Annual Report 2013–2014

Great state. Great opportunity.

Queensland Government

Acknowledgment to traditional owners

The Cairns and Hinterland Hospital and Health Service respectfully acknowledges the traditional owners and custodians both past and present of the land and sea which we service; and declare the Cairns and Hinterland Hospital and Health Service commitment to reducing inequalities between Indigenous and non-Indigenous health outcomes in line with the Australian Governments Close the Gap initiative.

Public Availability Statement

Our Annual Report is available on our website at: http://www.health.qld.gov.au/cairns_hinterland/

We invite your feedback on our report. Please contact our Community Engagement team, telephone (07) 4226 3243

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Cairns and Hinterland Hospital and Health Service 2013-14 Annual Report

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Attribution

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Interpreter Service Statement

We are committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you need help to understand our annual report, please telephone (07) 3120 5999 or free call 1800 077 308 (outside Brisbane) and we will arrange an interpreter to share the report with you.

Letter of compliance

The Honourable Lawrence Springborg MP
Minister for Health
Member for Southern Downs
Level 19, 147-163 Charlotte Street
Brisbane Qld 4000

Dear Minister,

I am proud to present the Annual Report and financial statements 2013-14 for the Cairns and Hinterland Hospital and Health Service.

I certify that this annual report complies with:

- the prescribed requirements of the *Financial Accountability Act 2009* and the *Financial and Performance management Standard 2009,* and
- the requirements set out in the *Annual report requirements for Queensland Government agencies for the 2013-14 reporting period.*

A checklist outlining the annual reporting requirements can be found at page 122 of this Annual Report or accessed at http://www.health.qld.gov.au/cairns_hinterland/

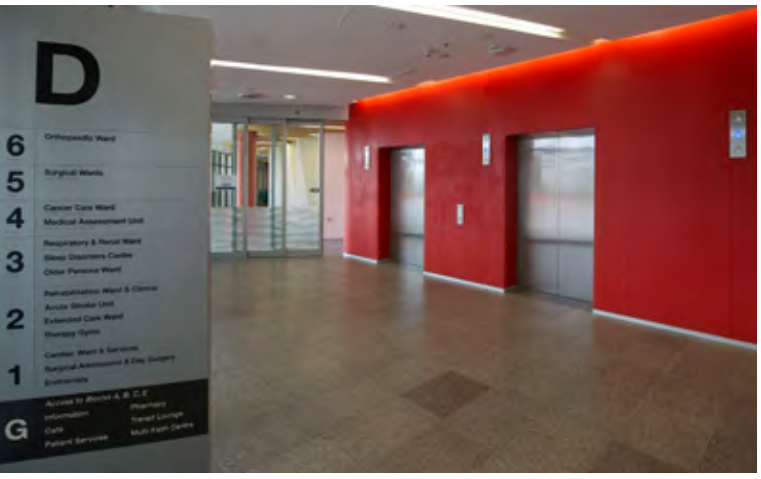
Yours sincerely

Robert Norman
Chair
Cairns and Hinterland Hospital and Health Board

27 August 2014

Building and Rebuilding
Annual Report 2013-2014

Contents



71% – **72%**
Proportion of **people admitted or treated and discharged within 4 hours of presentation** to an emergency department

4.21 – **4.08**
Average **number of days that patients stayed in our hospitals** (acute patients only, excluding day only patients)

1,303 – **672**
Number of people **who did not wait for treatment** in the emergency department

Elective surgery:

3,230
Number of **elective surgery patients treated** – up from 2426

82%
Elective surgery treated in turn: 30% in June last year, 82% in June 2014

3,155
Number of babies born: 3120 in 2012-13 and 3155 in 2013-14

Hospital in the Home (HITH) Utilisation:

403 – **523**
Patients (up 30%)

584 – **751**
Admissions (up 29%)

283,257
Number of **occasions of service** (excluding Emergency Department presentations)

132,569
Number of **attendances to our emergency departments**

The Cairns and Hinterland Hospital and Health Service

The Cairns and Hinterland Hospital and Health Service is committed to engaging and understanding our communities culturally diverse needs in providing holistic, innovative and responsive models of patient care.

Manner of establishment

On 1 July 2012 a Hospital and Health Service known as the Cairns and Hinterland Hospital and Health Service was established as a statutory body under the provisions of the *Hospital and Health Boards Act 2011* (Qld). The Cairns and Hinterland Hospital and Health Service through the Board, reports to the Queensland Minister for Health, the Honourable Lawrence Springborg, MP.

The functions of a Hospital and Health Service are outlined in the *Hospital and Health Board Act 2011* (Qld), with the main function being to deliver the hospital services, other health services, teaching, research and other services stated in our Service Agreement.

Our role

The Cairns and Hinterland Hospital and Health Service performs a key role in the provision of public health services in Far North Queensland. We are committed to collaborating and building strong relationships with community healthcare providers, such as General Practitioners, community health services and affiliated healthcare agencies.

Geographically, we cover the municipalities of Cairns Regional Council, Cassowary Coast Regional Council, Croydon Shire Council, Mareeba Shire Council, Douglas Shire Council, Etheridge Shire Council, Tablelands Regional Council and Hinchinbrook Shire Council.

Our Chair and Chief Executive

The 2013-14 financial year was one of foundation building for the Cairns and Hinterland Hospital and Health Service. Embracing resilience and sustainability, and continuing to improve our performance is a priority for us; and, during the year, we began to lay the groundwork for a stronger and more responsive organisation, now and into the future.

Robert Norman
Chair

Julie Hartley-Jones
Chief Executive

In our 2013-14 Annual Report we will highlight the foundations that have been laid to respond to the increasing demand for the many and varied health services we provide. We will also critique our performance and provide an outlook for the year ahead.

Throughout the past 12 months, we have been confronted with a series of challenges. In the face of strict performance targets, ever-increasing demand for services and a requirement for greater consumer involvement, our organisation has built its capacity to respond to these challenges and continues to fulfil its charter to provide top quality health care to the people of the Cairns and Hinterland and North East Australian Region.

In May 2014, the State Government released its quarterly performance report for the Cairns and Hinterland Hospital and Health Service. The results demonstrate the strides we have made across key categories. As at March 2013, there were 1307 people on the dental wait list, 12 months on that has been reduced to zero.

In 2013-14 the number of patients released from the Emergency Department within four hours has increased to 72 per cent, up from 66 per cent last financial year. The Health Service is now treating 91 per cent of patients requiring urgent surgery within the clinically recommended time, up more than 3 per cent from 2012-13.

These achievements are something that we as an organisation should be proud of and are necessary steps in ensuring that we can meet the challenges faced by providing care to a growing and ageing population.

In 2011, construction of part of a $454.6 million redevelopment at the Health Service's largest facility, Cairns Hospital, commenced. In 2014, the final touches are being made to Block D. Block D will become the hub of Cairns Hospital and will house 292 of the 531 inpatient beds. The new block includes three new operating theatres, a cardiac care unit, two therapy gymnasiums and a multi-professional rehab ward. The opening of Block D will provide a major boost to the capacity of the Cairns Hospital, enabling Cairns

Hospital to meet the demands of our community until at least 2026.

The demand for outpatient services has increased significantly in recent years with more than 18,300 waiting for a Specialist Outpatient Clinic across the Health Service. To meet this growing demand, we needed to free up capacity and resolved to clear the surgical long wait list by the end of the 2013-14 financial year – a goal that was met. As part of this process an audit was undertaken in mid-2013 that uncovered a series of double ups and multiple listings. The Health Service has received $2 million in funding to reduce the number of patients on the outpatient wait list. This project will mirror the successful strategy that was used to reduce the surgical long wait list.

We continue to rebuild models of care across the varied range of services we provide. By providing support to patients after they have been discharged they are able to return to their homes faster and are less likely to return to hospital.

This year, we announced the expansion of the Paediatric Hospital in the Home program. Under the program, patients are given medical clearance to be discharged, with Paediatric Nurses continuing their treatment at the family home. Not only is the program preventing an average of 43 overnight stays a month, there is also research that shows patients treated at home are more likely to recover faster than in a clinical environment.

In response to growing demand for mental health beds, we recognised and addressed the need for expanded services. A 20-bed Mental Health Community Care Unit is midway through construction and is due to open in early 2015. In partnership with the Stage 2 Mental Health Capital Works Program (MHCWP), the Community Care Unit will enhance the Health Service's ability to care for patients recovering from mental illness and deliver appropriate support to assist in their successful reintegration into the community.

At the Cairns and Hinterland Hospital and Health Service we value our partners and are committed to collaborating to improve health care services to the people of our region. One of the many examples from the past year has been our partnership with James Cook University to deliver dental care to patients at rural hospitals. Dental clinics at Mareeba and Tully have been expanded and will act as a training ground for fifth-year students who will work under the supervision of a qualified Health Service dentist. This partnership will ensure these communities receive services close to home and will also train the next generation of regional dental practitioners.

It is vital that we continue to challenge the status-quo by developing and expanding on innovative solutions that will be a cornerstone of health care delivery in the 21st Century.

For much of 2013-14, we have focused on the National Safety and Quality Health Service (NSQHS) Standards, as well as EQuIPNational Standards, to ensure that we not only meet, but maintain the requirements of national accreditation. We would like to acknowledge the work our employees have done in tackling this responsibility.

We encourage exceptional leadership, from service delivery at the bedside through to the Board. We would like to thank Board Members, the Executive Management Team, Divisional Directors, our Community Consultation Committees and all of the staff and volunteers who continue to deliver, provide or support health care to our community.

Now that 2014-15 is underway, we must continue to respond to the health needs of our communities. We are committed to strengthening our engagement with the community to ensure your input is reflected in the delivery of our health care services. There is a genuine sense of enthusiasm within the Organisation as we embark on a renewal and revitalisation of our Health Service and it is with great pleasure that we present the Cairns and Hinterland Hospital and Health Service's 2013-2014 Annual Report to you.


Cow Bay
Mossman
Gurriny
Yealamucka
Cairns
Mareeba
Gordonvale
Chillagoe
Dimbulah
Atherton
Babinda
Herberton
Malanda
Milla Milla
Innisfail
Mount Garnet
Ravenshoe
Tully
Croydon
Georgetown
Forsayth


Torres and Cape
Cairns and Hinterland
North West
Townsville
Mackay
Central West
Central Queensland
Wide Bay
South West
Darling Downs
SEQ

About us

The vision of the Cairns and Hinterland Hospital and Health Service is to provide world-class health services to improve the social, emotional and physical wellbeing of people in the Cairns and Hinterland and the North East Australian Region.

The Cairns and Hinterland Hospital and Health Service is responsible for providing health services to the people of the Far North. With a geographical area of 141,000 square kilometres spanning from Cairns to Tully in the south, Cow Bay in the north and Croydon in the west, our staff commit every day to improving the social, emotional and physical wellbeing of people in the Cairns and Hinterland and the North East Australian Region. The outer western region of our Hospital and Health Service encompasses extremely remote communities.

The Cairns and Hinterland Hospital and Health Service supports a population of 283,197 which is forecast to grow by 9% by 2026, with the highest level of growth occurring within the 65 and over age group. Tourism is a key industry and contributes to a relatively high transient population. It is estimated that 9% of the population are Indigenous Australians, compared to 3.5% for Queensland as a whole.

Cairns Hospital is the specialist referral Hospital for Far North Queensland, as we deliver health services across the continuum of care and provide health services to the Torres and Cape Hospital and Health Service.

Our purpose

The purpose of the Cairns and Hinterland Hospital and Health Service is to:

- Provide holistic, innovative and responsive models of patient care.
- Enable caring, highly skilled and dedicated staff.
- Facilitate partnerships providing internationally recognised education and research.
- Provide equitable, integrated and sustainable services.
- Engage and understand our communities' culturally diverse needs.

Our values

- Customers first
- Ideas into action
- Unleash potential
- Be courageous
- Empower people

Our hospital facilities

Atherton Hospital – 57 beds

Babinda Multi-Purpose Health Centre – 22 beds

Cairns Hospital – 347 overnight beds, 124 day beds

Gurriny Yealamucka Health Service (Yarrabah)

Gordonvale Hospital – 24 beds

Herberton Hospital – 38 beds

Innisfail Hospital – 49 beds

Mareeba Hospital – 54 beds

Mossman Multi-Purpose Health Service – 32 beds

Tully Hospital – 20 beds

Primary health centres

Chillagoe Primary Health Centre

Cow Bay Primary Health Centre

Croydon Primary Health Centre

Dimbulah Primary Health Centre

Forsayth Primary Health Centre

Georgetown Primary Health Centre

Malanda Primary Health Centre

Millaa Millaa Primary Health Centre

Mount Garnet Primary Health Centre

Ravenshoe Primary Health Care Centre

Community health centres

Community health services include: before and after hospital care; cardiac rehabilitation; community nursing; counselling services; hearing health screening; health education and promotion; home care services; immunisation services; oral health (dental clinics); Positive Parenting Program; school health; baby clinics.

