreach services			5,901,959	5,966,131
Total non-admitted weighted activity units:	13	250,000 –275,000	262,261	265,358
• emergency services				27,982
• speciality clinics				223,225
• diagnostic and outreach services				11,054
Percentage of women who gave birth and had 5 antenatal visits or more in the antenatal period:	1			
• non-Aboriginal and Torres Strait Islander women		92%	91.6%	92.0%
• Aboriginal and Torres Strait Islander women		78%	76.6%	76.9%

Service standards	Notes	2009–2010 target/est.	2009–2010 est. actual (a)	2009–2010 actual (b)
Proportion of patients attending emergency departments treated within standard timeframes for:	14,15			
• Category 1 (immediate)		100%	98%	99%
• Category 2 (within 10 minutes)		80%	75%	77%
• Category 3 (within 30 minutes)		75%	58%	59%
• Category 4 (within 1 hour)		70%	62%	63%
• Category 5 (within 2 hours)		70%	85%	86%
State contribution ($000)	7,8	1,250,886	1,261,337	1,273,520
Other revenue ($000)		565,406	582,996	597,731
Total cost ($000)		1,816,292	1,844,333	1,871,251

Service: Acute care				
Acute admitted patient episodes of care	1	850,000–890,000	888,432	890,778
Acute admitted patient weighted activity units	13	830,000–850,000	875,084	878,320
Patient days	1	2,500,000–2,900,000	2,552,176	2,540,569
Number of available bed and available bed alternatives for public acute hospitals	1	10,350–10,400	10,460	10,453
Percentage of patients admitted from emergency departments within 8 hours		65%	66%	66%
Percentage of admitted patients discharged against medical advice:	1,10			
• non-Aboriginal and Torres Strait Islander patients		0.75%	0.98%	0.95%
• Aboriginal and Torres Strait Islander patients		2.05%	3.26%	3.27%
Percentage of clinical indicator VLAD reviews (triggered as a result of variation from State average) completed within approved timeframes	16	100%	53%	55%
Number of days waited at the 50th percentile for elective surgery:	1,17,18			
• Category 1 (30 days)		-	11	11
• Category 2 (90 days)		-	43	44
• Category 3 (365 days)		-	85	96
Number of days waited at the 90th percentile for elective surgery:	1,17,19			
• Category 1 (30 days)		30	34	35
• Category 2 (90 days)		90	119	130
• Category 3 (365 days)		365	349	376

Average cost per weighted activity unit for acute admitted patients	13	$4,500-$4,800	$4,600	$4,630
State contribution ($000)	7,8	3,037,865	3,059,985	3,314,534
Other revenue ($000)		1,670,260	1,748,365	1,786,043
Total cost ($000)		4,708,125	4,808,350	5,100,576

Service: Rehabilitation and extended care				
Sub and non-acute patient days (including maintenance care, rehabilitation and palliative care)	1,11	460,000–480,000	512,446	484,751
Sub and non-acute weighted activity units	13	92,000	112,857	113,500
Average number of public hospital beds occupied each day by nursing home type patients	1	400	375	379
Number of State Government Residential Aged Care Facilities and services meeting National Accreditation Standards		20	20	20
Average cost per weighted activity unit for sub and non-acute patients	13	$4,400-$4,800	$5,100	$4,880
State contribution ($000)	7,8	399,092	409,044	423,949
Other revenue ($000)		344,922	377,944	384,381
Total cost ($000)		744,014	786,988	808,330

Service: Integrated Mental Health Services				
Mental health acute admitted patient episodes of care	1,20	14,000–15,000	14,612	14,481
Mental health acute admitted psychiatric care days	1,20,21	190,000–200,000	220,100	208,172
Mental health extended treatment accrued mental health care days	1	180,000–200,000	181,256	182,167
Weighted activity unit for mental health acute admitted patient episodes of care	13	55,000	63,067	63,350
Mental health patients accessing community mental health care	1,22	77,000–82,000	75,860	72,670
Community mental health occasions of service	1,23,24	1,300,000–1,350,000	858,749	880,046
Re-admission rate to acute psychiatric care within 28 days of discharge	1,25	15%-20%	16%	15.8%
Rate of community follow-up within seven days post-discharge from acute inpatient care	1	New measure	45.4%	45.8%
State contribution ($000)	7,8	536,094	544,290	516,139
Other revenue ($000)		273,902	279,248	281,960
Total cost ($000)		809,996	823,538	798,099

(a) As printed in the 2010–2011 SDS in June 2010. (b) The 2009–2010 actual data or most recent estimate for 2009–2010. In some cases this will be the same as the est actual due to data availability.

Notes:

1. Data is preliminary and involves estimation.
2. 2009–2010 actual figure relates to the most recent period for which data is available and reported (1 Jan 2008–31 Dec 2008). This figure is based on unpublished Australian Institute of Health and Welfare (AIHW) data which uses the estimated resident population as the denominator. The 2009–2010 actual is lower than the 2009–2010 target/est. due to the inclusion of 50-year-olds whose response rate is lower than 55 and 65-year-olds. However, reporting for people invited in the last three months of the calendar year is influenced heavily by lag times to complete the faecal occult blood test (FOBT) kit; therefore, participation rates are likely to be understated.
3. Coverage data for two-year-olds are reported quarterly by the Australian Childhood Immunisation Register (ACIR). Data for this report have been updated and measured using September 2009, December 2009, March 2010 and June 2010 quarterly reports. While fluctuations are expected in vaccination coverage, rates for these cohorts dropped slightly in this period due to the ACIR using different criteria for some of the vaccines reported.
4. HPV coverage for Year 8 female students is based on estimates for dose three vaccinations. The target of 75 per cent is consistent with targets for other vaccines delivered in the school program and with national targets for the program. The reported rates are preliminary as data is still being validated. This program will take some time to establish and it is expected that rates will improve over time. High coverage of multi-dose vaccination courses presents major challenges, particularly in the adolescent cohort. Uptake drops with each successive dose (coverage for dose 1 HPV is about 75.7 per cent).
5. The decrease in the 2009–2010 est. actual and the 2010–2011 target/est compared with the 2009–2010 target/est. is due to realignment of codes for falls to be consistent with national reporting. Independent of this change, the impact of the ageing population, more people in the high-risk bracket, migration of older people to Queensland and natural variation from year to year will affect the estimates. Data relates to hospitalisations for persons 65 years and older and not number of people admitted, as the same person can have multiple hospitalisations. It is estimated that the number of older people who are hospitalised with a fall will increase slightly due to the projected increase in population in this age group.
6. The determination of what constitutes a 'high-risk' complaint is currently being reviewed in the light of the data collected and analysed during the year with a view to developing a more predictable position for the 2010–2011 financial year. The risks were controlled for all complaints investigated.
7. Revenue allocated by services ($s). Subsequent to the production of the 2009–2010 Service Delivery Statement (SDS) a review was undertaken of expenditure splits across the services. A subsequent review was undertaken in relation to revenue allocation across services in the 2010–2011 SDS.
8. Effective 1 July 2009, the Queensland Health Shared Service Partner (QHSSP) was incorporated into Queensland Health. QHSSP total cost for 2009–2010 est. actual and 2009–2010 actual are allocated across the services to which they relate. Commonwealth funds received via Queensland Treasury are included in 'other' revenue in the Performance Statement. It also includes the share profits in associates. Therefore, these figures are not directly comparable with the Statement of Comprehensive Income by major services and SSP in the financial statements.
9. The 2009–2010 actual is lower than the 2009–2010 target/est. due to the reduced amount of clinical time available, due to staff being trained in the new information system used to electronically collect data. There was also a reduction in the number of dental chairs available due to refurbishments and replacements of mobile dental clinics to ensure compliance with contemporary workplace health and safety and infection control (sterilising) requirements.
10. The 2009–2010 target/est. cannot be directly compared with the 2009–2010 est. actual or 2010–2011 target/est. due to a change in the indicator methodology. The change is to reflect a more accurate way of counting the measure. Previously, factors such as deceased patients and those receiving renal dialysis were included in the denominator. The 2009–2010 est. actual and the 2010–2011 target/est have been amended to exclude these factors.
11. The estimated actual (512,446) was higher than the actual (489,301). The estimated actual was based on six months of data; however, the second half of the year has showed about a 10 per cent drop in this activity. This has lead to the overestimate.
12. The estimated actual figure was based on eight months worth of data and projected out to 12 months, which indicated that the annual total would be less than 11,000,000.
13. The 2009–2010 actual weighted activity units (WAUs) and average costs per WAUs are preliminary and involve estimation. The actual data is anticipated to be finalised by the end of September 2010.
14. The estimated actual figure was based on eight months worth of data. No estimation or forecasting occurred.
15. The actual result was unexpected as the June quarter usually sees an increase in emergency department attendances and subsequent slight decline in performance, due to the presentation of patients with winter symptoms. Last year's trend was particularly affected due to swine flu, and early indications were that such an epidemic may reappear this year.
16. Variance between the 2009–2010 target/est. and the 2009–2010 actual is due to the variable maturity/ experience of the districts to conduct and report a VLAD review. A slight improvement from 2008–2009 (37 per cent) to 2009–2010 (55 per cent) has occurred as a result of improved local review processes and the introduction of a new information system in late-2009 assisting hospitals in completing VLAD reviews and monitoring their review status.
17. The estimated actual figure was based on seven months worth of data with no estimation or forecasting involved.

18. The variation shown for category three patients is a result of the focus on treating elective surgery patients who had waited more than one year. Between January and June 2010, a higher number of these patients were treated than usual, increasing the median wait reported. Although this would indicate a decline in performance against this measure, elective surgery performance against other measures has improved. Once the majority of the backlog of 'long wait' patients is removed, the median wait result is expected to improve.
19. The variations shown for category two and three patients are a result of the focus on treating elective surgery patients who had waited more than one year. Between January and June 2010, a higher number of these patients were treated than usual, increasing the median wait reported. Although this would indicate a decline in performance against this measure, elective surgery performance against other measures has improved. Once the majority of the backlog of 'long wait' patients is removed, the median wait result is expected to improve.
20. At date of extract all 2009–2010 data had not been submitted to the Queensland Hospital Admitted Patient Data Collection. Therefore, the 2009–2010 'actual' is calculated on a pro-rata basis from the July 2009 to May 2010 figures.
21. 2009–2010 actual is higher than the 2009–2010 target/est due to a large number of separations from the acute units of one facility with extended lengths of stay in the first half of the reporting period.
22. The 2009–2010 target/est was calculated before introduction of the statewide clinical information system (CIMHA) in November 2008 which replaced previous systems that used data sourced from two different systems and resulted in duplication of consumer records, which artificially inflated estimates.
23. The 2009–2010 target/est was set based on data trends from the previous mental health information system.
24. Transition to the new system in November 2008 adversely impacted on compliance with record keeping. The Mental Health Directorate has initiated strategies to address these issues, but as a consequence, the capacity to accurately predict activity for 2009–2010 was reduced. Additionally, there are differences in the way information is recorded between CIMHA and the old systems. For instance, more than one intervention can be recorded within a single service contact. On average, there are 1.1 interventions per service contact. Additionally, initial analysis between 2008–2009 and 2009–2010 has shown that while the count of service contacts has reduced, the overall duration of client-related contacts has not.
25. At date of extract all 2009–2010 data had not been submitted to the Queensland Hospital Admitted Patient Data Collection. Therefore, the 2009–2010 'actual' is calculated on a pro-rata basis from the July 2009 to February 2010 figures.

Variable life adjusted displays

Measuring clinical outcomes

Queensland Health is determined to deliver the safest and highest-quality patient care. To help it achieve this, it monthly monitors 30 clinical indicators, using a statistical technique – variable life adjusted display (VLAD). Deloitte, in partnership with Communio, reviewed the VLAD process in late-2009 and practical recommendations to improve VLAD governance and processes were implemented.

VLADs give staff an easily understood pictorial view of patient outcomes over time to identify extraordinary trends and occurrences at or near the time they occur. This allows them to be promptly investigated and acted on.

Queensland Health's approach to VLADs is world-leading and incorporates the following principles:

- line management responsibility for patient safety and quality
- clinician involvement
- just and open approach to managing adverse events
- responsibilities articulated for all levels of Queensland Health
- measurement of outcomes and performance
- transparency and accountability
- emphasis on the need for Queensland Health to improve patient safety, quality and effectiveness.

Table 27 presents all upper (favourable) and lower (unfavourable) level 3 flags notified to hospitals between April 2009 and March 2010, and corresponding review results associated with the lower level 3 flags.

Each of these review results were reviewed external to the hospital by the Queensland Health Patient Safety and Quality Executive Committee VLAD subcommittee to ensure reviews were thorough and action plans addressed findings. For more information on the VLAD methodology, visit the VLAD website at www.health.qld.gov.au/quality/vlad.asp.

The indicators monitored during 2009–2010 are divided into four categories:

- surgical
- medical
- obstetrics and gynaecology
- mental health.

Surgical indicators

The surgical indicators cover in-hospital mortality, complications of surgery, re-admission rate and the rate of long-stay patients. Results for each surgical indicator is outlined in Table 27. Where a hospital's result against an indicator has been identified as potentially unfavourable, the results of the review are provided.

Fractured neck of femur in-hospital mortality

This indicator measures the number of patients who have died after an admission with fractured neck of femur.

Gold Coast Hospital

This group of patients are usually elderly with numerous pre-existing medical conditions, and can experience delays in accessing theatre time.

A dedicated operating theatre timetable and personnel have been established to fast-track this group. A geriatrician now reviews and manages this elderly group of patients, in collaboration with the orthopaedic team to ensure patients are in the best possible condition for surgery and discharge.

Nambour General Hospital

Ten cases were reviewed in which patients had undergone operative treatment for a fractured neck of femur and subsequently died in hospital. All cases had other significant medical conditions that were prime factors in the deaths. All care was appropriate and no deficiencies were identified that contributed to the deaths. The deaths were attributed to a series of patients with poor health at time of the injury.

Hip-replacement long-stay

This indicator measures the number of patients who remained in hospital for 14 days or more for hip-replacement surgery.

Gold Coast Hospital

Elective and unplanned accident/trauma cases were reviewed. A number of patients in each group had a range of complicated health problems. The group of patients admitted with a traumatic total hip replacement (THR) – unplanned admission and hip replacement required – had delays in accessing theatre time resulting in delays in discharge.

A dedicated operating theatre timetable and personnel have been established to fast-track the unplanned patients. A geriatrician now reviews and helps manage this elderly group of patients, in collaboration with the orthopaedic team. Process improvements have been identified for the elective THR cases and are progressing in 2010.

Royal Brisbane and Women's Hospital

An extensive audit and review identified that apart from multiple co-morbidities, there were a number of reasons impacting on patients' extended length of stay.

An action plan was developed to address surgery delay, including an additional theatre list, acute trauma theatre and orthopaedic acute care coordinator. The multidisciplinary-focused clinical pathway for comprehensive patient care was introduced.

The Prince Charles Hospital

In early-2010, The Prince Charles Hospital will open a new 24-bed, acute orthopaedic ward, which will increase access for patients needing surgical intervention, ultimately improving patient outcomes.

Identification of any service issues will continually be monitored and acted upon accordingly.

Hip-replacement (primary) re-admissions within 60 days

This indicator measures the number of patients re-admitted to any Queensland public hospital within 60 days after discharge following an admission for hip-replacement surgery.

Nambour General Hospital

A total of eight cases, which contributed to the trend of excess numbers of re-admissions after hip replacement, were identified and examined by the Executive Director Medical Services, the Director of Orthopaedic Surgery and Health Information Manager. Of these cases, multiple factors were involved and no specific care concerns identified.

Two cases were infection of the joint replacement for one particular surgeon, who had no previous such infections during their appointment at the hospital. This was considered to be a statistical anomaly, but continued surveillance will occur to eliminate a new trend.

One case was related to a deep venous thrombosis (DVT). The patient was given DVT prophylaxis. The hospital has finalised its policy on venous thrombo-embolism (VTE) prophylaxis and has started using the protocol. Ongoing monitoring of episodes of VTE is in place.

Knee-replacement complications of surgery

This indicator measures the number of patients who had complications after knee-replacement surgery.

Queen Elizabeth II Jubilee Hospital

Of the 12 cases reviewed, all were reviewed by the Director of Orthopaedics director and Health Information manager. Four cases related to data quality (coding issues).

Three cases relating to post-operative pneumonia were reviewed by a secondary clinician (respiratory physician) for further clarification. These three were incorrectly coded as post-operative pneumonia. One case did not have cardiomyopathy as a risk adjustor. These cases have been corrected on HBCIS.

The remaining eight cases related to process of care/professional. There were four cases with post-operative DVT, one case with post-operative pneumonia, one case with post-operative wound infection, one case with post-operative anaemia and one with intra-operative fracture.

The management action plans include:

- clinical coders made aware of importance of coding risk adjustors
- further consultation with clinician before allocation of post-operative pneumonia
- information and education of medical, nursing and physiotherapy in recognising post-operative chest problems
- continue education on medical and chemical prophylaxis for DVT prevention and monitor the compliance of these.

Cases will also be discussed and tabled at the Hospital Patient Safety and Quality meetings.

Knee-replacement long-stay

This indicator measures the number of patients who remained in hospital for 12 days or more for knee-replacement surgery.

Gold Coast Hospital

The cases reviewed were identified as having a number of pre-existing medical conditions or complications post-surgery that impacted on their length of stay. Patient flow processes from pre-admission to discharge are being reviewed with several improvement initiatives.

Logan Hospital

Review of 12 charts showed some patients had pre-existing complicated medical conditions, such as older age, obesity and poor circulation, which added to their length of stay. The multidisciplinary review determined all 12 patients received appropriate care with nil significant concerns.

The review team made a range of recommendations on access to resources (for example, rehabilitation, equipment, staffing) to improve length of stay.

Princess Alexandra Hospital

Clinical and non-clinical staff reviewed 12 knee-replacement cases, in response to this flag. All 12 cases were identified as complex, with patients having a range of other health problems, including diabetes in four cases. Ten of the 12 patients were older than 70.

The need for extensive rehabilitation before discharge for six patients, who lived alone or had poor social support, was another factor contributing to the stay in hospital of longer than 12 days.

Princess Alexandra Hospital will continue its endeavours to reduce the length of stay for knee-replacement patients.

Toowoomba Hospital

Review of the eight long-stay cases identified as leading to the flag point revealed five patients with a history of diabetes and/or circulatory disease experienced heart rhythm irregularities after surgery. The other three were regarded as slow to progress.

It was agreed to review access to rehabilitation and transition care programs which was sometimes difficult because of demand being greater than available places.

Knee-replacement (primary) re-admissions within 60 days

This indicator measures the number of patients readmitted to any Queensland public hospital within 60 days after discharge following an admission for knee-replacement surgery.

The Prince Charles Hospital

Following a recurrent level 3 flag for re-admissions after total knee replacement, an external review was requested. This found no deficiency in the standard of care during the initial admission.

The orthopaedic unit deals with a high proportion of patients with other conditions and who travel to the hospital from outside the area. Some superficial infections or irritation were identified. This is being addressed with a review of ways to cleanse the skin and close wounds.

Paediatric tonsillectomy and adenoidectomy long-stay

This indicator measures the number of patients who remained in hospital for two days or more for removal of tonsils and/or adenoids.

Ipswich Hospital

The hospital review of the 10 long-stay tonsillectomy cases found poor oral intake was the primary reason for extended stays. Actions proposed to reduce the long-stay rate included a review of the pain management protocol and possible benchmarking exercise with Toowoomba Hospital.

Mater Children's Public Hospital

Fifteen paediatric cases were flagged as long-stay, following tonsillectomy/adenoidectomy in the Mater Children's Hospital.

The extended length of stay for these patients was not due to any complications of surgery, but reflects the tertiary nature of the ENT service, where many patients have pre-existing high-risk underlying conditions, including Down's Syndrome and other chromosomal abnormalities, congenital abnormalities, and complex cardiac or respiratory conditions.

Due to these underlying conditions, these children were expected to need more than one night's stay in hospital. An overnight stay in the Paediatric Intensive Care Unit after surgery was planned as part of the post-operative recovery for many of them.

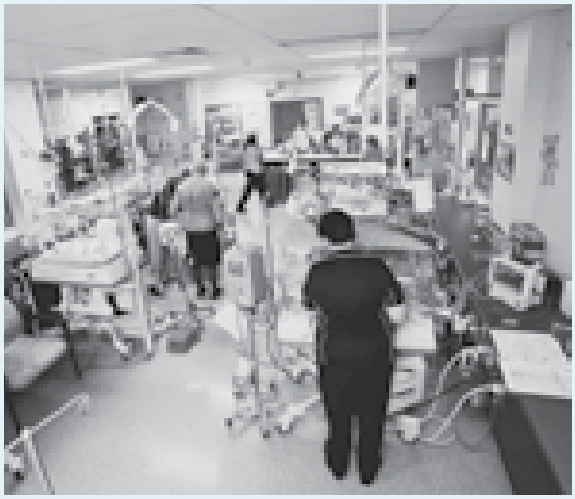
Royal Children's Hospital

Clinical staff investigated nine cases and identified poor oral intake (dehydration) and other non-related complicating health problems (for example, neurological disorders) as the two main reasons leading to an extended length of stay.

The hospital has introduced two new information brochures for parents explaining care following discharge and how to manage oral intake, such as food and fluids.

Medical indicators

The medical indicators cover in-hospital mortality, re-admission rate and rate of long-stay patients. Results for each medical indicator is outlined in Table 27. Where a hospital's result against



an indicator has been identified as potentially unfavourable, the summaries of the review are provided.

Acute myocardial infarction (AMI) mortality

This indicator measures the number of patients who have died following an admission for AMI (heart attack).

Caboolture Hospital

A review by hospital staff showed this indicator continues to display a gradual decline.

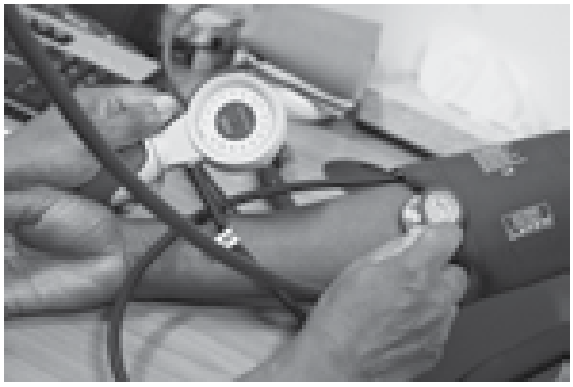
An in-depth review identified that more than 3,500 patients with cardiac symptoms present each year to the Caboolture Hospital emergency department. Of the 2,000 admitted, less than five per cent (94) fall under the AMI parameters.

The review confirmed a robust decision-making system that identifies the most appropriate ongoing care for these patients consistent with nationally accepted guidelines. This includes the decision whether to transfer the patient to a tertiary facility.

High success has been identified for these patients, showing a 97 per cent survival rate, supporting the transfer decision. The review revealed patients who remained in Caboolture Hospital were patients who could not or should not be transferred for clinical reasons and were for palliative measures only.

Acute myocardial infarction re-admission

This indicator measures the number of patients re-admitted to any Queensland public hospital within 30 days of discharge following admission for acute myocardial infarction (heart attack).



Mackay Base Hospital

This flag was investigated by senior clinicians. Causal factors identified included case-mix, resource issues and process of care. Two patients were re-admitted. Both had a significant range of health problems that impacted on the process of care. This has been addressed with an escalation process between the two hospitals.

Toowoomba Hospital

A clinical chart audit was conducted of the six cases identified as AMI re-admissions. The audit found the primary reason for re-admissions was the delay in accessing diagnostic angiography services for public patients.

Toowoomba Hospital has reviewed its arrangements for interventional cardiac services with these facilities.

Heart failure in-hospital mortality

This indicator measures the number of patients who have died following an admission for heart failure.

Beaudesert Hospital

Beaudesert Hospital has developed an inpatient and outpatient palliative care service in conjunction with Logan Hospital. This has allowed patients in the palliative stage of their illness who need inpatient care and treatment to be managed locally.

With the increased number of patients in this class being treated locally, the heart failure in-hospital mortality VLAD was triggered. The hospital has undertaken a comprehensive review of the specific cases and did not identify any issues of concern.

A review of the local mortality review procedures was also undertaken and notified areas for improvement which have subsequently been addressed.

Bundaberg Hospital

A review by health service staff determined five cases for consideration. Data-coding issues were identified for three cases. Three cases were identified as being at the end stage of their illness and, therefore, death was the expected outcome. It was determined that the process of care for all cases was appropriate. The hospital will continue to monitor this indicator to ensure optimal care delivery processes.

Cairns Base Hospital

Six patient charts were reviewed by the coder, quality officer and director of Medical Services, with no coding errors identified. All six patients presented with complex health problems. Of the six cases, three were expected deaths, a third case involved withdrawing treatment after consultation with the family, and the remaining two cases did not respond to active treatment and resuscitation.

All six patients had access to appropriate clinical care, support services, and health professional expertise as required. No actions were identified from this review.

Logan Hospital

The heart failure in-hospital mortality VLAD has been extensively reviewed by clinical and health information staff. The review has identified the mortality rate had been falsely elevated in the data, as cases that were not expected to recover were coded as acute care rather than palliative care.

Education on episode of care classification has been provided to staff to ensure coding and classification is undertaken in accordance with Queensland Health standards.

Proserpine Hospital

The hospital reviewed each case and found these patients had medical conditions that made them at higher risk than normal of complications.

All care of the patients was found to be given in line with the current National Heart Foundation Guidelines, including discussion of the possible poor outcomes with the patient and their family.

The Townsville Hospital

A hospital level review has been undertaken and approved by the Patient Safety and Quality Executive Committee VLAD subcommittee. A final summary from the hospital is pending.

Toowoomba Hospital

A hospital review of the seven heart failure cases dying in hospital found patient characteristics to be the main contributor to the increased number.

Five of the seven cases were aged over 75 years. All cases had long established history of heart failure and other co-morbidities, including ischaemic heart disease and chronic kidney disease (stage three or higher).

The review considered all clinical care to be consistent with the clinical guidelines of the National Heart Foundation for Heart Failure, including treatment, medications and the management of co-morbidities.

Heart failure re-admission

This indicator measures the number of patients re-admitted to any Queensland public hospital within 30 days of discharge following an admission for heart failure.

Ingham Hospital

A hospital-level review has been undertaken and approved by the Patient Safety and Quality Executive Committee VLAD subcommittee. A final summary from the hospital is pending.

Heart failure long-stay

This indicator measures the number of patients who remained in hospital for 14 days or more following an admission for heart failure.

Toowoomba Hospital

Hospital review of the 16 of 19 heart failure cases with stays in hospital of 14 days or more found administrative processes and patient characteristics as the main contributors to the increased number.

In five cases, there was a change in the focus of care from acute to non-acute before 14 days. Thirteen of the 16 cases were aged 70 years or more, seven being 80 years or more.

All cases had long-established history of heart failure and other co-morbidities, including ischaemic heart disease and chronic kidney disease (stage 3 or higher).

The review considered all clinical care at the hospital to be consistent with the clinical guidelines of the National Heart Foundation for heart failure, including treatment, medications and the management of co-morbidities. However, concern was raised concerning the delay.

An audit was conducted on waiting times for externally provided heart studies and found the delay was uncharacteristic as studies were generally performed in a timely manner. The administrative processes are to be corrected.

Pneumonia in-hospital mortality

This indicator measures the number of patients who have died following an admission for pneumonia.

Caboolture Hospital

An extensive review was conducted on nine patient cases. Each case reviewed identified the patient as critically unwell upon admission with multiple co-morbidities.

In addition, all cases reviewed were formally recognised with a ‘Not for Resuscitation’ status. Shortfalls were identified with data. Strategies to improve the quality have been implemented with electronic discharge summaries and education on documentation.

Cairns Base Hospital

Ten patient charts were reviewed and one chart was recoded to a different diagnosis. The remaining nine patients were considered complex with multiple health problems that contributed to their death in hospital. Of these nine patients, four had advanced liver disease and five were diagnosed with a terminal disease and received palliative care.

The standard of clinical care was assessed as appropriate by the clinical director and quality officer. No actions were required beyond correcting the coding error.

Gold Coast Hospital

All 19 cases of pneumonia mortality were jointly reviewed by the quality coordinator and the director of respiratory services. Four cases were incorrectly included in the cohort. One case was incorrectly coded.

Of the remaining 14 cases, four had severe co-morbidities, eight had incorrect episode of change documentation to palliative. The review identified no clinical practice issues. Coding education sessions have started in 2010 to increase medical officers' knowledge of coding.

Mackay Base Hospital

Case mix had been identified as the contributor to this flag. Almost all the patients had complex co-morbidities and had appropriately determined 'Not for Resuscitation' orders. All except one patient were subjected to a death review.

Stroke in-hospital mortality

This indicator measures the number of patients who have died in hospital following an admission for stroke.

Hervey Bay Hospital

A hospital-level review has been undertaken and approved by the Patient Safety and Quality Executive Committee VLAD subcommittee. A final summary from the hospital is pending.

Obstetrics and gynaecology indicators

The obstetrics indicators include third and fourth-degree perineal tears, episiotomy, instrumental delivery, induction of labour and caesarean section for selected primiparae mothers.

The gynaecological indicators include complications of surgery after abdominal or vaginal hysterectomy.

Results for each obstetrics and gynaecological indicator is outlined in Table 27. Where a hospital's result against an indicator has been identified as potentially unfavourable, the findings from the review undertaken are provided.

Selected primiparae episiotomy

This indicator measures the number of episiotomies performed for selected primiparae patients giving birth vaginally (non–instrumental).

Redcliffe Hospital

A review was conducted on six patient cases. Each case was analysed and identified that the clinical decision to perform episiotomies was made on a case-by-case basis. Each case was managed appropriately and episiotomy performed to facilitate delivery according to labour and delivery concerns.

The review highlighted that if the decision was not made to perform an episiotomy, the patients' outcome would not have been positive. Additional audits identified minor data issues that have been addressed with supporting education strategies.

Redland Hospital

The hospital has a VLAD indicator showing that the episiotomy rate is higher than the Queensland average.

On review, the hospital has been unable to find any process of care or professional problems, with the exception of documentation issues.