Location of community health centres

Atherton Primary Health Care Centre

Cairns Community Health *(Cairns North Community Health Facility, Cairns Community Health, Edmonton Community Health Centre, Smithfield Community Health Centre)*

Innisfail Community Health Centre

Jumbun Community Health Care Centre

Mission Beach Community Health Centre

Tully Community Health Centre

Other services

There is an Integrated Mental Health Program and a Sexual Health Service in Cairns. In addition, there are Alcohol, Tobacco and Other Drug Service (ATODS) centres in Cairns, Mossman, Innisfail and Mareeba.

Lotus Glen Health Service

Clinical services provided

We provided the following services through the facilities listed above (Note: not all facilities provide all services):

Inpatient services

Anaesthetic services
Breast surgery
Burns (low acuity burns)
Cardiology
Chemotherapy and radiotherapy
Children's services
Colorectal surgery
Critical care
Dental surgery
Dermatology
Diagnostic endoscopy
Drug and alcohol services
Ear, nose and throat
Endocrinology
Gastroenterology
General medicine
General surgery
Gynaecology
Haematology
Head and neck surgery
Immunology and infections
Interventional cardiology
Maternity
Medical oncology
Neurology
Ophthalmology
Orthopaedics
Pain management
Palliative care
Plastic and reconstructive surgery
Psychiatry
Renal
Respiratory medicine
Rheumatology
Sub-acute
Thoracic Surgery
Urology
Vascular Surgery

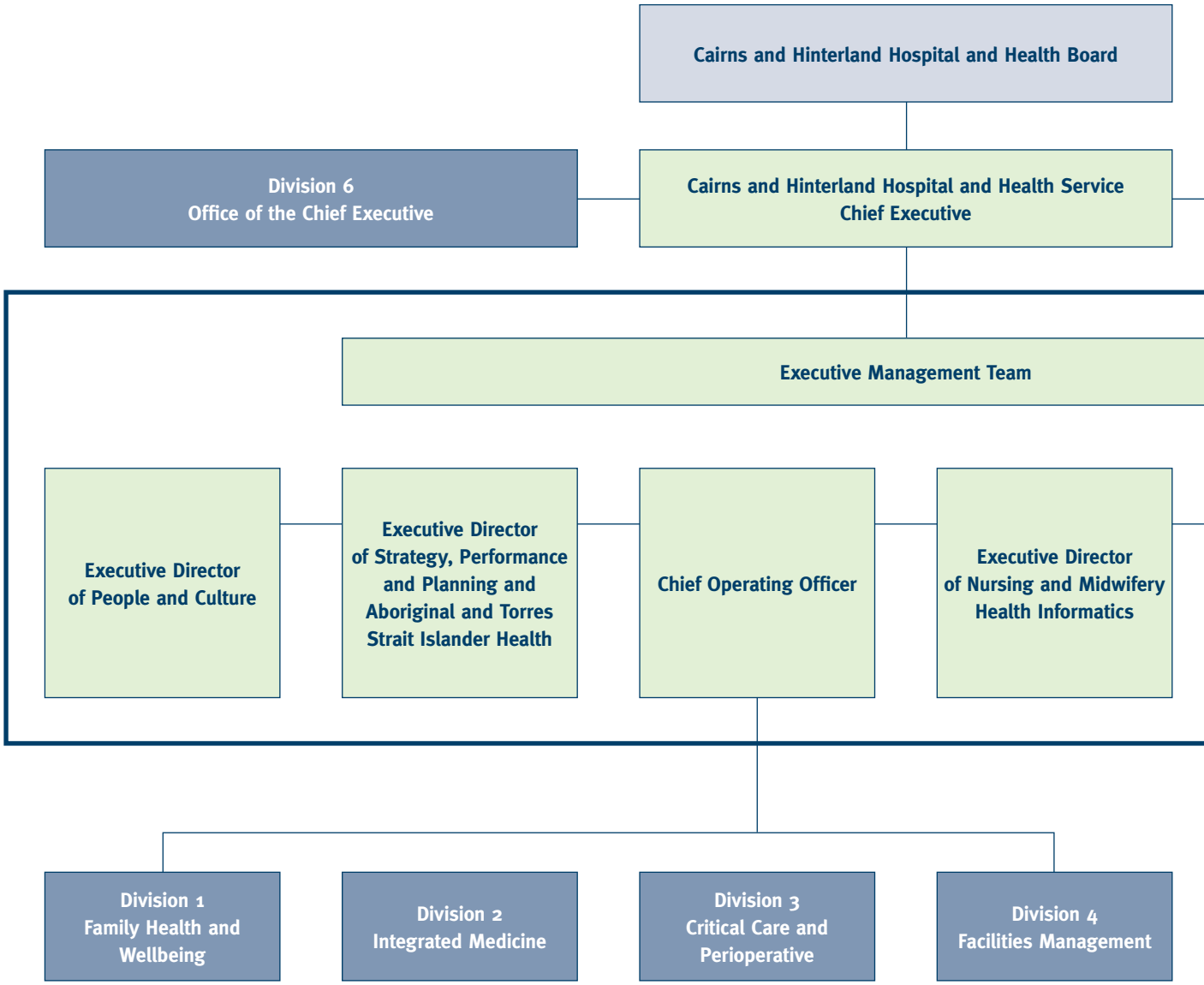
Outpatient and ambulatory services

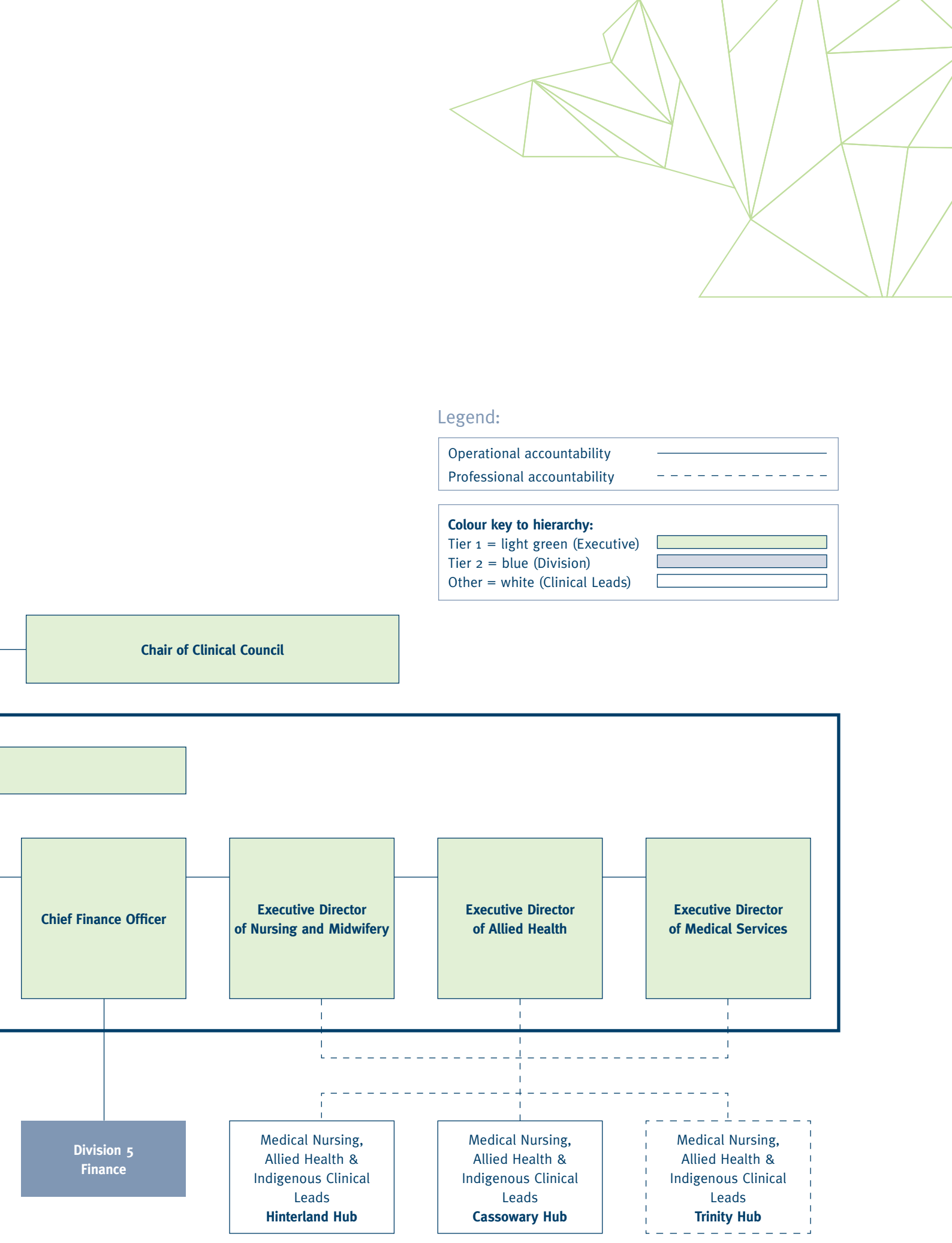
Allied Health *(psychology, nutrition, podiatry, prosthetics, physiotherapy, occupational therapy, social work and speech pathology)*

Cardiac surgery
Cardiology
Children's services
Dementia
Dermatology
Diabetes
Drug and Alcohol
Ear nose & throat
Emergency Department
Endocrinology
Gastroenterology
General surgery
Gynaecology
Haematology
Infectious diseases
Internal medicine
Maternity
Mental health
Neonatal
Neurology
Neurosurgery
Older persons
Oncology
Ophthalmology
Paediatric medicine
Paediatric surgery
Pain management
Palliative Care
Plastic and reconstructive Surgery
Rehabilitation
Renal
Rheumatology
Thoracic Medicine
Urology
Interventions and Procedures
Chemotherapy
Dialysis
Endoscopy
Interventional cardiology
Radiation oncology

Our organisational structure

Cairns and Hinterland Hospital and Health Service Executive Organisation Chart




Legend:
Operational accountability
Professional accountability
Colour key to hierarchy:
Tier 1 = light green (Executive)
Tier 2 = blue (Division)
Other = white (Clinical Leads)
Chair of Clinical Council
Chief Finance Officer
Executive Director of Nursing and Midwifery
Executive Director of Allied Health
Executive Director of Medical Services
Division 5 Finance
Medical Nursing, Allied Health & Indigenous Clinical Leads Hinterland Hub
Medical Nursing, Allied Health & Indigenous Clinical Leads Cassowary Hub
Medical Nursing, Allied Health & Indigenous Clinical Leads Trinity Hub

Our corporate performance

In 2013-14 we continued to build on the foundations of 2012-13, to create and maintain a high performing organisation, by prioritising improvements in safety, efficiency and sustainability. We also significantly advanced our extensive capital works and building program throughout the Cairns and Hinterland Hospital and Health Service.

Risk management

Risk is an ever present element of service delivery, and the Cairns and Hinterland Hospital and Health Service risk management system supports the organisation to deliver services, while managing risk and threats to an acceptable degree, and making informed decisions about opportunities and challenges to achieving strategic objectives and delivering services efficiently and effectively.

The Cairns and Hinterland Hospital and Health Service use an integrated risk management framework for clinical and corporate services in accordance with the Department of Health Risk Management Policy and Risk Analysis Matrix. This model is embedded in the organisational culture and governance at both an operational and strategic level, and is most evident within the decision making structures where risk is a key consideration of the decision making chain, including project management and business cases.

Various information systems such as the clinical incident reporting system, consumer feedback system, and staff incident reporting system are used to inform our risk management process which is outlined in the AS/NZS ISO 31000:

- establishing the context;
- risk identification
- risk analysis
- risk evaluation
- risk treatment
- communication and consultation, and
- monitoring and review

This standardised process provides a vehicle for risks which may require escalation, delegation or consolidation both vertically and horizontally within the organisation.

A strong governance structure is in place to manage the dynamic nature of risk with the Divisional Management Committees playing a key role in managing operational risk, while escalating strategic risk to the Executive Management Team via Divisional Service reports.

We continue to utilise the Department of Health QHRisk information system to record, review and monitor risk, while an alternative solution is being developed to provide advanced reporting and monitoring capacity.

The new risk management information solution is in the final stages of completion, and testing of the system in a 'live' site commenced in March 2014.

Accreditation

For the first time, all Cairns and Hinterland Hospital and Health Service facilities will be surveyed for Accreditation together, during November 2014. In 2013-14 we have been focused on reviewing our services against the 15 standards and making changes to improve safety and quality of care for patients and carers.

Achieving the Standards is imperative as it will demonstrate to our community that we meet the minimum levels of safety and quality stipulated by the National Quality and Safety Commission, and this work has been a dominant priority for the Hospital and Health Service. We are committed to achieving accreditation and we understand that this requires a dedication to continuous improvement as we strive to provide excellent patient care.

The highlights of our progress towards the implementation of the new National Safety and Quality Health Service (NSQHS) Standards, as well as the five EQuIP National Standards include:

1. The establishment of a Committee for each Standard, to lead the Accreditation process across the organisation;
2. The appointment of temporary EQuIPNational Coordinators for each of the Divisions;
3. The completion and review of Self-Assessments against the 15 standards and collection of evidence to verify the standards are met.
4. Engaging senior clinicians to lead the way in developing processes and structures to implement the requirements of the standards within our organisation which aim to prevent avoidable harm and improve the quality of care provided.

Internal audit

In line with Queensland Government directions to optimise efficiency within the public sector, and to ensure good governance our Audit and Risk Management Committee determined that an internal audit function was necessary.

On the 28 August 2013, the Audit and Risk Management Committee approved an Internal Audit Partnering co-source model to deliver the internal audit function and on 23 October 2013, the Board approved that PwC be awarded the primary contract for provision of internal audit services.

The Internal Audit Charter and Annual Plan for the Cairns and Hinterland Hospital and Health Service were approved by the Board on 20 November 2013.

The Internal Audit Charter identifies the role and responsibility of the function together with how it will ensure independence and objectivity by reporting functionally to the Chief Executive and having a direct reporting line to the Audit and Risk Management Committee where required.

The Principal Internal Auditor was appointed and commenced on 26 November 2013 and has worked effectively with the co-sourced partner PwC to fulfil the approved Internal Audit Plan for the financial year 2013-14.

In the first year of operations the majority of completed audits had a financial focus with reviews of payroll, month end, revenue, patient trust, contract management, unrecorded leave and Cairns Hospital redevelopment reporting. Operational reviews included theatre time out and credentialing.

All review reports are presented to the relevant operational manager for management responses and then submitted to the Chief Executive and Audit and Risk Management Committee. Subsequent follow up of all review recommendations are completed and presented to senior management, the Chief Executive and Audit and Risk Management Committee on a quarterly basis.

External scrutiny

The Cairns and Hinterland Hospital and Health Service's operations are subject to regular scrutiny from external oversight bodies. In 2013-14, the Queensland Audit Office conducted cross-service audits which included coverage of our Hospital and Health Service.

Report 1 : 2013-14 Right of private practice in Queensland public hospitals

This interim report was the first of two reports dealing with the performance audit of the right of private practice arrangements in the public health system. The audit considered whether these arrangements are achieving their intended public health outcomes and are financially sustainable.

In conducting the audit, the Queensland Audit Office pursued three lines of inquiry to determine if:

- the intended health and financial benefits of the scheme are being realised
- the scheme is being administered efficiently

- practitioners are participating in the scheme with probity and propriety and in full compliance with their contractual conditions.

Report 8 : 2013-14 Results of audit: Hospitals and Health Services entities 2012-13

This report examined the results of the 2012-13 financial audits of the 17 Hospital and Health Services established on 1 July 2012 to provide public health services in Queensland.

This report summarised the results of the financial audits, the timeliness and quality of financial reporting and the systemic issues with internal controls identified during the Queensland Audit Office audits. The Queensland Audit Office also analysed indicators of financial performance and sustainability which each Hospital and Health Service could be assessed.

Report 13 : 2013–14 Right of private practice: Senior medical officer conduct

This report, is the second of two reports dealing with the performance audit of the right of private practice arrangements in the public health system.

In conducting the audit, the Queensland Audit Office pursued three lines of inquiry to determine if:

- the intended health and financial benefits of the scheme are being realised
- the scheme is being administered efficiently
- practitioners are participating in the scheme with probity and propriety and in full compliance with their contractual conditions.

Right to information and records management

Right to Information Act 2009 (Qld) and Information Privacy Act 2009 (Qld)

The Cairns and Hinterland Hospital and Health Service respects the right of people to access their personal information, as well as to access information about our operations that will give them a better understanding of the decisions we make. The Right to Information Act 2009 (Qld) is a mechanism by which the public may apply for administrative, financial, personnel and patient related documents not normally available to them.

For further information about applying, please follow the following link: http://www.health.qld.gov.au/foi/default.asp

2013-14 RTI / IP STATS	
RTI	**TOTAL**
Total applications received	74
Application completed within timeframe	67
Application not completed within timeframe	0
Application currently in progress	7

IP	**TOTAL**
Total applications received	109
Application completed within timeframe	96
Application not completed within timeframe	0
Application currently in progress	13

EXTERNAL REVIEW	**TOTAL**
All of the external reviews were dealt with in an 'informal' process and therefore both parties agreed to extend the timeframe for completion	0

2013-14 ACCESS STATS	
Administrative Access (which includes MAI Act, Medico legal reports, PIPA, Subpoena etc, Work Cover Queensland, other e.g. Certificates, Insurance forms)	**TOTAL**
Received access requests	2441

Public Records Act 2002 (Qld)

Administrative records

The Cairns and Hinterland Hospital and Health Service is responsible for the management and safe custody of administrative records in accordance with Section 8 of the Public Records Act 2002 (Qld) and Queensland Government Information Standard: 40 Recordkeeping and Queensland Government Information Standard: 31 Retention and Disposal of Public Records.

The Cairns and Hinterland Hospital and Health Service seeks to comply with the General Retention and Disposal Schedule for Administrative Records, Version 6, Queensland State Archives (5 August 2011). Administrative records are only created, stored and maintained for some of the business activities undertaken.

The Cairns and Hinterland Hospital and Health does not have a dedicated record keeping officer. Building and maintaining best practice record keeping is the responsibility of all employees.

Medical records

Our Medical Records Department was accredited in 2012. It comprises both an historical (paper) record system and has implemented an integrated electronic medical record system. We complete ad-hoc auditing of our medical records to ensure compliance with record keeping standards. The Cairns and Hinterland Hospital and Health Service has systems in place to ensure all paper and electronic records are secure from unauthorized access, damage or misuse.

The Cairns and Hinterland Hospital and Health Service seeks to comply with the Health Sector (Clinical Records) Retention and Disposal Schedule, QDAN 683 Version 1 (14 December 2012).

Capital works, buildings and facilities

The Cairns Hospital Redevelopment

The $454.6 million redevelopment of Cairns Hospital will provide an additional 168 beds (overnight and same day beds) by 2015, bringing the total capacity to 531 beds.

The redeveloped Cairns Hospital when completed will have delivered the following improved health services:

- an ambulatory cancer care centre with a new radiation oncology service;
- additional cardiac care facilities;
- additional surgical capacity including day surgery;
- expanded intensive care capacity;
- expanded birthing services, special care babies unit and a new low risk birth centre;
- additional aged care and rehabilitation services;
- additional beds for mental health services; and
- new pathology facilities.

The redevelopment had already provided a new Cardiac Catheterisation Lab, the Liz Plummer Cancer Care Centre and a new MRI suite for Cairns. The expansion of the Intensive Care Unit, Special Care Nursery and the birthing suites were completed in 2013.

There will be a 70% increase in hospital floor area when the redevelopment of Cairns Hospital is complete in 2015. The $454.6 million redevelopment of Cairns Hospital will create about 2600 construction jobs over the life of the project.

The Cairns Hospital Block D Clinical Services building

Construction of Block D commenced in January 2011 and is part of the $454.6 million Cairns Hospital Redevelopment.

The number of workers employed on the construction of the new clinical services building at Cairns Hospital peaked in July 2013 at just under 400 including 28 apprentices.

The Cairns Hospital Redevelopment, and specifically Block D, was designed and purpose-built to consider the future health needs of the Far North including space for growth, state-of-the-art hybrid operating theatre and for a replacement cardiac catheter laboratory.

Employee and community consultation played an important role in the design of Block D.

Employee input was vital when designing the clinical areas in Block D. Specific staff user groups were formed to ensure building designs met the needs of each unit and its patients.

Community consultation was significant not only in the renaming of Cairns Hospital in 2013 but the relocation of the hospital's main entrance from the Esplanade to Lake Street.

In May 2014, a Community Open Day celebrated the opening of the new clinical services building, Block D at Cairns Hospital.

The purpose of the event was to give locals, staff and their families an opportunity to visit the new building prior to it becoming operational and to showcase the new main entry to Cairns Hospital.

More than 3000 locals and visitors were able to take a rare, behind-the-scenes look inside different departments and participate in health promotion activities in a family fun atmosphere.

The design of the new building has taken into consideration patient satisfaction and care, with an increase in the number of single rooms, with most wards having 50 per cent single rooms, and all patient bedrooms having ensuite bathrooms and views of either the Esplanade or the Hinterland. The number of single rooms is 153.

Opening of the Mareeba Rural Student Dental Clinic on 31 July 2014.
L-R Mr David Kempton, MP, the Hon Lawrence Springborg, the Hon Ian Macdonald, Senator and Chair Mr Bob Norman.

The Cairns Hospital Health Workforce Australia Education Centre

The Cairns Hospital Health Workforce Australia Education Centre is a testament to our commitment to collaborating with our partners to improve health care delivery. It is a joint submission between James Cook University and the Cairns and Hinterland Hospital Health Service to increase undergraduate clinical training capacity by renovating and equipping a new integrated teaching, training and research facility within existing buildings at Cairns Hospital.

The new facility at Cairns Hospital will incorporate the existing James Cook University Clinical School and the Cairns Hospital Library, a complete renovation to include shared teaching and office space, a virtual ward and other training facilities and additional research, teaching and office space.

As a result this project will double the floor space previously allocated to teaching, training and education at the completion of the redevelopment, from approximately 960 square metres to 1320 square metres.

The Education Centre will be a technology-rich learning environment with the flexibility to support clinical training, block-mode teaching, part-time and distance mode course delivery and Higher Degree Research (HDR) students. There is an emphasis on multiple usages to enable economies of resource sharing and cost effective capital development as well as the flexibility to respond to community needs and host special events.

Flexible teaching and study spaces will enable team-based collaborative learning, simulation and specialist clinical skills teaching through the use of information and communication technologies, wireless networking and adaptable furniture and partitioning.

Maintenance at Mossman Multi-Purpose Health Service

The Mossman Multi-Purpose Health Service has had many additions and alterations over the years. We have been prioritising and addressing the issues progressively through the Backlog Maintenance Remediation Program and the maintenance budget.

Building and expanding Mareeba Dental Services

A $2.6 million project has seen the number of chairs at the Mareeba Rural Student Dental Clinic tripled from two to six. The project was funded by $1.885 million from the Commonwealth Government's Health Workforce Australia with James Cook University contributing a further $800,000.

Cairns and Hinterland Hospital and Health Service provide a dental officer to supervise students in the final year of James Cook University's five-year Bachelor of Dental Surgery.