The hospital is also conscious that it does not wish to affect clinical care, in the absence of a clear clinical care concern. On the other hand, given the VLAD finding, it needs to be assured that the correct care is being provided.

Therefore, it will concentrate on prospectively clinically reviewing the episiotomy cases, as they occur, to closely monitor the situation. It will also continue to monitor nationally benchmarked data on the care of the perineum and wider perinatal outcomes, such as caesarean-section rates.

Redland Hospital

Sixteen patient cases were reviewed by a multi-disciplinary team encompassing midwifery and obstetric staff, including the Director of Obstetrics and Gynaecology.

With the exception of documentation issues, the review did not reveal any professional or process of care concerns. Documentation standards continue to be monitored by midwifery and obstetric staff.

To be confident of appropriate care for obstetric patients, retrospective clinical reviews of all episiotomy cases are being completed and outcomes are discussed with the multi-disciplinary team. Nationally benchmarked data on the care of the perineum also continues to be monitored.

Rockhampton Hospital

Rockhampton Hospital investigated factors contributing to the higher-than-expected rate of episiotomy. There were clearly documented appropriate reasons for episiotomy in most cases.

In some cases, the documented reasons were less comprehensive. Feedback on the investigation has been given to midwifery staff. Education on recording an indication for episiotomy in the medical record has been provided.

The Statewide Maternity and Neonatal Clinical Network Guideline group will develop a guideline for management of normal labour (including episiotomy) as a matter of priority.

Royal Brisbane and Women's Hospital

An audit to investigate the episiotomy rates identified genuine reasons for the women undergoing this intervention. Peer review did not identify any areas that required practice change.

The rate and prevalence will continue to be monitored and any deviation from the restrictive use policy will be actioned accordingly.

Selected primiparae instrumental delivery

This indicator measures the number of selected primiparae patients where the method of delivery was instrumental.

Mater Mothers' Public Hospital

The clinical safety officer conducted a review of about 90 records. This review confirmed the data was accurate and that although the rate of instrumental delivery was higher than other facilities, there were clinical reasons to justify this type of delivery in all cases reviewed (for example, foetal distress, failure to progress/maternal exhaustion).

The review also confirmed that there was no long-term or significant harm caused to the babies delivered instrumentally. The results of the review were reported to the hospital executive. Monitoring and review will be ongoing.

Selected primiparae third and fourth-degree perineal tears

This indicator measures the number of third and fourth-degree tears for selected primiparae patients giving birth vaginally.

Caboolture Hospital

An in-depth review on 18 patient cases identified that the appropriate clinical decisions were made in each case for the safety of both the mother and the baby. Each patient is managed on a case-by-case basis.

The audit confirmed there were no issues identified due to a lack of resources. It also confirmed the appropriate care and management of each patient during labour, delivery and admission. Vaginal Birth Clinical Pathways were also followed.

An additional quality audit identified minor data issues that have been addressed with supporting education strategies for documentation and coding.

Royal Brisbane and Women's Hospital

After an extensive audit and literature review, it was identified there was a high proportion of women of Asian and Indian ethnicity in this cohort of cases. A reporting plan was developed to highlight risk factors and criteria and education sessions have identified an improvement in classification of tears.

Vaginal hysterectomy complications of surgery

This indicator measures the number of patients who had complications arising out of vaginal hysterectomy surgery.

Queen Elizabeth II Jubilee Hospital

The review of the cases for this indicator discovered that the omission of coding risk adjusters was largely responsible for flagging this VLAD. All coding errors have been corrected and the data resubmitted.

Cases with any quality of care questions were reviewed by the gynaecology director. Advice was that the hospital is currently following gold standard of care for the trial of void patients.

All patients also currently have perioperative prophylactic antibiotics for those undergoing a vaginal hysterectomy to avoid post-operative infection. There were no patterns of omission of care. The gynaecology department will continue to audit their care.

Mental health indicators

The mental health indicators cover re-admission rates and the rate of long-stay patients. Results for each mental health indicator is outlined in Table 19. Where a hospital's result against an indicator has been identified as potentially unfavourable, the summaries of the review are provided.

Depression long-stay

This indicator measures the number of patients who remained in hospital for 35 days or more following an admission for depression.

Cairns Base Hospital

Of 12 patient charts reviewed, all patients were considered to be complex cases with additional factors that contributed to their delayed discharge, including mania, brain injury and ECT treatments.

The extended length of stay for two patients related to their forensic status. All patients received a high standard of clinical care by the appropriate professionals.

On review of the coding, the data's suitability was questioned as it included bipolar affective disorder, as well as depression. This concern has been referred to the Mental Health Clinical Network for further discussion and action.

Gold Coast Hospital

The hospital review now includes a mental health senior coder to help clinicians with the investigation process.

A consortium of key stakeholders (including government and non-government agencies) has been established to address specific issues impacting on the length of stay for clients admitted to our services with depression, such as community accommodation on the Gold Coast, and employment, training, education and rehabilitation opportunities.

Internal bed management processes continue to be reviewed via a weekly bed management meeting. This forum allows monitoring of discharge plans, bed management and length of stay for individual clients.

Schizophrenia long-stay

This indicator measures the number of patients who remained in hospital for 35 days or more following an admission for schizophrenia.

Cairns Base Hospital

Fourteen patient charts were reviewed by the clinical director, quality officer and coder. All charts were found to be correctly coded, and no case-mix issues were identified.

The extended length of stay was related to various factors, predominantly forensic status and homelessness. To address the difficulties in discharging homeless patients, the far-north Queensland rehabilitation and recovery team have permanently extended the hours of the service. All patients were assessed as receiving a high standard of clinical care.

Results for each surgical, medical, obstetrics/ gynaecology and mental health indicators are outlined in the appendices (Table 27).

4 our people

The majority of Queensland Health staff are doctors, nurses, allied health, mental health, community health and health promotional professionals, supported by a team of dedicated workers from a wide variety of occupations.

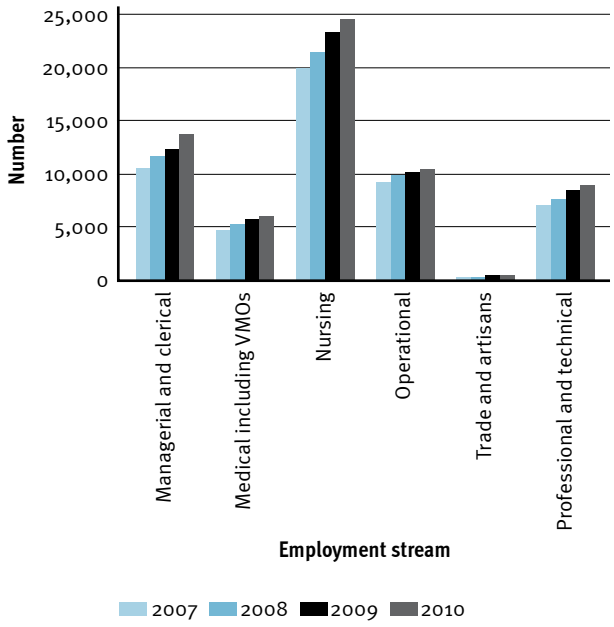
Staff profile

Queensland Health employed more than 60,000 full-time-equivalent staff during 2009–2010. The majority of Queensland Health staff are doctors, nurses, allied health, mental health, community health and health promotion professionals.

The remainder support the department's operations from 15 health service districts and Corporate Office.

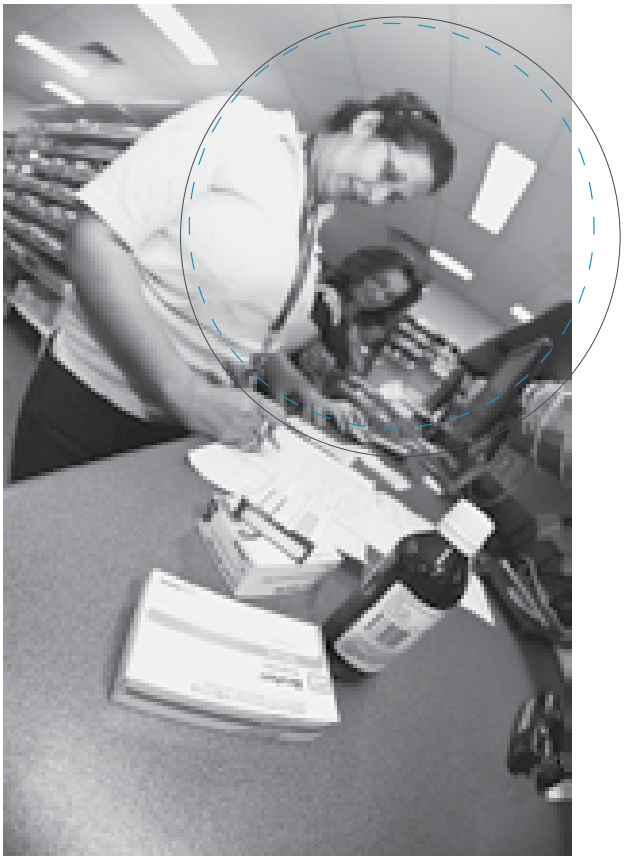
Graph 19 shows the number of Queensland Health full-time-equivalent employees by employment stream. Nearly two-thirds of Queensland Health staff are health practitioners, professionals and technicians, medical (including visiting medical officers), or nursing employees.

Graph 27: MOHRI occupied FTE by employment stream



Source: Minimum Obligatory Human Resource Information (MOHRI)

Queensland Health's retention rate for permanent employees was 91.2 per cent in 2009–2010. The retention rate is the number of permanent staff employed by the organisation at the start of the financial year and who remain employed at the end of the financial year, expressed as a percentage of total staff employed.



Queensland Health's 2009–2010 separation rate is 6.9 per cent, compared with 7 per cent in 2008–2009, and describes the number of permanent employees per 100 who left the department in the reporting year.

Communication of government services is essential to keep the community informed on matters such as swine flu, provide a 24/7 service to ensure information about health-related emergent issues is conveyed to the public in a timely and efficient manner, and produce communications about important issues on health awareness and preventative health behaviour.

As at 30 June 2010, the department employed 61.5 full-time-equivalent staff whose functions relate to media and public relations.

Attracting and retaining our people

Attracting our people

Queensland Health continues to attract and recruit skilled practitioners via its internal agency Work For Us.

In 2009–2010, Work For Us targeted its recruitment activities to support rural, remote and regional healthcare facilities, and work alongside innovative programs and projects, such as Allied Health Relief Pool, on alternative recruitment pathways into these facilities.

Work For Us also increased its support for case management of clinicians through to employment at districts, with additional liaison officers.

In addition, a Candidate Care project established guidelines and tools that help districts to support new recruits and their families or spouse to transition to their new Queensland Health role.

Retaining our people

As part of Queensland Health's continuous improvement and performance monitoring activities, the department has measured staff satisfaction through confidential surveys.

Since 2006, all Queensland Health staff have been able to comment on workplace culture through confidential Better Workplaces Staff Opinion surveys. Local action plans have been developed in response to survey results and positive changes recorded in most workplace culture indicators.

Groups surveyed in September 2007 and April 2008 were again surveyed in October 2009 and April 2010. While there is still room for improvement, staff responded positively to changes in the workplace over the two years.

This is revealed in improvement indicators, such as workplace morale, peer support, role clarity and supervisor support. Importantly, frontline doctors and nurses reported significant positive workplace culture improvements.

Efforts to improve workplace culture are supported by a Leadership Development Program – one of the most ambitious and challenging leadership development programs in the national and international health industry.

In 2009–2010, a fourth series of executive leadership residential workshops started with seven workshops delivered to 137 participants and 30 non-residential manager/supervisor workshops delivered to 619 participants.

In addition, 401 participants completed a third series of 360-degree feedback and 253 participants undertook executive coaching.

Research conducted by Queensland Health in 2009 shows a direct link between workplace culture and patient outcomes. The reform process is ongoing and work will continue with employees to improve their work environment for better health outcomes for Queenslanders.

Table 19: The following table summarises the key achievements in 2009–2010.

Program	2009–2010 activities	Evaluation
Top 500 Executive Leadership Development Program	• 7 Top 500 workshops • 137 participants	88 per cent of participants rated program as good or excellent
360-degree feedback	• 401 participants	Leadership strengths identified include: • drive for improvement • drive for results • empowering others
Executive Coaching	• 253 participants	92 per cent of participants reported that coaching objectives/ goals were achieved
Manager and Supervisor Leadership Workshops	• 30 workshops • 619 participants	98 per cent of participants rated program as good or excellent
Emerging Clinical Leaders Program	• 2 cohorts started – total of 55 participants	96 per cent of participants rated program as good or excellent
Energising from Conflict Workshops	• 32 workshops • 486 participants	98 per cent rated program as good or excellent
Personal Leadership Qualities Workshops	• 28 workshops • 527 participants	98 per cent rated program as good or excellent
Delivering the Service Workshop	• 30 workshops • 524 participants	98 per cent rated programs as good or excellent
Setting the Direction Workshop	• 26 workshops • 472 participants	98 per cent rated programs as good or excellent
Coaching Skills for Leaders Workshop	• 34 workshops • 565 participants	99 per cent rated programs as good or excellent
Indigenous Leaders Program	• 2 workshops • 18 participants	100 per cent rated programs as good or excellent
Medical Leaders in Action Program	• 1 cohort • 22 participants	100 per cent rated programs as good or excellent

Healthy lifestyles

In 2009, Queensland Health launched its Healthy Lifestyle program to support and educate staff about a range of health and wellbeing initiatives.

Activities throughout the state to support staff achieve a healthy lifestyle with information and resources, include:

- achieving a healthy weight
- becoming more physically active
- being sociable
- leading a cancer-smart lifestyle
- achieving family health and work-life balance
- the Heart Foundation
- having a healthy home
- having a healthy mind
- monitoring alcohol intake
- quit smoking
- sexual health
- sleeping better
- stressing less.

A Better Choice

Queensland Health has clear responsibility for leadership in promoting healthier lifestyles throughout the state to prevent chronic diseases.

A Better Choice Healthy Food and Drink Supply Strategy (A Better Choice) aims to make healthier choices easier with a framework to ensure food and drinks of good nutritional quality are supplied in Queensland Health facilities.

A Better Choice will increase the availability and promotion of nutritious foods and drinks, while limiting the supply and promotion of less healthy options. The strategy applies to all situations where food or drinks are provided to staff, visitors and the general public, including:

- canteens or kiosks
- cafes or coffee shops
- vending machines
- catering at functions or meetings
- fundraising activities, events or prizes
- special events, such as program launches.

Since 1 September 2008, A Better Choice has been mandatory across all facilities owned and operated by Queensland Health, such as hospitals, community health centres and office buildings.

Cycle Centre

The Royal Brisbane and Women's Hospital Cycle Centre gives cyclists, pedestrians and joggers access to a state-of-the-art end-of-trip facility. The centre is available to all staff, visitors, local business staff and the general public. The centre supports members to be active and healthy, help reduce congestion, improve the environment and enhance their lifestyle.

Breastfeeding in the workplace

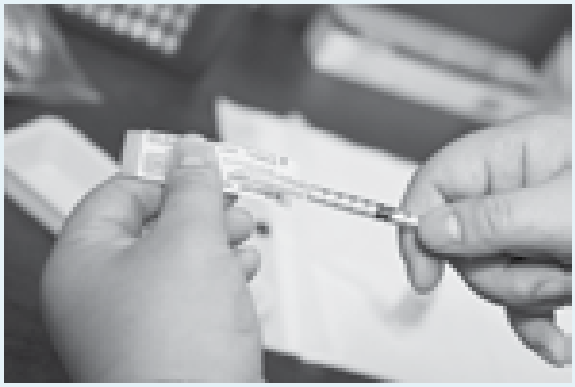
Queensland Health has a key role in advocating breastfeeding in the community and also encourages and supports employees who choose to continue breastfeeding after their return to paid work with facilities and practices.

Staff vaccinations

Queensland Health is committed to protecting its greatest asset – our employees – with a safe and healthy working environment.

This commitment includes adopting a screening, education and immunisation policy that minimises the risk to healthcare workers against vaccine preventable illnesses that may occur in the workplace.

Queensland Health employees are entitled to free influenza and measles, mumps, rubella (MMR) vaccinations in Queensland Health hospitals and corporate office.



Work/life balance

Queensland Health is committed to promoting flexible working arrangements and conditions to enable workers with family responsibilities to balance their work and family life.

Existing policies such as work/life balance, job-sharing, telecommuting and purchased leave, give employees and managers options to achieve a balance between service delivery and family needs.

Key considerations of Queensland Health's work/life balance initiatives include:

- flexibility to accommodate workers' needs with family responsibilities and Queensland Health requirements
- access to family-friendly conditions of employment to ensure employees can balance work and family responsibilities without discrimination
- equity for employees by ensuring they are not disadvantaged by family responsibilities and are supported in contributing to their fullest potential.

Queensland Health's commitment to employees' work/life balance is further evidenced through enterprise bargaining agreements that include development and promotion of work/life balance strategies with enhanced flexibility in working hours, permanent part-time work, job-sharing and family leave provisions.

Queensland Health continues to work with relevant industrial organisations for flexible service delivery options and an equitable balance between work and family across all occupational groups within the department.

Enterprise bargaining

Queensland Health implements a number of initiatives under the Queensland Public Health Sector Certified Agreement (No. 7) 2008 (EB7) and the Queensland Health Building, Engineering and Maintenance Services Certified Agreement (No. 4) 2008, including:

- a centralised unit and statewide process to develop benchmark position descriptions and review and reclassify specific hospital administrative positions
- review of the health information manager stream and structure
- initiation of a project involving unions and health practitioners to trial the use of allied health assistants (in the operational stream) in areas such as radiology and physiotherapy
- ongoing management of Queensland Health's central consultative arrangements with unions representing administrative, operational and building and engineering employees.

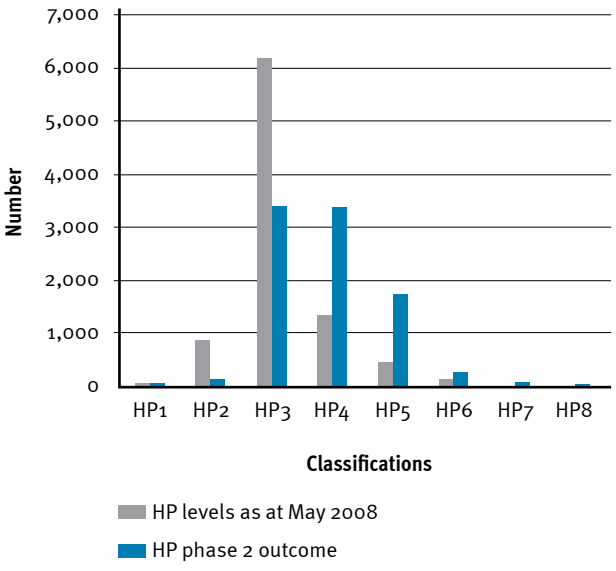
Allied health

Overview of the implementation of the Health Practitioners (Queensland Health) Certified Agreement (No.1) 2007 continued throughout the year. This included completion of Phase 2 Work Level Evaluation process, involving about 10,000 health practitioner positions.

At translation, most health practitioners were employed at the HP3 classification level. As a result of the Phase 2 Work Level Evaluation process, the health practitioner workforce is more evenly spread across all levels.

A graph depicting the spread of the health professional workforce before and after the Phase 2 process is below.

Graph 28: Health practitioners workforce classification levels



Medical

The Medical Officers' (Queensland Health) Certified Agreement (No.2) 2009 (MOCA2) was certified by the Queensland Industrial Relations Commission on 16 November 2009, replacing the Medical Officers' (Queensland Health) Certified Agreement (No.1) 2005.

The new agreement covers more than 5,000 salaried medical officers and was developed over an 18-month period.

Round three of the eminent and pre-eminent classification process for senior medical officers who have demonstrated national and international recognition in their respective specialist fields also started.

A review of the first two rounds of the classification process was completed and adjustments to improve the application and assessment processes were incorporated in the round three process.

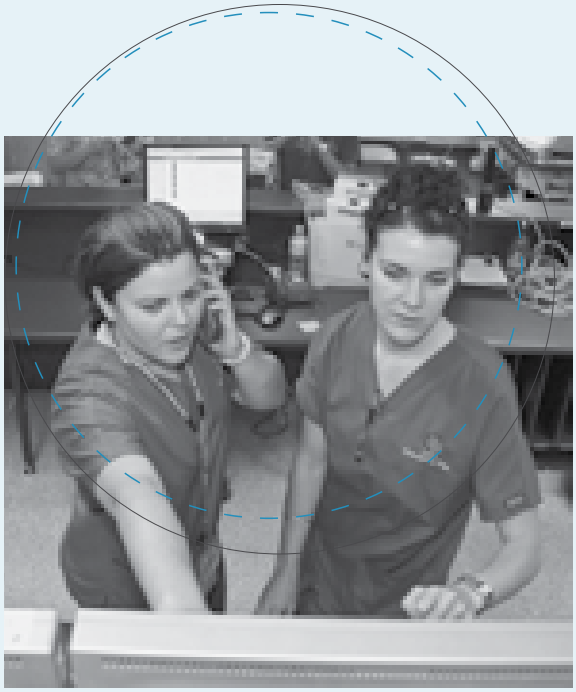
A successful review of the private practice arrangements for senior medical officers was completed in 2009, including creation of three-year contracts to reduce the administrative burden on districts.

Nursing and midwifery

In terms of the Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009, the parties have worked constructively to start the four key interdependent projects to enhance the nursing and midwifery workforce. These include:

- further development of the Business Planning Framework – a tool for workload management
- identifying, supporting and evaluating innovative models of nursing and midwifery that promote best practice
- review of the best-practice rostering guidelines
- review of the classification and career structure to support contemporary models of nursing and midwifery.

The four projects will ensure industrial provisions promote best-practice contemporary nursing care for patients throughout Queensland, regardless of service setting.



Queensland Health has also worked closely with the Queensland Nurses' Union and the Australian Workers' Union on the award provisions of the proposed Queensland Health Nurses and Midwives Award – State 2010, which will replace three existing awards.

The proposed award consolidates existing conditions into one accessible industrial instrument and will not reduce the existing entitlements of nurses and midwives.

The parties are working with the Queensland Industrial Relations Commission to finalise the proposed award as a consent matter.

HR Practitioners Network

During 2009–2010, Queensland Health focused on strengthening and growing the department's human resources (HR) practitioners through the HR Practitioners' Network (the network).

This is a department-wide virtual community for people working in, or interested in, human resources.

The network aims to improve the quality and consistency of HR services to Queensland Health by giving practitioners across the state information, support, and opportunities to learn and develop skills and build relationships with professional colleagues.

The network coordinates a range of regular professional development activities developed in line with the Queensland Health HR Competency Development Framework.

Based on international research and modelling best-practice organisations, the framework has been accredited by the Australian Human Resource Institute as meeting standards of HR excellence. It is a tool to inform training, recruitment and selection, succession planning and eventually performance feedback and development.

In November 2009, the annual Queensland Health People Forum brought together 200 People and Culture professionals from across the state. The launch of the Queensland Health People and Culture Plan 2009–2012 shaped the forum, targeting the theme 'Shaping our future: the culture of Queensland Health'.

The 2009 Queensland Health People Forum also included an opportunity to showcase success, professionalism and excellence in HR service delivery with the annual HR Program Recognising Achievement, Innovation and Service Excellence (HR PRAISE) awards.

These awards recognise outstanding achievement of individuals and project teams within Queensland Health who strive for innovation and excellence in the delivery of HR and people-related services and initiatives.

Voluntary early retirement

Under the Queensland Public Service Workforce Rejuvenation Scheme, tenured senior officers and tenured senior executive service officers in corporate support and business support roles in Queensland Government departments were eligible to be offered voluntary early retirement packages.

Within Queensland Health, voluntary early retirement packages were approved for 13 tenured senior officers who were either in the senior officer level 1 or 2 classifications as seen in Table 21.

Table 20: Voluntary Early Retirement

Classification level	Severance benefit	Incentive payment	Leave payment	Total gross payment
Senior officer classification level 1	$1,098,010.86	$264,990.00	$872,392.29	$2,235,393.15
Senior officer classification level 2	$55,721.49	$20,506.50	$40,939.23	$117,167.22

Developing our people

Queensland Health's employees come from a range of clinical and professional backgrounds with a strong commitment to deliver quality health services to Queensland.

Queensland Health's values – caring for people, leadership, integrity and respect – guide the work of staff and form the basis of the department's approach to developing staff and delivering quality health services.

The Queensland Health People and Culture Plan 2009–2012 was launched by the Director-General in November 2009, replacing the Queensland Health People Plan 2007–2012.

The People and Culture Plan outlines the culture and employment experience in Queensland Health to meet the health service challenges of today and tomorrow.

Key achievements

- publishing the Indigenous Health Worker Career Structure and Conditional Progression Scheme
  - The Aboriginal and Torres Strait Islander Health Worker Career Structure was revised and published in December 2009.
  - Generic role descriptions for each health worker role were finalised and the Aboriginal and Torres Strait Islander Health Worker Conditional Advancement Scheme and application kit was released in November 2009.
- developing and implementing the Learning and Development Framework
  - The Learning and Development Special Interest Group established professional development forums and communications with a networked group of more than 500 learning and development practitioners across Queensland Health.
  - The Human Resources Graduate Program had five graduates complete the 2009 program and four graduates are completing the 2010 program.
- strengthening leadership and management capabilities and performance
  - 11 Managing Your Business Programs were completed to June 2010, with further programs scheduled for 2010–2011. The program gives managers practical knowledge and skills across core business management topics, including financial management, business planning, decision-making, risk management and information management.
  - Developing Business Excellence Program was designed to meet the specific professional development needs of current and future corporate services leaders. Participants gain a better understanding of their leadership style, impact on others and participate in development activities targeted at corporate services leadership.
  - Organisational Change Centre of Excellence provided support service and advice on such things as generic and change specialist training, change coaching, measurement of change capability, change tools and management of a change special interest group, including change forums and communications.
  - People and Culture Executive (PACE), comprising People and Culture executive directors from all districts and divisions, was established to give advice on strategic people and culture issues and implementing consistent People and Culture frameworks across Queensland Health.

Clinical education and training

Queensland Health manages a number of programs to build capacity and skills in our staff to meet Queenslanders' current and future healthcare needs.

Clinical Education and Training Queensland (ClinEdQ) started operation in 2009 for a more coordinated approach to clinical education and training across the health professions.

Key achievements in 2009–2010 include:

- establishment and support of effective discipline specific jurisdictional committees across the health and education sector
- Education for Practice in Queensland — a post-registration education program for nurses and midwives
- four new medical education registrars across the state to help develop the capacity, quality and capability of medical education in Queensland
- a unit web portal for education purposes
- a statewide research capacity and culture development framework for allied health
- 10 postgraduate scholarships awarded to clinical staff across a number of oral health disciplines to support career development and retention of the workforce.

Clinical skills development

The Clinical Skills Development Service gives healthcare professionals tools and training to improve their skills and enhance the quality of patient care. The focus is on large-scale, statewide best-practice clinical skills training, research into efficient educational methods, and systems redesign.

Key achievements in 2009–2010 include:

- increasing the simulation training capability across the state by installing in situ simulation facilities and training key local staff to run simulations on site
- e-learning participant numbers increased by 500 per cent in 2009–2010, with a growth of 40 per cent in the number of courses available online
- volume of core and suite courses delivered has increased 33 per cent over the past 12 months, and external bookings have increased substantially. With the growth of in situ simulation events, enabling opportunistic teaching in the workplace, simulation equipment usage increasing, with 60 per cent of equipment used around the state and 40 per cent at the central campus of the Skills Development Centre at Herston
- research collaboratives include colonoscopy training, simulation as a physiotherapy clinical placement, effective deteriorating patient charts, and others
- expanded training into other areas less traditionally associated with simulation-based training, including oral health (dealing with emergencies in the dental clinic) and podiatry (effective treatment of the at-risk diabetic foot)
- developed, piloted and accredited a Vocational Graduate Certificate in Healthcare Simulation under the Australian Qualifications Framework. This will provide training in simulation-based education for health simulation professionals and improve the quality and effectiveness of training for Queensland Health staff
- the visiting professor program continued
- the first simulation centre in Australia to undergo a survey for accreditation with the international Society for Simulation in Healthcare. The outcome is expected in August 2010.

Medical leadership

During 2009–2010, Queensland Health launched its Medical Leadership in Action Program — a unique development program designed for senior medical officers.

Participants learn skills and techniques to lead and manage high-performance clinical teams and communicate more effectively with their colleagues, staff and patients.

The program was developed in consultation with senior clinical leaders across Queensland Health with an in-depth understanding of issues confronting the medical workforce.

Rural Generalist Medicine

The Rural Generalist Pathway is giving trainees a supported training path through medical school to the end point of fellowship and practising rural generalist medicine in rural and remote Queensland.

As at 30 June 2010, 138 trainees were tracking through the prevocational, advanced specialised and vocational training stages of the rural generalist pathway. This is an increase of 24 trainees from 2009. Additionally, as at 30 June 2010:

- 67 rural doctors were receiving the specialist equivalent remuneration package for practice in rural generalist medicine.
- 22 practising rural doctors/senior medical officers have committed to attain formal qualifications in rural generalist medicine within five years.

Queensland Country Practice

Queensland Country Practice (the practice) is designed to enhance the sustainability of rural medical services and promote excellence through integrated medical practice and training.

Now in its first year of extended operation, the practice has worked to address immediate workforce improvement opportunities, in partnership with rural and remote facilities.

The practice has a longer-term focus to improve sustainability of medical services in rural and remote communities.

The introduction of the Practice Services advisory function has enhanced linkages across the multipurpose service environments in rural and remote service. Practice Services supports public rural primary medical services, operating under the Rural and Remote Medical Benefits Scheme, the Council of Australian Government's *(Health Insurance Act 1973)* Section 19(2) Exemption Program and in Queensland Health primary care facilities.

Medical scholarships

In 2005, the Queensland Government made a commitment to fund 235 new medical student places at Griffith University Gold Coast campus in response to the increasing shortage of doctors in Queensland.

In May 2008, the Australian Government agreed to reimburse the Queensland Government $60 million for the cost of training 235 medical students studying the Griffith University Medical Course from 2006–2013.