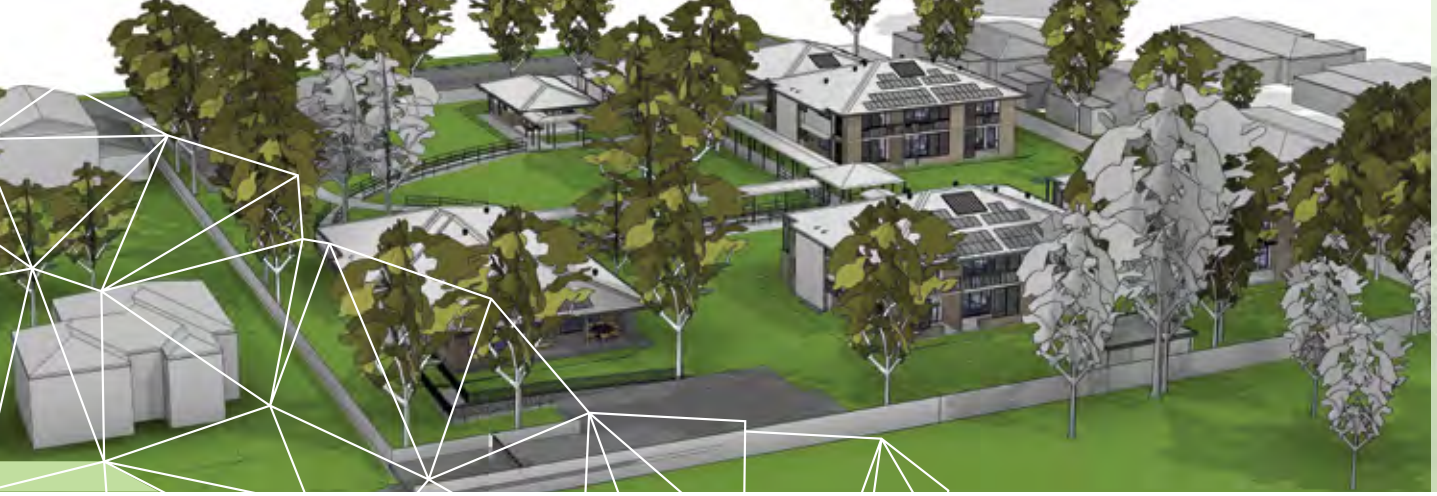
Each year, eight fifth year dental students will complete one Semester of rural dental clinical placement at the clinic.

The increased capacity at Mareeba Rural Student Dental Clinic has contributed to a huge reduction in the average wait time for an appointment. It is also providing a clinical site to train the next generation of rural and regional dentists.

On 31 July 2014, Senator the Hon Ian Macdonald; Minister for Health, the Hon Lawrence Springborg; Member for Cook Mr David Kempton, MP and Chair Mr Bob Norman, formally opened the Mareeba Rural Student Dental Clinic, refer to picture.

Major maintenance at Chillagoe Primary Health Centre

The Chillagoe Primary Health Centre was built in the 1930-40's and as part of our asset management process a site investigation was carried out on 13 August 2013 and scope of works identified to rectify deficiencies.



Artist impression of an aerial view of the Mental Health Community Care Unit.

$400,000 of maintenance work commenced on Chillagoe Hospital as part of the Maintenance Enhancement Program through the Department of Health.

Upgrades of staff accommodation and kitchen, electrical system, fire protection systems, window and door repairs, new flooring and paint form some of the works being conducted by R & M William Building Contractors.

Building and developing Tully Dental Services

Tully residents will have increased access to oral health services when an additional dental chair opens at Tully Hospital. The dental chair will be staffed by James Cook University dental students four days a week for 35 weeks of the year under supervision of Queensland Health dental officers.

The final year dental students will be further trained and their practical placement overseen by the Tully Hospital dentist.

Construction commenced in June 2014, and is anticipated to be completed in August 2014. This initiative is the result of a partnership with the James Cook University Dental School, with $475,000 in capital works funding being provided by James Cook University.

Ground breaking mental health facility for Cairns

The construction of our 20-bed Mental Health Community Care Unit signals a new era in community rehabilitation for adults recovering from a mental health condition in our region.

This is part of our broader plan to expand health care services for people who are recovering from mental health associated conditions. Adults recovering from a mental health condition will be provided with patient-centred rehabilitation services in the community to facilitate their successful transition to independent community living.

The Community Care Unit will be the first of its kind in the Far North. Community Care Unit's are situated in the community to simulate an independent living environment, but have the added benefit of providing around the clock clinical care and supervised residential rehabilitation.

Following competitive responses from an extensive applicant pool, Hutchinson Builders was awarded the tender to build the Community Care Unit, with construction commencing in March 2014. The funding for the build has been provided by the Commonwealth Government. The Cairns and Hinterland Hospital and Health Service will operate the facility once opened.

Artist impression of the entrance to the Mental Health Community Care Unit.

Our operational performance

In 2013-14 we were focused on reducing waiting lists for elective surgery, maintaining surgical activity, clearing our surgical long wait list and achieving shorter stays in our emergency departments.

The Key Performance Indicators table below provides a summary of our performance against major Tier 1 key performance indicators described in the Cairns and Hinterland Hospital and Health Service's service agreement with the Department of Health.

Key performance indicators

Service standards	Notes	2013-2014 Target/est.	2013-2014 Est.Actual
Percentage of patients attending emergency departments seen within recommended timeframes:			
• Category 1 (within 2 minutes)		100%	100%
• Category 2 (within 10 minutes)		80%	83%
• Category 3 (within 30 minutes)		75%	71%
• Category 4 (within 60 minutes)		70%	77%
• Category 5 (within 120 minutes)		70%	92%
• All categories	1	..	77%
Percentage of emergency department attendances who depart within four hours of their arrival in the department	2	80%	72%
Median wait time for treatment in emergency departments (minutes)	3	20	15
Median wait time for elective surgery (days)	3	25	33
Percentage of elective surgery patients treated within clinically recommended times:			
• Category 1 (30 days)		100%	91%
• Category 2 (90 days)		91%	49%
• Category 3 (365 days)	2	96%	51%
Percentage of specialist outpatients waiting within clinically recommended times:			
• Category 1 (30 days)		49%	35%
• Category 2 (90 days)		38%	28%
• Category 3 (365 days)	4	90%	57%
Total weighted activity units:			
• Acute Inpatient		56,741	55,608
• Outpatients		17,963	16,640
• Sub-acute		9,297	6,879
• Emergency Department		15,604	17,694
• Mental Health		3,935	7,195
• Interventions and Procedures	5, 6	8,810	8,489

Key performance indicators

Service standards	Notes	2013-2014 Target/est.	2013-2014 Est.Actual
Average cost per weighted activity unit for Activity Based Funding facilities	7	$4,145	$4,054
Rate of healthcare associated Staphylococcus aureus (including MRSA) Bloodstream (SAB) infections/10,000 acute Public hospital patient days	8	0.9	1.6
Number of in-home visits, families with newborns		4,189	4,545
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit		>60%	61.5%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	9	<12%	12.6%
Ambulatory mental health service contact duration	10	74,156 – 91,010	61,343

Notes:

1. A target is not included as there is no national benchmark for all triage categories, however the service standard has been included (without a target) as it is a nationally recognised standard measure. The 2013-14 estimated actual figures are based on data from July to December 2013.
2. The 2013-14 targets were set as the midway point between the 2013 and 2014 calendar year National Elective Surgery Target (NEST) and National Emergency Access Target (NEAT), as per the National Partnership Agreement on Improving Public Hospital Services. The 2014-15 targets have been set as the midway point between the 2014 and 2015 calendar year NEST and NEAT. The 2013-14 estimated actual figures are based on data from July 2013 to February 2014.
3. There is no nationally agreed target for median waiting time for treatment in emergency departments or in elective surgery. The 2013-14 estimated actual figures are based on data from July 2013 to February 2014.
4. The 2013-14 targets for Category 1 and 2 were based on actual 2012-13 performance, and the target for Category 3 aligns with the Blueprint for better healthcare in Queensland. Specialist outpatient performance is reported for patients waiting as at 1 January 2014.
5. Estimates of average cost per WAU are affected by the parameters of the ABF model and are specific to the ABF model under which they are calculated. The 2013-14 Target/Est. that was published in the 2013-14 Service Delivery Statements and the 2013-14 Est. Actuals have been recalculated based on the Phase 17 ABF model to enable comparison with 2014-15 Target/Est. figures. The 2013-14 Target/Est. and 2014-15 Target/Est. have been calculated as per Value for Money indicator methodology, excluding Site Specific Grants and Clinical Education and Training.
6. The 2013-14 Target/Est. has been amended to reflect Phase 17 ABF model WAUs to enable comparison with both 2013-14 Est. Actuals and 2014-15 Target/Est. figures.
7. The Statewide cost per WAU is for all activity, not specifically Acute care.
8. Staphylococcus aureus are bacteria commonly found on around 30% of people's skin and noses and often cause no adverse effects. Infections with this organism can be serious, particularly so when they infect the bloodstream. The data reported for this service standard are for bloodstream infections with Staphylococcus aureus (including MRSA) and are reported as a rate of infection per 10,000 patient days aggregated to HHS level. The target/estimate for 2014-15 has been revised to align with the national benchmark of 2.0 cases per 10,000 acute public hospital patient days. For further information on this benchmark, see https://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129545750
9. The target for mental health readmissions is the nationally indicative target identified in the Fourth National Mental Health Plan Measurement Strategy. As such, it represents a stretch target of good practice for HHSs to attain rather than an incremental improvement from prior year performance. This HHS has made improvements on this measure over the past five years and a range of initiatives continue to be progressed to achieve targets on this measure.
10. For 2013-14, a standard methodology was adopted based on previous investment in mental health services, with adjustments for variation expected due to geographic locality. Similar methodology has been employed for 2014-15. Based on the level of investment made in community mental health services, the 2014-15 target is conservative from a service delivery perspective. A range of issues, including known under-reporting within clinical information systems that capture the data, mean that the target will be a stretch for some HHSs to attain. A range of strategies, statewide and localised, are being implemented with the aim of improving performance against this measure.

Building on health care service delivery initiatives

The Cairns and Hinterland Hospital and Health Service strives to be a leader in innovation with an emphasis on effectively meeting community health need through the provision of safe, consistent and equitable health services. The underlying objectives are to improve access to services, reduce inequality in health status and promote a patient centred continuum of care.

Medical Assessment Unit

The Cairns and Hinterland Hospital and Health Service has seen a 7% growth in Emergency Department presentations to Cairns Hospital. In order to manage demand for services, a Medical Assessment Unit was thoroughly investigated. A Medical Assessment Unit is an evidence based strategy to provide a 24/7 service to improve patient flow by providing rapid assessment of suitable patients who initially present to the Emergency Department. In 2013-14 a model of care submission was presented to the Department of Health to secure funding. The Department of Health have supported this innovative approach providing $6.6M for a 24 bed Medical Assessment Unit (MAU) in 2014-15 to streamline and better manage emergency department medical admissions, with the aim of reducing length of stay for these patients.

Acute Stroke Unit

Each year between 250-300 patients are admitted to Cairns Hospital with acute stroke, with Aboriginal and Torres Straight Islanders over-represented.

Cairns Hospital has a 20 per cent higher rate of Aboriginal and Torres Strait Islander patients admitted with acute stroke than the national and Queensland average. In 2013, the National Stroke Foundation Acute Stroke Audit found that almost one in four stroke clients admitted to Cairns Hospital identified as Aboriginal or Torres Strait Islander.

To improve the care of our Aboriginal and Torres Strait Islander patients, the Aboriginal and Torres Strait Islander Stroke Team was formed through the Federal Government's Closing the Gap program.

A team of eight provides rehabilitation services from physiotherapy, dietetics, speech and occupational therapy as well as a dedicated Aboriginal and Torres Strait Liaison Officer to patients our Health Service.

The care of stroke patients in Far North Queensland is set to improve even further next year when our new Acute Stroke Unit opens as part of the Cairns Hospital redevelopment in Block D. The Acute Stroke and Rehabilitation Unit will provide an additional 12 acute stroke beds and 20 rehabilitation beds.

Whilst Cairns Hospital already provides acute stroke care, this new unit will have the latest technology including full monitoring at the patient's bedside. With the Acute Stroke Unit being co-located with the rehabilitation ward and rehabilitation facilities our patients will be able to commence therapy almost immediately which has been shown to improve patient outcomes.

In addition, patient care will be improved by remaining in the one area with familiar staff to monitor their progress throughout their treatment, rather than moving between wards as their treatment progresses.

Mental Health Annexe

Providing care for mental health clients in a more appropriate setting as opposed to the Emergency Department has been a key priority for the Cairns and Hinterland Hospital and Health Service.

In November 2013, we opened our 10 bed Mental Health Annexe at Cairns Hospital. The Mental Health Annex has had a significant and direct impact on waiting times in the Cairns Hospital Emergency Department, especially for our mental health clients.

There are now Mental Health Clinical Nurse Consultants staffed in the Cairns Hospital Emergency Department 24 hours a day that provide a timely and appropriate response to our clients needing emergency mental health services.

The Cairns Mental Health Acute Care Team has expanded to become a 24 hour service as we continue to address the mental health challenges faced by some Far North Queenslanders.

Digital hospital

The Cairns and Hinterland Hospital and Health Board has committed almost $3M over the next three years to guarantee that the Cairns Hospital becomes one of the first digital hospitals in Australia.

The Cairns Hospital has been selected to participate in the Digital Exemplar Hospital Project. This will be a joint project between our Health Service, Health Service Information Agency through the Department of Health and Cerner Corporation.

At the service-delivery level the benefits derived from this project should result in significantly less data entry on paper, less double-handling of information, more direct data entry and better reporting functionality. Most importantly, the project will significantly improve clinician access to patient information at the point of care. By the completion of the project in 2016, Cairns Hospital will be one of Australia's first fully digital hospitals.

The Cairns Hospital will lead and develop solutions beginning with Community Health, Cerner Mobile Electronic Medical Records and Dragon Voice Dictation.

The Community Health Solution will feature communication tools to enhance case coordination and timely dissemination of emergent information including on-screen prompts, links, and warnings to promote consistency in documentation, reduce errors, simplify the documentation process, and support regulatory requirements for reporting.

Cerner Mobile Electronic Medical Records solution will allow for immediate access to patient medical records for clinicians working in outreach and off-site services. This solution allows clinical review of existing vital information, as well as the ability to create and edit current patient medical information at the site of visitation while reducing the duplication of documentation giving more time for patient care.

Dragon Voice Dictation transcribes verbal case notes in real-time, enabling physicians to spend more time with their patients by reducing documentation turnaround time and eliminating traditional transcription costs.

Expertise in disaster preparedness - Tropical Cyclone Ita

In April 2014, as Tropical Cyclone Ita impacted Far North Queensland, we again showed why the Cairns and Hinterland Hospital and Health Service is a leader in disaster preparedness and management.

Our Disaster Plan was activated, with all staff, across the Hospital and Health Service making preparations to ensure that patient care was not compromised. All of our major facilities maintained essential health services throughout the duration of Tropical Cyclone Ita, caring for more than 500 inpatients.

On 15 April 2014, the Minister for Health, the Honourable Lawrence Springborg and the Chief Health Officer, Dr Jeannette Young visited the Cairns and Hinterland Hospital and Health Service to thank our staff for their dedication to patient care during Tropical Cyclone Ita.

Operational divisions performance

The realigned organisational structure for the Cairns and Hinterland Hospital and Health Service has been operating since May 2013. The structure is based on a professional clinical leadership model with a focus on front line service. The structure continues to be monitored and reviewed to ensure that every opportunity is realised and built upon.

Division of Family Health and Wellbeing

The implementation of our Midwifery Group Practice will support women and their families by providing continuity of care through pregnancy, child birth and early postnatal care. This is something that the community and midwives have been petitioning for and is something we are very pleased to be providing for the Cairns community.

Our Division of Family Health and Wellbeing includes the following services:

- Mental Health and Alcohol, Tobacco and other Drugs Service;
- Oral Health;
- Child Health;
- Sexual Health;
- Women's' Health;
- Offender Health; and
- Public Health.

Along with maintaining core business, the Division of Family Health and Wellbeing has been supporting the transition towards implementation of the Midwifery Group Practice model of care which has been driven by the team in Women's Health. The Cairns and Hinterland Hospital and Health Board approved the Midwifery Group Practice model for Cairns Hospital.

This new model of service delivery will mean that women who attend Cairns Hospital for care throughout pregnancy and child birth will be allocated a primary maternity care health professional (midwife) who will provide care, education and support during pregnancy, birth, the postnatal period and early parenthood. There is good evidence that continuity of midwifery care provides an expectant mother with a more positive experience of labour that is more likely to result in a normal birth. This model of care has also been shown to assist mothers to successfully breastfeed and ultimately achieve better health outcomes.

The Division has also increased the Paediatric Hospital in the Home initiative which has been driven by the team within Child Health. Under this program, patients are given medical clearance to be discharged from hospital much earlier than what would happen using a traditional model. The patients are cared for in their home by Paediatric Nurses.

Paediatric Hospital in the Home commenced in 2011, and services children from Palm Cove in the north to Gordonvale in the south. In May 2014, the service expanded its hours of operation from 8am until 4.30pm to 8am to 8.30pm. This service required expansion in order to provide the most appropriate care for children and their families.

The Division continues to monitor, review and determine options for the re-development of the Paediatric and Mental Health Services, both of which are planned to be carried out with the services continuing.

In 2014-15 a likely challenge will be the health service delivery at Lotus Glen Correctional Centre, as this facility has expanded by more than 30%.

Division of Integrated Medicine

Patients no longer have to commute to Cairns three times per week for life-saving haemodialysis treatment since the Indigenous Health Worker Assisted Haemodialysis Service model commenced in Yarrabah on 20 February 2014.

The Division of Integrated Medicine provides a range of Acute, Sub-Acute, Community, Allied Health and Chronic Disease services across the Cairns and Hinterland Hospital and Health Service; including:

- Acute Medicine, including the Medical Assessment Unit;
- Rheumatology Services;
- Dermatology Services;
- Gastroenterology and Hepatology Services;
- Cancer Care Services including Radiation Oncology;
- Hospital Alternative Services;
- Infectious Diseases;
- Cardiology Services;
- Renal Services;
- Diabetes and Endocrine Services;
- Respiratory Services;
- Neurology Services;
- Rehabilitation and Stroke Services;
- Geriatric Evaluation and Management Services;
- HACC and Transition Care Services; and
- Palliative Care.

In 2013-14, the Division of Integrated Medicine has focused on enhancing and developing the governance framework, fostered a culture of research and innovation in care, strengthened the public private partnerships and focused on quality and safety in providing care to our community.

During the year, there have been a number of achievements accomplished to meet the strategic priorities of the Hospital and Health Service.

The Cairns Hospital's 16 bed Older Persons Evaluation Rehabilitation and Assessment Unit opened in November 2013 and improves the care of older persons through comprehensive geriatric assessment and interdisciplinary management. Herberton Hospital also extended its bed capacity to incorporate a secure unit for low care dementia patients.

The Cairns Community Rehabilitation Team commenced services in November 2013.

An Apheresis Service commenced in February 2014, eliminating the need for patients to travel outside of the Cairns and Hinterland Hospital and Health Service catchment area to receive this service.

The Division has also been responsible for implementing a number of initiatives to improve health outcomes for Indigenous people. In a first for Queensland, the implementation of the Yarrabah Assisted Care Dialysis service has enabled patients to receive more culturally appropriate treatment within their community. In addition to providing care closer to patients' homes in a culturally appropriate setting, this service provides an educational opportunity to teach others about haemodialysis treatment and the links between risk-taking lifestyle behaviour

The Aboriginal and Torres Strait Islander Stroke Project has made significant improvements in providing multidisciplinary stroke care to clients across the catchment area. The team has developed culturally appropriate therapies across the continuum of care following community consultation with stroke survivors and stakeholders from Cape and Torres communities.

The Chronic Kidney Disease – Clinical Pharmacy and Telehealth project has increased access for geographically isolated clients to specialist renal physicians and clinical pharmacy services. The team utilise an intensive case management approach to assist patients in self-managing their illness.

The Division has also invested in building a skilled clinical workforce to meet the current and future needs of the community. Successful recruitment of senior clinicians included the Clinical Directors of the three service groups, the Clinical Director of Cancer Care, our staff Rheumatologist, a staff Oncologist and a Geriatrician. Other key appointments included the Health Worker Cluster Coordinator and Business Manager.

Cancer Care Services was successful in gaining funding from the Prostate Cancer Foundation of Australia for the appointment of a Prostate Cancer Specialist Nurse. This role will provide specialised and tailored information and education, psychological support and clinical care to meet the health needs of men with prostate cancer.

After hours interventional cardiology services will commence to provide patients who have a myocardial infarction a primary or rescue angioplasty.

The Division was successful in obtaining funding to implement the nurse endoscopy initiative. This new service provision will help address the growing demand for endoscopy services across the Hospital and Health Service.

Challenges for 2014-15 include the demand for medical inpatient beds coupled with the ongoing demand to care for nursing home and disability patients. The Division will be challenged with implementing strategies to reduce potentially preventable hospitalisations for chronic disease. Achieving shorter waits for specialist outpatient clinics and ensuring patients are seen within the clinically recommended time for a specialist outpatient appointment will also be a focus area for the Division.

Division of Critical Care and Perioperative Services

The Cairns and Hinterland Hospital and Health Service has achieved its goal of having no patients on the general surgical long wait list by the end of the financial year.

The Division of Critical Care and Perioperative Services includes the following clinical services:

- Anaesthetics and Perioperative Medicine;
- Emergency Medicine;
- Intensive Care Medicine;
- Perioperative services such as Operating Theatres, Day Surgery, Overnight Stay Unit and Central Sterilizing Department;
- Orthopaedic and Surgical Ward's; and
- Medical Imaging Service.

In addition to maintaining its core business, the Division has focussed on a project to rapidly reduce the number of patients waiting for surgery longer than the clinically recommended timeframe. Funding from the Department of Health, combined with challenging project targets, has necessitated strong collaboration between all clinical and non-clinical streams. Significant improvements in processes and efficiencies was required to achieve the project goals of meeting National Elective Surgery Targets (NEST) including the reduction of the general surgical long waiting patients to zero by 30 June 2014. The success of this project has resulted in over $12M in additional recurrent funding for elective surgery.

The Division has also successfully implemented many improvements related to achieving National Emergency Access Targets (NEAT). Emergency, Surgical and Orthopaedic services have changed rostering practices, implemented innovative solutions (such as a virtual Short Stay unit in the Emergency Department) and improved data capture, analysis and distribution. These improvements were essential for the Cairns and Hinterland Hospital and Health Service to achieve the January 2014 target for its NEAT Project, which has resulted in funding to improve our Mental Health bed capacity.

Division of Facilities Management

Release One of the integrated electronic Medical Record (ieMR) is a significant step in the introduction of an ieMR for not only Cairns Hospital but all public hospitals in Queensland, and is the culmination of four years of extensive consultation, collaboration and engagement with clinical, administrative and technical staff across the Hopital and Health Sevices, Health Services Information Agency and other Department of Health divisions.

The Division of Facilities Management manages quality health services for our 19 regional facilities; and Operational Services and Medical Records to the entire Hospital and Health Service.

On 12 December 2013, Cairns Hospital was the first hospital in the state to 'Go Live' with the integrated electronic Medical Record (ieMR). The 'Go Live' event was a successful initial launch of the ieMR and well supported by the Cairns local Project Team, the ieMR Program Implementation team and support from staff at Cairns Hospital.

The ieMR Program aims to enable a patient centric focus to health care delivery across a networked model of care. This will be achieved with the implementation of an ieMR solution that allows clinicians and supporting staff to securely access a single view of a patient's medical record. To ensure the ieMR solution is delivered in an effective manner, it is being rolled out through a phased approach.

The benefits of Release 1 are as follows:

- Improve the ability of clinicians and administrative staff to concurrently access a patient's medical records.
- Reduced time spent locating and waiting for a patient's medical record from within the ieMR network.
- Reduction in administration time through reduced volume of physical chart retrievals and logistics activities.
- Reduction in time spent on chart maintenance and preparation tasks in the clinical environment.

The Division has successfully recruited Medical Superintendents to our Cassowary and Hinterland hubs, and also implemented a newly devised medical roster for Atherton, Mareeba and Innisfail.

A major reorganisation of Cairns Hospital catering was conducted in September 2013 in anticipation of the relocation to Block D, Cairns Hospital. The kitchen has now successfully been moved to Block D and has been operating effectively since May 2014. The kitchen is one of the largest and most modern kitchens in North Queensland. Its floor area has doubled to 1133m2 (excluding staff dining) and staff will produce more than 1400 main meals and more than 1000 between-meal snacks every day.

Our financial performance

The Cairns and Hinterland Hospital and Health Service achieved a financial deficit of $0.11 million for the year ending 30 June 2014 compared with a surplus in the prior year of $5.37 million. Services are provided under a purchaser-provider model whereby the Department of Health purchase health services from the Hospital and Health Service, which is facilitated and monitored through a service level agreement and underpinned by a performance framework.

Financial highlights

The deficit of $0.11 million achieved represents a 0.02 per cent variance against the revenue base of $656.75 million. The Hospital and Health Service also delivered on key performance indicators relating to activity, which are measured by weighted average units (WAU).

This position was able to be achieved through the ongoing implementation of savings initiatives to meet the productivity and efficiency targets outlined within the service level agreement.

In 2013-14, the Hospital and Health Service continued to build on the strategies and structure put in place to better align services, and to ensure sustainable service delivery and enhanced clinical outcomes.