The Queensland Health Bonded Medical Scholarship Program aims to train extra doctors to work in Queensland areas of priority service for six years after graduation from the Griffith University course.

The scholarships cover the cost of university tuition and give scholarship recipients a generous education support allowance.

The final cohort of scholarship holders were recruited at the end of 2009 for the 2010 Griffith University intake, bringing the total number of scholarship holders to 233.

Allied health scholarships

In 2010, 13 allied health scholarships were awarded under the Queensland Health Rural Scholarship Scheme. These scholarships give financial support to students in the final two years of their undergraduate degree and bond the student to work in rural or remote communities for two years after graduation.

Another 12 allied health area of priority scholarships were awarded to students in the final year of their undergraduate degree. This program gives financial assistance during the final year of university in return for one year of bonded service and guaranteed employment with Queensland Health facilities where there is a priority need for allied health skills.

Commonwealth funding has been provided through the Queensland Cancer Control Team to establish three scholarships under the Allied Health Area of Priority Scholarship Scheme for students studying radiation oncology medical physics. Additionally, funding for one other scholarship has been provided. The four scholarships are managed by the Office of Rural Health.

There are currently 223 allied health professionals, including dentists and oral health therapists, participating in these schemes.

Health Service Planning Postgraduate Partnerships

The department has established postgraduate courses specific to health service planning – at certificate, diploma and masters level – in partnership with University of Technology Sydney and NSW Health.

The course curriculum and learning methodologies are designed to produce graduates who can guide health services through the complex challenges faced by Australia and other countries.

The postgraduate certificate course started in February 2010. To encourage course attendance and support development of capability within the department, Queensland Health offered scholarships to staff working in service planning.

Scholarships were departmentally advertised and 10 were awarded in December 2009.

Overseas travel

In the health industry, travel by clinical and professional staff is critical to upgrading knowledge and skills, keeping pace with trends in health care, particularly with health systems and medical technology, and transferring Queensland Health knowledge and expertise to other countries.

Funding sources for all travel comprised $421,092 from operational budgets and $253,963 from trust fund monies. Additional funding of $38,288 was provided from external sources and is not included in the overseas travel figures below.

Table 21: Summary of destinations:

Destinations	Number of trips	% of trips
Asia	27	13.5
Europe	51	25.5
New Zealand	38	19.0
North America	70	35.0
Oceania (South Pacific)	14	7.0
Total	200	100

A detailed listing of overseas travel undertaken at the expense of the department is contained in the table ‘Overseas travel 2009–2010’ on the following pages.

Table 22: Overseas travel 2009–2010

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Bonita Anderson Cardiac Sciences Echo Educator	US September–October 2009	Attended 17th Annual Echocardiography for the Sonographer	Nil	$3,000 Mayo Clinic Rochester
Simon Anstey Visiting Medical Officer	United Kingdom August–September 2009	Attended 27th Politzer Society Meeting, London	$3,867	Nil
Paul Babyn Radiologist	Australia July 2009	Visiting from Toronto, Canada, for Radiology Lecture in 2009	$18,455	Nil
Sally Ball Radiographer	US November–December 2009	Attended Radiological Society of North America 2009 Conference	$8,544	Nil
Graeme Banks Biomedical Technician	Germany September 2009	Attended Siemens Mammomat Inspiration maintenance course	$5,801	Nil
Dianne Barnett District Director Nursing	United Kingdom October 2009	Attended Health Jobs Around the World Recruitment expos in London, Manchester, Glasgow and Dublin to meet potential recruits	$7,200	Nil
Alison Barry Project Coordinator Diabetes in Pregnancy	Italy March–April 2009	Attended 5th International Symposium on Diabetes and Pregnancy	$210	Nil
Julia Bates Pharmacist	New Zealand October–November 2009	Attended Auspen Annual Scientific Conference	$1,653	Nil
Fusun Baumann Research Fellow-Neurology	US October 2009	Attended American Association of Neuromuscular and Electro Diagnostic Medicine, 56th annual meeting	$2,924	Nil
Kacy Baumann Radiation Therapist	New Zealand March 2010	Attended Trans Tasman Radiation Oncology Group 2009	$1,730	Nil
Catherine Bautista Supervising Scientist Microbiology Pathology	New Zealand August 2009	Attended 26th National Serology Reference Laboratory Workshop 2009, Christchurch, New Zealand	$1,881	Nil
Jennifer Baxter Director, Radiation Therapy Services	US October–November 2009	Attended Eleka User Meeting, 51st annual meeting for the American Society for Radiation Oncology	$4,383	Nil
Jill Becker Charge Radiation Therapist	Netherlands August–September 2009	Attended Euro School of Radiotherapy and Oncology 2009	$434	Nil
Wendy Becker Registered Nurse	Netherlands August–September 2009	Attended Euro School of Radiotherapy and Oncology 2009	$5,501	Nil
Brian Bell Medical Superintendent	US March 2009	Attended meeting with Institute of Healthcare Improvement in Boston and meeting with Clinical Advisory Board in Washington	$966	Nil
Debra Berg Manager Amputee Limb Service	United Kingdom May 2010	Attended 13th World Congress of the International Society for Prosthetics and Orthotics and International Trade Show for Prosthetics, Orthotics and Rehabilitation Technology followed by an invitation to visit the new Scientific Centre for Medical Technologies in Berlin and Otto Bock Health Care Facility and International Prosthetics Manufacturing Plant. Then attended meetings with managers and prosthetists at three prosthetic and rehabilitation facilities in London UK – Royal National Orthopaedic Hospital, Queen Mary's Hospital, Crystal Palace Rehabilitation Centre	$5,956	Nil

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Odette Best Indigenous Nurse Advisor Office Chief Nursing Officer	Switzerland September 2009	Attended International Nursing Leadership Program conducted by the International Council of Nurses in Geneva	$3,283	Nil
Rachel Beswick Senior Project Officer for Health Hearing Program	Italy June 2010	Attended The Newborn Hearing Screening Conference in Italy about programs that deal with hearing losses	$2,125	Nil
Sean Birgan A/Executive Director of Nursing Services	Philippines and India November 2009	Attended 'Delegation Exploratory Tour' to investigate key health service sites and educational institutions in the Philippines and India as part of the development of an Ethical Nurse Migration Strategy for Queensland – tasked to assess the clinical educational and regulatory standards of the Philippines and India compared with Australia	$8,763	Nil
Sean Birgan Nursing Director Division of Surgery	US September–October 2009	Attended American Nurses Credentialing Centre Management Conference	$4,313	Nil
Elizabeth Black Medical Education Officer	Spain August–September 2009	Attended Association of Medical Education Europe Conference 2009	$3,421	Nil
Cheryl Bletchly Supervising Scientist Molecular Diagnostic Unit	New Zealand August 2009	Attended 26th National Serology Reference Laboratory Workshop 2009 – Christchurch, NZ	$1,869	Nil
William Boss Registered Nurse High Secure Unit	Thailand October 2009	Escorted mental health patient back home to Thailand	$1,760	Nil
Amy Brown Radiation Therapist	New Zealand March 2010	Attended Trans-Tasman Radiation Oncology group meeting	$775	Nil
Bryan Burmeister Director Radiation Oncology	US October–November 2009	Attended American Society of Therapeutic Radiation Oncology	$13,287	Nil
Juliet Burton Radiographer/ Sonographer, Medical Imaging	New Zealand August 2009	Attended for recruitment – New Zealand Institute of Medical Radiation Technology and New Zealand Manipulative Physiotherapists Association Conferences at Rotorua Convention Centre, Rotorua	$1,611	Nil
Peter Buttrum Director Physiotherapy Services	US June 2009	Attended Annual Conference and Exposition of the American Physical Therapy Association at the Baltimore Convention Centre	$3,842	Nil
Amanda Calwell Patient	New Zealand June 2009	Patient escorted home by mother. Mother paid for her own flights	$176	Nil
Rolla Bruce Campbell Staff Specialist Emergency Department	US October 2009	Attended American College of Emergency Physicians 41st Scientific Assembly in Boston USA for clinical recruitment purposes of qualified emergency physicians	$5,398	Nil
Katrina Campbell Principal Research Officer Dietetics and Nutrition	United Kingdom May–June 2010	Attend Investigators Meeting for Obesity in Kidney Disease Study (London) then attended International Society of Renal Nutrition and Metabolism Conference (Switzerland)	$1,264	Nil
Maeli Campbell-McNulty, Clinical Trial Coordinator, Cancer Care	New Zealand March 2010	Attended Trans-Tasman Radiation Oncology Group annual scientific meeting	$2,292	Nil

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Vicki Carson A/Nursing Director Children's Services	Philippines and India November 2009	Attend 'Delegation Exploratory Tour' to investigate key health service sites and educational institutions in the Philippines and India as part of the development of an Ethical Nurse Migration Strategy (ENMS) for Queensland – tasked to assess the clinical educational and regulatory standards of the Philippines and India compared with Australia	$8,745	Nil
Robyn Carter Acting Chief Scientist Queensland Mycobacterium Reference Laboratory	Papua New Guinea May 2009	Conduct site assessment for National Tuberculosis Program for Papua New Guinea associated with World Health Organisation.	$4,047	Nil
Pretorius Casper non-agency employee	Australia August 2009	Site visit before accepting employment	$3,315	Nil
Darren Cassidy Principal Medical Physicist	US June 2010	Attended Tomotherapy Physics Training Course	$3,028	Nil
Victoria Chalmers Director Health Contact Centre	New Zealand December 2009	Attended the Australian and New Zealand School of Government final subject for the Executive Master Program	$883	Nil
Raymond Chan Nurse Researcher	Singapore October 2009	Attended 17th Cochrane Colloquium	$2,237	Nil
Keat Choong Registrar	US September 2009	Attended Interscience Conference on Anti-microbial Agents and Chemotherapy	$6,803	Nil
Darren Clark Assistant Director of Nursing	US January 2010	Attended National Database of Nursing Quality Indicators, New Orleans	$6,091	Nil
Michael Cleary Executive Director Medical Services	US October 2009	Attend American College of Emergency Physicians 41st Scientific Assembly in Boston, US, for clinical recruitment purposes of qualified emergency physicians	$7,388	Nil
Aleasha Collier A/Project Officer	New Zealand May 2010	Attend as a 'Work for Us' exhibitor at the Royal Australian and New Zealand College of Psychiatrists Congress 2010 in Auckland	$2,221	Nil
Tiffany Cordwell Telehealth Facilitator	Canada October 2009	Attended annual conference undertaken by Canadian Society of Telehealth (CST) at Sheraton Wall Centre, Vancouver, Canada, to present outcomes from successful collaboration project for use of videoconferencing technology in emergency/retrieval patients	$4,942	Nil
Elissa Cox Occupational Therapist	New Zealand March 2010	Attended Australian Academy of Cerebral Palsy and Development Medicine	$606	Nil
Arun Dahiya Registrar	US June 2009	Attended the American Society of Echocardiography 2009 20th annual scientific sessions	$5,100	Nil
Kevin Daynes Service Director – Specialist Breast Screening	US February 2010	Attended Breast MR and Guided Biopsy Course in Washington and then attended a second course for Computed Body Tomography	$2,726	Nil
Karen De Boni CT Radiographer	US November–December 2009	Attended Radiology Society of North America 95th Scientific Assembly and annual meeting	$4,266	Nil
Brain Dolan external presenter	New Zealand December 2009	External presenter on 'Transforming Care Conference' and subsequent meeting presentations on behalf of Gold Coast Health	$657	Nil

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Sanja Doneva Senior Cardiac Scientist	France June 2010	Attended 17th World Congress in Cardiac Electrophysiology and Cardiac Techniques	$18	Nil
Kylie Dunn Vacancy Management Officer Work for Us Clinical Workforce Solutions	US June 2009	Attended annual conference and exposition of the American Physical Therapy Association at Baltimore Convention Centre	$10,799	Nil
Sophie Dwyer A/Executive Director Health Protection	New Zealand August 2009	Queensland Health representative at the Food Regulation Standing Committee meeting as part of Queensland Health responsibilities under the Inter-Governmental Food Regulation Agreement 2000.	$1,807	Nil
Laura Dyer Nursing Unit Manager	US October 2009	Attended American Psychiatric Nurses Association annual conference in Charleston, South Carolina, US, for recruitment of mental health nurses	$2,836	Nil
Jennifer Edmunds Clinical Trial Coordinator - Cancer Care	New Zealand March 2010	Attended Trans-Tasman Radiation Oncology Group annual scientific meeting	$2,166	Nil
Megan Ellis Tissue Bank Manager	US May 2009	Attended conference in Oregon to improve/ maintain Australian tissue resources	$577	Nil
Benjamin Feiner Fellow	Italy June 2009	Attended International Urogynaecological Association 34th annual meeting	$794	Nil
Jennifer Fleming Chair of Human Research Ethics Committee	New Zealand July 2009	Attended American Bar Association's/The American Industrial Hygiene Conference 2009	$1,441	Nil
Mandy Forster Director Clinical Policy Unit, Policy Branch	Ireland June 2010	Attend and present at the Health Technology Assessment International Conference in Dublin, Ireland	$1,557	Nil
Tenille Fort Director Food Safety Policy and Regulation	New Zealand February 2010	Attended Food Regulation Implementation Sub-Committee, which will benefit Queensland Health through deliberation and decision-making on food regulations, standards implementation and enforcement activities for consistent approaches across jurisdictions and between Australia and New Zealand	$1,061	Nil
Areti Garvilidis Director of Research and Ethics Development	New Zealand September 2009	Attended Australian Research Management Care Conference	$927	Nil
Susan Gauld Rehab Co-ordinator	US March 2010	Attended International Brain Injury Association Conference	$4,256	Nil
Robert Gibb Supervising Scientist Microbiology Pathology	New Zealand August 2009	Attended 26th National Serology Reference Laboratory Workshop 2009 in Christchurch, NZ	$1,637	Nil
Glenda Gilmore Supervising Scientist Serology Pathology	New Zealand August 2009	Attended 26th National Serology Reference Laboratory Workshop 2009 in Christchurch, NZ	$985	Nil
Nevin Glendenning Medical Imaging Technician Biomedical Technology Services	US May 2010	Attended Varian Clinic High Energy Technical Maintenance 1 and 2 training courses in Las Vegas, United States	$3,465	Nil
Susan Golding Registered Nurse	US July–August 2009	Attended 13th World Conference on Lung Cancer	$3,388	Nil

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Kirryn Gordon Assistant Project Officer, Candidate Management Team, Work for Us, Clinical Workforce Solutions	New Zealand August 2009	Attend for recruitment purposes the New Zealand Institute of Medical Radiation Technology and New Zealand Manipulative Physiotherapists Association Conferences at Rotorua Convention Centre, Rotorua	$2,308	Nil
Kathleen Hall Physiotherapist	Spain June 2010	Attended 33rd European Cystic Fibrosis Conference and site visit to Adult Cystic Fibrosis Centre Belfast Hospital	$3,723	Nil
Kerrod Hallett Dental Specialist Children's Oral Health Service	US August 2008	Attended 9th Annual World Congress of Minimally Invasive Dentistry	$5,636	Nil
Heloise Halsey Sonographer/ Radiographer	Hong Kong June 2009	Attended Focus in Obstetrics and Gynaecology Conference	$1,285	Nil
Christian Hamilton-Craig, Cardiologist/ Cardiac Imaging Fellow	US July 2009	Attended Society of Cardiovascular Computed Tomography 4th annual scientific meeting	$5,855	$1,000 Siemens
Kelli Hancock Senior Speech Pathologist	US December 2009	Attended Lymphedema Therapy Course	$2,946	Nil
Kim Harris Registered Nurse	Ireland October 2009	Attended International Society for Quality in Health Conference	$4,442	Nil
Julie Hartley-Jones Chief Executive Officer Cairns and Hinterland Health Service District	New Zealand October 2009	Attended Hardy Group International Learning Set	$1,619	Nil
Wayne Hazell non-agency employee	Australia January 2010	Site visit for position	$576	Nil
Kaye Hewson Principal Policy Officer Clinical Policy Unit	Singapore June 2009	Attended 6th Annual Meeting of Health Technology Assessment International in Singapore	$2,471	Nil
Jan Hill A/Program Manager Patient Safety Centre	Netherlands September 2009	Attended 12th Annual European Pressure Ulcer Advisory Panel Meeting, Amsterdam	$3,808	Nil
Leigh Horsfall Research and Clinical Trials Coordinator	US October–November 2009	Attended 60th Annual American Association for the Study of Liver Diseases Meeting, visit to Yale University and Hepatology Clinic Hyunes Convention Centre, Boston	$3,374	Nil
Joan Howells Nursing Unit Manager	US November–December 2009	Attended 95th Annual Meeting of the Radiological Society of North America	$5,671	Nil
Rosina Hoy Senior Occupational Therapist	United Kingdom June–July 2009	Attended British College of Occupational Therapists 33rd Annual Conference at Brighton UK and Australia Needs Skills Expo in London, UK	$4,374	Nil
Cheryl Hutchins Laboratory Director	US May 2010	Attended International Society of Cellular Therapy, 15th Annual Meeting	$1,730	Nil
Rita Hwang Physiotherapist	Sweden May 2009	Attended Europrevent 2009, launch of European Heart Health Charter	$93	Nil
Adrienne Irvine Manager Victim Support Service	US June–July 2009	Presentation of paper at the International Congress on Law and Mental Health about the work of the Queensland Victim Support Service.	$3,364	Nil
Catherine Isaac Registered Nurse	US October 2009	Attended Otorhinolaryngology and Head and Neck 33rd Annual Congress and Nursing Symposium	$2,415	Nil

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Karen Johnson Scientist Queensland Mycobacterium Reference Laboratory	Papua New Guinea August–September 2009	Deliver training for Ausaid Project, Port Moresby, Papua New Guinea	$5,775	Nil
Karen Johnson Scientist Queensland Mycobacterium Reference Laboratory	Papua New Guinea November–December 2009	Deliver training for Ausaid Project, Port Moresby, Papua New Guinea	$3,977	Nil
Karen Johnson Scientist Queensland Mycobacterium Reference Laboratory	Papua New Guinea March 2010	Deliver ongoing training for Ausaid Project Port Moresby, Papua New Guinea	$5,030	Nil
Malcom Johnston-Leek Director of Emergency	Bali October 2009	Escort an Indonesian palliative patient back to his home in Bali	$1,806	Nil
Sallyanne Jones Clinical Nurse Consultant Cancer Care Services	Singapore August 2008	Attended 15th International Conference on Cancer Nursing	$180	Nil
Jacqueline Keller Manager Clinical Trials Cancer Care Services	New Zealand March 2010	Attended Trans-Tasman Radiation Oncology Group annual scientific meeting	$2,292	Nil
Lizbeth Kenny Medical Director Cancer Services	Austria March 2009	Attended European Congress of Radiology 2009	$2,806	Nil
Lizbeth Kenny Medical Director Cancer Services	US November–December 2008	Attended Radiological Society of North America 94th Scientific Assembly and annual meeting and facilities visits (Boston and Dallas)	$3,516	Nil
Kieran Keyes, Director, Business Capability Team, Corporate Services	New Zealand November–December 2009	Ongoing participation in Learning Set since December 2007, including tour of the recently developed Wellington Hospital	$1,396	Nil
Kate Kilpatrick, Principal Project Officer, Mental Health Work for Us	US October 2009	Attended American Psychiatric Nurses Association annual conference in Charleston, South Carolina, US, for recruitment of mental health nurses	$4,462	Nil
Beth King Physiotherapist	New Zealand August 2009	Attend for recruitment – New Zealand Institute of Medical Radiation Technology and New Zealand Manipulative Physiotherapists Association Conferences at Rotorua Convention Centre, Rotorua	$1,570	Nil
Rebecca Klee Scientist Immunology	India November 2009	Attended 33rd Annual Scientific Meeting of the Australasian and South East Asian Tissue Typing Association in Delhi, India	$3,494	Nil
Evelyn Lavu non-agency employee	Australia May–June 2010	Visit Queensland Mycobacterium Reference Laboratory	$809	Nil
Trang Le Pharmacist	Czech Republic May 2010	Attended 12th Symposium of the International Society of Oncology Pharmacy Practitioners	$6,032	Nil
Clement Lee Clinical Nurse Consultant	Spain August–September 2009	Attended Solstice Investigator meeting	Nil	$17,000 Glaxo-SmithKline
Steven Leong Medical Officer Respiratory Medicine	US April 2010	Attended International Society for Heart and Lung Transplants	$2,051	Nil
Azman Lim non-agency employee	Australia October 2009	Attended RBWH Health Care Symposium	$5,295	Nil
Margaret Lind Acting Clinical Network Coordinator	United Kingdom and US May 2009	Attended the Royal College of Nursing Congress Exhibition 2009 and the American Association of Critical Care Nurses National Teaching Institute and Critical Care Exposition.	$408	Nil

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Andrew Lindgren Biomedical X-Ray Technician – Mammography Coordinator	Germany July–September 2009	Attended Technical Training Course – Siemens 'Inspiration' Digital Mammography Diagnostic Imaging System, Erlangen-Germany.	$2,916	Nil
Geraldine Lipka Clinical Research Coordinator Gastroenterology and Hepatology	US May–June 2009	Attended American Transplant Congress 2009	$3,248	Nil
Nick Lord, Deputy Director, Medical Workforce Advice and Coordination	US May 2010	Attended meeting of International Delegates for Physician Assistant Certification	$3,638	Nil
Lynette Loy Director of Pharmacy	United Kingdom August 2009	Attended Roche Pharmaceuticals Tour of Pharmaceuticals Research and Development facilities within the United Kingdom	$1,659	$10,779 Roche Pharma-ceuticals
Ryan Lusk Radiation Therapist	France June 2009	Attended Euro School of Radiotherapy and Oncology Teaching Course "Imaging for target volume determination in radiotherapy"	$6,399	Nil
Kathleen Mackrodt Clinical Nurse Perioperative Services	US June 2008	Attended Tripartite meeting of American Society of Colon and Rectal Surgeons	$350	Nil
Nicole Mair Director Health Information Services	New Zealand August–September 2008	Attended 6th Australasian Conference on Safety and Quality Health Care	$54	Nil
Apeo Manoni non-agency employee	Australia May–June 2010	Attended training in Mycobacterial Culture Techniques and Drug Susceptibility Testing	$989	Nil
Angela Matson Dietitian	Spain June 2010	Attended 33rd European Cystic Fibrosis Conference	$3,723	Nil
Bradley Maunder Nurse Educator	France April 2010	Attended 2010 International Forum on Quality and Safety in Healthcare	$2,474	Nil
Andrew Mccutchan Program Coordinator Quality Officer	New Zealand October 2009	Flew to Auckland City Hospital to collect cells for a patient located in Townsville Health Service District	$2,114	Nil
Deborah McIntyre Clinical Nurse Consultant Hepatology, Share Care	Austria April 2010	Attended European Association for the Study of the Liver 45th Annual International Liver Congress	$5,665	Nil
Keith McNeil Chief Executive Officer Metro North Health Service District	Canada October 2009	Attended World Health Executive Forum	$11,955	Nil
Keith McNeil Chief Executive Officer Metro North Health Service District	New Zealand August 2009	Attended Learning Set 14 – Intensive executive learning meeting and some didactic presentations with health executives from Australia and New Zealand	$1,983	Nil
Rebecca Meldrum Clinical Physicist	US June 2010	Attended Tomotherapy Physics Training Course	$3,028	Nil
Catherine Martin Social Worker	US October–November 2009	Attended North American Liver Transplant Social Workers Association Conference	$2,046	Nil
Eleanor Milligan Clinical Ethics Coordinator	US May 2010	Attended The 6th International Conference on Clinical Ethics Consultation	$756	Nil
Young Sook Moon patient	Korea March 2010	Patient was transferred to Busan National University Hospital in Korea	$1,727	Nil

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Shannon Morris, Principal Project Officer Medical,Work for Us, Clinical Workforce Solutions	US October 2009	Attended for clinical recruitment – American College of Emergency Physicians 41st Scientific Assembly in Boston, US	$9,624	Nil
Robin Mortimer Senior Director Office of Health and Medical Research	US June 2009	Attended Inaugural Forum on Personal Health, Seattle, US	$773	Nil
Robin Mortimer Senior Director Office of Health and Medical Research	US May 2009	Attended Biotechnology Industry Organisation 2009 Conference in Seattle	$3,928	Nil
Robin Mortimer Senior Director Office of Health and Medical Research	US April–May 2010	Attended two pre Bio10 Health Symposium meetings – Seattle and Vancouver	$1,450	Nil
Shannon Morton Psychology Registrar	Italy and France June–July 2009	Invitation to La Sapienza University, Rome, to observe and discuss research techniques professors Lenzi and Dazzi at Neurological Sciences Department; attend World Congress of Biological Psychiatry and presentation of paper on Tourette's Syndrome in Paris, France	$6,020	Nil
Michelle Mutzelburg Clinical Nurse	New Zealand March 2009	Attended Conference – Renal Society of Australasia National Conference 2009	$262	Nil
Jodie Nixon Occupational Therapist	US November 2009	Attended American Speech and Hearing Association Convention, New Orleans	$5,656	Nil
Lyle Norris Principal Dentist Community Programs	Singapore August–September 2009	Attended Federation Dentaire Internationale World Dental Congress in Singapore	$1,127	Nil
Adrian Nowitzke Chief Executive Officer Gold Coast Health Service District	US June–July 2009	Attended the Wharton School of Management Nursing Excellence Program 2009 in Philadelphia. Also attended the United States Government Veteran Affairs Health Department and met with The Advisory Board Company and the International Council of Hospitals – all in Washington	$8,397	Nil
Nichalas Nuttall Clinical Coordinator Transplant Coordinator	Germany October 2009	Attended International Society of Organ Donation	$1,403	Nil
Tony O'Connell Chief Executive Officer Centre for Healthcare Improvement	Germany November–December 2009	Attended Health Tracker Conference in Berlin	$3,395	Nil
Michelle Padget Resus Coordinator	US September–October 2009	Attended American Nurses Credentialing Centre Management Conference	$4,841	Nil
Natalie Paton Clinical Nurse	France July 2009	Attended XIX International Association of Gerontology and Geriatrics Congress of Gerontology and Geriatrics	$1,500	Nil
Gilbert Pavillion Medical Officer	South Korea May–June 2010	Attended Asia Pacific Congress of Cardiovascular and Interventional Radiology	$2,076	Nil
Dunstan Peniyamina Torres Strait Communication Officer Tropical Population Services	Papua New Guinea May 2009	Install high-frequency radio and telephone interchange base station in western province of PNG Health radio network for effective and regular communication with health staff in western province	$2,193	Nil

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Dunstan Peniyamina Torres Strait Communication Officer Tropical Population Services	Papua New Guinea November–December 2009	Visit 13 treaty villages to follow up nationals who are currently on treatment and participate in the exploration and development of effective mechanisms to improve follow-up, continued care and treatment of these communicable disease patients in their subsequent return to villages in Western Province Papua New Guinea.	$3,204	Nil
Kittiphan Permsirivalop Patient	Thailand October 2009	Mental health patient being returned home to Thailand	$863	Nil
Julia Peters Emergency Department Registrar	New Zealand November 2008	Attended 'Results of the Research Project – The Impact of a new emergency department on patient presentations and ambulance service delivery in health service districts in Australia' in Wellington.	$1,204	Nil
Leah Peut Registered Nurse	Singapore June–July 2009	Attended BO21990 Asia Pacific Investigator Meeting	$96	Nil
Jan Phillips, Senior Director, Health Culture and Leadership Services	Singapore March 2010	Attended Health Executives Action Learning Set as a facilitator	$3,038	Nil
Amanda Pike Intensive Care Dietitian	Netherlands May 2010	Attended The Advance Course in Clinical Nutrition, Maastricht, The Netherlands	$2,656	Nil
Anne Pink Supervising Scientist Immunology	India November 2009	Attended 33rd Annual Scientific Meeting of the Australasian and South East Asian Tissue Typing Association in Delhi, India	$3,730	Nil
Kerri Prain Senior Scientist Pathology	Germany September 2009	Attended European Federation of Neurological Societies Congress and visit the Euroimmune Diagnostics Laboratory.	$6,847	Nil
Stephen Radley Donor Transplant Coordinator	Poland March 2010	Attended Advanced Course in Tissue Bank Management in Warsaw Poland	$3,659	Nil
Michael Ray Supervising Scientist Haematology Pathology	US July 2009	Attended XXII Congress International Society on Thrombosis and Haemostasis, Boston, US	$5,948	Nil
Maree Raymer Assistant Program Manager Orthopaedic Physiotherapy Screening Clinics	New Zealand August 2009	Attended for recruitment – New Zealand Institute of Medical Radiation Technology and New Zealand Manipulative Physiotherapists Association Conferences at Rotorua Convention Centre, Rotorua	$1,573	Nil
Michael Reid Director-General Queensland Health	United Kingdom March 2010	Attended 'Transforming Health Systems to Deliver Value' International Leadership Summit for senior health leaders at Cambridge University to present on 'The Australian Experience: patient safety, funding and bureaucracy'	$10,555	Nil
Kerry Richard Senior Research Scientist Chemical Pathology	US June 2009	Present paper to The 91st Endocrine Society's annual meeting ENDO09 in Washington DC.	$1,714	Nil
Brent Richards Director Intensive Care Unit	Amsterdam, Belgium, Norway September–October 2008	Site visit for the Intensive Care Unit Clinical Information System (ICU CIS), as suggested by the Evaluation Working Group (EWG)	$4,359	Nil
Julianne Richards Clinical Nurse Acute Pain Service	Mexico March 2010	Attended 8th International Symposium Paediatric Pain	$2,428	Nil

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Michelle Rose Radiographer	New Zealand August 2009	Attended for recruitment – New Zealand Institute of Medical Radiation Technology and New Zealand Manipulative Physiotherapists Association Conferences at Rotorua Convention Centre, Rotorua	$2,075	Nil
Pauline Rose Nurse Unit Manager Radiation Oncology	US February–March 2010	Attended 16th International Conference Cancer Nursing Atlanta Georgia then site visits Pennsylvania, North Carolina, New York and Canada	$6,299	Nil
Pauline Ross Chief Nursing Officer Queensland Health	Philippines and India November 2009	Attended 'Delegation Exploratory Tour' to investigate key health service sites and educational institutions in the Philippines and India as part of the development of an Ethical Nurse Migration Strategy for Queensland	$9,376	Nil
Pieter Scheellings Supervising Scientist Food Chemistry	China April 2009	Attended Delegation and Quads Meetings, Formal Codex Committee on Pesticides Residues 41st meeting	$1,575	Nil
Pieter Scheellings Supervising Scientist Food Chemistry	China April 2010	Attended Delegation and Quads Meetings, Formal Codex Committee on Pesticides Residues 42nd meeting	$4,375	Nil
Bernd Walter Scheithauer non-agency employee	Australia May 2010	Attended Pathology QLD Surgical Pathology of the Central Nervous System Short Course	$1,894	Nil
Russell Scott Consultant Psychiatrist	Thailand October 2009	Escorted mental health patient back home to Thailand	$1,809	Nil
Isaac Seidl Deputy Executive Director Medical Services	United Kingdom September–October 2009	Attended British Medical Journal Careers Fair in London to directly interact with potential candidates and provide information about employment with Queensland Health in fields of emergency medical, general medical and psychiatry in regional locations	$5,269	Nil
Lawrence Sim Scientific Advisor Radiology Support	Germany June 2009	Attended Computer Assisted Radiology and Surgery (CARS) 2009 23rd International Congress and Exhibition Berlin, Germany	$1,696	Nil
Adelle Simpson Registered Nurse	Korea March 2010	Escorted patient to Busan National University Hospital in Korea.	$2,957	Nil
Kirstine Sketcher-Baker Manager, Clinical Monitoring Team Clinical Practice Improvement Team	Ireland October 2009	Attended 26th International Conference of the International Society for Quality in Health Care, Dublin, Ireland	$4,122	Nil
Kellee Slater, Staff Hepatobiliary Surgeon	United Kingdom July 2009	Attended the Northwick Park Microsurgery Course for additional skill training	$13,940	Nil
Jye Smith Medical Physicist	New Zealand April 2010	Attended Australian and New Zealand Society of Nuclear Medicine Annual Conference	$1,358	Nil
Sharon Smith Rehab Coordinator	Hong Kong June 2010	Attended 2010 Joint World Conference on Social Work and Social Development	$1,700	Nil
Paul Stephens Director Work for Us	United Kingdom October 2009	Attended Health Jobs Around the World Recruitment expos in London, Manchester, Glasgow and Dublin to meet potential recruits	$7,579	Nil
Kirsten Stewart Principal Project Officer, Allied Health, Work for Us, Clinical Workforce Solutions	United Kingdom June–July 2009	Attended British College of Occupational Therapists 33rd Annual Conference at Brighton, UK, Australia Needs Skills Expo in London, UK	$8,967	Nil
Damion Stimson Radiochemist	US and Canada July 2009	Attended Bioscan Radiochemistry Training/18th International Symposium of Radiopharmaceutical Sciences	$6,115	Nil

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Maxine Stuart Clinical Nurse Oncology	US September–October 2009	Attended Clinical Oncology Group meeting	$3,621	Nil
Glynda Summers Executive Director Of Nursing	New Zealand May 2009	Attended Conference Study Tour Director of Nursing and Midwifery, Wellington, and attended Conference HGI (Hardy Group International) Learning Sets	$1,107	Nil
Kaylene Sutherland Acting Director, Major Projects Gold Coast	Singapore June 2009	Attended the Design and Health 6th World Congress and Exhibition in Singapore	$4,402	Nil
Bryson Swan Assistant Director of Pharmacy	Italy July 2009	Site Visit to Campus Bio Medico Hospital to review robotic IV and cytoxic compounding devices	$922	Nil
Peter Szep Diagnostic Radiographer	US April 2009	Attended International Society for Magnetic Resonance in Medicine and Section for Magnetic Resonance Technologists in Honolulu	$1,056	Nil
Jillian Tate Senior Scientist Chemical Pathology	US July 2009	Attended American Association of Clinical Chemistry annual meeting 2009	$320	Nil
Tiero Tateaba non-agency employee	Australia May–June 2010	Attended Train the Trainer course for professional development	$1,560	Nil
Susan Thomas Cancer Care Coordinator	Canada August 2009	Attended World Congress on Thyroid Cancer	$4,829	Nil
Bridie Thompson Senior Analyst/PHD Scholar	New Zealand August–October 2009	Attended 18th Australasian Epidemiological Association annual scientific meeting	$1,394	Nil
Ujang Tinggi Senior Scientist Food Chemistry	China and Japan May–June 2010	Attended and presented research paper at the 9th International Symposium on Selenium in Biology and Medicine at Japan and 2010 International Academic and Training Symposium on Food Safety and Analysis at China	$630	Nil
Sue Torenbeek District Liaison Officer Work for Us	United Kingdom September–October 2009	Attended British Medical Journal Careers Fair in London to directly interact with potential candidates and provide information about employment with Queensland Health in emergency medical, general medical and psychiatry in regional locations; and attend Health Jobs Around the World Recruitment expos in London, Manchester, Glasgow and Dublin to meet potential recruits	$10,515	Nil
Mimoza Trenceva Consultant Psychiatrist	New Zealand May 2010	Attended as a Work for Us exhibitor at the Royal Australian and New Zealand College of Psychiatrists Congress 2010 in Auckland	$1,491	Nil
Tracy Tse Clinical Pharmacist	US April 2010	Attended International Society for Heart and Lung Transplantation 30th Anniversary meeting and scientific sessions and Actelion Professionals Investigator meeting	$3,473	Nil
Benjamin Turner STEPS Programme Coordinator	US October 2009	Attended American Congress of Rehab Medicine and the American Society of Neuro Rehab	$4,044	Nil
Scott Turner, Acting Senior Cardiac Scientist Pacing, Cardiac Investigations Unit	US May 2010	Attended Heart Rhythm 2010	$1,792	Nil

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Andrew Van Dern Hurk Research Entomologist	US April–July 2010	Awarded an inaugural Queensland International Fellowship to undertake the project 'The risk of yellow fever to Australia' at University of Texas Medical Branch in Galveston	$5,673	Nil
Melissa Vartzokas Nuclear Medicine Technologist	New Zealand April 2010	Attended Australian and New Zealand Society of Nuclear Medicine Annual Conference	$562	Nil
Miriam Vassallo Registrar Thoracic Medicine	Malaysia July 2010	Malaysia advanced trainee work exchange	$4,549	Nil
Geoffrey Waghorn Senior Scientist	New Zealand August 2009	Attended and presented papers at the Cross Agency Training Day and meeting with staff and management of Workwise Employment Offices in Hamilton and Auckland	$256	$1,267 Workwise Employ-ment Agency
Geoffrey Waghorn Senior Scientist	United Kingdom May 2010	Attended meetings with Sainsbury Centre for Excellence in London and attend International Initiative for Mental Health Leadership Conference in Ireland – 'Exchange Themes in Ireland'	$5,991	Nil
Narelle Wallace Radiation Therapist	New Zealand March 2010	Attended Trans Tasman Radiation Oncology Group 2009	$1,650	Nil
James Walsh Physiotherapist	US April 2010	Attended International Society for Heart and Lung Transplantation 30th Anniversary Meeting and Scientific Sessions and Actelion Professionals Investigator Meeting	$3,470	Nil
Darren L Walters SMO Director Cardiology	US November 2008	Member of the Physician Assistant Interview Team undertaking a coordinated interview program to select suitable candidates for the Physician's Assistant Pilot Program	$534	Nil
Drew Watson Senior Health Physicist	US May 2010	Attended Residual Radiation (RESRAD) training workshops to receive intensive training in the use of the RESRAD family of radiation dosimetry software. Train other staff	$3,435	Nil
Marcus Watson Senior Director Skills Development Centre	US January 2010	Attended and presented at the 9th Annual International meeting of Simulation in Healthcare Orlando, US	$4,749	Nil
Drew Watson Health Physicist	US April 2010	Attended Residual Radioactivity (RESRAD) computer program in Burr Ridge Chicago, Illinois, US	$638	Nil
Suzanne Watson Registered Nurse	US July–August 2009	Attended 13th World Conference on Lung Cancer	$4,704	Nil
Peter White Manager Capital Development	France December 2009	Factory inspection testing of capital equipment in France and inspection of robotics applications in hospital pharmacies in Wales	$8,861	Nil
Bronwyn Williams Haematologist	US September–October 2009	Attended International Society for Cellular Therapy Conference	$5,031	Nil
Ged Williams Executive Director Nursing and Midwifery Services	US June–July 2009	Attended the Wharton School of Management Nursing Excellence Program 2009 in Philadelphia	$1,398	Nil
Helene Williams Senior Program Advisor	United Kingdom November 2009	Invited to be a keynote speaker at the 11th International Hepatitis Conference in Manchester, UK	$373	Nil

Name and position	Destination and date	Reason for travel	Agency cost	Contribution from external sources
Andrew Wilson Deputy Director Policy, Planning and Resourcing	India September–October 2009	Recalled from duty during overseas recreational leave to visit two private hospitals in Delhi and Hyderabad in India. Trip cancelled, part-refund	$274	Nil
Peter Wilson Senior Staff Specialist	US September–October 2009	Attended Clinical Oncology Group meeting	$4,823	Nil
Gregory Wilson Clinical Nurse Consultant	Netherlands June 2010	Attended World Congress on Vascular Access Devices	$186	Nil
Adrienne Young Dietitian/nutritionist	France July 2009	Attended World Congress of Gerontology and Geriatrics	$5,351	Nil
Jeannette Young Chief Health Officer	China March–April 2010	Invited to provide a keynote address at a forum by Hangzhou Centre for Disease Control and Prevention. All travel and accommodation costs covered by Hangzhou Centre For Disease Control	Nil	$5,242 Hangzhou Centre for Disease Control
Total			$675,055	

The above table includes travel in the previous financial year paid in 2009–2010.

Equity and diversity

Queensland Health acknowledges and values the contribution of its talented, diverse and motivated workforce.

The department's commitment to equity and diversity is demonstrated through initiatives to attract and retain a representative Indigenous workforce and to encourage and support women in leadership and mentoring roles.

Indigenous participation

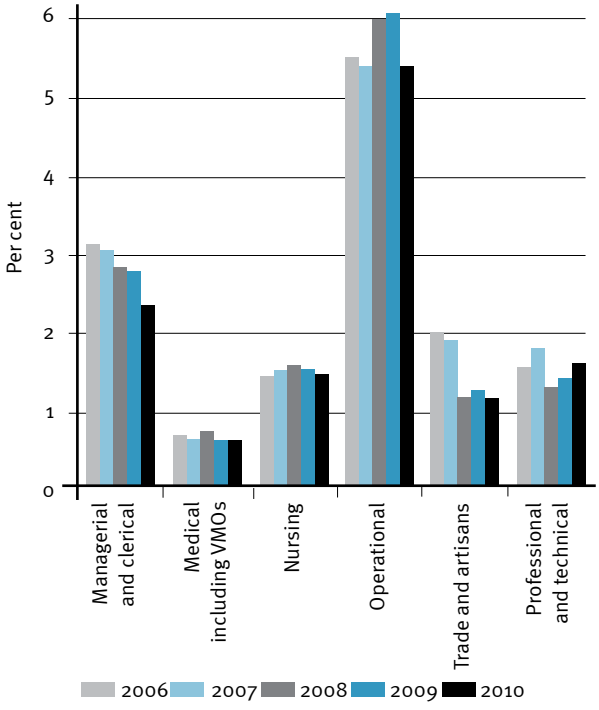
Queensland Health is committed to attracting and retaining a representative Aboriginal and Torres Strait Islander workforce.

A number of strategies have been implemented to improve representation of Aboriginal and Torres Strait Islander workforce, including:

- rollout of the Indigenous Health Worker – Isolated Practice Authorisation course, with 16 health workers enrolled
- Queensland Aboriginal and Torres Strait Islander Workforce Strategy 2009–2012 to increase Aboriginal and Torres Strait Islander representation in the workforce

- Promotion of Indigenous nursing with:
  - 70 cadetships
  - a University of Southern Queensland research fellowship for Indigenous nursing
  - employment of three Indigenous nurse practitioner candidates
  - launch of the Aboriginal and Torres Strait Islander Nursing Strategy.

Graph 29: Percentage Aboriginal and Islander workforce

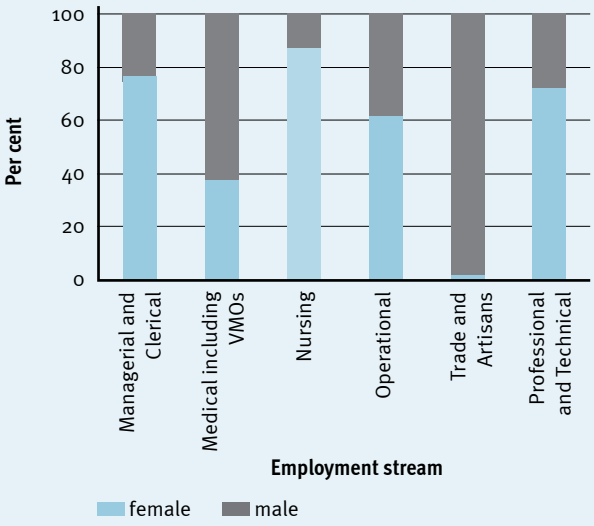


Source: Monthly Workforce Profile, Queensland Health

Initiatives for women

The representation of women in the workforce remains consistent with healthcare industry standards, with women accounting for 75.19 per cent of the total MOHRI head count and 56 per cent of occupied full-time-equivalent. Graph 22 gives a breakdown by stream and gender.

Graph 30: Percentage of MOHRI occupied FTE by stream and gender



Source: Minimum Obligatory Human Resource Information (MOHRI)

In 2009–2010, average fortnightly earnings for Queensland Health employees were $4,446.39 for males and $3,382.93 for females.

The percentage of women on boards under the Health Portfolio is 54 per cent. Of the 179 new and renewed appointees for 2009–2010, 43 per cent were women. Of all new appointees for the same period, 12 per cent were women.

While training and development initiatives are well attended by women across Queensland Health, it is not mandatory to register gender information in Queensland Health leadership program registrations.

However, data available indicates that, over the past 12 months, 782 women out of 2,118 women participated in Queensland Health leadership programs (about 37 per cent).

There has also been a continued increase in support for flexible work practices offered by the department.

Recognising excellence and achievements

The Queensland Health Awards for Excellence are an opportunity to recognise and celebrate the excellent contributions of healthcare staff from across Queensland.

On a daily basis, Queensland Health staff work hard to maintain safety and sustainability in our facilities, meet the health needs of patients, improve service delivery, develop and support staff and create and maintain beneficial community relationships.

The Queensland Health Awards for Excellence celebrate the dedication, innovation and vision of Queensland Health teams who deliver high-quality healthcare programs to improve the lives of all Queenslanders.

Queensland Health recognises and celebrates staff in the following award categories:

Excellence Awards

- safety and sustainability
- meeting health needs
- service delivery
- developing and supporting staff
- developing beneficial partnerships
- improving health and wellbeing of Queenslanders

Performance Awards

- improvement in population health
- improvement in access to services
- improvement in safety and quality
- improvement in workplace environment

Special Awards

- Deputy Premier's Award
- Director-General's Encouragement Award

Ethics and Code of Conduct

Queensland Health is committed to ensuring all staff understand the department's commitment and obligation to the public.

Queensland Health's values – caring for people, leadership, respect and integrity – are at the core of Queensland Health and central to Queensland Health's Code of Conduct.

The code is developed under the *Public Sector Ethics Act 1994*, which sets out the following five ethics principles:

- respect for people
- integrity
- respect for the law and the system of government
- diligence
- economy and efficiency.

The code provides standards of behaviour expected of all employees within Queensland Health so the department can build a positive workplace culture.

All Queensland Health employees are required to undertake training in the code during induction and the department provides flexible delivery options to support staff training.

Queensland Health's Code of Conduct can be found at www.health.qld.gov.au/about_qhealth/cc.

5 community interest

Community engagement and involvement in planning of future health services play a crucial role in Queensland Health delivering an efficient and cohesive healthcare system.

Community interest

Queensland Health's responsibilities extend beyond the wellbeing of those who use our services or promotion of healthy lifestyle choices. It also has a responsibility to respond to community needs and emergent issues.

Queensland Health's participation in events, festivals and community meetings ensures that relevant health issues are at the forefront for every Queenslander.

Community councils

On 9 July 2007, 36 health community councils were appointed as advisory bodies under the *Health Services Act 1991* to work in partnership with Queensland Health. The councils give a community perspective for feedback and advice about public sector district health services.

Councils do this through community engagement, enhancing community education and monitoring the quality, safety and effectiveness of public sector district health services.

Councils undertake activities, including:

- community engagement, such as seeking formal/informal community feedback on health issues, alternatives, opportunities and solutions and networking with other community and health-related groups within the district
- community education, such as sharing information on local health services to enhance the community's understanding of new or existing health services
- feedback and recommendations to the district chief executive officer about the quality, safety and effectiveness of health service delivery within the district.

As a result of the Independent Review of Queensland Government Boards, Committees and Statutory Authorities, councils were reviewed to better align with service delivery areas to ensure maximum effectiveness.

The alignment review has been completed and is now being considered in terms of the Australian Government's proposed National Health and Hospitals Network Reforms.

Patient satisfaction

The Annual Patient Satisfaction Survey tracks patient satisfaction and measures improvements against national standards. Health service districts' action plans in response to patient surveys give direct benefits to consumers, such as:

- Robina Hospital's southern car park
- Mackay Health Service District's on-call pharmacist and the Queensland Health enterprise discharge summary system
- resources for Northern Cluster of Sunshine Coast–Wide Bay Health Service District outlining hospital procedures and routines for patients to view.

Consumer complaints

Consumer Complaints Management gives a framework to support ethical, comprehensive and consumer-friendly complaints management.

The web-based consumer complaints portal is available statewide so consumers can give direct feedback, and Queensland Health can better manage, monitor and report on complaints, and give feedback to the Health Quality and Complaints Commission.

In March 2010, the updated Queensland Health Consumer Complaint Management Handbook was launched across Queensland Health.

Practitioner engagement

Queensland Health participates in the General Practice Advisory Council for formal consultation, communication and collaboration between general practitioners, government agencies, general practice peak bodies and the non-government sector.

This year, Queensland Health renewed its commitment to partnership with General Practice Queensland, giving a commitment to and framework for future collaborative action to improve health outcomes for individuals and communities, and the healthcare system's effectiveness in Queensland.

Multipurpose services

The Multipurpose Health Service Program brings together local health and aged care services to give small communities – that may lack support for a range of independently run services – the opportunity for a more coordinated and cost-effective approach to health service delivery.

Queensland Health manages 26 multipurpose service sites in rural and remote communities. They run regular community advisory network meetings to engage local communities to plan and review services provided to their communities.

Highlights in 2009–2010 include:

- new services in Mitchell, Mungindi and Augathella
- engaging with the Rural Women's Symposium Working Group
- starting work on the Rural Sustainability project to give a planning framework for small rural services.

Local partnerships

In 2009–2010, 15 local partnership councils were established, involving primary healthcare service providers and community representatives across Queensland.

Partnership councils jointly develop and deliver programs to address the Queensland Government's health priorities of:

- chronic and complex care
- integrated health promotion and illness prevention
- early childhood health
- community mental health
- drug and alcohol services.

An independent review of the Connecting Healthcare in Communities initiative by La Trobe University found a high level of participation by key stakeholders, and that councils are a good foundation to develop partnerships for an integrated comprehensive primary healthcare system.

Infrastructure projects

Engagement on delivering infrastructure includes the following projects:

Cairns

- consultation on hospital redevelopment on existing site, in favour of a greenfield development on a new site

Sunshine Coast

- consultation on preliminary Sunshine Coast University Hospital masterplan for Kawana site with clinicians, Sunshine Coast Regional Council, Stockland, the Board of Urban Places, State Architect and all key Government agencies
- preliminary Sunshine Coast University Hospital masterplan received in-principle support from key stakeholders, including Department of Transport and Main Roads, Sunshine Coast Regional Council, Department of Community Safety and Board of Urban Places. Dialogue will continue as the masterplan evolves

Queensland Children's Hospital

- more than 300 planning meetings and more than 1,500 stakeholders consulted in past 12 months
- a wide range of stakeholders, including staff from Royal Children's and Mater Children's, consulted through various targeted forums, panels, workshops, interviews and surveys.

Native title

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

All dealings on land held by, or on behalf of, Queensland Health must first consider native title. These dealings include disposal, acquisition, development, redevelopment, clearing, fencing and granting of leases, licences or permits. Dealings may proceed on departmental owned land where native title still exists, provided native title holders/claimants receive the necessary procedural rights.

In accordance with State Government Land Policies, generally once native title over a particular holding is cleared, Queensland Health must convert the tenure to freehold ownership.

As at 30 June 2010, Queensland Health has completed 64.41 per cent of native title assessments of departmental land holdings and 86.04 per cent have been converted to freehold tenure.

With the help of Crown Law, Queensland Health is currently negotiating several Indigenous Land Use Agreements (ILUA) with native title holders. These Indigenous Land Use Agreements will give trustees leases to validate the tenure of current and future facilities.

Five native title claims were lodged in 2009–2010.

Table 23: Native title claims lodged from 1 July 2009 to 30 June 2010 in Queensland Health service districts:

District	Number of claims
Mount Isa	2
South West	1
Sunshine Coast–Wide Bay	2
Total	5

Source: National Native Title Tribunal

Funded organisations

In 2009–2010, 562 organisations and individuals received grants totalling about $741 million which was integral to providing health services.

Organisations and individuals who received grants can be found at www.health.qld.gov.au under publications, annual reports.

Caring for carers

The Carers (Recognition) Act 2008 recognises and supports the role of carers and requires government departments to report on how they have implemented the Act, including the Australian Charter of Healthcare Rights principles.

Apart from the legislative requirements, recognising and supporting carers makes good business sense and contributes to improving the lives of carers, which helps everyone in the community.

In 2009–2010, Queensland Health met with Health Consumers Queensland and Carers Queensland to discuss the impact of health policy, planning and service delivery on consumers and carers.

Queensland Health works closely with community representative bodies to assess, plan, deliver and review services affecting consumers and their carers, including young people caring for parents and other family members.

Queensland Health gives carers access to a wide range of responsive and affordable services through the Medical Aids Subsidy Scheme, including resources, information, workshops and communication tools for consumers and their carers.

Consumer and carers are encouraged to participate in discussions about treatment options. Free interpreter services can be provided in person or by phone, if required. Information on the Carers Matter website helps reduce difficulties faced by carers, especially those in rural and remote locations.

The online Consumer Complaints Management system enables carers to express their concerns, which are carefully considered by healthcare professionals.

Queensland Health recognises that staff can also be carers and that achieving a balance between work and family responsibilities contributes to employee job satisfaction and effectiveness. Queensland Health's Carers Policy 2009, which is available on the department's intranet site, enables employees to use sick leave, unpaid leave, recreation leave or time off in lieu of overtime when they need to care for members of their immediate family or household.

Consultancy expenditure

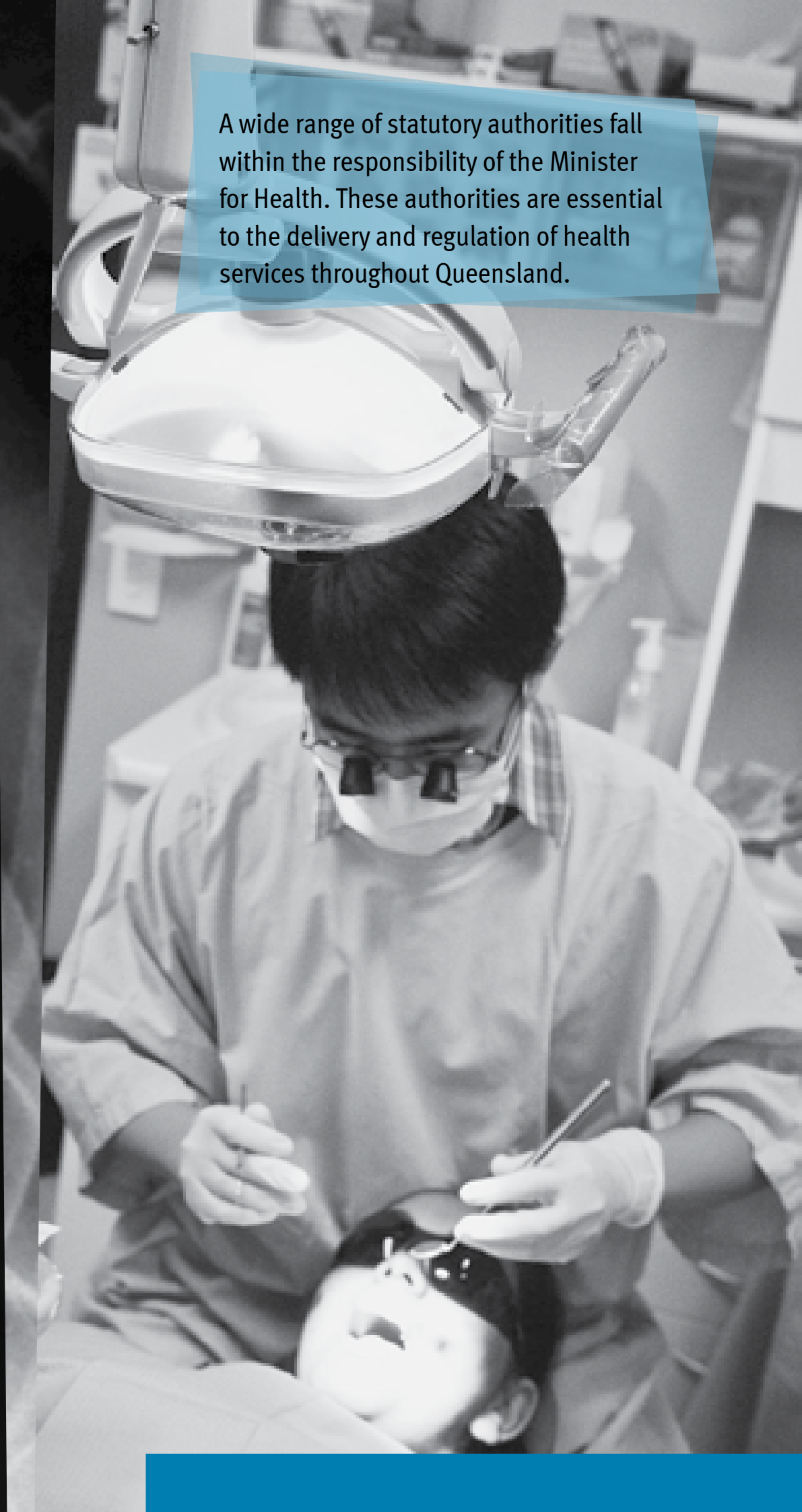
Table 24: Consultancies undertaken for Queensland Health during 2009–2010 were:

Consultancy category	Category description	Expenditure ($)
Professional and technical*	Professional and technical consultants provide a range of services, including: • review of clinical governance and services within Queensland Health • health service delivery strategies, models and service plans • review of current palliative care service provision against national standards • strategy to communicate information on health services.	4,972,434
Financial and accounting	Financial and accounting consultants provide a range of services, including: • professional expertise in developing new costing model • assistance in meeting legislative requirements • assessment of revenue retention capability and development of modelling tools.	2,872,483
Administration	Administrative consultants provide a range of services, including: • leadership and capability development training • operational efficiency reviews • education reviews and programs • master and service planning studies.	954,838
Human resource management	Human resource consultants provide a range of services, including: • career transition workshops • change management strategies for health service districts.	263,722
Total		9,063,477

**Some consultancy expenditure was incurred to support the major hospital redevelopments and, hence, was capitalised. The above figures do not include the capitalised consultancy expenditure which equated to a total of $4,367,204 for the 2009–2010 financial year.*

6 related entities

A wide range of statutory authorities fall within the responsibility of the Minister for Health. These authorities are essential to the delivery and regulation of health services throughout Queensland.



Statutory authorities

Hospital foundations

Hospital foundations are constituted under the *Hospitals Foundations Act 1982*. The foundations aim to acquire, manage and apply property and any associated income to continuing projects within or associated with their respective hospitals.

The following hospital foundations report directly to the Minister for Health:

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

Queensland Nursing Council

The Queensland Nursing Council is an independent statutory body established under the *Nursing Act 1992* to provide the registration and enrolment of nurses, accreditation of nursing courses, and establishment of standards of conduct within the profession.

Council of the Queensland Institute of Medical Research

The council is established under the *Queensland Institute of Medical Research Act 1945* and its function is to ensure the proper control and management of the institute established for the purpose of carrying out research into any branch or branches of medical science.

Health Consumers Queensland — Ministerial Advisory Committee

The committee is established under the *Health Services Act 1991* to contribute to the continued development and reform of health systems and services in Queensland by giving the Minister for Health information and advice from a consumer (patient) perspective, as well as supporting and promoting consumer engagement and advocacy.

Health Quality and Complaints Commission

The commission is established under the *Health Quality and Complaints Commission Act 2006* and responsible for overseeing quality activities in all public and private health services, and for addressing complaints from anyone associated with health service delivery, in a quality improvement context.

Consumer Advisory Committee

The committee is established under the *Health Quality and Complaints Commission Act 2006* to advise the commission on consumers' concerns about health services and other matters relevant to the commission's functions.

Clinical Advisory Committee

The committee is established under the *Health Quality and Complaints Commission Act 2006* to advise the commission about clinical matters relevant to the commission's functions.

HIV/AIDS, Hepatitis C and Sexual Health — Ministerial Advisory Committee

The committee is established under the *Health Services Act 1991* to contribute to a broader advisory process to monitor, review, evaluate and report on the Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005–2011.

Mental Health Court

The Mental Health Court is established under the *Mental Health Act 2000*. Its primary function is to determine issues such as criminal responsibility and fitness for trial, and remove the mentally

ill and intellectually disabled offender from the criminal justice system into the mental health system. The court is also the appeal body to the Mental Health Review Tribunal – another statutory body established under the Act, with special powers of inquiry into the lawfulness of detention of people in authorised mental health services.