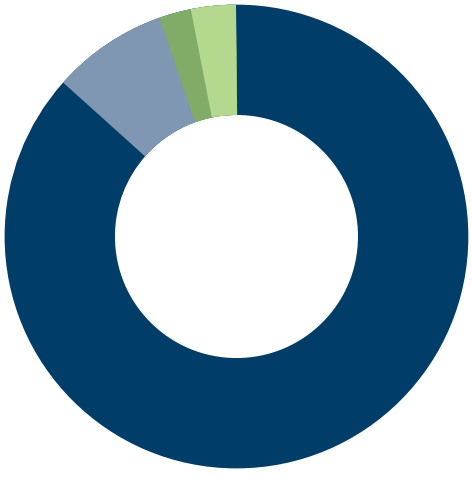
Where the funds came from

The Hospital and Health Service's income from all funding sources for 2013-14 was $656.75 million and was principally derived from the ABF model with the Department of Health purchasing 109,088 WAU's.

Total income comprised:

- Funding from State and the Australian Government for the provision of health services ($566.19 million)
- Other user charges and fees ($53.10 million)
- Australian Government contributions ($16.38 million)
- Donations, other revenue, other grants and recoveries ($21.08 million)

CHART 1: Income by revenue sources



86.2% Funding for provision of health services

8.1% Other user charges and fees

3.2% Donations, other revenue, other grants and recoveries

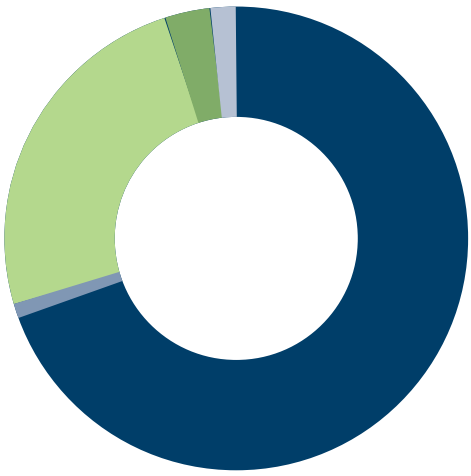
2.5% Australian Government contributions

Where funding was spent

Total expenses were $656.87 million, averaging $1.80 million per day to provide public health services. Expenditure increased in the latter part of the financial year due to increased activity to achieve the National Elective Surgery targets and increased expenditure to improve infrastructure in line with funding received.

The Hospital and Health Service's main expenditure was Health service employee expenses which made up almost 70 per cent of total costs. Depreciation and amortisation of the Hospital and Health Service's assets is 3.3 per cent, representing the consumption of a $597.16 million asset portfolio.

▶ Chart 2: Expenses by major category



69.8%	Health service employee expenses
0.2%	Employee expenses
24.8%	Supplies and services
3.3%	Depreciation and amortisation
1.9%	Other expenses

Cash and investments

As at balance date, the Hospital and Health Service had $35.96 million in cash and investments. This balance is largely a result of the timing of payables including payroll and the reported surplus. Depreciation is not cash funded.

Comparison of 2013-14 financial result to prior year

The Hospital and Health Service 2014 result compared to the prior year is presented in the following tables with accompanying notes:

a. Statement of financial position at 30 June 2014

	Notes	2014 $'000	2013 $'000	Variance %
Current assets				
Cash and cash equivalents	1	35,956	17,980	100%
Receivables	2	18,675	21,617	-14%
Inventories		3,850	3,339	15%
Other current assets		24	390	-94%
Total Current Assets		58,505	43,326	
Non-current assets				
Intangible assets		408	147	178%
Property, plant and equipment	3	596,756	331,609	80%
Total Non-Current Assets		597,164	331,756	
Total assets		655,669	375,082	
Current liabilities				
Payables	4	51,731	36,720	41%
Accrued employee benefits		63	39	60%
Unearned revenue	5	2,175	153	1325%
Total current liabilities		53,969	36,912	
Total liabilities		53,969	36,912	
Net assets		601,700	338,170	
Equity				
Contributed equity	6	575,338	314,426	83%
Accumulated surplus		5,252	5,366	-2%
Asset revaluation surplus	7	21,110	18,378	15%
Total equity		601,700	338,170	

Notes:

1. Increase from 2013 reflects timing of payroll period and higher payables at 30 June 2014.
2. Decrease predominantly due to decrease in funding receivable from Department of Health.
3. Increase reflects capitalisation of Block D in June 2014 of $0.24 million.
4. Increase in line with higher expenditure in 2014 and timing of the payroll periods.
5. Increase reflects funding for health services received in advance of delivering the service.
6. Increase predominantly relates to transfer of Block D from Department of Health through Equity.
7. Increase relates to Land and Building revaluations performed in June 2014.

b. Operating result for the year ended 30 June 2014

	Notes	2014 $'000	2013 $'000	Variance %
Income				
User charges and fees	1	619,286	595,985	4%
Grants and other contributions		20,441	18,007	14%
Interest		138	55	151%
Other revenue	2	16,886	12,940	30%
Total revenue		656,751	626,987	
Gains on disposal / remeasurement of assets		-	63	-100%
Total income		**656,751**	**627,050**	
Expenses				
Employee expenses	3	1,604	946	70%
Health service employee expenses	4	458,735	441,624	4%
Supplies and services	5	162,800	145,116	12%
Grants and subsidies		665	1,654	-60%
Depreciation and amortisation		21,587	20,120	7%
Impairment losses		1,868	3,862	-52%
Revaluation decrement		-	159	-100%
Other expenses		9,606	8,203	17%
Total expenses		**656,865**	**621,684**	
Operating result for the year		**(114)**	**5,366**	

Notes:

1. Increase reflects higher Pharmaceutical Benefit Scheme revenue and increase in funding from State and Australian Government for purchases of health services. Increase in government funding reflects additional revenue provided in amendments to the service level agreement.
2. Increase reflects higher salary and cost recoveries from other entities, including other Hospital and Health Services.
3. Increase reflects higher number of staff employed directly by the Hospital and Health Service in 2014.
4. Increase reflects higher number of FTE in 2014 from 3,736 to 4,047 in line with additional funds provided by the Department of Health.
5. Increase predominantly relates to expenditure offset by Revenue recoveries such as patient travel for other Hospital and Health Services, Maintenance works under specific funding agreements and drugs funded under the Pharmaceutical Benefits Scheme.

Activity based funding

From 1 July 2012, the services provided by Cairns and Hinterland Hospital and Health Service have been purchased by the Department of Health, with activity to be purchased detailed within the service level agreement. The basic measure of activity is the weighted activity unit (WAU). In 2013-14, WAU activity reporting is based on the phase 16 iteration of the case-mix model in Queensland.

The Hospital and Health Service produced 109,509 WAUs which was 0.4 per cent above the purchased activity (109,021 WAUs) and within the allowed tolerance of plus or minus two per cent. This represents an increase of 2013 activity of 3%.

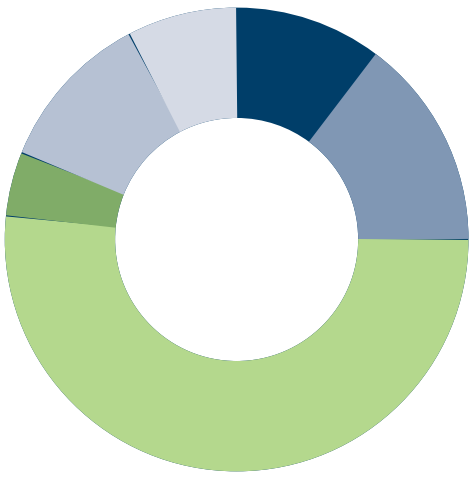
Chart 3 shows the breakup of activity by purchasing category, while **Chart 4** illustrates the monthly performance to the agreed target phased through the year.

The increase in target from March 2014 is in line with increased surgery activity undertaken.

Chief Finance Officer statement

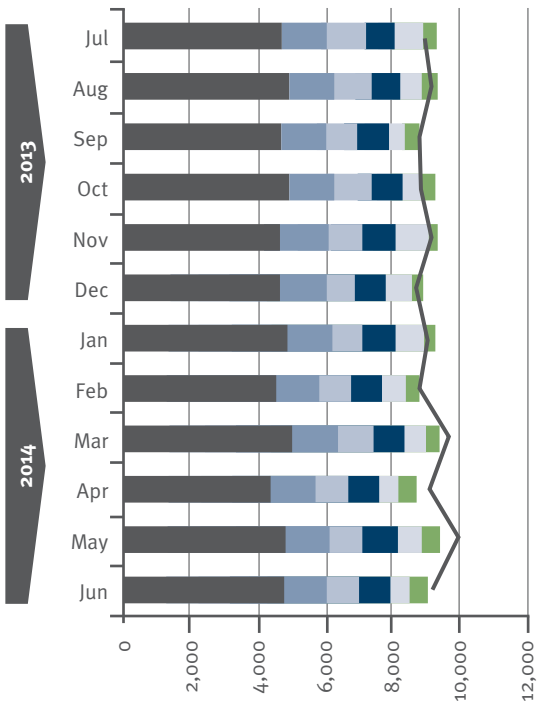
For the financial year ended 30 June 2014 the Chief Finance Officer provided a statement about the Service to the Board and Chief Executive in relation to financial internal controls, compliance with prescribed requirements for establishing and keeping the financial accounts and preparation of the financial statements to present a true and fair view, in accordance with accounting standards.

Chart 3: Weighted activity units by category



10% Interventions and Procedures
11% Outpatient
14% Emergency Department
8% SNAP
52% Inpatient
5% Mental Health

Chart 4: Weighted activity units by months



Our strategic priorities

During 2013–14, we improved our performance by applying our strategic approach to all of our operations.

We measure our success by our ability to achieve the objectives set out in our Strategic Plan 2013 – 2017. The strategic objectives for the Cairns and Hinterland Hospital and Health Service are aligned with the Queensland Government Blueprint for Better Healthcare in Queensland and the Government's objectives for the community to deliver better infrastructure and planning and revitalise frontline services for families.

NATIONAL HEALTH REFORM		
Helping patients receive more seamless care across sectors of the health system	Improving the quality of care patients receive through higher performance standards, unprecedented levels of transparency and improved engagement of local clinicians	Providing a secure funding base for health and hospitals into the future

GETTING QUEENSLAND BACK ON TRACK				
We will grow a four pillar community	We will lower the cost of living	We will restore accountability in government	We will invest in better infrastructure and use better planning	We will revitalise front line services

STATEMENT OF GOVERNMENT HEALTH PRIORITIES			
Revitalising services for patients	Reforming Queensland's health system	Focusing resources on frontline services	Restoring accountability and confidence in the health system

BLUEPRINT FOR BETTER HEALTHCARE IN QUEENSLAND			
Health services focused on patients and people	Empowering the community and our health workforce	Providing Queenslanders with value in health services	Investing, innovating and planning for the future

Our strategic directions are divided into eight objectives that we use to prioritise our activities:

- We will strive to continually improve patient care, safety and outcomes.
- We will provide integrated and coordinated health care services that are patient-focussed and culturally appropriate.
- We will actively engage stakeholders and consider their input in the delivery of healthcare services.
- We will:
  - *Deploy the right people to the right service in the right place at the right time and;*
  - *Create and maintain a positive and productive workplace culture that will enable our workforce to be fully engaged, educated and supported.*
- We will ensure fiscally responsible decision making while providing stable and sustainable health services.
- We will establish engaged, consistent and timely decision making processes at all levels of the organisation and at the closest point to service delivery.
- We will build, develop and implement information technology and systems that support integrated health care delivery and enhance organisational performance.
- We will recognise and promote our standing and our achievements – locally, nationally and internationally.