Mental Health Review Tribunal

The Mental Health Review Tribunal is established under the *Mental Health Act 2000* and its primary role is to independently review people subject to involuntary detention and treatment under the Act.

Panels of Assessors

Panels of Assessors are established under the *Health Practitioners (Professional Standards) Act 1999* and may help the tribunal with disciplinary matters about a registrant, other than disciplinary matters that may, if proved, provide grounds for suspending or cancelling the registrant's registration.

Queensland Fluoridation Committee

The committee is established under the *Water Fluoridation Act 2008* and provides for promotion of good oral health in Queensland by the safe fluoridation of public potable water supplies.

Queensland Institute of Medical Research Trust

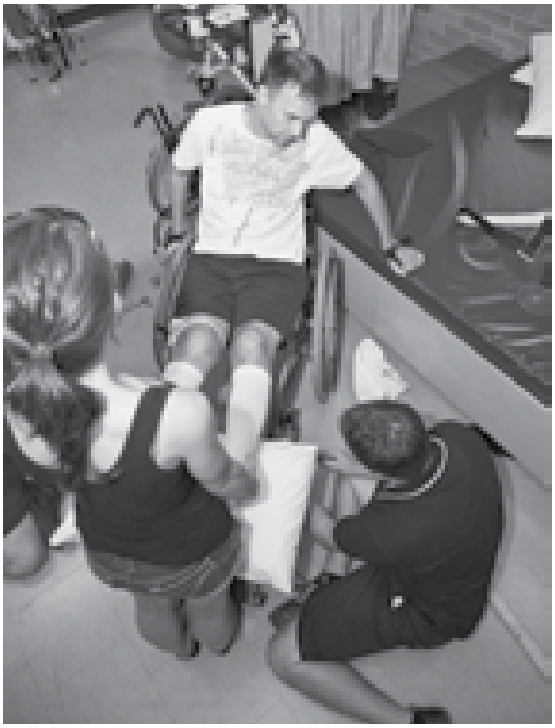
The trust is established under the *Queensland Institute of Medical Research Act 1945* and its function is to raise money for, and on behalf of, the Queensland Institute of Medical Research Council and to manage investments in accordance with the requirements of the Act.

Radiation Advisory Council

The council is established under the *Radiation Safety Act 1999* and its functions are to examine, and make recommendations to the Minister for Health about the operation and application of the *Radiation Safety Act*, proposed amendments, radiation safety standards, issues on radiation; and research into radiation practices, and transport of radioactive materials in Queensland.

Health practitioner registration boards

Twelve health practitioner registration boards are supported by the Office of Health Practitioner Registration Boards. Each board is established



under individual legislation with the primary function of registering their professional group and ensuring health care is delivered by registrants in a professional, safe and competent way.

The 12 boards are:

- Chiropractors Board of Queensland
- Dental Board of Queensland
- Dental Technicians and Dental Prosthetists Board of Queensland
- Medical Radiation Technologists Board of Queensland
- Occupational Therapists Board of Queensland
- Optometrists Board of Queensland
- Osteopaths Board of Queensland
- Pharmacists Board of Queensland
- Physiotherapists Board of Queensland
- Podiatrists Board of Queensland
- Psychologists Board of Queensland
- Speech Pathologists Board of Queensland.

Medical Board of Queensland

The Medical Board of Queensland is established under the *Medical Practitioners Registration Act 2001* and responsible for registering suitably qualified medical practitioners to ensure safe and competent health service delivery. The Office of the Medical Board provides dedicated administrative and operational support to the Medical Board.

Acts and subordinate legislation

Chiropractors Registration Act 2001

Chiropractors Registration Regulation 2002

Dental Practitioners Registration Act 2001

Dental Practitioners Registration Regulation 2001

Dental Technicians and Dental Prosthetists Registration Act 2001

Dental Technicians and Dental Prosthetists Registration Regulation 2002

Food Act 2006

Food Regulation 2006

Health Act 1937

Health (Drugs and Poisons) Regulation 1996

Health Regulation 1996

Health Practitioner Registration Boards (Administration) Act 1999

Health Practitioner Regulation National Law Act 2009

Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008

Health Practitioners (Professional Standards) Act 1999

Health Practitioners (Professional Standards) Regulation 2000

Health Practitioners (Special Events Exemption) Act 1998

Health Practitioners (Special Events Exemption) Regulation 1998

Health Quality and Complaints Commission Act 2006

Health Services Act 1991 (jointly administered with the Minister for Disability Services and Multicultural Affairs)

Health Services Regulation 2002

Hospitals Foundations Act 1982

Hospitals Foundations Regulation 2005

Mater Public Health Services Act 2008

Medical Board (Administration) Act 2006

Medical Practitioners Registration Act 2001

Medical Practitioners Registration Regulation 2002

Medical Radiation Technologists Registration Act 2001

Medical Radiation Technologists Registration Regulation 2002

Mental Health Act 2000

Mental Health Regulation 2002

Mental Health Review Tribunal Rule 2009

Nursing Act 1992

Nursing Regulation 2005

Occupational Therapists Registration Act 2001

Occupational Therapists Regulation 2001

Optometrists Registration Act 2001

Optometrists Registration Regulation 2001

Osteopaths Registration Act 2001

Osteopaths Registration Regulation 2002

Pest Management Act 2001

Pest Management Regulation 2003

Pharmacists Registration Act 2001

Pharmacists Registration Regulation 2001

Physiotherapists Registration Act 2001

Physiotherapists Registration Regulation 2001

Podiatrists Registration Act 2001

Podiatrists Registration Regulation 2002

Private Health Facilities Act 1999

Private Health Facilities Regulation 2000

Private Health Facilities (Standards) Notice 2000

Psychologists Registration Act 2001

Psychologists Registration Regulation 2002

Public Health Act 2005

Public Health Regulation 2005

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

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

Queensland Institute of Medical Research Act 1945

Radiation Safety Act 1999

Radiation Safety Regulation 1999

Radiation Safety (Radiation Safety Standards) Notice 1999

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

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

Speech Pathologists Registration Act 2001

Speech Pathologists Registration Regulation 2001

Tobacco and Other Smoking Products Act 1998

Tobacco and Other Smoking Products Regulation 1998

Transplantation and Anatomy Act 1979

Transplantation and Anatomy Regulation 2004

Water Fluoridation Act 2008

Water Fluoridation Regulation 2008

Table 25

Body	Constituting Act	Reporting arrangements
Chiropractors Board of Queensland	*Chiropractors Registration Act 2001*	Annual Report to Parliament
Council of the Queensland Institute of Medical Research **Queensland Institute of Medical Research Trust**	*Queensland Institute of Medical Research Act 1945*	Annual Report to Parliament
Dental Board of Queensland	*Dental Practitioners Registration Act 2001*	Annual Report to Parliament
Dental Technicians and Dental Prosthetists Board of Queensland	*Dental Technicians and Dental Prosthetists Registration Act 2001*	Annual Report to Parliament
Director of Mental Health	*Mental Health Act 2000*	Annual Report to Parliament
Health Community Councils (36)	*Health Services Act 1991*	Annual Report to Parliament
Health Consumers Queensland — Ministerial Advisory Committee	*Health Services Act 1991*	Annual Report to the Deputy Premier and Minister for Health
Health Quality and Complaints Commission	*Health Quality and Complaints Commission Act 2006*	Annual Report to Parliament
Hospital Foundations (12)	*Hospitals Foundations Act 1982*	Annual Report to Parliament
Medical Board of Queensland	*Medical Practitioners Registration Act 2001*	Annual Report to Parliament
Medical Radiation Technologists Board of Queensland	*Medical Radiation Technologists Registration Act 2001*	Annual Report to Parliament

Mental Health Court **Mental Health Review Tribunal**	*Mental Health Act 2000*	Annual Report to Parliament
Occupational Therapists Board of Queensland	*Occupational Therapists Registration Act 2001*	Annual Report to Parliament
Optometrists Board of Queensland	*Optometrists Registration Act 2001*	Annual Report to Parliament
Osteopaths Board of Queensland	*Osteopaths Registration Act 2001*	Annual Report to Parliament
Pharmacists Board of Queensland	*Pharmacists Registration Act 2001*	Annual Report to Parliament
Physiotherapists Board of Queensland	*Physiotherapists Registration Act 2001*	Annual Report to Parliament
Podiatrists Board of Queensland	*Podiatrists Registration Act 2001*	Annual Report to Parliament
Psychologists Board of Queensland	*Psychologists Registration Act 2001*	Annual Report to Parliament
Queensland Nursing Council	*Nursing Act 1992*	Annual Report to Parliament
Speech Pathologists Board of Queensland	*Speech Pathologists Registration Act 2001*	Annual Report to Parliament

Cost of statutory authorities

Table 27 outlines costs associated with those bodies within the Health portfolio that are not required to prepare separate financial statements.

Table 26

Authority	Cost ($)
Clinical Advisory Committee	4,433.00
Consumer Advisory Committee	25,244.00
Health Consumers Queensland – Ministerial Advisory Committee	42,625.00
HIV/AIDS, Hepatitis C and Sexual Health – Ministerial Advisory Committee	0.00
Mental Health Court	379,152.00
Mental Health Review Tribunal	3,167,446.38
Panel of Assessors	69,174.00
Queensland Fluoridation Committee	302.20
Radiation Advisory Council	7,420.00
Total	3,695,796.58

7 appendices

- Reports required under legislation
- VLADs (Variable Life Adjusted Displays)
- Glossary
- Compliance checklist

Queensland Health reports required under legislation

Queensland Health Annual Report
Financial Accountability Act 2009
www.health.qld.gov.au/publications/corporate/annual_reports

Annual Report of the Director of Mental Health
Mental Health Act 2000
www.health.qld.gov.au/mha2000/annual_reports

Right to Information Publication Scheme
Right to Information Act 2009 and Information Privacy Act 2009
www.health.qld.gov.au/foi/rti

Queensland Health Quarterly Public Hospitals Performance Report
Health Services Amendment Act 1991
www.health.qld.gov.au/performance

Table 27: VLADs

Legend
- ✓ hospital vs peer: satisfactory
- ★ hospital vs state: favourable
- ● hospital vs state: unfavourable
- ★● hospital vs state: once unfavourable and once favourable in the time period
- ▭ indicator not applicable to

Peer group	Hospital	Surgical											
		Fractured neck of femur in-hospital mortality	Fractured neck of femur complications of surgery (whole admission)	Colorectal carcinoma complications of surgery (whole admission)	Hip replacement (primary) complications of surgery (whole admission)	Hip replacement (primary) readmissions within 60 days	Hip replacement long-stay	Knee replacement (primary) complications of surgery (whole admission)	Knee replacement (primary) readmissions within 60 days	Knee replacement long-stay	Prostatectomy complications of surgery	Paediatric tonsillectomy and adenoidectomy readmission	Paediatric tonsillectomy and adenoidectomy long stay
Principal referral and specialised	Cairns Base Hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	★
	Gold Coast Hospital	●	✓	✓	✓	✓	●	✓	✓	●	✓	✓	✓
	Mater Children's Public Hospital											✓	●
	Mater Mothers' Public Hospital												
	Nambour General Hospital	●	✓	✓	✓	●	★	✓	✓	✓	✓	✓	✓
	Princess Alexandra Hospital	★	✓	✓	✓	✓	✓	✓	✓	●	✓		
	Royal Brisbane and Women's Hospital	★	✓	✓	✓	✓	●	✓	✓	✓	✓		
	Royal Children's Hospital											✓	●
	The Prince Charles Hospital			✓	✓	✓	★	✓	●	★			
	The Townsville Hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	★	★
Large	Bundaberg Hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
	Caboolture Hospital			✓									
	Hervey Bay Hospital	✓	✓	✓	✓								
	Ipswich Hospital	✓	✓	✓	✓	★	✓	✓	✓	★	✓	✓	●
	Logan Hospital	✓	✓	✓	✓	✓	✓	✓	✓	●			
	Mackay Base Hospital	✓	✓		✓	✓	✓	✓	✓	✓			
	Maryborough Hospital												
	Mater Adult Public Hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
	Mount Isa Base Hospital											✓	✓
	Queen Elizabeth II Jubilee Hospital	✓	✓	✓	✓	✓	✓	●	✓	✓	✓		
	Redcliffe Hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
	Redland Hospital												
	Rockhampton Hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	★
	Toowoomba Hospital	✓	✓	✓	✓	✓	✓	✓	✓	●	✓	★	✓
Medium and small	Atherton Hospital												
	Ayr Hospital												
	Beaudesert Hospital												
	Biloela Hospital												
	Bowen Hospital												
	Caloundra Hospital												
	Charleville Hospital												
	Charters Towers Hospital												
	Chinchilla Hospital												
	Cloncurry Hospital												
	Collinsville Hospital												
	Cooktown Hospital												
	Dalby Hospital												
	Emerald Hospital												
	Gladstone Hospital												
	Goondiwindi Hospital												
	Gympie Hospital											✓	★
	Ingham Hospital												
	Innisfail Hospital												
	Joyce Palmer Health Service												
	Kingaroy Hospital												
	Longreach Hospital											✓	✓
	Mareeba Hospital												
	Miles Hospital												
	Mossman Hospital												
	Normanton Hospital												
	Proserpine Hospital											✓	✓
	Roma Hospital												
	St George Hospital												
	Stanthorpe Hospital												
	Thursday Island Hospital												
	Tully Hospital												
	Warwick Hospital										✓		
	Yeppoon Hospital												

Medical								Gynaecology/Obstetric							Mental Health			
AMI in-hospital mortality	AMI readmission	AMI long-stay	Heart failure in-hospital mortality	Heart failure readmission	Heart failure long stay	Stroke in-hospital mortality	Pneumonia in-hospital mortality	Abdominal hysterectomy complications of surgery	Vaginal hysterectomy complications of surgery	Selected primip induction of labour	Selected primip caesarean section (public)	Selected primip third and fourth-degree Perineal tears	Selected primip episiotomy (public)	Selected primip instrumental delivery (public)	Depression readmission	Depression long-stay	Schizophrenia readmission	Schizophrenia long-stay
✓	✓	✓	●	✓	✓	✓	●	✓	✓	✓	✓	✓	✓	✓	✓	●	✓	●
✓	★	✓	✓	✓	✓	✓	●	✓	✓	✓	✓	✓	✓	✓	✓	●	✓	✓
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✓	✓	✓	●	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	★
●	✓	✓	✓	✓	✓	✓	●	✓	✓	✓	✓	●	✓	✓	✓	✓	★	✓
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★	●	✓	●	✓	●	✓	✓	✓		✓	✓	✓	★	✓	✓	✓	✓	✓
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Glossary

Accessible	• accessible health care is characterised by the ability of people to obtain appropriate health care at the right place and right time, irrespective of income, cultural background or geography
Activity-based funding	• a management tool with the potential to enhance public accountability and drive technical efficiency in the delivery of health services by: – capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery – creating an explicit relationship between funds allocated and services provided – strengthening management's focus on outputs, outcomes and quality – encouraging clinicians and managers to identify variations in costs and practices so these 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 which could threaten life or normal function – perform diagnostic or therapeutic procedures
Acute hospital	• is generally a recognised hospital that provides acute care • excludes dental and psychiatric hospitals
Admission	• the process whereby the hospital accepts responsibility for a patient's care and/or treatment • follows a clinical decision, based on specified criteria, that a patient requires same-day or overnight care or treatment, which can occur in hospital and/or in the patient's home (for hospital-in-the-home patients)
Admitted patient	• is a patient who undergoes a hospital's formal admission process as either an overnight stay patient or a same-day patient
Allied health staff	• professional staff with qualifications and ongoing competence in one or any combination of the following specialties: audiologist, clinical measurements scientist, dietitian, medical imaging technologist, occupational therapist, orthotists, pharmacist, physiotherapist, podiatrist, prosthetist, psychologist, social worker and speech pathologist. It may also include access to an Aboriginal and Torres Straight Islander health worker
Ambulatory setting	• a non-inpatient setting
Available bed	• a bed which is immediately available for use by an admitted patient if required. A bed is immediately available for use if located in a suitable place for care, with nursing and auxiliary staff available within a reasonable period, to service patients who might occupy them
Benchmarking	• involves the collection of 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 of benchmarking – that can be expected to lead to sustainable work class positive outcomes
Capital expenditure	• expenditure on large-scale non-current assets (for example, new buildings and equipment with a useful life extending over several years)
Care type	• overall nature of a clinical service given to an admitted patient during an episode of care (admitted care), or the type of service provided by the hospital for boarders or posthumous organ procurement (other care)
Casemix	• range and type of patients (the mix of cases) treated by a hospital or other health service • casemix classifications are a way of describing and comparing hospitals and other services
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
Continuing care	• uninterrupted, seamless and integrated care provided across the continuum
Critical care	• critical care services include intensive care units (ICU), high-dependency units (HDU) and coronary care units (CCU) • critical care services provide care for the critically ill or those vulnerable to critical illness, focusing on the level of care individual patients need, that may or may not be provided in the unit
Decision support system (DSS)	• consolidates data suitable for finance, human resources, pharmacy and pathology-related information for decision-support purposes
Elective care	• care which, in the opinion of the treating clinician, is necessary, and admission for which can be delayed for at least 24 hours
Electronic liaison medication system (eLMS)	• helps healthcare staff to manage and use medication-related information for patients and to facilitate exchange of medication information with community health practitioners (GPs community pharmacists)
Emergencies	• immediately, imminently or potentially life-threatening conditions
Emergency department waiting time to service delivery	• 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
Emergency surgery	• surgery, which in the opinion of the treating clinician, is necessary and for which admission cannot be delayed more than 24 hours
Episode of care	• period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type
Full-time-equivalent staff	• refers to occupied full-time-equivalent staff (full-time-equivalent staff currently working in a position)
Health behaviours	• accumulation of attitudes, beliefs, knowledge and practices that result in a person's health behaviours, for example, patterns of eating, physical activity, excess alcohol consumption and smoking

Health outcome	• change in the health of an individual, or group of people or population, attributable to an intervention or series of interventions
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-in-the-home care	• provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation
Immunisation	• process of inducing immunity to an infectious agency by administering a vaccine
Incidence	• number of new cases of a condition occurring within a given population, over a certain period of time
Indigenous health worker	• Indigenous health workers provide primary health care to Aboriginal and Torres Strait Islander individuals, families and communities
Length of stay	• length of stay of an overnight patient is calculated by subtracting the date the patient is admitted from the date of separation and deducting days the patient was on leave • a same-day patient is allocated a length of stay of one day
Medical practitioner	• person who is registered by the Medical Board of Queensland to practise medicine in Queensland, including both general and specialist practitioners
Non-admitted patient	• a patient who does not undergo a hospital's formal admission process
Non-admitted patient occasion of services	• an occasion of examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service facility
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 assessment and management of 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 clinic 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	• patient who is admitted to, and separated from, the hospital on different dates (not same-day patients)
Performance indicator	• a measure that provides an 'indication' of progress towards achieving the organisation's objectives • usually has targets that define the level of performance expected against the performance indicator
Population health	• prevention of illness and injury; and protection and promotion through organised efforts and informed choices of society, organisations (public and private), communities and individuals
Private hospital	• either a private hospital or a 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 by insurers • patients admitted to private hospital are treated by a doctor of their choice

Public patient	A public patient is a patient who: • elects to be treated as a public patient, and 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	• hospital controlled by a state or territory health authority • public hospitals offer free diagnostic services, treatment, care and accommodation to all eligible patients
Queensland Health Data Dictionary	• publication with a core set of uniform definitions for the full range of health services and range of population parameters
Registered nurse	• an individual registered under national law to practise in the nursing and midwifery professions as a nurse, other than as a student
Sustainable	• a health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs, for example, research, monitoring within available resources
Telehealth	• delivery of health-related services and information via telecommunication technologies, including: – live, audio and or/video inter-active link for clinical consultations and educational purposes – store-and-forward Telehealth, including digital images, video, audio and clinical data being captured ('stored') on the client computer, then transmitted securely ('forwarded') to a clinic at another location where they are studied by relevant specialists – teleradiology for remote reporting and clinical advice for diagnostic images – Telehealth services and equipment to monitor people's health in their home
Triage category	• urgency of the patient's need for medical and nursing care

Compliance checklist

FA ACT *Financial Accountability Act 2009*
FPMS *Financial and Performance Management Standard 2009*
ARRs Annual Report Requirements for Queensland Government Agencies

Summary of requirement		Basis for requirement	Annual report reference
Accessibility	Table of contents Glossary	ARRs – section 8.1	Introduction p 3 Ch 7 appendices p 150-153
	Public availability	ARRs – section 8.2	Introduction (inside cover)
	Interpreter service statement	*Queensland Government Language Services Policy*	Introduction (inside cover)
	Copyright notice	*Copyright Act 1968*	Introduction (inside cover)
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister(s)	ARRs – section 9	Introduction p 1
Introductory information	Agency role and main functions	ARRs – section 10.3	Ch 1 Our organisation p 6
	Operating environment	ARRs – section 10.3	Ch 3 Our performance p 52-106
	External scrutiny	ARRs – section 10.3	Managing our Business Ch 2 p 29
	Machinery-of-government changes	ARRs – section 10.3	n/a
	Review of proposed forward operations	ARRs – section 10.3	Managing our Business Ch 2 p 32
Non-financial performance	Government objectives for the community	ARRs – section 11.2	Ch 3 Our performance p 53
	Agency objectives and performance indicators	ARRs – section 11.5	Ch 3 Our performance p 53-90; 98-106
	Agency outputs and output performance measures	ARRs – section 11.6	Ch 3 Our performance p 91-97
Financial performance	Summary of financial performance	ARRs – section 12.1	Ch 1 Our organisation p 14
	Disclosure of budget v actual results	ARRs – section 12.2	(strongly encouraged)
	Chief Finance Officer (CFO) statement	ARRs – section 12.3	Managing our Business Ch 2 p 17
Governance – management and structure	Organisational structure	ARRs – section 13.1	Ch 1 Our organisation p 8-9
	Executive management	ARRs – section 13.2	Managing our Business Ch 2 p 17-19
	Related entities	ARRs – section 13.3	Ch 6 Related entities p 140-145
	Schedule of statutory authorities or instrumentalities	ARRs – section 13.4	Ch 6 Related entities p 141-145
	Boards and committees	ARRs – section 13.5	Managing our Business Ch 2 p 20-27
	Public Sector Ethics Act 1994 – implementation statement giving details of the action taken during the reporting period	*Public Sector Ethics Act 1994* (section 23 and schedule)	Ch 4 Our people p 134
	Whistleblowers Protection Act 1994 – public interest disclosures received	*Whistleblowers Protection Act 1994* (sections 30–31 and schedule)	Managing our business Ch 2 p 34

Summary of requirement		Basis for requirement	Annual report reference
Governance – risk management and accountability	Risk management	ARRs – section 14.1	Managing our business Ch 2 p 27
	Audit committee	ARRs – section 14.2	Managing our Business Ch 2 p 24-26
	Internal Audit	ARRs – section 14.3	Managing our Business Ch 2 p 25 and p 28
Governance – human resources	Workforce planning, attraction and retention	ARRs – section 15.1	Ch 4 Our people p 109-118
	Early retirement, redundancy and retrenchment	Directive No.17/09 Early Retirement, Redundancy and Retrenchment	Ch 4 Our people p 114
	Initiatives for women	ARRs – section 15.1 and 15.3	Ch 4 Our people p 133
Governance – operations	Consultancies	ARRs – section 16.1	Ch 5 Community interest p 139
	Overseas travel	ARRs – section 16.2	Ch 4 Our people p 118-131
	Information systems and recordkeeping	*Public Records Act 2002*	Managing our business Ch 2 p 39
	Waste management	*Environmental Protection (Waste Management) Policy 2000, Environmental Protection Act 1994*	Managing our business Ch 2 p 41
Other prescribed requirements	Indigenous matters (Queensland Government Reconciliation Action Plan 2009–2012)	Queensland Government Reconciliation Action Plan 2009–2012	Managing our business Ch 2 p 38
	Shared services	ARRs – section 17.1	Managing our business Ch 2 p 50
	Carbon emissions	Premier's Statement	Managing our business Ch 2 p 41
Optional information that may be reported	Corrections to previous annual reports	ARRs – section 18.2	n/a
	Right to Information	*Right to Information Act 2009*	Managing our business Ch 2 p 39-40
	Information privacy	*Information Privacy Act 2009*	Managing our Business Ch 2 p 40
	Native title	N/A	Ch 5 Community interest p 138
Financial statements	Annual general purpose financial statements	Financial Reporting Requirements for Queensland Government Agencies	Chapter 8 Financials p 158-201
	Certification of financial statements	FA Act – section 62 FPMS – sections 42, 43 and 50	Chapter 8 Financials p 202
	Independent Auditors Report	FA Act – section 62 FPMS – section 50	Chapter 8 Financials p 203
	Remuneration disclosures	Financial Reporting Requirements for Queensland Government Agencies	Chapter 8 Financials p 172; 178

8 financial statements

Diligent financial overview is essential to delivering health services that are well planned and organised and meet the evolving needs of the community.

Queensland Health
Financial Statements
2009–10

General Information

The Department of Health is a Queensland Government Department established under the *Public Service Act 2008* and its registered trading name is Queensland Health.

Queensland Health is controlled by the State of Queensland which is the ultimate parent entity.

The principal address of the department is:
147-163 Charlotte Street, Brisbane Q 4000.

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

Department of Health
Statement of Comprehensive Income
For the year ended 30 June 2010

	Notes	2010 $'000	2009 $'000
Income from continuing operations			
Revenues			
Departmental services revenue	4	8,584,754	5,641,207
User charges	5	688,758	503,934
Grants and other contributions	6	235,902	2,401,638
Other revenue	7	27,142	33,744
Gains			
Gains on sale of property, plant and equipment	8	1,181	818
Total income from continuing operations		**9,537,737**	**8,581,341**
Expenses from continuing operations			
Employee expenses	10	6,138,715	5,357,796
Supplies and services	11	2,237,743	2,135,083
Grants and subsidies	12	741,338	681,551
Depreciation and amortisation	13	326,521	301,608
Impairment losses	14	14,572	14,288
Other expenses	15	92,703	87,722
Total expenses from continuing operations		**9,551,592**	**8,578,048**
Share of profit/(loss) in associates	9	**14,687**	**-**
Operating result from continuing operations		**832**	**3,293**
Other comprehensive income			
Increase/(decrease) in asset revaluation surplus	28	(602,939)	103,930
Total other comprehensive income		**(602,939)**	**103,930**
Total comprehensive income		**(602,107)**	**107,223**

The Statement of Comprehensive Income should be read in conjunction with accompanying notes.

Department of Health
Statement of Financial Position
As at 30 June 2010

	Notes	2010 $'000	2009 $'000	Restated as at 1 July 2008 $'000
Current assets				
Cash and cash equivalents	16	33,068	164,667	545,139
Receivables	17	452,294	294,944	323,315
Inventories	18	120,187	120,514	92,130
Other	21	84,744	69,810	61,556
Total current assets		**690,293**	**649,935**	**1,022,140**
Non-current assets				
Intangibles	22	96,853	83,624	75,448
Property, plant and equipment	23	6,190,270	6,112,474	5,537,761
Other financial assets	19	20,000	20,000	20,000
Investments in associates	20	14,687	-	-
Other	21	8,022	13,140	9,259
Total non-current assets		**6,329,832**	**6,229,238**	**5,642,468**
Total assets		**7,020,125**	**6,879,173**	**6,664,608**
Current liabilities				
Payables	24	381,434	253,194	756,800
Accrued employee benefits	25	306,986	516,549	325,840
Other	27	878	8,947	6,754
Total current liabilities		**689,298**	**778,690**	**1,089,394**
Non-current liabilities				
Finance lease advanced	26	17,235	-	-
Other	27	2,617	1,901	1,669
Total non-current liabilities		**19,852**	**1,901**	**1,669**
Total liabilities		**709,150**	**780,591**	**1,091,063**
Net assets		**6,310,975**	**6,098,582**	**5,573,545**
Equity				
Contributed equity		2,759,878	1,948,184	1,531,160
Accumulated surplus		2,397,181	2,393,543	2,389,460
Asset revaluation surplus	28	1,153,916	1,756,855	1,652,925
Total equity		**6,310,975**	**6,098,582**	**5,573,545**

The Statement of Financial Position should be read in conjunction with accompanying notes.

Department of Health
Statement of Changes in Equity
For the year ended 30 June 2010

	Notes	2010 $'000	2009 $'000
Accumulated surpluses			
Balance at the beginning of the financial year		2,393,543	2,389,460
Operating result from continuing operations		832	3,293
Transactions with owners as owners			
Correction of asset balance not previously recognised		3,014	1,349
Transfer from asset revaluation surplus		164	-
Net asset stocktake gain/(loss)		(372)	(559)
Balance at the end of the financial year		**2,397,181**	**2,393,543**
Asset revaluation surplus			
Balance at the beginning of the financial year		1,756,855	1,652,925
Total other comprehensive income			
Increase/(decrease) in asset revaluation surplus	28	(602,939)	103,930
Balance at the end of the financial year		**1,153,916**	**1,756,855**
Contributed equity			
Balance at the beginning of the financial year		1,948,184	1,531,160
Transactions with owners as owners			
Equity injections		1,020,003	626,431
Equity withdrawals		(207,695)	(206,682)
Net equity injection	4	**812,308**	**419,749**
Net machinery of Government transfers			
Assets received	3, 30	3,000	8,784
Assets transferred	3, 30	(3,614)	(6,059)
Balance at the end of the financial year		**2,759,878**	**1,948,184**
Total equity		**6,310,975**	**6,098,582**

The Statement of Changes in Equity should be read in conjunction with the accompanying notes.

	Notes	2010 $'000	2009 $'000
Cash flows from operating activities			
Inflows			
Departmental services receipts		8,554,541	5,680,607
User charges		587,383	585,407
Grants and other contributions		225,529	2,399,961
Interest received		3,955	4,921
GST collected from customers		26,935	23,201
GST input tax credits from ATO		357,020	334,952
Other		22,479	29,014
Outflows			
Employee expenses		(6,384,512)	(5,163,551)
Supplies and services		(2,124,963)	(2,224,008)
Grants and subsidies		(742,461)	(682,391)
Performance return expense		-	(273)
Insurance		(62,485)	(49,531)
GST paid to suppliers		(373,378)	(337,459)
GST remitted to ATO		(25,390)	(23,016)
Other		(34,708)	(448,106)
Net cash provided by operating activities	29	**29,945**	**129,728**
Cash flows from investing activities			
Inflows			
Sales of property, plant and equipment		4,769	3,501
Advances redeemed		17,848	47,009
Outflows			
Payments for property, plant and equipment		(985,283)	(760,864)
Payments for intangibles		(34,110)	(31,058)
Advances made		(12,524)	(149,137)
Net cash used in investing activities		**(1,009,300)**	**(890,549)**
Cash flows from financing activities			
Inflows			
Equity injections		1,020,003	626,431
Finance lease advanced	26	17,235	-
Outflows			
Equity withdrawals		(189,482)	(246,082)
Net cash provided by financing activities		**847,756**	**380,349**
Net decrease in cash and cash equivalents		(131,599)	(380,472)
Cash and cash equivalents at the beginning of the financial year		**164,667**	545,139
Cash and cash equivalents at the end of the financial year	16	**33,068**	**164,667**

The Statement of Cash Flows should be read in conjunction with the accompanying notes.

Department of Health **Statement of Comprehensive Income by Major Departmental Services and SSP** For the year ended 30 June 2010

	Prevention Promotion, Protection*		Primary Health Care*		Ambulatory Care		Acute Care		Rehabilitation and Extended Care		Integrated Mental Health Services		Subtotal All Major Departmental Services	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Income from continuing operations														
Revenue														
Departmental services revenue	363,309	189,055	552,195	491,389	1,706,334	1,052,303	4,518,237	3,101,525	582,752	402,629	770,002	404,306	8,492,829	5,641,207
User charges	20,115	14,319	1,959	1,542	126,454	36,087	488,342	422,374	37,578	24,880	14,139	4,030	688,587	503,232
Grants and other contributions	6,664	180,662	13,363	35,157	12,283	536,520	23,905	1,133,172	177,017	274,043	2,664	242,071	235,896	2,401,625
Other revenue	4,530	3,660	960	1,515	4,504	6,650	14,988	21,158	1,119	1,889	1,022	1,680	27,123	36,552
Gains														
Gains on sale of property, plant and equipment	71	24	69	61	228	147	641	428	83	64	89	61	1,181	785
Total income from continuing operations	394,689	387,720	568,546	529,664	1,849,803	1,631,707	5,046,113	4,678,657	798,549	703,505	787,916	652,148	9,445,616	8,583,401
Expenses from continuing operations														
Employee expenses	199,334	175,974	374,623	346,311	1,179,488	991,181	3,104,354	2,761,710	554,581	459,866	624,076	518,146	6,036,456	5,253,188
Supplies and services	125,786	154,250	128,605	121,601	488,475	457,524	1,233,489	1,243,211	162,505	169,320	111,333	99,894	2,250,193	2,245,800
Grants and subsidies	51,973	40,505	38,787	36,786	102,408	114,490	485,371	437,052	41,939	38,525	20,860	14,143	741,338	681,501
Depreciation and amortisation	10,660	9,653	18,854	16,080	64,826	54,116	176,863	179,494	32,321	26,910	20,865	12,595	324,389	298,848
Impairment losses	1,044	664	1,166	894	2,362	2,681	7,206	7,774	1,144	1,164	1,650	1,111	14,572	14,288
Other expenses	6,637	6,580	7,325	7,773	15,132	11,174	46,352	48,010	7,290	7,488	10,422	6,047	93,158	87,072
Total expenses from continuing operations	395,434	387,626	569,360	529,445	1,852,691	1,631,166	5,053,635	4,677,251	799,780	703,273	789,206	651,936	9,460,106	8,580,697
Share of profit/(loss) in associates	754	–	826	–	2,926	–	7,627	–	1,248	–	1,306	–	14,687	–
Operating result from continuing operations	9	94	12	219	38	541	105	1,406	17	232	16	212	197	2,704
Other comprehensive income														
Increase/(decrease) in asset revaluation surplus	(24,950)	4,643	(36,317)	6,342	(117,358)	19,540	(320,345)	56,029	(51,128)	8,424	(50,834)	7,810	(600,932)	102,788
Total other comprehensive income	(24,950)	4,643	(36,317)	6,342	(117,358)	19,540	(320,345)	56,029	(51,128)	8,424	(50,834)	7,810	(600,932)	102,788
Total comprehensive income	(24,941)	4,737	(36,305)	6,561	(117,320)	20,081	(320,240)	57,435	(51,111)	8,656	(50,818)	8,022	(600,735)	105,492

*The Prevention, Promotion and Protection major service has been increased and Primary Health Care decreased by $126.7m due to an error in the distribution methodology in the 2008-09 financial year.

Department of Health Statement of Comprehensive Income by Major Departmental Services and SSP For the year ended 30 June 2010

	Subtotal All Major Departmental Services		QHSSP		Inter- Departmental Services Elimination		Total	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Income from continuing operations								
Revenue								
Departmental services revenue	8,492,829	5,641,207	91,925	-	-	-	8,584,754	5,641,207
User charges	688,587	503,232	30,979	132,349	(30,808)	(131,647)	688,758	503,934
Grants and other contributions	235,896	2,401,625	6	13	-	-	235,902	2,401,638
Other revenue	27,123	36,552	19	417	-	(3,225)	27,142	33,744
Gains								
Gains on sale of property, plant and equipment	1,181	785	-	33	-	-	1,181	818
Total income from continuing operations	9,445,616	8,583,401	122,929	132,812	(30,808)	(134,872)	9,537,737	8,581,341
Expenses from continuing operations								
Employee expenses	6,036,456	5,253,188	102,259	104,608	-	-	6,138,715	5,357,796
Supplies and services	2,250,193	2,245,800	17,186	24,155	(29,636)	(134,872)	2,237,743	2,135,083
Grants and subsidies	741,338	681,501	-	50	-	-	741,338	681,551
Depreciation and amortisation	324,389	298,848	2,132	2,760	-	-	326,521	301,608
Impairment losses	14,572	14,288	-	-	-	-	14,572	14,288
Other expenses	93,158	87,072	717	650	(1,172)	-	92,703	87,722
Total expenses from continuing operations	9,460,106	8,580,697	122,294	132,223	(30,808)	(134,872)	9,551,592	8,578,048
Share of profit/(loss) in associates	14,687	-	-	-	-	-	14,687	-
Operating result from continuing operations	197	2,704	635	589	-	-	832	3,293
Other comprehensive income								
Increase/(decrease) in asset revaluation surplus	(600,932)	102,788	(2,007)	1,142	-	-	(602,939)	103,930
Total other comprehensive income	(600,932)	102,788	(2,007)	1,142	-	-	(602,939)	103,930
Total comprehensive income	(600,735)	105,492	(1,372)	1,731	-	-	(602,107)	107,223

The Statement of Comprehensive Income by Major Departmental Services and SSP should be read in conjunction with the accompanying notes.

Department of Health **Statement of Assets and Liabilities by Major Departmental Services and SSP** For the year ended 30 June 2010

	Prevention Promotion, Protection		Primary Health Care		Ambulatory Care		Acute Care		Rehabilitation and Extended Care		Integrated Mental Health Services		Subtotal All Major Departmental Services	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Total assets	290,020	215,713	421,800	530,349	1,363,226	1,282,246	3,720,679	3,718,301	593,873	556,650	590,591	531,574	6,980,189	6,834,833
Total liabilities	29,198	24,338	42,465	59,838	137,247	144,673	374,590	419,527	59,790	62,805	59,459	59,976	702,749	771,157

	Subtotal All Major Departmental Services		QHSSP		Inter-Departmental Services Elimination		Total	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Total assets	6,980,189	6,834,833	39,936	44,340	-	-	7,020,125	6,879,173
Total liabilities	702,749	771,157	6,401	9,434	-	-	709,150	780,591

The Statement of Assets and Liabilities by Major Services and SSP should be read in conjunction with the accompanying notes.

1 Objectives and strategic priorities of the department

The department's objective is to create dependable health care and better health for all Queenslanders. To achieve this, it is essential that services are well planned and organised and that they evolve and change in line with changing practice and community needs. This is reflected in the following four strategic priorities:

- *Making Queenslanders healthier* with a focus on prevention, promotion and protection as effective interventions in addressing the rates of chronic disease
- *Meeting Queenslanders' healthcare needs safely and sustainably* by addressing the challenge of meeting the healthcare needs of Queenslanders across the continuum of care
- *Reducing health service inequities across Queensland* which seeks to provide greater equity of access to health services for specific population groups most at risk
- *Developing our staff and enhancing organisational performance* which values the role of people and resources in our organisation while maximising our achievement of these strategic priorities.

The department is predominantly funded for the major departmental services it delivers by parliamentary appropriations and by grants from the Australian Government. It also provides health services on a fee-for-service basis mainly for inpatient care.

2 Summary of significant accounting policies

(a) Statement of compliance

The financial statements have been prepared in compliance with section 42 of the *Financial and Performance Management Standard 2009*.

These financial statements are general purpose financial statements and have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations. In addition, the financial statements comply with Queensland Treasury's Minimum Reporting Requirements for the year ending 30 June 2010, and other authoritative pronouncements.

With respect to compliance with Australian Accounting Standards and Interpretations, the financial statements have applied the requirements applicable to not-for-profit entities as Queensland Health is a not-for-profit department. Except where stated, the historical cost convention is used.

(b) The reporting entity

Queensland Health is managed through a corporate office which has a range of statewide services. Direct service delivery is provided by a network of fifteen Health Service Districts (districts). Districts include all the health operating activities of the department, including hospital facilities, community, mental and residential health centres. Districts are not separate reporting entities. In the process of reporting on the department as a single economic entity, all transactions and balances internal to the economic entity including the shared service partner, districts and other divisions have been eliminated in full when preparing this financial report.

The Mater Misericordiae Public Hospital, although treated as a district for operational purposes, does not form part of Queensland Health. As such, they are not included in the financial statements except to the extent that an annual amount is paid by way of a grant to the hospital for the provision of public hospital services in accordance with a binding service agreement.

The major departmental services undertaken by Queensland Health and the activities of Queensland Health Shared Service Partner (QHSSP) are disclosed in Note 3.

The financial statements include the value of all assets, liabilities, equity, revenues and expenses of Queensland Health. The department has no controlled entities as at 30 June 2010 due to a change in accounting policy in regards to QHSSP. Refer Note 2 (d).

The associated entities of Queensland Health are those entities in which the department has significant influence, but no control, over the financial and operating policies. As at 30 June 2010, Queensland Health has three associates – *Translational Research Institute Pty Ltd*, *Translational Research Institute Trust* and *Queensland Children's Medical Research Institute (QCMRI)*.
For further details refer to Notes 2 (c), 31 (c), 20 and 34.

(c) Investments in associates

Queensland Health's investment in associates is accounted for using the equity method of accounting in the financial statements. The associates are entities over which Queensland Health has significant influence and that are neither subsidiaries nor joint ventures.

Queensland Health deems to have significant influence if it holds between 20 and 50 percent of the voting power of another entity.

Under the equity method, investments in associates are carried in the Statement of Financial Position at cost plus post-acquisition changes in the Queensland Health's share of net assets of the associates. Goodwill relating to an associate is included in the carrying amount of the investment and is not amortised. After application of the equity method, Queensland Health determines whether it is necessary to recognise any impairment loss with respect to the net investment in associates. Goodwill included in the carrying amount of the investment in associates is not tested separately, rather the entire carrying amount of the investment is tested for impairment as a single asset. If impairment is recognised, the amount is not allocated to the goodwill of the associate. Queensland Health has not recognised any goodwill in its accounts for the current reporting period.

The Queensland Health's share of its associates' post-acquisition profits or losses is recognised in the Statement of Comprehensive Income, and its share of post-acquisition movements is recognised in asset revaluation surplus. The cumulative post-acquisition movements are adjusted against the carrying amount of the investment. Dividends receivable from associates are recognised in the Statement of Comprehensive Income as a component of other income. Queensland Health has not received any dividends for the current reporting period.

When the share of losses in an associate equals or exceeds its interest in the associate, including any unsecured long-term receivables and loans, Queensland Health does not recognise further losses, unless it has incurred obligations or made payments on behalf of the associate.

The associates' accounting policies conform to those used by Queensland Health for like transactions and events in similar circumstances. For further details refer to Notes 3, 20, 31 (c) and 34.

(d) Changes in accounting policies

Queensland Health voluntarily changed its accounting policy in regards to its Shared Service Partner (SSP) in the current financial year. As a result, the department is now reporting the QHSSP as an integral part of Queensland Health and no longer prepares separate general purpose financial statements. The department applied this policy change retrospectively to the earliest comparative period and restated its Statement of Financial Position for comparative periods reporting restated statements as at 30 June 2009 and 1 July 2008 in accordance with AASB 108 *Accounting Policies, Changes in Accounting Estimates and Errors* accounting standard.

(e) Administered transactions and balances

Queensland Health administers, but does not control, certain resources on behalf of the Government. In doing so, it has responsibility and is accountable for administering related transactions and items, but does not have the discretion to deploy the resources for the achievement of these departments' objectives.

Administered transactions and balances are disclosed in Note 40. These transactions and balances are not significant in comparison to the department's overall financial performance and financial position.

(f) Trust transactions and balances

The department acts in a fiduciary trust capacity in relation to patient trusts. As the department acts in a custodial role in respect of these transactions and balances, they are not recognised in the financial statements. Although these funds are not controlled by the department, these transactions are included in the audit review performed annually by the Auditor-General of Queensland. Note 36 provides additional information on these balances.

(g) Major departmental services revenue and administered revenue

Appropriations provided under the Annual Appropriation Act are recognised as revenue when received or as a receivable when approved by Queensland Treasury.

Amounts appropriated to the department for transfer to other entities in accordance with legislative or other requirements are reported as an administered appropriation item.

(h) User charges, fees and fines

User charges and fees are controlled by the department where they can be deployed for the achievement of departmental objectives.

User charges and fees controlled by the department are comprised of hospital fees, sales of goods and services and rental income. Hospital fees mainly consist of private patient hospital fees, interstate patient revenue and Department of Veterans' Affairs revenue.

Private patient hospital fees revenue is recognised as revenue when invoices for the related services are raised. Interstate patient revenue and Department of Veterans' Affairs revenue are recognised as revenue based on an estimation and reconciliation of the amount due for the financial year.

Where user charges are received for services that are to be performed in the future the revenue is not recognised until the services are performed.

Fees and fines collected, but not controlled, by the department are recognised and reported as administered revenue in Note 40.

Arrangements exist between Queensland Health and various hospital foundations for the running of hospital car parks constructed by the department. Under these arrangements, approved by Government, revenues generated by the operation of these car parks are retained by Hospital Foundations which are separate statutory bodies which prepare their own financial statements.

(i) Grants and other contributions

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

Where grants are received that are reciprocal in nature, revenue is recognised over the term of the funding arrangements.

Contributed assets are recognised at their fair value. Contributions of services are recognised only when a fair value can be determined reliably and the services would be purchased if they had not been donated.

(j) Financing and borrowing costs

Financing and borrowing costs are recognised as an expense in the period in which they are incurred.

Borrowing costs include interest on bank overdrafts, short-term and long-term borrowings, and ancillary administration charges.

(k) Cash and cash equivalents

For the purposes of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques receipted but not banked at 30 June as well as deposits at call with financial institutions. It also includes investments with short periods to maturity that are readily convertible to cash on hand at the department's option and that are subject to a low risk of changes in value.

(l) Receivables

Trade debtors are recognised at the amounts due at the time of sale or service delivery. The collectability of receivables is assessed periodically with provision being made for impairment.

Bad debts are reviewed on an ongoing basis during the year, and all that are known to be uncollectible are written off when identified. Increases in the provision for impairment are based on loss events disclosed in Note 39.

Trade and other debtors are generally settled within 60 days, while advances may take longer than twelve months. Collectability of advances is reviewed on an ongoing basis at an operating unit level. Advances include insurance claims, property purchases, long service leave reimbursements, amounts advanced to employees to align the payment of salaries and wages to a uniform pay day throughout the department and amounts advanced to entities for services to be performed. No collateral is held for advances made and no interest is charged on outstanding amounts.

Queensland Health does not have the capacity to grant loans to other entities, except where specific approval is granted by the Treasurer under the *Financial Accountability Act 2009*. Approval currently exists to the extent of the financial arrangements for funding the public hospital component of the redevelopment of the Mater Hospital. These balances are regarded as administered (Note 40) and are recorded at book value with no interest charged.

(m) Inventories

Inventories are held for distribution and are provided for no or nominal consideration. These consist mainly of medical supplies provided primarily for hospital care. Inventories held for distribution are measured at cost adjusted, where applicable, for any loss of service potential. Cost is allocated on a weighted average basis for inventories recorded on a perpetual system and includes expenditure incurred in acquiring the inventories and bringing them to their existing condition.

Unless material, inventories do not include supplies held ready for use in wards throughout the hospital facilities. These supplies are expensed on issue from the department's main storage facilities.

(n) Property, plant and equipment

Acquisition
Items of property, plant and equipment are initially recorded at actual cost when acquired. Cost is determined as the value given as consideration plus costs incidental to the acquisition and all other costs incurred to bring the asset to a state where it is ready for use.

Where assets are received free of charge from another Queensland department (whether as a result of a machinery-of-Government or other involuntary transfer), the acquisition cost is recognised as the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation.

Assets acquired at no cost or for nominal consideration, other than from an involuntary transfer from another Queensland Government entity, are initially recognised at their fair value at the date of acquisition in accordance with AASB 116 *Property, Plant and Equipment*.

Recognition
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 in the year of acquisition.

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

Items below these values are expensed in the year of acquisition.

Items or components that form an integral part of an asset are recognised as a single asset (functional asset). The recognition threshold is applied to the aggregate cost of each functional asset.

Artwork assets are not disclosed separately as they are not considered material to the total assets held by the department. They form part of the plant and equipment asset class.

Heritage buildings are included in the buildings asset class as they are held primarily for the purpose of service delivery.

Revaluations
Land and buildings are measured at fair value in accordance with AASB 116 *Property, Plant and Equipment* and *Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector.* In respect of these asset classes, the cost of items acquired during the financial year has been judged by management of the department to materially represent the fair value at the end of the reporting period.

Plant and equipment is measured at cost in accordance with *Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector.*

Land and buildings are measured at fair value with comprehensive revaluations being undertaken at least once every five years and interim valuations, using appropriate indices, being otherwise performed on an annual basis where there has been a material variation in the index.

The department is in year five of a five-year building revaluation program. In 2009-10, comprehensive independent revaluations were completed for approximately 25.6% of the gross value of the building portfolio reported in Note 23. As a result, the land and building portfolio assets have been fully revalued during the five years between 2005-06 and 2009-10 financial years.

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 in the revaluation surplus relating to that class.

The gross method of reporting comprehensively revalued assets has been adopted. This method restates separately the gross amount and related accumulated depreciation of the assets comprising the class of revalued assets. Accumulated depreciation is

restated proportionally in accordance with the independent advice of the appointed valuers/quantity surveyors. The proportionate method has been applied to those assets that have been revalued by way of indexation.

Where an asset is identified for disposal, it is revalued to its market selling price in accordance with *Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector.*

The useful life of thirty years for buildings has been determined based on the complex nature of Queensland Health's building portfolio and the renewal work undertaken over the asset's life cycle. The useful life for buildings is reassessed annually by management to ensure the reliability for continued use. The remaining useful life of each building is also independently assessed when a comprehensive revaluation is performed.

Where heritage buildings are included in the valuation of the building asset class, these heritage buildings will be valued for the functional services they provide. The heritage utility component of these assets have not been included in these values as they can not be reliably measured.

Depreciation
Land is not depreciated as it has an unlimited useful life.

Included in the class of plant and equipment are 15 artworks valued at $0.413 million (2008-09: $0.413 million). These items are not depreciated as their value is not expected to diminish with time.

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 installed ready for use in accordance with its intended application. These assets are then reclassified to the relevant classes of property, plant and equipment.

Property, plant and equipment is depreciated on a straight-line basis so as to allocate the net cost or revalued amount of each asset, less its estimated residual value, progressively over its estimated useful life to the department.

Items comprising the department's technical library are expensed on acquisition.

Where assets have separately identifiable components that are subject to regular replacement, these components are assigned useful lives distinct from the asset to which they relate and are depreciated accordingly. Queensland Health does not currently have any significant component assets where the depreciation impact resulting from separate recording of this component is material for the asset class.

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 to the department.

Major spares purchased specifically for particular assets are capitalised and depreciated on the same basis as the asset to which they relate.

The depreciable amount of improvements to or on leasehold land is allocated progressively over the estimated useful lives of the improvements or the unexpired period of the lease, whichever is the shorter. The unexpired period of leases includes any option period where exercise of the option is probable.

Plant and equipment subject to a finance lease is amortised on a straight-line basis over the term of the lease, or, where it is likely that the department will obtain ownership of the asset, the expected useful life of the asset to the department.

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

Class	Depreciation rates
Buildings and Land Improvements	2.50% – 3.33%
Plant and Equipment	5.0% – 20.0%

Leased plant and equipment
Leased plant and equipment for which Queensland health assumes substantially all the risks and benefits of ownership are classified as finance leases. Other leases are classified as operating leases. As at 30 June 2010 the department had no finance leases.

Operating lease payments, being representative of benefits derived from the leased assets, are recognised as an expense of the period in which they are incurred.

Impairment of non-current assets
All non-current physical and intangible assets are assessed for indicators of impairment on an annual basis. If an indicator of possible impairment exists, the department determines the asset's recoverable amount. Any amount by which the asset's carrying amount exceeds the recoverable amount is considered an impairment loss.

The asset's recoverable amount is determined as the higher of the asset's fair value less costs to sell and depreciated replacement cost.

An impairment loss is recognised immediately in the Statement of Comprehensive Income, unless the asset is carried at a revalued amount. When the asset is measured at a revalued amount, the impairment loss is offset against the asset revaluation surplus of the relevant class to the extent available.

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

(o) Intangibles

Acquisition
Intangible assets are initially recorded at cost. Cost is determined as the value given as consideration plus costs incidental to the acquisition. Internally generated software cost includes all direct costs associated with its development. All training and general overhead costs are expensed as incurred.

Recognition
Intangible assets with a cost or other value greater than $100,000 are recognised in the financial statements, items with a lesser value being expensed.

It has been determined that there is not an active market for any of the department's intangible assets. As such, the assets are recognised and carried at cost less accumulated amortisation and accumulated impairment losses.

Expenditure on research activities relating to internally-generated intangible assets is recognised as an expense in the period in which it is incurred.

Amortisation
Each intangible asset is amortised on a straight-line basis so as to allocate the net cost of each asset over its estimated useful life to the department, less any anticipated residual value. The residual value is zero for all the department's intangible assets.

Software is amortised from the time of acquisition or, in respect of internally developed software, from the time an asset is completed and held ready for use.

The following amortisation rates were used for software:

Class	Amortisation rate
Software	10% – 20%

Intellectual property
Queensland Health controls both registered intellectual property in the form of patents, designs and trade marks and other un-registered intellectual property in the form of copyright.

As at 30 June 2010, the department's controlled intellectual property assets do not meet the recognition criteria as assets for reporting purposes.

(p) Arrangements for the provision of public infrastructure by other entities

Queensland Health has entered into a number of contractual arrangements with private sector entities for the construction and operation of public infrastructure facilities for a period of time on departmental land. After an agreed period of between fifteen and twenty-five years, ownership of the facilities will pass to Queensland Health. Arrangements of this type are known as Build Own Operate Transfer (BOOT) type arrangements. BOOT arrangements in operation as at 30 June 2010 are listed in Note 37.

Queensland Health does not control the facilities associated with these arrangements, therefore, although the land on which the facilities have been constructed remains an asset of the department, the facilities are not recorded as assets of the department. The department receives rights and incurs obligations under these arrangements and these include:

- rights to receive the facility at the end of the contractual terms
- rights and obligations to receive and pay cash flows in accordance with the respective contractual arrangements.

The arrangements have been structured to minimise risk exposure for the department.

Currently there is no specific Australian Accounting Standard for the treatment of Private Provision of Public Infrastructure (PPPI) arrangements. Consequently, Queensland Health has not recognised any rights or obligations that may attach to those arrangements, other than those recognised under generally accepted accounting principles. Refer Note 37.

(q) Collocation agreements

Queensland Health has entered into a number of contractual arrangements with private sector entities for the construction and operation of private health facilities for a period of time on departmental land. After an agreed period of twenty-five years, ownership of the facilities will pass to Queensland Health.

As with BOOT type agreements, Queensland Health does not recognise these facilities as assets.

Consequently, Queensland Health has not recognised any rights or obligations that may attach to those agreements, other than those recognised under generally accepted accounting principles. Current collocation agreements in operation are listed in Note 38.

(r) Other financial assets

Queensland Health has fixed rate deposits with Queensland Treasury Corporation (QTC) approved by the Treasurer. The investment is non-derivative with known payments and a fixed maturity date. The department has the ability and intention to continue this investment until maturity as the investment contributes towards the Government's objective of promoting high-quality health research under the Smart Health Research Grants Program. Refer Notes 19 and 39.

(s) Payables

Payables are recognised for amounts to be paid in the future for goods and services received, whether or not billed to Queensland Health. Trade creditors are measured at the agreed purchase/contract price, gross of applicable trade and other discounts. The amounts are unsecured and normally settled within 60 days.

(t) Other financial liabilities

Finance lease advanced
Leases are classified as finance leases when the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee. Finance lease payments received in advance are recorded as liabilities. Refer Notes 20 and 26.

Administered borrowings
Queensland Health administers the borrowings of the public component of the Mater Hospital redevelopment loan. There is no financial benefit derived from the transactions by the department and the financial risk associated with the public component of the project has been covered by the State Government and is treated as an administered balance. Refer Note 40.

(u) Financial instruments

Recognition
Financial assets and financial liabilities are recognised in the Statement of Financial Position when the department becomes party to the contractual provisions of the financial instruments.

Classification
Financial instruments are classified and measured as follows:

- cash and cash equivalents – held at fair value through profit or loss
- receivables – held at amortised cost
- held-to-maturity investment – held at amortised cost
- payables – held at amortised cost
- borrowings – are held at amortised cost

Any borrowing costs are added to the carrying amount of the borrowing to the extent they are not settled in the period in which they arise.

The department does not enter into transactions for speculative purposes, nor for hedging. Apart from cash and cash equivalents, the department holds no financial assets classified at fair value through profit or loss.

All other disclosures relating to the measurement and financial risk management of other financial instruments held by the department are included in Note 39.

(v) Employee benefits

Employer superannuation contributions, annual leave levies and long service leave levies are regarded as employee benefits.

Payroll tax and workers' compensation insurance are a consequence of employing employees, but are not included in an employee's total remuneration package. They are not employee benefits and are recognised separately as employee related expenses. Refer Note 10.

Wages, salaries and sick leave
Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at the current wages and salary rates.

History indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised.

For the 2009-10 financial year, there were 27 pay periods instead of 26 with the last pay day being 30 June 2010. Due to timing issues, associated payroll payments for the last pay period, including those to the ATO, QSuper and other external vendors remained unpaid at financial year end. Refer Notes 24 and 25.

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

Annual leave
The Queensland Government's Annual Leave Central Scheme (ALCS) became operational on 30 June 2008 for departments, commercialised business units and shared service providers. Under this scheme, a levy is made on the department to cover the cost of employees' annual leave (including leave loading and on-costs). The levies are expensed in the period in which they are payable. Amounts paid to employees for annual leave are claimed from the scheme quarterly in arrears. Refer Note 25.

From 1 July 2008, no provision for annual leave is recognised in the department's financial statements as the liability is held on a whole-of-Government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting.*

Long service leave
Under the Queensland Government's long service leave scheme, a levy is made on the department to cover the cost of employees' long service leave. The levies are expensed in the period in which they are payable. Amounts paid to employees for long service leave are claimed from the scheme quarterly in arrears.

No provision for long service leave is recognised in the department's financial statements, the liability being held on a whole-of-Government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting.*

Superannuation
Employer superannuation contributions are paid to QSuper, the superannuation plan 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. The department's obligation is limited to its contribution to QSuper.

Therefore, no liability is recognised for accruing superannuation benefits in the department's financial statements, the liability being 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.*

Executive remuneration
The executive remuneration disclosures in the employee expense in the financial statements (Note 10) include:

- the aggregate remuneration of all senior executive officers (including the Chief Executive Officer) whose remuneration for the financial year is $100,000 or more
- the number of senior executives whose total remuneration for the financial year falls within each successive $20,000 band, commencing at $100,000.

The remuneration disclosed is all remuneration paid or payable, directly or indirectly, by the department or any related party in connection with the management of the affairs of the department or any of its controlled entities, whether as an executive or otherwise. For this purpose, the remuneration includes:

- wages and salaries
- accrued leave (that is, the increase/decrease in the amount of annual and long service leave owed to an executive, inclusive of any increase in the value of leave balances as a result of salary rate increases or the like)
- performance pay paid or due and payable in relation to the financial year, provided that a liability exists (namely a determination has been made prior to the financial statements being signed), and can be reliably measured even though the payment may not have been made during the financial year

- accrued superannuation (being the value of all employer superannuation contributions during the financial year, both paid and payable as at 30 June)
- car parking benefits and the cost of motor vehicles such as lease payments, fuel costs, registration/insurance, repairs/maintenance and fringe benefits tax on motor vehicles incurred by the agency during the financial year, both paid and payable as at 30 June, net of any amounts subsequently reimbursed by the executives
- allowances (which are included in remuneration agreements of executives, such as airfares or other travel costs paid to/for executives whose homes are situated in a location other than the location they work in)
- fringe benefits tax included in remuneration agreements.

The disclosures apply to all senior executives appointed under the *Public Service Act 2008* and classified as SES1 and above, with remuneration above $100,000 in the financial year. The disclosure does not include senior executives appointed as Health Executive Service (HES) employees under the *Health Services Act 1991*.

'Remuneration' means any money, consideration or benefit, but excludes amounts:

- paid to an executive by the department or its controlled entities where the person worked during the financial year wholly or mainly outside Australia during the time the person was so employed or
- in payment or reimbursement of out-of-pocket expenses incurred for the benefit of the department or any of its controlled entities.