The following information highlights some of our achievements under our strategic objectives in 2013-14 *(overleaf)*:

Strategic objective	Strategies	Progress in 2013-14
We will strive to continually improve patient care, safety and outcomes.	Improve the quality and safety of health services through the ongoing development of our quality and safety programs. Target the reduction of variation and adverse events and develop a culture which supports patient safety and manages risks effectively. Improve emergency and elective service access.	Service standards for the Cairns and Hinterland Hospital and Health Service are defined under the National Safety and Quality Health Service Standards. Accreditation is a broad process that reviews all aspects of how the service is managed and operates, to ensure sustainable quality of care for our patients and community. We are currently performing self-assessments under these standards prior to the external surveyors undertaking the formal review of our Hospital and Health Service in November 2014. As part of Queensland wide changes, this will be the first time we will be assessed as a whole organisation, whereas in the past the individual facilities have been assessed as standalone units. A Service wide approach will ensure that consistent standards of service delivery are met across the entire organisation. As part of the accreditation process we have reviewed and made improvements to service quality in the specified accreditation areas of: 1. *Governance for Safety and Quality in Health Service Organisations* 2. *Partnering with Consumers* 3. *Preventing and Controlling Healthcare Associated Infections* 5. *Patient Identification and Procedure Matching* 6. *Clinical Handover* 7. *Blood and Blood Products* 8. *Preventing and Managing Pressure Injuries* 9. *Recognising and Responding to Clinical Deterioration in Acute Health Care* 10. *Preventing Falls and Harm from Falls* 11. *Service Delivery* 12. *Provision of care* 13. *Workforce Planning and Management* 14. *Information Management* 15. *Corporate Systems and Safety* In 2013-14 we achieved a significant milestone in terms of service accessibility in having reached a position of zero long-waits for elective surgery. This position was reached following the number of long-wait patients having peaked at over 700 in September 2013. Significant improvements have also been made in Emergency Department Access Times, in the face of increasing numbers of presentations to the Emergency Department.

Strategic objective	Strategies	Progress in 2013-14
		Performance against the National Emergency Access Time standard of patients departing the ED within four hours peaked in February 2014 at 78.4%, before declining due to a number of factors, most notably availability of bed stock and a high case-load of complex acute patients.
We will provide integrated and coordinated health care services that are patient-focussed and culturally appropriate.	Completion of the transition to community control at Yarrabah. Streamline the transition of care from hospital to extended care and community settings. Improve clinical pathways for priority disease groups. Implement Whole of Government plans and priorities (Closing the Gap, Mental Health and Alcohol and Other Drugs, Chronic Disease Strategy).	This year we completed the transition of primary health care services in Yarrabah to community control, under the management of Gurriny Yealamucka (Good Healing) Health Services. As a community controlled organisation, managed by a community Board, these services will be better able to respond to community needs and provide services in a way that is more response to local conditions. This transition marks the first time in Queensland that a primary health care service has been transitioned from the Government to the community. The Yarrabah renal dialysis unit was opened in 2013-14, and is largely staffed by Health Workers. This service provides thrice weekly dialysis to patients who previously had to commute to Cairns, a two-hour round trip. We delivered on a number of projects designed to provide more co-ordinated and accessible services, including: • *Enhanced diabetes outreach services;* • *Regional Network of Indigenous Alcohol, Tobacco and other Drugs (ATDOS) Youth Program;* • *Rheumatic Heart Disease State-wide Register and Control Program;* • *Multidisciplinary Chronic Kidney Disease Clinic and Service;* • *Yarrabah Smiles;* • *Care for Indigenous Stroke Survivors in Queensland;* • *Nurse practitioner Candidate-Diabetes; and* • *Enhanced Hospital Liaison officer Renal services.* We developed new service models that better meet the needs of the local community, including formation of the Cairns Community Rehabilitation Team (CCRT). The previously separate teams of the Smithfield, Cairns North and Edmonton Community Health Centres have merged to become one integrated adult community rehabilitation team, accessed through a central point of referral.

Strategic objective	Strategies	Progress in 2013-14
		The purpose of this team is to provide therapeutic interventions that improve the safety, independence and functional capacity of clients whose capacity has been significantly diminished by a recent health event. This intervention helps to avoid admissions, facilitate hospital discharge and improve independence. The team works collaboratively with other service providers including the Aged Care Assessment Team, inpatient teams, Home and Community Care, Chronic Conditions Management Team, Integrated Hospital Alternative Service and General Practitioners.
We will actively engage stakeholders and consider their input in the delivery of healthcare services.	Plan our services to meet the needs of the community. Involve patients, clinicians, other staff and the local community in the planning, delivery and evaluation of their care.	In 2013-14 we initiated the modelling of our population and acute service provision requirements, which has instigated a deeper analysis of the service utilisation, social and health infrastructure and the broader determinants of health in the community. Three Community Consultation Committees have been established, made up of community and consumer representation. These Committees are structured around the hubs of Trinity (Cairns and immediate surrounds, including Yarrabah), Cassowary (Innisfail and the Southern portion of the Hospital and Health Service) and Hinterland (including the Tablelands and Douglas Shire Council) Our Clinical Council developed the Clinician Engagement Strategy which has now been implemented across the organisation.
We will deploy the right people to the right service in the right place at the right time.	Involve patients, clinicians, other staff and the local community in the planning, delivery and evaluation of their care. Develop a workforce that better reflects our community. Create a culture that values leadership, innovation, local decision making, and accountability.	We have initiated and implemented our Community and Clinician Engagement Strategies. We have also commenced the development of planning frameworks that are sensitive to the needs of local populations. In 2013-14, we developed a range of strategies to strengthen and support our workforce which include: • *development of a critical roles register and commencement of succession planning;* • *rollout of recruitment and selection training for recruiters;* • *demographic assessment of community and compare to workforce demographics for future planning;* • *develop Strategic Workforce Plan;* • *explore contemporary recruitment methods to enhance traditional recruitment methods for hard to fill or strategic positions;* • *provision of local support to the implementation of medical contracts*

Strategic objective	Strategies	Progress in 2013-14
		The Queensland Public Service values have been adopted by our organisation and have influenced the development of: • *a CHHHS Leadership Framework;* • *a Cultural Renewal Plan;* • *a 360° survey instrument based on our new leadership framework;* • *leadership training modules for new framework and values.* This financial year has seen us achieve the highest external audit rating for Occupational Health and Safety of any Hospital and Health Service within Queensland, demonstrating robust systems within our organisation to protect the health and safety of our staff, patients and visitors.
We will ensure fiscally responsible decision making while providing stable and sustainable health services.	Comprehensively plan for the most efficient utilisation of available funding and maximise revenue generation. Implement long term financial modelling to drive a focus on future financial sustainability. Improve the efficiency of our operations through eliminating waste and increasing productivity. Drive a culture of financial accountability throughout the organisation. Promote sustainability through contemporary capital planning, waste reduction and recycling. Complete strategic asset planning to effectively address our aging infrastructure.	We ended the financial year within 1% of the agreed budgetary position, in line with the Service Agreement requirements. The Cairns and Hinterland Hospital and Health Service continued to be significantly more efficient on a cost per weighted activity unit ($/WAU) basis than the State average. Our low $/WAU, and our lower than average adjusted Length of Stay show that our organisation, and Cairns Hospital in particular, provides value for money for our community. Efforts to reduce waste and inefficiency have been ongoing in 2013-14, including specific work on making the processes of Patient Travel Subsidy Scheme applications more efficient, while also allowing greater scrutiny of the appropriateness of expenditure in this area. Improved contracts management processes have been put in place within the Hospital and Health Service to achieve better outcomes from products and services delivered under contract. These benefits include: • *a more complete register of all contracts;* • *reduced administrative overhead in establishing a contract;* • *greater transparency of contract approval delegations;* • *stronger capacity to manage the performance of contractors/suppliers.* New and enhanced budgeting tools have been developed that increase both the accuracy and transparency of the budget development process.

Strategic objective	Strategies	Progress in 2013-14
We will establish engaged, consistent and timely decision making processes (within approved delegations) at the closes point of care delivery.	Develop, implement and embed robust governance, delegation and risk management frameworks and processes. Create a culture of personal accountability throughout the organisation.	Our organisational Performance and Accountability Framework, which defines clearly the professional and operation accountabilities and lines of management for officers within our organisation has now been implemented. Financial and Human Resource delegations are in line with these accountabilities. Regular monthly performance meetings at Divisional and Hospital and Health Service level ensure that underperformance issues that have the capacity to impact our organisation are identified and addressed. Comprehensive reporting to the Board on a monthly basis ensures transparency of performance against financial and service delivery targets. While risk management is currently undertaken using the Queensland Health IT system (QHRisk), development of an in-house system that will allow significantly greater transparency in the allocation, management and control of risk throughout the organisation has been undertaken during 2013-14 and will go on-line following Accreditation in December 2014.
We will build and develop information technology that supports integrated health care delivery and organisational performance.	Develop robust Information and Communication Technology (ICT) Strategy and plans, to include ICT requirements around the Cairns Base Hospital redevelopment. Provide reliable, contemporary technologies to support health service delivery.	As detailed earlier in this Report, the first release of an integrated electronic medical record (ieMR), which will allow clinicians greater access to the patient's records, independent of a paper chart was successfully rolled out at Cairns Hospital in 2013-14. To support the implementation of the ieMR at Cairns Hospital, we tested the market and approved the installation of integrated patient information and entertainment systems in Block D. These systems will allow our patients to access a broader range of entertainment options, and will ensure that medical records and progress notes are updated at the bedside, which has been demonstrated to lead to better care outcomes. We continue to support and develop the delivery of services via telehealth, allowing patients to receive a significant range of services closer to home.

Strategic objective	Strategies	Progress in 2013-14
We will recognise and promote our standing in our achievements – locally, nationally and internationally.	Develop informal relationships and formal partnerships with leading research, academic and innovation institutes and organisations Maintain and improve the status of a high performing HHS within the Queensland Health performance framework. Recognise the current levels of research taking place within the Cairns and Hinterland Hospital and Health Service, recognise and develop partnerships and enhance those relationships going forward.	A baseline environmental scan was conducted to determine as an organisation, what our reputation is and what evidence supports this. Subsequently to the environmental scan, we have developed measures to enhance our reputation, including: • *Encouraging leaders and managers to nominate staff for Awards;* • *Publicising staff and organisational achievements in internal and external publications; and* • *Use of internet / Intranet to disseminate information about our clinical services, education and research opportunities, our current staff, our performance as and organisational innovations.* The Cairns and Hinterland Hospital and Health Service has enhanced the research capacity of itself and its partners through a number of activities designed to encourage and develop early and mid-career researchers. Whilst at the same time ensuring that all research undertaken leads directly to the improvement of clinical services and outcomes. These activities include the development of the Cairns and Hinterland Hospital and Health Service Research and Education Strategic Framework 2013-2018 and the development of strategic plans to guide our research and education activities. To promote research activities across professional groups, an interdisciplinary Research and Education Working Group has now been established. This Group will guide the strategic direction for our research and education activities, document strategy, and oversee an annual conference to showcase research and education.

Our governance

The Cairns and Hinterland Hospital and Health Service is a statutory body as defined by the *Hospital and Health Boards Act 2011* and is independently and locally controlled by a seven-person Board appointed by the Governor in Council, as recommended by the Queensland Minister for Health.

The Board must perform its functions and exercise its powers in accordance with any direction given by the Queensland Minister for Health and subject to the provisions of the *Hospital and Health Boards Act 2011 (Qld)*.

The Board has the responsibility to ensure that the Cairns and Hinterland Hospital and Health Service performs its functions under Section 19 of the *Hospital and Health Boards Act 2011 (Qld)*. This includes but is not limited to the obligation to develop statements of priorities and strategic plans for the corporate governance of the Cairns and Hinterland Hospital and Health Service, and to monitor compliance with those statements and plans. The Board also has the responsibility for the appointment of the Chief Executive.

Our Board Members have a mix of qualifications, skills and experience and contribute to the governance of the Cairns and Hinterland Hospital and Health Service collectively as a Board through attendance at Board Meetings. The Board meets monthly on average; 12 meetings are typically scheduled each financial year.