In addition, separate disclosure of separation and redundancy/termination benefit payments is also included.

(w) Allocation of overheads to major departmental services

The revenues and expenses of the department's corporate services are allocated to departmental services on the basis of the services they primarily support and are included in the Statement of Comprehensive Income by Major Departmental Services and SSP. Refer Note 3.

(x) Insurance

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

The department also pays premiums to WorkCover Queensland in respect of its obligations for employee compensation.

(y) Services received free of charge or for nominal value

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

(z) Contributed equity

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

(aa) Taxation

Queensland Health is a state body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). FBT and GST are the only Commonwealth taxes accounted for by the department. GST credits receivable from and GST payable to the ATO are recognised and accrued. Refer Note 17.

(bb) Issuance of financial statements

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

(cc) Judgments

The preparation of financial statements necessarily requires the determination and use of certain critical accounting estimates, assumptions and management judgments that have the potential to cause a material adjustment to the carrying amounts of assets

and liabilities within the next financial year. Such estimates, judgments and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised and in future periods as relevant.

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

User charges – Note 2 (h)
Valuation of property, plant and equipment – Note 23
Contingencies – Note 32

(dd) Rounding and comparatives

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

Comparative information has been restated where necessary to be consistent with disclosures in the current reporting period.

(ee) New and revised accounting standards

The only voluntarily change Queensland Health made during 2009-10 to its accounting policy was to recognise QHSSP as part of its economic entity. Refer Note 2 (d).

Those new and amended Australian Accounting Standards that were applicable for the first time in the 2009-10 financial year that had a significant impact on the department's financial statements are as follows.

The department complied with the revised AASB 101 *Presentation of Financial Statements* as from 2009-10 financial year. This revised standard does not have any measurement or recognition implications. Pursuant to the change in terminology used in the revised AASB 101, the Balance Sheet is now re-named to the Statement of Financial Position, and the Cash Flow Statement has now been re-named to Statement of Cash Flows. The former Income Statement has been replaced by a Statement of Comprehensive Income. In line with the new concept of 'comprehensive income', the bottom of this new statement contains certain transactions that previously were detailed in the Statement of Changes in Equity (refer to the items under sub-heading 'Other Comprehensive Income' in the new Statement of Comprehensive Income). The Statement of Changes in Equity includes details of transactions with owners in their capacity as owners and other total comprehensive income for the relevant components of equity.

In compliance with the revised AASB 101, an additional Statement of Financial Position as at the beginning of the earliest comparative period is presented pursuant to the inclusion of QHSSP in the department economic entity. The effect of this change has been included in a restated Statement of Financial Position. The department is not permitted to adopt a new Accounting Standard ahead of the specified commencement date unless approval is obtained from Queensland Treasury. Consequently, the department has not applied any Australian Accounting Standards and interpretations that have been issued but are not yet effective. The department will apply these standards and interpretations in accordance with their respective commencement dates.

At the date of authorisation of the financial statements, the only significant impacts of new or amended Australian Accounting Standards with future commencement dates are set out below.

AASB 2009-5 *Amendments to Australian Accounting Standards arising from the Annual Improvement Project* includes certain amendments to AASB 117 Leases, effective from reporting periods beginning on or after 1 January 2010. These amendments revise the criteria for classifying leases involving land and buildings. Queensland Health will be required to reassess classification of the land element of all unexpired leases the department has entered into as at 1 July 2010, on the basis of information existing at the inception of the relevant leases. If any such leases are reclassified to become finance leases, retrospective accounting adjustments will be processed as far as practicable.

AASB 9 *Financial Instruments* and AASB 2009-11 *Amendments to Australian Accounting Standards arising from AASB 9 [AASB 1,3,4,5,7,101,102,108,112,118,121,127,128,131,132,136,1023 &1038* and *Interpretations 10 & 12]* become effective from reporting periods beginning on or after 1 January 2013. The main impacts of these standards are that they will change the requirements for the classification, measurement and disclosures associated with financial assets. Under the new requirements financial assets will be more simply classified according to whether they are measured at either amortised cost or fair value. On initial application of AASB 9, the department will need to reassess the measurement of its financial assets against the new classification and measurement requirements, based on the facts and circumstances existing at that date.

All other Australian Accounting Standards and Interpretations with future commencement dates are either not applicable to the department or have no material impact.

3 Major departmental services, SSP and activities of the department

Major services and SSP

Queensland Health has six major departmental services and the Shared Service Partner. These reflect the department's planning priorities as articulated in the Queensland Statewide Health Services Plan 2007-2012 and supports investment decision-making based on the health continuum.

The identity and purpose of each major departmental service undertaken by Queensland Health during the reporting period is summarised as follows:

Prevention, Promotion, Protection
Aims to prevent illness or injury, promote and protect good health and wellbeing of the population and reduce the health status gap between the most and least advantaged in the community.

Primary Health Care
Address health problems or established risk factors of individuals and small targeted groups providing curative, promotive, preventative and rehabilitation services. The services include early detection and intervention services and risk factor management programs.

Ambulatory Care
Aims to provide equitable access to quality emergency and outpatient services provided by Queensland's public hospitals and incorporate activities of Queensland public hospitals outpatient department as well as emergency medical services provided in the public hospital emergency departments.

Acute Care
Aims to increase equity and access to high-quality acute hospital services for patients on a statewide basis and includes the provision of medical, surgical and obstetric service in Queensland hospitals.

Rehabilitation and Extended Care
Aims to improve the functional status of patients with an impairment or disability, slow the progression of a person's health condition and assist them to maintain and better manage their health condition. This major departmental service predominantly targets the needs of people with long-term conditions that have chronic consequences.

Integrated Mental Health Services
This major departmental service spans the health continuum through the provision of mental health promotion, community-based illness prevention activities, acute mental health services, outpatient treatment and mental health support services, as well as the extended treatment services provided through designated mental health units.

Shared Service Partner
Queensland Health's Shared Service Partner provides a standard suite of corporate services to Queensland Health, linen services and some additional out of scope services.

Major activities

Assets received from DEEDI for research facility
The Department of Employment, Economic Development and Innovation (DEEDI) was previously the lead agency in the Translational Research Institute initiative. In 2009-10 Queensland Health was nominated by Government to take on the role of lead agency. Subsequently $3 million of work in progress relating to the Translational Research Institute Facilities held by DEEDI was transferred to Queensland Health. Refer Notes 2 (c), 20, 31 (c) and 34.

Transfer of payroll system asset to CorpTech
Part of the Government's Shared Service Solution agenda is the development and implementation of whole-of-Government SAP systems. It is whole-of-Government policy that the SAP systems will be maintained and owned by CorpTech. The Cabinet Budget Review Committee (CBRC) endorsed Queensland Government agencies making involuntary non-reciprocal transfers of intangible system assets created as a result of the implementation of the Shared Service Initiative. In 2009-10 Queensland Health transferred $3.614 million (2008-09: $8.784 million) development expenditure through a non-appropriated equity transfer to CorpTech, representing the cost incurred in the development of the whole-of-Government payroll system.

New system implementation — payroll
Queensland Health implemented a new payroll system in March 2010. The existing payroll system which had been in use since 1997 needed to be replaced as the product was no longer supported by its supplier. The rollout of the new system was part of a whole-of-Government strategy for consistent finance and HR systems across Queensland Government agencies.

Difficulties were experienced during the implementation of the new payroll system. The major factors as identified by the *Auditor-General's Report to Parliament No. 7 for 2010*, were as follows:

- The governance structure for the system implementation was not clear, causing confusion over the roles and responsibilities of the various parties involved in the project.
- The numerous awards structures and complex industrial agreements added to the complexity of the combinations of calculations required to be performed by the new system.
- Inadequate documentation of the business end-to-end requirements at project initiation.
- System and process testing prior to go-live had not identified a number of significant implementation risks. Consequently, it was not determined whether the systems, processes and infrastructure were in place for the effective operation of the new system.

Queensland Health has taken steps to implement an action plan as announced by Government in response to the Auditor-General's report. The action plan includes the following:

- establishing a decentralised payroll operating model, based on local partnerships between health service districts and payroll hubs, offering simpler and more responsive payroll services
- improving and simplifying the rostering software. Advisors have been appointed to review payroll and rostering solutions in Australia and overseas to assist the department with selecting the most appropriate solution
- strengthening HR and finance functions within Corporate Services.

While Queensland's Health acknowledges the difficulties surrounding the implementation of the new payroll system, these factors have not materially impacted the integrity of the department's financial systems.

Included in trade debtors is an amount of $15.689 million relating to salary overpayments and $5.852 million relating to interim cash payments (for example, cheque, cash or EFT) made as a response to issues related to the implementation of the new payroll and rostering system. Refer Note 17.

Queensland Health acknowledges that there is a high risk regarding the possibility of bad debt write-offs in relation to the recovery of salary overpayments. Refer Notes 39 (c) and 42.

Translational Research Institute

The State of Queensland, through Queensland Health, together with the University of Queensland, Queensland University of Technology and the Mater Medical Research Institute, are joint shareholders of the *Translational Research Institute Pty Ltd*, which has been established to create a facility for biopharmaceutical research and development.

A proprietary limited company, the *Translational Research Institute Pty Ltd (TRI Pty Ltd),* was incorporated with the Treasurer's approval in June 2009. *TRI Pty Ltd* does not trade and the Company's main purpose is to act as trustee for the *Translational Research Institute Trust (TRI Trust)*. The *TRI Trust* was created to execute and manage the operations of the research facility.

The State of Queensland, through Queensland Health, has committed to contributing a sum of $97 million towards the total cost of the facility. Queensland Health will construct the facility at the Princess Alexandra Hospital on State land (currently owned by Queensland Health) and lease the facility to the *TRI Trust*. Also refer to Notes 2(b), 20, 31 (c) and 34.

	2010 $'000	2009 $'000

4 Reconciliation of payments from consolidated fund to departmental services revenue recognised in Statement of Comprehensive Income

Budgeted departmental services appropriation*	8,326,338	5,457,139
Transfers from other headings	117,113	223,468
Unforeseen expenditure	111,090	-
Total departmental services receipts	8,554,541	5,680,607
Less: Opening balance of departmental services revenue receivable	-	39,400
Plus: Closing balance of departmental services revenue receivable	30,213	-
Departmental services revenue recognised in Statement of Comprehensive Income*	**8,584,754**	**5,641,207**

* Departmental services revenue includes Australian Government contribution of $2,353.928 million appropriated through Queensland Treasury. This was previously paid directly to the department as a grant payment (refer Note 6).

Reconciliation of payments from consolidated fund to equity adjustment recognised in Contributed Equity (Statement of Changes in Equity)

Budgeted equity adjustment appropriation	948,157	626,024
Transfers to other headings	(117,636)	(201,064)
Lapsed appropriation	-	(44,611)
Equity adjustment receipts	830,521	380,349
Plus: Opening balance of equity withdrawal payable	-	39,400
Less: Closing balance of equity withdrawal payable	18,213	-
Equity adjustment recognised in Contributed Equity	**812,308**	**419,749**

5 User charges

Hospital fees	412,538	347,048
Sale of goods and services	271,507	152,796
Rental income	4,713	4,090
	688,758	503,934

6 Grants and other contributions

Australian Government grants		
Australian health care agreement grants*	-	1,912,600
Home and community care grants	-	50
Nursing home grants	56,165	56,165
Other specific purpose recurrent grants*	60,554	327,526
Other specific purpose capital grants	6,016	6,785
Total Australian Government grants	122,735	2,303,126
Other grants	95,868	90,486
Donations-other	6,925	6,452
Donations inventory**	1,618	-
Donations-non-current physical assets	7,996	1,269
Other	760	305
	235,902	2,401,638

*The Australian health care agreement ceased from 2009-10 financial year. Funds from the Australian Government are received as departmental services revenue through Queensland Treasury and as specific purpose grants (refer Note 4).
** Inventory is donated by the Australian Government as part of the vaccinations Australia-wide initiative.

	2010 $'000	2009 $'000

7 Other revenue

Interest	4,029	4,748
Sale proceeds of non-capitalised assets	88	130
Licences and registration charges	2,049	1,934
Other		
Recoveries	12,671	16,206
Other	8,305	10,726
	27,142	**33,744**

8 Gains

Gain on sale of property, plant and equipment	**1,181**	**818**

9 Other Income

Share of profit from associates	**14,687**	**-**

10 Employee expenses

Employee benefits		
Wages and salaries	4,705,269	4,190,282
Employer superannuation contributions*	537,731	470,879
Annual leave expense*	630,444	447,776
Long service leave levy*	94,186	83,276
Other employee benefits	6,714	6,518
Employee related expenses		
Workers' compensation premium*	50,861	47,982
Payroll tax*	44,049	37,270
Other employee related expenses	69,461	73,813
	6,138,715	**5,357,796**

*Refer to Note 2 (v) Employee benefits.

Number of employees	**64,158**	**60,770**

The number of employees includes full-time employees and part-time employees measured on a full-time equivalent basis.

	2010	2009
Executive remuneration		
The number of senior executives and chief executives who received or were due to receive total remuneration of $100,000 or more:		
$100,000 to $119,999	-	1
$120,000 to $139,999	-	1
$140,000 to $159,999	-	2
$160,000 to $179,999	4	2
$180,000 to $199,999	3	1
$200,000 to $219,999	3	-
$220,000 to $240,000	1	-
$440,000 to $459,999	-	1
$540,000 to $559,999	1	-
	12	**8**

10 Employee expenses (continued)

	2010 $'000	2009 $'000
Total remuneration of executives shown above*	2,667	1,514
Total amount of separation and redundancy/termination payments to executives shown above	Nil	Nil

*The amount calculated as executive remuneration in these financial statements includes the direct remuneration received, as well as items not directly received by senior executives, such as the movement in leave accruals and fringe benefit tax paid on motor vehicles. This amount will differ from advertised executive remuneration packages which do not include the latter items.

11 Supplies and services

Consultants and contractors	306,995	292,364
Electricity and other energy	66,748	64,114
Patient travel	45,535	41,120
Other travel	51,686	56,157
Water	8,879	6,639
Building services	13,626	11,247
Computer services	82,636	80,646
Motor vehicles	10,974	11,662
Communications	60,706	54,708
Repairs and maintenance	170,698	176,087
Expenses relating to capital works	24,805	23,272
Operating lease rentals	111,335	95,977
Drugs	372,500	367,397
Clinical supplies and services	653,669	616,452
Catering and domestic supplies	140,704	139,811
Other	116,247	97,430
	2,237,743	**2,135,083**

12 Grants and subsidies

Public hospital support services	568,385	523,778
Home, community and rural health services	134,942	127,026
Mental health services	8,978	7,574
Medical research programs	24,819	16,251
Other	4,214	6,922
	741,338	**681,551**

13 Depreciation and amortisation

Buildings and land improvements	186,076	169,033
Plant and equipment	123,626	115,628
Software purchased	1,870	1,169
Software developed	14,949	15,778
	326,521	**301,608**

14 Impairment losses

Impairment losses on trade receivables	9,484	9,578
Bad debts written off	5,088	4,710
	14,572	**14,288**

15 Other expenses

	2010 $'000	2009 $'000
External audit fees*	1,254	850
Bank fees	392	392
Insurance**	50,022	42,116
Inventory written off	2,726	2,143
Losses from the disposal of non-current assets	5,735	7,114
Losses		
Public monies	3	14
Public property	16	46
Special payments		
Donations/gifts	159	163
Ex-gratia payments**	1,576	1,294
Other legal costs	6,142	6,085
Journals and subscriptions	7,103	5,306
Advertising	11,080	16,995
Other	6,495	5,204
	92,703	**87,722**

*Total external audit fees relating to the 2009-10 financial year are estimated to be $1.254 million (2008-09: $0.850 million). There are no non-audit services included in this amount.
** Certain losses of public property and health litigation costs are insured by the Queensland Government Insurance Fund (QGIF). Insurance premiums are paid to QGIF each year and are reported in Note 21. Insurance claims outstanding with QGIF are reported in Note 32 (b).

16 Cash and cash equivalents

Cash at bank and on hand	(30,464)	103,435
24 hour call deposits*	63,532	61,232
	33,068	**164,667**

*Cash deposited at call with the Queensland Treasury Corporation earns interest at a rate of 5.06% (2009: 3.3%). See Note 35 for restricted assets.

17 Receivables

Current		
Trade debtors*	244,147	147,975
Less: Provision for impairment	21,008	15,919
	223,139	**132,056**
GST input tax credits receivable	63,074	46,716
GST payable	(4,280)	(2,735)
Net receivable	**58,794**	**43,981**
Annual leave reimbursements	106,146	73,745
Appropriation receivable	30,213	
Long service leave reimbursements	16,588	10,990
Insurance claims	9	11,643
Advances	17,100	22,424
Other	305	105
	170,361	**118,907**
	452,294	**294,944**

17 Receivables (continued)

	2010 $'000	2009 $'000
Movements in the allowance of provision for impairment		
Current		
Balance at the beginning of the year	15,919	11,210
Amounts written off during the year	(9,366)	(9,557)
Amounts recovered during the year	(117)	(22)
Increase in allowance recognised in profit or loss	14,572	14,288
Balance at the end of the year	**21,008**	**15,919**

* Included in trade debtors are outstanding payments for the following:
- $59.7 million from the Commonwealth Department of Veteran Affairs for interstate patient revenue.
- $15.689 million relating to salary overpayments. Refer Note 3.
- $5.852 million relating to interim cash payments (for example, cheque, cash or EFT) made as response to issues related to the new payroll and rostering system. Refer Note 3.

18 Inventories

Inventories held for distribution – at cost:		
Medical supplies and equipment	116,316	116,281
Catering and domestic	1,392	1,476
	117,708	**117,757**
Less: Loss of service potential	465	388
	117,243	**117,369**
Engineering – at cost	1,692	1,840
Other – at cost	1,252	1,305
	120,187	**120,514**

19 Other financial assets

Non-current		
Fixed rate deposits	**20,000**	**20,000**

In 2006-07 the Treasurer approved the investment of $20 million with Queensland Treasury Corporation (QTC) with the interest earned being used for the funding of the Smart State Research Grants Program. Interest earned from this investment totalled $0.799 million. (2008-09:$1.080 million). Refer Note 7. As at 30 June 2010 there is one deposit with QTC worth $20 million. Refer Note 39.

20 Investments in associates

(a) Movements in the carrying amount of the investment in associates

Translational Research Institute Trust	14,534	-
Queensland Children's Medical Research Institute	153	-
	14,687	**-**
Translational Research Institute Trust		
Balance at the beginning of the financial year	-	-
Add: New investments during the year	-	-
Share of profit/(loss) in associates after income tax	14,534	-
Balance at the end of the year	**14,534**	**-**
Queensland Children's Medical Research Institute		
Balance at the beginning of the financial year	-	-
Add: New investments during the year	-	-
Share of profit/(loss) in associates after income tax	153	-
Balance at the end of the year	**153**	**-**

20 Investments in associates (continued)

	2010 $'000	2009 $'000
(b) Summarised financial information		
Translational Research Institute Trust		
Extract from the Statement of Financial Position		
Current assets	45,227	-
Non-current assets	20,237	-
	65,464	**-**
Current liabilities	2,331	-
Non-current liabilities	5,000	-
	7,331	**-**
Net assets	**58,133**	**-**
Net asset percentage share	25%	-
Share of associates' net assets	**14,534**	**-**
Extract from the Statement of Comprehensive Income		
Revenue	**58,780**	**-**
Net profit	**58,133**	**-**
Queensland Children's Medical Research Institute		
Extract from the Statement of Financial Position		
Current assets	1,959	-
Non-current assets	228	-
	2,187	**-**
Current liabilities	1,830	-
Net assets	**357**	**-**
Net asset percentage share	43%	-
Share of associates' net assets	**153**	**-**
Extract from the Statement of Comprehensive Income		
Revenue	**4,936**	**-**
Net profit	**357**	**-**
(c) Share of associates' profit and net asset percentages		
Translational Research Institute Pty Ltd	**25%**	**-**
Translational Research Institute Trust	**25%**	**-**
Queensland Children's Medical Research Institute	**43%**	**-**

	2010 $'000	2009 $'000

21 Other assets

Current		
Insurance premium prepayment*	62,485	49,531
Other prepayment	22,259	20,279
	84,744	**69,810**
Non-current		
Prepayments	**8,022**	**13,140**

* An insurance premium of $62.485 million (2008-09: $49.531 million) was paid to the Queensland Government Insurance Fund (QGIF). The increase in insurance premium in 2009-10 can be attributed to the resolution of a number of significant 'long tail claims'. Additionally, the number of claims is increasing, along with compensation amounts and legal costs. Insurance claims outstanding with QGIF are reported in Note 32 (b).

22 Intangibles

Software purchased		
At cost	21,148	12,388
Less: Accumulated amortisation	10,825	9,060
	10,323	**3,328**
Software internally generated		
At cost	204,803	209,827
Less: Accumulated amortisation	160,255	170,093
	44,548	**39,734**
Software work in progress		
At cost	**41,982**	**40,562**
	96,853	**83,624**

Projects in the research phase of the software development program expensed $9.167 million (2008-09: $3.451 million) and were mainly classified as salaries and wages expense.

Intangibles reconciliation

	Software purchased		Software internally generated		Software work in progress		Total	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Carrying value at start of the year	3,328	4,104	39,734	49,883	40,562	21,461	83,624	75,448
Acquisitions	8,951	370	1,551	3,848	23,608	30,688	34,110	34,906
Disposals	-	(28)	-	(62)	-	-	-	(90)
Transfer between classes	(86)	51	18,212	1,843	(18,573)	(1,843)	(447)	51
Transfers in/(out)	-	-	-	-	(3,615)	(9,744)	(3,615)	(9,744)
Amortisation charge for the year	(1,870)	(1,169)	(14,949)	(15,778)	-	-	(16,819)	(16,947)
Carrying value at end of period	10,323	3,328	44,548	39,734	41,982	40,562	96,853	83,624

The department's Hospital Based Corporate Information System (HBCIS) has an original cost of $0.952 million (2008-09 $0.952 million) or 0.43% (2008-09: 0.43%) of the total gross value of the class of assets. HBCIS has been written down to zero and is still being used in the provision of services. As assessment of this software was conducted in 2009-10 and it is anticipated that this module will be replaced in the next five to seven years.

23 Property, plant and equipment

	2010 $'000	2009 $'000
Land		
At fair value	1,074,121	1,097,738
	1,074,121	**1,097,738**
Buildings		
At fair value	5,814,143	6,533,643
Less: Accumulated depreciation	2,449,498	2,884,013
	3,364,645	**3,649,630**
Plant and equipment		
At cost	1,404,762	1,253,428
Less: Accumulated depreciation	676,914	608,746
	727,848	**644,682**
Capital works in progress		
At cost	**1,023,656**	**720,424**
Total property, plant and equipment	**6,190,270**	**6,112,474**

The State Valuation Service of the Department of Environment and Resource Management performed an independent valuation of all land using site specific indices. Where a material movement in value would have resulted from applying an interim index a market valuation was performed.

An interim revaluation of buildings not subject to an independent revaluation was performed as at 30 June 2010 by indexation using the Asset Revaluation Index: Non-residential construction, Queensland (Source: Australian Bureau of Statistics, Construction Work Done, Australia, preliminary, Cat.no. 8755.0) supplied by the Office of Economic and Statistical Research. A revaluation index of negative 9.7% was applied as at 30 June 2010.

An independent revaluation of 25.6% of the gross value of the building portfolio was performed as at 1 July 2009 by registered valuers of Davis Langdon using "fair value" principles using depreciated replacement cost. Queensland Health is in year five of a five year rolling revaluation program. In respect of buildings, such valuations are also influenced by factors as age, functionality and the physical condition of each building.

The Davis Langdon valuation team for 2009-10 comprised of:

Mr Damien Hirst – BSc (Hons) Quantity Surveying AAIQS
Mr Calvin Ling – B. App. Sc (Hons) Quantity Surveying AAIQS
Mr Christopher Luong – B. App. Sc Quantity Surveying
Mr Corey Stewart – B. App. Sc (Hons) Quantity Surveying
Mr Sam Pullen – BSc Construction Management (Building)
Mr Greg Shaw – AAPI CPV Reg No. QLD 2537
Mr Andrew McInness – AAPI CPV Reg No. QLD 2635
Ms Amy Hamilton – AAPI CPV Reg. No. QLD 3013

The comprehensive revaluation in 2009-10, the fifth year of the five year rolling revaluation program, resulted in a decrement of $256.688 million to the carrying value of buildings.

Plant and equipment and capital works in progress are valued at cost in accordance with *Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector.*

Property, plant and equipment reconciliation

	Land		Buildings		Plant and equipment		Work in progress		Total	
	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000	2010 $'000	2009 $'000
Carrying value at start of the year	1,097,738	977,051	3,649,630	3,476,576	644,682	598,160	720,424	485,974	6,112,474	5,537,761
Acquisitions	22,780	40,375	103,418	122,982	200,093	154,805	658,991	437,583	985,282	755,745
Donation received	-	-	7,045	85	939	1,181	-	-	7,984	1,266
Disposals	(1,814)	(626)	(201)	(350)	(5,830)	(6,974)	(1,338)	-	(9,183)	(7,950)
Donations made	-	-	-	-	(107)	(97)	-	-	(107)	(97)
Transfer between classes	7,442	235	341,576	189,718	8,850	13,129	(357,421)	(203,133)	447	(51)
Transfers in	-	5,873	3	552	2,847	106	3,000	-	5,850	6,531
Revaluation Increments/(decrements)	(47,325)	74,830	(548,504)	40,024	-	-	-	-	(595,829)	114,854
Impairment decrement	(4,700)	-	(2,246)	(10,924)	-	-	-	-	(6,946)	(10,924)
Depreciation charge for the year	-	-	(186,076)	(169,033)	(123,626)	(115,628)	-	-	(309,702)	(284,661)
Carrying value at end of period	1,074,121	1,097,738	3,364,645	3,649,630	727,848	644,682	1,023,656	720,424	6,190,270	6,112,474

The Department has plant and equipment with an original cost of $21.028 million (2008-09: $24.827 million) or 1.5% (2008-09: 2.02%) of total plant and equipment gross value and a written down value of zero still being used in the provision of services. These assets will be replaced in future years based on Queensland Health priorities as identified through the Asset Strategic Planning process.

Included in the valuation of buildings are 67 heritage buildings held at gross value of $108.346 million (2008-09: 77 buildings at gross value of $164.782 million).

	2010 $'000	2009 $'000

24 Payables

Trade creditors*	356,387	248,110
Equity withdrawal payable	18,213	-
Other creditors	6,834	5,084
	381,434	**253,194**

* Included in trade creditors are associated employee payroll payments of $89.42 million owed to external vendors due to timing issues with the final pay period being 30 June 2010. Refer Note 2 (v).

25 Accrued employee benefits

Current		
Wages outstanding*	88,364	342,260
Other employee entitlements payable	8,776	35,668
Annual leave levy payable	184,600	116,033
Long service leave levy payable	25,246	22,588
	306,986	**516,549**

* The reduction in wages outstanding is due to the number of days accrued (3 days) at year end in comparison to 2008-09 (16 days). Refer Note 2 (v).

26 Finance lease advanced

Non-current		
Finance lease advanced*	**17,235**	**-**

* This includes advanced lease payments from the *Translational Institute Research Trust*. Refer Note 2 (t).

27 Other liabilities payables

Current		
Unearned other revenue	**878**	**8,947**
Non-current		
Unearned other revenue	**2,617**	**1,901**

	2010 $'000	2009 $'000

28 Asset revaluation surplus by class

Land		
Balance at the beginning of the financial year	740,200	665,370
Revaluation increment/(decrement)	(47,325)	74,830
Impairment losses through equity*	(4,700)	-
Balance at the end of the financial year	**688,175**	**740,200**
Buildings		
Balance at the beginning of the financial year	1,016,655	987,555
Revaluation increment/(decrement)	(548,504)	40,024
Asset revaluation prior year	(164)	-
Impairment losses through equity**	(2,246)	(10,924)
Balance at the end of the financial year	**465,741**	**1,016,655**
Balance at the end of the financial year	**1,153,916**	**1,756,855**

The asset revaluation surplus represents the net effect of revaluation movement of assets at fair value.
* The land impairment loss of $4.7 million recognised in 2009-10 (2008-09: Nil) relates to a land parcel which is held by Queensland Health as Trustee of a Reserve for Hospital in terms of the Land Act 1994. Local council planning scheme has the land use as open space, therefore, the land's fair value has been impaired.
** The building impairment loss of $2.246 million recognised in 2009-10 (2008-09: $10.924 million) predominantly related to buildings with shorter than expected useful lives located on the site of health facility redevelopments. The majority of the buildings impaired have been demolished as at reporting date.

29 Reconciliation of operating surplus to net cash from operating activities

Operating result from continuing operations	832	3,293
Non-cash items:		
Depreciation expense	309,702	284,661
Amortisation expense	16,819	16,947
Assets written off/scrapped	156	173
Contributed assets and other non-cash donations	(10,374)	(1,574)
Loss on sale of property, plant and equipment	5,596	7,107
Gain on sale of property, plant and equipment	(1,182)	(818)
Share of profits in associates	(14,687)	-
Other non cash items	2,134	1,261
Changes in assets and liabilities:		
Increase in GST input tax credits receivable	(14,813)	(2,322)
(Increase)/decrease in appropriation receivables	(30,213)	39,400
Increase in LSL reimbursement receivable	(5,598)	-
Increase in annual leave reimbursements	(32,400)	-
(Increase)/decrease in net receivables	(79,649)	93,421
(Increase)/decrease in inventories	328	(28,384)
Increase in recurrent prepayments	(9,816)	(12,136)
Increase/(decrease) in unearned revenue	(7,353)	2,195
Increase/(decrease) in accrued salaries and wages	(253,896)	64,633
Increase/(decrease) in annual leave payable	(26,892)	8,096
Increase/(decrease) in payables	110,028	(464,206)
Increase in annual leave levy payable	68,567	116,033
Increase in LSL levy payable	2,656	1,948
Net cash provided by operating activities	**29,945**	**129,728**

30 Non cash financing and investing activities

Assets and liabilities received or transferred by the department are set out in the Statement of Changes in Equity. The activities for the financial year are explained in Note 3.

	2010 $'000	2009 $'000

31 Commitments for expenditure

Commitments at reporting date are inclusive of anticipated GST and are payable as follows:

(a) Non-cancellable operating leases

Not later than one year	60,146	49,235
Later than one year and not later than five years	150,317	126,326
Later than five years	28,070	28,677
	238,533	**204,238**

The aggregate net present value of cancellable and non-cancellable operating leases with individual net present values in excess of $5 million is $270.251 million (2008-09: $240.041 million). Of this amount $54.655 million (2008-09: $50.324 million) relates to cancellable operating leases.

(b) Expenditure commitments

Material expenditure commitments contracted for but not recognised are payable as follows:

Capital works*	2,984,848	3,571,831
Supplies	37,852	4,702
Repairs and maintenance	64,715	26,691
Employment	1,346	3,633
Other	37,787	26,063
	3,126,548	**3,632,920**
Not later than one year	463,044	533,076
Later than one year and not later than five years	2,654,142	3,099,844
Later than five years	9,362	-
	3,126,548	**3,632,920**

* Includes capital expenditure for the development of three new tertiary hospitals and continuing redevelopment and refurbishment of existing hospitals and health care facilities currently being delivered under a partnering agreement between Queensland Health and Project Services. These projects have been approved by the Cabinet Budget Review Committee and have been included as commitments. Each of these projects are currently at different stages of the contractual cycle.

(c) Grants and other contributions

Commitments for grants and other contributions:

Not later than one year*	152,930	83,031
Later than one year and not later than five years*	171,914	42,470
Later than five years	5,545	4,320
	330,389	**129,821**

*Grant and other contribution commitments include:
– Queensland Health's contribution to the Translational Research Institute Facility. For more details refer to Notes 2 (c), 3, 20 and 34.
– a payable to Noosa Hospital in the 'not later than one year' category as they are subject to annual review. For more detail refer Note 37.

	2010 $'000	2009 $'000

32 Contingencies

(a) Guarantees and undertakings

As at 30 June 2010, the department held the following guarantees and undertakings from third parties. These amounts have not been recognised as assets in the financial statements.

Guarantees	-	25
Undertakings	13,283	1,000
	13,283	1,025

(b) Litigation in progress

	2009 cases	Increase cases	Decrease cases	2010 cases
Cases have been filed with the courts as follows:				
Federal court	-	-	-	-
Supreme court	32	-	29	3
District court	16	-	15	1
Magistrates court	1	-	-	1
Tribunals, commissions and boards	109	42	-	151
	158	42	44	156

	2008 cases	Increase cases	Decrease cases	2009 cases
Federal court	-	-	-	-
Supreme court	19	13	-	32
District court	12	4	-	16
Magistrates court	0	1	-	1
Tribunals, commissions and boards	126	-	17	109
	157	18	17	158

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). Queensland Health's liability in this area is limited to an excess per case – refer Note 2 (x).

The department's legal advisers and management believe it would be misleading to estimate the final amounts payable (if any) in respect of the litigation before the courts at this time.

From 1 July 2010, the management of all Queensland Health indemnified claims are managed by the Queensland Government Insurance Fund.

The special claims management process ("the special process") approved by Government to expeditiously resolve claims related to treatment by Dr. Patel, has continued. The key features of the special process are an acceptance of liability by the State, payment for the cost of medical assessment, a contribution to the claimants' legal fees and payment of the cost of mediation (if needed). These features are a significant departure from the prevailing legislative scheme. As at 30 June 2010, 387 (2008-09: 387) special process claims had been received and 385 (2008-09: 383) of these claims were resolved. An additional two special process claims have been reopened with approval from the Attorney-General. Claims relevant to the current reporting period are included in the above table.

In addition to current proceedings before the court, Queensland Health has received notifications and claims under the *Personal Injury Proceedings Act 2002* (PIPA). These claims fall into different categories under PIPA as determined by the age of, and type of claim by the claimant. For example, if the claim is a child or adult and whether it is as a result of medical malpractice or a public liability claim. Generally, a claimant must provide notice of their claim within a prescribed timeframe after the incident, and Queensland Health is obliged to respond. The parties to the claim are then required to enter into negotiations in an effort to resolve the claim without the necessity of litigation. As at 30 June 2010 there were 298 (2008-09: 315) claims currently under these negotiations, some of which may never be litigated or result in payment to claimants.

32 Contingencies (continued)

(c) Native Title

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

All dealings pertaining to land held by or on behalf of Queensland Health must take native title into account before proceeding. These dealings include disposal, acquisition, development, redevelopment, clearing, fencing and the granting of leases, licences or permits. Dealings may proceed on departmental land, where native title continues to exist, provided native title holders/claimants receive the necessary procedural rights.

In accordance with State Government land policies, in most cases once native title over a particular holding has been cleared, Queensland Health is required to convert the title to freehold tenure.

Queensland Health has completed 64.41% of native title assessments of departmental land holdings and 86.04% have now been converted to freehold tenure.

Queensland Health is currently negotiating with the assistance of Crown Law, a number of *Indigenous Land Use Agreements* (ILUA) with native title holders. These ILUAs will provide trustee leases, to validate the tenure of current and future facilities.

A total of 5 native title claims have been lodged in 2009-10 (2008-09: 2 claims).

33 Controlled entity

Effective from 1 July 2009, Queensland Health Shared Service Partner (QHSSP) became an integral part of Queensland Health due to a voluntary change in policy as agreed with Queensland Treasury. Consequently, the department is no longer required to prepare separate general purpose financial statements for QHSSP. For further details refer to Note 2 (d).

34 Associated entities

Translational Research Institute Pty Ltd
The *Translational Research Institute Pty Ltd* (the Company) was registered as an Australian proprietary company, limited by shares, on 12 June 2009. Queensland Health is one of four founding shareholders, each holding 25 shares at $1 per share in the Company. The Company does not trade and its sole purpose is to act as trustee of the *Translational Research Institute Trust (TRI Trust)*. There have been no transactions recorded in this entity for the period 1 July 2009 to 30 June 2010. As the Company is a non-trading entity, it has not prepared financial statements for the financial year ended 30 June 2010. Also refer Notes 2 (c), 20 and 31 (c).

Translational Research Institute Trust
The *Translational Research Institute Trust* (*TRI Trust*) was created as a Discretionary Unit Trust on 16 June 2009. Queensland Health is one of four founding members, each holding 25 units in the *TRI Trust* and equal voting rights. The objectives of the *TRI Trust* are to:

(i) design, construct and maintain the Translational Research Institute Facility (TRI Facility); and
(ii) operate and manage the TRI Facility to promote medical study, research and education.

The Trust's annual reporting period is on a calendar year basis. Audited financial statements were prepared for the financial year ending 31 December 2009. A set of Management Accounts were prepared for the period 1 January 2010 to 30 June 2010. Also refer Notes 2 (c), 20 and 31 (c).

Queensland Children's Medical Research Institute
Queensland Children's Medical Research Institute (QCMRI) is a child and adolescent health focused research institute, based at the Royal Children's Hospital, Brisbane. *QCMRI* was incorporated as an Australian public company limited by guarantee on 17 June 2009. The entity is a registered health promotion charity for Commonwealth Income Taxation purposes. Queensland Health is one of three founding members. The entity meets the criteria for significant influence by virtue of founding member status and associated significant board representation. Queensland Health employees hold three out of the seven positions on the Board of Directors and therefore record a 43% share of the entity's profit. *QCMRI* prepares financial statements as at 30 June.

35 Restricted assets

The department receives cash contributions primarily from private practice clinicians under an agreement and from external entities to provide for education, study and research in clinical areas. Contributions are also received from benefactors in the form of gifts, donations and bequests for stipulated purposes.

At 30 June 2010, the amount of $76.823 million (2008-09: $73.199 million) is set aside for the specified purpose underlying the contribution.

36 Fiduciary trust transactions and balances

The department acts in a custodial role in respect of these transactions and balances and are therefore not recognised in the financial statements, but are disclosed here for information purposes.

	2010 $'000	2009 $'000
Fiduciary trust receipts and payments		
Receipts		
Patient trust receipts	30,481	32,475
Total receipts	**30,481**	**32,475**
Payments		
Patient trust related payments	30,671	32,048
Total payments	**30,671**	**32,048**
Increase/(decrease) in net patient trust assets	**(190)**	**427**
Increase in net refundable deposits	**5**	**18**
Fiduciary trust assets		
Current assets		
Cash		
Patient trust deposits	**4,709**	**4,899**
Other refundable deposits	**111**	**106**
Total current assets	**4,820**	**5,005**

37 Arrangements for the provision of public infrastructure by other entities

BOOT (refer Note 2 (p)) arrangements in operation as at 30 June 2010 are:

Facility	Health Service District	Counterparty	Term of Agreement	Commencement Date
Butterfield Street Car Park	Metro North	International Parking Group Pty Limited	25 years	January 1998
Bramston Terrace Car Park	Children's Health Services	International Parking Group Pty Limited	25 years	November 1998
The Prince Charles Hospital Car Park	Metro North	International Parking Group Pty Limited	22 years	November 2000
The Prince Charles Hospital Early Education Centre	Metro North	Queensland Child Care Services Pty Ltd	20 years	April 2007
Central Energy Facility	Metro North	APT Facility Management Pty Ltd	15 years	February 1999
Noosa Hospital and Specialist Centre	Sunshine Coast –Wide Bay	Ramsay Health Care	20 years	September 1999
Townsville Hospital Support Facilities Building and Walkway	Townsville	Trilogy Funds Management Ltd	25 years	April 2002
Childcare Centre	Townsville	Trilogy Funds Management Ltd	25 years	September 2004
The Princess Alexandra Hospital Multi Storey Car Park	Metro South	International Parking Group Pty Limited	25 years	February 2008

Assets and liabilities

The land where the facilities have been constructed is recognised as departmental land, subject to an operating lease. Pending the finalisation of a formal accounting standard for these types of arrangements, the department has not recognised any rights or obligations relating to these facilities other than those associated with land rental and the provision of services under the agreements.

	2010 $'000	2009 $'000
Accrued expenses		
Current	2,112	2,146
Unearned revenue		
Current	230	228
Non-current	1,328	1,499
	1,558	1,727

Revenues and expenses

Revenues and expenses recognised in relation to these arrangements:

User charges	824	812
Grants and other contributions	25,257	25,059

37 Arrangements for the provision of public infrastructure by other entities (continued)

Butterfield Street Car Park
A $2.5 million up-front payment for rental of land on which the car park has been built was received at the commencement of the car park operations in January 1998. This amount is being recognised over the term of the agreement. Rental of $0.3 million per annum is also received from the car park operator up to January 2019 increasing to $0.6 million for the remainder of the lease period. Although the car park operator charges a fee for use of the car park facility, under the agreement, Queensland Health staff are entitled to concessional rates.

Bramston Terrace Car Park
A $1.32 million upfront payment for rent of land on which the car park has been built was received on commencement of the car park operations in November 1998. This amount was fully recognised in the year of receipt. A peppercorn rental of $1 is paid each year over the term of the agreement. Although the car park operator charges a fee for use of the car park facility, under the agreement, Queensland Health staff are entitled to concessional rates.

The Prince Charles Hospital Car Park
A $1.0 million up-front payment for rental of land on which the car park has been built was received at the commencement of the car park operations in November 2000. This amount is being recognised over the term of the agreement. Rental of $0.05 million per annum is also received from the car park operator. Although the car park operator charges a fee for use of the car park facility, under the agreement, Queensland Health staff are entitled to concessional rates.

The Prince Charles Hospital Early Education Centre
The developer has constructed a 150-place early education centre in April 2007 on site at the hospital. The developer operates and maintains the facility at its sole cost and risk. Under the agreement staff on site are given priority access to child care. Rental of $0.07 million per annum is charged for the land.

Central Energy Facility
Under this arrangement the Central Energy Facility has been constructed on site at the Redcliffe Hospital and has been operating since February 1999. The operator manages and maintains the facility at its sole cost and risk. The operator has exclusive right to supply energy to Redcliffe Hospital for the term of the agreement in accordance with a pricing methodology specified within the underlying agreement. The operator cannot supply energy to any other party without the consent of Queensland Health. Right, title and interest in the central energy facility plant and equipment pass to Queensland Health on expiry of the agreement for consideration of $1.

Noosa Hospital and Specialist Centre
This agreement has been structured to transfer substantially the risks associated with the operation of public hospital to a private sector entity. The Noosa Hospital and Specialist Centre commenced operations in September 1999. Under this arrangement, Queensland Health funds the operators for the provision of services to public patients. The level of services and the amount paid is subject to an annual review.

A capital recovery charge is paid to the operator as part of the service agreements for the purpose of maintaining public infrastructure. An estimate of the value of the assets to be transferred on completion of the agreements has not yet been determined. The operator is not permitted to charge any fees to public patients other than those normally charged for a service in a public hospital.

Townsville Support Facilities Building, Walkway and Childcare Centre
Under this arrangement, a support facilities building and childcare centre have been constructed on the department's land with a walkway linking the support facilities building to the Townsville Hospital. This facility has been in operation since April 2002. Annual rental is charged for the land of $0.035 million varying with tenant turnover figures.

The Princess Alexandra Hospital Multi Storey Car Park
The developer has constructed a 1403-space multi-storey car park on site at the hospital. Rental of $0.295 million per annum escalated for CPI annually is received from the car park operator up to February 2033. The developer operates and maintains the facility at its sole cost and risk. Although the car park operator charges a fee for use of the car park facility, under the agreement, Queensland Health staff are entitled to concession rates.

37 Arrangements for the provision of public infrastructure by other entities (continued)

Indicative cashflow

	Butterfield Street Carpark	Bramston Terrace Carpark	The Prince Charles Hospital Carpark	The Prince Charles Hospital Early Education Centre	Central Energy Facility	Noosa Hospital and Specialist Centre	Townsville Support Facilities	The Princess Alexandra Hospital Multi Storey Carpark	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Inflows									
Not later than 1 year	300	-	66	77	-	-	45	315	803
Later than 1 year but not later than 5 years	1,200	-	265	308	-	-	194	1,261	3,228
Later than 5 years but not later than 10 years	2,100	-	331	384	-	-	277	1,577	4,669
Later than 10 years	1,920	-	133	538	-	-	406	3,995	6,992
Outflows									
Not later than 1 year	(300)	-	(66)	(77)	(2,232)	(23,896)	-	-	(26,571)
Later than 1 year but not later than 5 years	(1,200)	-	(265)	(308)	(6,052)	(107,896)	-	-	(115,721)
Later than 5 years but not later than 10 years	(2,100)	-	(331)	(384)	-	(157,521)	-	-	(160,336)
Later than 10 years	(1,920)		(133)	(538)	-	-	-	-	(2,591)
Net indicative cash flow	-	-	-	-	(8,284)	(289,313)	922	7,148	(289,527)

38 Collocation arrangements

Collocation (refer Note 2 (q)) arrangements in operation as at 30 June 2010 are:

Facility	Health Service District	Counterparty	Term of Agreement	Commencement Date
Holy Spirit Northside Private Hospital	Metro North	The Holy Spirit Northside Private Hospital Limited	25 years	July 2001
Redlands Private Hospital	Metro South	Sister of Mercy	25 years	August 1999
Caboolture Private Hospital	Metro North	Affinity Health Ltd	25 years	September 1997

39 Financial instruments

(a) Categorisation of financial instruments

The department has the following categories of financial assets and financial liabilities:

Category	Note	2010 $'000	2009 $'000
Financial assets			
Cash and cash equivalents	16	33,068	164,667
Receivables	17	452,294	294,944
Fixed rate deposits	19	20,000	20,000
		505,362	**479,611**
Financial liabilities			
Payables	24	**381,434**	**253,194**

On 1 July 2004, Queensland Health established a business card facility (corporate card) with the Commonwealth Bank of Australia with an approved credit limit of $7 million. The balance of this facility is cleared monthly, and remains fully un-drawn at 30 June 2010 and is available for use in the next reporting period. This facility is not subject to an interest rate.

(b) Financial risk management

Queensland Health is exposed to a variety of financial risks – credit risk, liquidity risk, market risk and interest rate risk.

Financial risk is managed in accordance with the departmental policies. The department policies provide written principles for overall risk management and aim to minimise potential adverse effects of risk events on the financial performance of the department.

(c) Credit risk exposure

Credit risk exposure refers to the situation where the department may incur financial loss as a result of another party to a financial instrument failing to discharge their obligation.

The maximum exposure to credit risk at balance date in relation to each class of recognised financial asset is the gross carrying amount of those assets inclusive of any provisions for impairment.

The following table represents Queensland Health's maximum exposure to credit risk based on contractual amounts net of any allowances as per AASB 139 *Financial Instruments: Recognition and Measurement*.

39 Financial instruments (continued)

Maximum exposure to credit risk

	2010 $'000	2009 $'000
Cash	33,068	164,667
Receivables	452,294	294,944
Fixed rate deposits	20,000	20,000
	505,362	479,611

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

Queensland Health manages credit risk by ensuring that the department invests in secure assets and monitors all funds owed on a timely basis. Exposure to credit risk is monitored on a regular basis. The method for calculating any provisional impairment for risk is based on past experience and review of current outstanding accounts over 60 days. The main factors affecting current calculation for provisions are disclosed below as loss events.

No financial assets and financial liabilities have been offset and presented net in the Statement of Financial Position.

There are no amounts offset as per AASB 132 *Financial Instruments: Presentation*. The recognised impairment loss is $14.572 million (2008-09: $14.288 million) for the current year. Refer Note 14.

This is an increase of $0.284 million and is comprised primarily of the following loss events:

- ineligible overseas patients treated in public hospitals where the cost was irrecoverable $5.484 million (2008-09: $3.402 million);
- householders debts including general private patients and staff related irrecoverable debts $2.119 million (2008-09: $2.374 million);
- mental health patients debts $0.606 million (2008-09: $0.887 million);
- irrecoverable debts from private businesses $0.203 million (2008-09: $0.517 million);
- irrecoverable third party claim settlements from patients involved in motor vehicle accidents $1.072 million (2008-09: $1.781 million).

Based on past experience there is an expectation that there will be future loss events similar to the above resulting in doubtful debts of $5.088 million (2008-09: $4.710 million).

Concentration of credit risk on trade and other debtors is summarised as General Public $283.650 million (2008-09: $168.783 million) and the Public Sector $168.644 million (2008-09: $126.161 million).

With the implementation of the new payroll and rostering system, there is a high risk regarding the possibility of bad debt write-offs in relation to the recovery of salary overpayments. Refer Note 17.

No financial assets have had their terms renegotiated so as to prevent them from being past due or impaired and are stated at the carrying amounts as indicated.

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

Financial assets past due but not impaired 2009-10

	Contractual maturity date				
	Less than 30 days $'000	30-60 days $'000	61-90 days $'000	More than 90 days $'000	Total financial assets $'000
Receivables	369,667	12,609	6,440	63,578	452,294

39 Financial instruments (continued)

Financial assets past due but not impaired 2008-09

	Contractual maturity date				
	Less than 30 days	30-60 days	61-90 days	More than 90 days	Total financial assets
	$'000	$'000	$'000	$'000	$'000
Receivables	271,183	7,839	5,195	10,727	294,944

Financial assets impaired 2009-10

	Less than 30 days	30-60 days	61-90 days	More than 90 days	Total financial assets
	$'000	$'000	$'000	$'000	$'000
Receivables	1,346	497	1,132	18,033	21,008

Financial assets impaired 2008-09

	Contractual maturity date				
	Less than 30 days	30-60 days	61-90 days	More than 90 days	Total financial assets
	$'000	$'000	$'000	$'000	$'000
Receivables	1,321	373	1,194	13,031	15,919

(d) Liquidity risk

Liquidity risk refers to the situation where the department may encounter difficulty in meeting obligations associated with financial liabilities.

Queensland Health is exposed to liquidity risk through its trading in the normal course of business. The department aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times. The department has an approved overdraft facility of $500 million to manage any short term cash shortfalls.

The department's exposure to liquidity and interest rate risks and effective interest rates of financial assets and liabilities are shown in the 'liquidity and interest risk' table. All assets and liabilities are shown by maturity or contract repricing dates and at face value.

(e) Market risk

Queensland Health has minimal exposure to foreign exchange risk through its capital works program and purchase of supplies required as part of providing health services. Queensland Health's Integrated Risk Management Policy Framework encompasses a process to identify and manage all risks in the department. In regards to market risk, there have been no risks identified that required action by the department in the current and foreseeable future.

39 Financial instruments (continued)

Interest rate sensitivity analysis

The department has interest rate exposure on the 24 hour call deposits and there is no interest rate exposure on its cash and fixed rate deposits. The department does not undertake any hedging in relation to interest risk. The changes in interest rate would not materially affect the operating result of the department.

Liquidity and interest risk 2009-10

	Maturity date					
	1 year or less $'000	1 to 5 years $'000	More than 5 years $'000	Non interest bearing $'000	Total $'000	Weighted average rate %
Financial assets						
Cash	-	-	-	(30,464)	**(30,464)**	
24 hour call deposits	63,532	-	-	-	**63,532**	5.06
Receivables	-	-	-	452,294	**452,294**	
Fixed rate deposits	-	20,000	-	-	**20,000**	4.79
	63,532	**20,000**	**-**	**421,830**	**505,362**	
Financial liabilities						
Payables	**-**	**-**	**-**	**381,434**	**381,434**	

Liquidity and interest risk 2008-09

	Maturity date					
	1 year or less $'000	1 to 5 years $'000	More than 5 years $'000	Non interest bearing $'000	Total $'000	Weighted average rate %
Financial assets						
Cash	-	-	-	103,435	**103,435**	
24 hour call deposits	61,232	-	-	-	**61,232**	3.30
Receivables	-	-	-	294,944	**294,944**	
Fixed rate deposits	-	20,000	-	-	**20,000**	3.02
	61,232	**20,000**	**-**	**398,379**	**479,611**	
Financial liabilities						
Payables	**-**	**-**	**-**	**253,194**	**253,194**	

(f) Fair value

The fair value of financial assets and liabilities is determined as follows:

- The fair value of receivables and payables are assumed to approximate their nominal value less estimated credit adjustment.
- Held-to-maturity financial assets are measured at cost as fair value cannot be reliably measured therefore no fair value is disclosed.

The carrying amount of all financial assets and liabilities equates to net fair value.

40 Administered transactions and balances

The administered transactions and balances are comprised primarily of Health Quality and Complaints Commission (HQCC) and Mater Hospital related transactions.

The HQCC was established on 1 July 2006 following the adoption of the *Health Quality and Complaints Commission Act 2006*. The HQCC provides assurance to the community that health care services providers in Queensland provide the highest possible standard in the quality of care. The Commission is responsible for the overseeing of quality activities in all health services in Queensland. It is also responsible for addressing complaints from any person associated with health service delivery, in a quality improvement context. In performing its functions, the Commission acts independently, impartially and in the public interest.

The Mater Public Hospital redevelopment was completed in June 2008 with funding provided from Government borrowings managed as administered transactions. Further details on this arrangement are outlined below.

The Administered transactions and balances for 2009-10 are as follows.

	2010 $'000	2009 $'000
Administered revenues		
Administered item appropriation	24,592	25,569
Taxes, fees and fines	260	304
Total administered revenues	**24,852**	**25,873**
Administered expenses		
Grants	17,000	17,494
Borrowing costs	7,591	8,074
Other expenses	261	305
Total administered expenses	**24,852**	**25,873**
Administered assets		
Current		
Cash	12	78
Receivables	8,329	7,802
Non-current		
Receivables	104,309	112,608
Total administered assets	**112,650**	**120,488**
Administered liabilities		
Current		
Payables	42	97
Other financial liabilities	8,299	7,783
Non-current		
Other financial liabilities	104,309	112,608
Total administered liabilities	**112,650**	**120,488**

40 Administered transactions and balances (continued)

Receivables

Receivables reflect the passing on of funds to the Mater Hospital for the redevelopment of the public hospital component. The receivable for this will be extinguished once the redevelopment is completed with the repayment of the underlying borrowings by Government over a ten year term.

Payables

Borrowings are provided by Queensland Treasury Corporation. The interest rate on borrowings is fixed at 6.46%. The repayment term is ten years. Borrowings are all in Australian dollar denominated amounts.

The market value of the debt as notified by Queensland Treasury Corporation at 30 June 2010 was $117.965 million (2008-09: $122.875 million). The market value of debt represents the value of the debt if the department repaid the debt at 30 June 2010.

An amount of $7.591 million (2008-09: $8.074 million) comprising interest on funds and administration fees from Queensland Treasury Corporation has been recognised as an expense in the reporting period.

41 Reconciliation of payments from consolidated fund to administered revenue

	2010 $'000	2009 $'000
Budgeted appropriation	24,069	24,131
Transfers from other headings	523	1,437
Total appropriation receipts	24,592	25,568
Add: Opening balance of appropriation in advance	-	1
Administered revenue recognised in Note 40	**24,592**	**25,569**

42 Events occurring after balance date

New system implementation – payroll

Salary overpayment waiver
On 14 July 2010, the Deputy Premier and Minister for Health announced that any staff member who has been overpaid by an amount up to and including $200, since the commencement of the new payroll system will not be required to repay these amounts. This repayment waiver is valid for overpayments received between 8 March and 30 June 2010, and is a one-off arrangement.

An amount of approximately $1.5 million will be waived in 2010-11, extinguishing overpayments to approximately 11,500 employees. Analysis is currently underway to determine the precise amount.

Financial disadvantage
On 20 July 2010, the Director-General announced that Queensland Health is committed to addressing any financial disadvantage incurred by employees as a result of pay errors associated with the new payroll and rostering system, which delivered its first pay on 24 March. As part of this commitment, agreement has now been reached with unions regarding the reimbursement of financial costs or penalties that are attributable to a pay error.

Queensland Health will pay costs and penalties, but not limited to, that have been incurred by an employee as a result of pay errors, including:

- bank and financial institution charges
- additional interest charges arising from an inability to meet repayments
- council rates or utility discounts forgone, that is, gas, water, electricity, telephone/communications
- lost interest earnings
- tax agent fees where an amendment to the lodgement of a 2010 income tax return is necessary
- reimbursement for additional tax paid, should back payment of wages be paid in a subsequent tax period resulting in a higher overall tax rate payable by the employee, than if received in the year of earnings
- any FBT liability incurred by exceeding the FBT exemption cap
- additional tax imposed as a result of employees' salary sacrificing superannuation beyond the concessional cap.

The value of these payments is not able to be quantified at the date of completion of these financial statements.

Management Certificate

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

a) the prescribed requirements for establishing and keeping the accounts have been complied with in all material respects, except that deficiencies have been identified regarding the completeness, accuracy and timely payment of employee expenses since the department went live with the new payroll system on 14 March 2010. These deficiencies represent non-compliance with the prescribed requirements for the department to maintain an appropriate system of internal control in relation to its expense management system for employee expenses; and

b) the statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of the Department of Health for the financial year ended 30 June 2010 and of the financial position of the department at the end of that year.

Brigid Bourke, CPA
Chief Finance Officer
12 / 8 / 2010

Michael Reid
Director-General
12 / 8 / 2010

INDEPENDENT AUDITOR'S REPORT

To the Accountable Officer of the Department of Health

Matters Relating to the Electronic Presentation of the Audited Financial Report

The auditor's report relates to the financial report of the Department of Health for the financial year ended 30 June 2010 included on the Department of Health's website. The Department is responsible for the integrity of the Department of Health's website. I have not been engaged to report on the integrity of the Department of Health's website. The auditor's report refers only to the statements named below. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements. If users of the financial report are concerned with the inherent risks arising from electronic data communications they are advised to refer to the hard copy of the audited financial report, available from the Department of Health, to confirm the information included in the audited financial report presented on this website.

These matters also relate to the presentation of the audited financial report in other electronic media including CD Rom.

Report on the Financial Report

I have audited the accompanying financial report of the Department of Health, which comprises the statement of financial position and statement of assets and liabilities by major departmental services and SSP as at 30 June 2010, and the statement of comprehensive income, statement of changes in equity, statement of cash flows and statement of comprehensive income by major departmental services and SSP for the year ended on that date, a summary of significant accounting policies, other explanatory notes and the certificates given by the Director-General and Chief Finance Officer.

The Accountable Officer's Responsibility for the Financial Report

The Accountable Officer is responsible for the preparation and fair presentation of the financial report in accordance with prescribed accounting requirements identified in the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2009*, including compliance with Australian Accounting Standards (including the Australian Accounting Interpretations). This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

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

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

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

Independence

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

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

Basis of Qualified Auditor's Opinion

Section 61(b) of the *Financial Accountability Act 2009* requires the accountable officer to establish and maintain appropriate systems of internal control. Further, s.19 of the *Financial and Performance Management Standard 2009* requires the accountable officer to manage the Department's expenses in accordance with an expense management system that provides for the prompt identification, approval, managing, recording and timely payment of expenses.

As disclosed in Note 3, on 14 March 2010 the Department went live with a new payroll system. Since that date significant deficiencies have been identified regarding the completeness, accuracy and timely payment of employee expenses. These deficiencies arose as a result of control weaknesses at the Department since the decision to go-live.

While these deficiencies were identified I am satisfied they do not have a material effect on the completeness and accuracy of employee expenses disclosed in the Statement of Comprehensive Income ($6,138,715,000). The deficiencies in internal control identified represent material non-compliance with the prescribed requirements for the Department to maintain an appropriate system of internal control in relation to its expense management system for employee expenses.

Qualified Auditor's Opinion

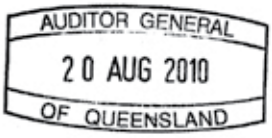
In accordance with s.40 of the *Auditor-General Act 2009* –

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

(b) in my opinion –

(i) except for the matters described in the preceding paragraph, the prescribed requirements in respect of the establishment and keeping of accounts have been complied with in all material respects; and

(ii) the financial report has been drawn up so as to present a true and fair view, in accordance with the prescribed accounting standards of the transactions of the Department of Health for the financial year 1 July 2009 to 30 June 2010 and of the financial position as at the end of that year.



G G POOLE FCPA
Auditor-General of Queensland

Queensland Audit Office
Brisbane