During 2013-14, Cairns and Hinterland Hospital and Health Service's seven Board Members were:

Mr Robert Norman FAICD

(1 July 2012 to 17 May 2013,
18 May 2013 to 17 May 2016)

- Chair of the Cairns and Hinterland Hospital and Health Board
- Member, Audit and Risk Management Committee
- Member, Finance and Performance Committee
- Member, Safety and Quality Committee

Current professional positions
- Managing Director, Norman Properties Pty Ltd

Ms Carolyn Eagle B.Com, FCA, CIA, CGAP, CRMA

(1 July 2012 to 17 May 2013,
18 May 2013 to 17 May 2014,
18 May 2014 to 17 May 2017)

- Deputy Chair of the Cairns and Hinterland Hospital and Health Board
- Member, Audit and Risk Management Committee
- Chair, Finance and Performance Committee
- Member, Safety and Quality Committee

Current professional positions
- Director, Pacifica Pty Ltd
- Chair of the Audit Committee of three Queensland Local Government Authorities
- Councillor, Queensland Chapter Council of the Institute of Internal Auditors

Ms Leeanne Bou-Samra LLB

(1 July 2012 to 17 May 2013,
18 May 2013 to 17 May 2016)

- Member, Cairns and Hinterland Hospital and Health Board
- Member, Audit and Risk Management Committee
- Member, Finance and Performance Committee
- Deputy Chair, Safety and Quality Committee

Current professional positions
- Lawyer, Miller Bou-Samra Lawyers

Mr Mario Calanna B.Pharm. FAIM FACP MACID MAACP

(18 May 2013 to 17 May 2016)

- Member, Cairns and Hinterland Hospital and Health Board
- Member, Audit and Risk Management Committee
- Member, Finance and Performance Committee
- Member, Safety and Quality Committee
- Member, Far North Queensland Hospital Foundation Board

Current professional positions
- CEO – Calanna Pharmacy Group

Mr Bruce Peden FCA (Fellow of the Institute of Chartered Accountants in Australia)

(18 May 2013 to 17 May 2016)

- Member, Cairns and Hinterland Hospital and Health Board
- Chair, Audit and Risk Management Committee
- Member, Finance and Performance Committee
- Member, Safety and Quality Committee

Current professional positions

- Chair Tablelands Regional Council Audit and Risk Management Committee
- Member Uniting Church Queensland Finance Investment and Property Board
- Member Chartered Accountants Advisory Group, Queensland

Dr Felicity Croker PhD; B.ED(Hons), RN, RM (current registration)

(23 August 2013 to 17 May 2014, 18 May 2014 to 17 May 2017)

- Member, Cairns and Hinterland Hospital and Health Board
- Member, Audit and Risk Management Committee
- Member, Finance and Performance Committee
- Member, Safety and Quality Committee
- Chair, Cairns and Hinterland Hospital and Health Service Community Advisory Group

Current professional positions

- Associate Dean Teaching and Learning, Faculty of Medicine, Health and Molecular Sciences, James Cook University
- Senior Lecturer, School Medicine & Dentistry, James Cook University.

Dr Peter Smith FRACGP

(18 May 2013 to 17 May 2016)

- Member, Cairns and Hinterland Hospital and Health Board
- Member, Audit and Risk Management Committee
- Member, Finance and Performance Committee
- Chair, Safety and Quality Committee

Current professional positions

- Principal at Clifton Beach Medical and Surgical, Cairns
- Lecturer, James Cook University
- Senior examiner for FRACGP exam
- Member of the Australian College of Tropical Medicine
- Member of the Skin Cancer College of Australasia
- Practice Assessor for Tropical Medical Training
- Supervisor for Tropical Medical Training Program
- Educator for Tropical Medical Training
- Medical Mentor for the Ramus program
- Board Member of Mental Health Advisory Committee for Cairns Private Clinic
- Fellow of the Royal Australian College of General Practitioners

	Board Meeting	Resolution out of Session	Audit and Risk Management	Finance and Performance	Safety and Quality
Robert Norman	12 of 12	9 of 9	5 of 5	1 of 1	4 of 4
Carolyn Eagle	12 of 12	9 of 9	5 of 5	1 of 1	4 of 4
Leeanne Bou-Samra	12 of 12	9 of 9	5 of 5	1 of 1	4 of 4
Mario Calanna	12 of 12	8 of 9	5 of 5	0 of 1	4 of 4
Felicity Croker*	10 of 12	9 of 9	4 of 5	1 of 1	1 of 4
Bruce Peden	12 of 12	9 of 9	5 of 5	0 of 1	4 of 4
Peter Smith	12 of 12	9 of 9	5 of 5	1 of 1	4 of 4

*Board Member, Dr Felicity Croker commenced her appointment on 23 August 2013.

Our board committees

Individual Board Members contribute to the governance of the Cairns and Hinterland Hospital and Health Service by participating in, or chairing of the various committees of the Board.

The Board has established those prescribed committees required under the *Hospital and Health Boards Act 2011* (Qld) and may, from time to time, establish such other committees as it considers necessary to assist in carrying out its functions.

The Board ultimately remains accountable for the decisions of the Board committees and:

- Each formally constituted committee has a Terms of Reference, approved by the Board and updated annually;
- Membership of Board committees is based on the needs of the Cairns and Hinterland Hospital and Health Service and the skill and experience of individual board members and/or officers of the Cairns and Hinterland Hospital and Health Service. The Board has sole responsibility for the appointment of Board Members and officer to committees.

The following committees have been established by the Cairns and Hinterland Hospital and Health Board and continue to operate:

- Audit and Risk Management Committee;
- Safety and Quality Committee;
- Finance and Performance Committee;
- Community Advisory Group.

The Board has established the Board Executive Committee in accordance with Section32B of the *Hospital and Health Boards Act 2011* (Qld). All Board Members are members of this Committee. The Executive Committee did not independently convene in 2013-14 as the functions were subsumed by the Board Meeting.

Strategic matters were addressed by the Board at regular Saturday workshops throughout the financial year.

Audit and Risk Management Committee

The Audit and Risk Management Committee is a formal committee of the Board established in accordance with Schedule 1, Section 8 of the *Hospital and Health Boards Act 2011* (Qld) and Section 35 of the *Financial and Performance Management Standard 2009* (Qld).

The Audit and Risk Management Committee performs the functions as so described under Part 7, Section 34, of the *Hospital and Health Boards Regulation 2012* (Qld).

The primary function of the Audit and Risk Management Committee is to assist the Board to understand the Cairns and Hinterland Hospital and Health Service risks, identify issues and ensure that an audit plan and risk management plan are in place.

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

Safety and Quality Committee

The Safety and Quality Committee is a formal committee of the Board established in accordance with Schedule 1, Section 8 of the *Hospital and Health Boards Act 2011* (Qld) and performs the functions described under Part 7, Section 32 of the *Hospital and Health Boards Regulations 2012* (Qld).

The purpose of the Safety and Quality Committee is to assist the Cairns and Hinterland Hospital and Health Service and its Board by fulfilling its oversight responsibilities by ensuring effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services provided by the health service.

The Chief Executive, Executive Director Medical Services, Executive Director Nursing and Midwifery, Executive Director Allied Health and Director of Clinical Governance are required to attend each meeting as non-voting attendees.

Finance and Performance Committee

The Finance and Performance Committee is a formal committee of the Board established in accordance with Schedule 1, Section 8 of the *Hospital and Health Boards Act 2011* (Qld) and performs the functions described under part 7, Section 33 of the *Hospital and Health Boards Regulation 2012* (Qld).

The purpose of the Finance and Performance Committee is to assist Cairns and Hinterland Hospital and Health Service and its Board by providing oversight and strategic direction in the key areas of financial management, financial and operating performance, revenue management, legislative compliance and financial risks in provision of health services by the Cairns and Hinterland Hospital and Health Service and its long term financial viability.

The Finance and Performance Committee convened on one occasion during 2013-14, however finance and performance was otherwise addressed at every Board Meeting.

Community Advisory Group

In response to the legislative requirement for community engagement and the desire of the Cairns and Hinterland Hospital and Health Board to involve the community in local health care delivery the Board established three Community Consultation Committees – Trinity, Hinterland and Cassowary Coast hubs.

The purpose of the Committees is to provide advice to the Board through the Community Advisory Group on the health care services provided from a consumer and community perspective. The Committees through the Community Advisory Group are accountable to the Board.

Dr Felicity Croker is the Chair of the Community Advisory Group, and the inaugural meeting was held on 30 May 2014. It has been agreed that the Community Advisory Group will convene on a quarterly basis.

Our executive

Our Executive Management Team is responsible for ensuring that there are correct systems and processes in place to maximise organisational performance within the Cairns and Hinterland Hospital and Health Service.

Our Executive Management Team demonstrate the behaviours that align with the organisational values of customers first, ideas into action, unleash potential, be courageous and empower people. They monitor the quality of care provided to patients and the workplace for employees and also monitor the financial performance of the Cairns and Hinterland Hospital and Health Service.

Chief Executive
Ms Julie Hartley-Jones, CBE
RN, BSc (Hons), MBA

Adjunct Associate Professor, James Cook University

Ms Julie Hartley-Jones was appointed by the Board with an effective date of 1 July 2012, previously being the Chief Executive Officer of the then Cairns and Hinterland Health Service District since 2009.

Julie was the Director of Nursing and Midwifery and then Director of Clinical Operations for the Northern Sydney Central Coast Area Health Service in New South Wales from 2006-2009.

Prior to arriving in Australia Julie held a number of senior nursing and management positions in England, the most recent being Chief Nurse of the Oxford Radcliffe Hospitals National Health Service Trust between May 2001 and August 2006. Julie also spent two years in the UK Department of Health as Policy Advisor in Acute and Specialist services between 1999 and 2001.

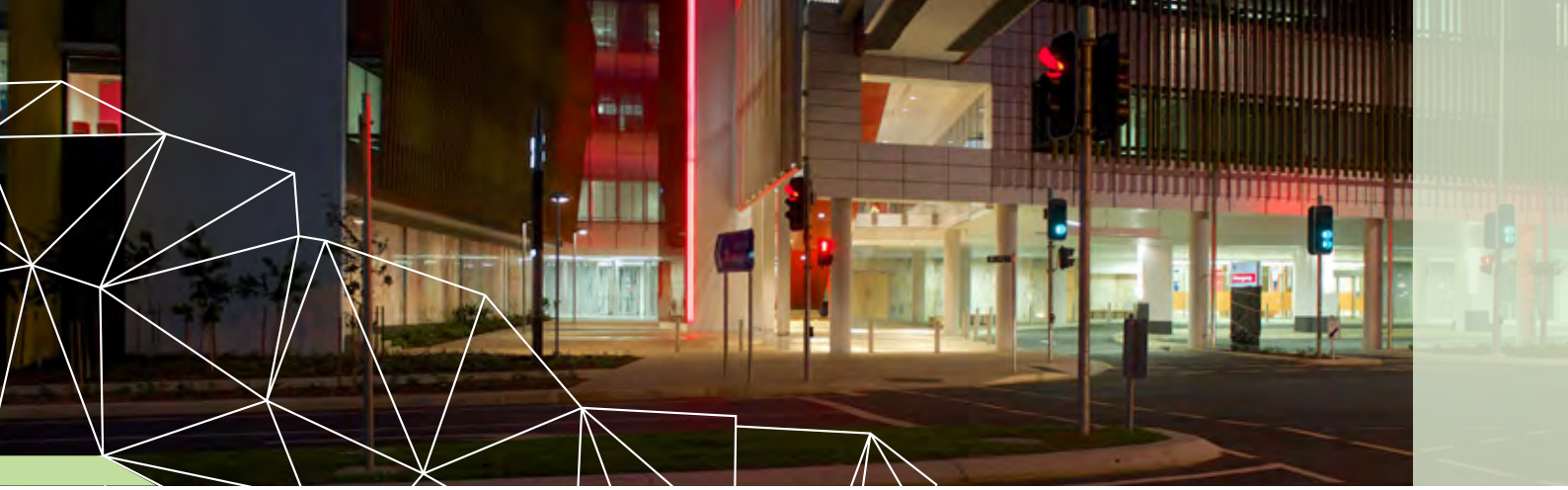
Julie holds a four year appointment to the Expert Panel which provides advice to the Commonwealth Government on the National Partnership Agreement targets.

Julie holds a Board appointment to the Far North Queensland Hospital Foundation and is on the Advisory Board to The Australian Institute of Tropical Health Medicine and the Salvation Army Advisory Board, Australian Eastern Territory.

Chief Finance Officer
Mr John Slaven B. Commerce

Member of Institute of Chartered Accountants of Australia

Mr John Slaven has been the Chief Finance Officer of the Cairns and Hinterland Hospital and Health Service for the past 5 years. John commenced his career with 12 years working for PricewaterhouseCoopers, employed in business services, taxation, audit and management accounting. From 1993, John was employed in a range of senior financial management roles in manufacturing, aged care and telecommunications sectors.



Chief Operating Officer
Mr Robin Moore Ba Nsg. FGLF

Mr Robin Moore was appointed as the Chief Operating Officer in March 2013.

Previously, Robin was the Director of Operations at Flinders Medical Centre within the Southern Adelaide Health Service. Robin comes from a nursing background and has extensive experience in tertiary, acute, primary, population and mental health services.

Robin has a Bachelor of Nursing from Flinders University and is a fellow of the Graduate Leadership Foundation. He is also undertaking a Masters of Primary Health Care and International Development from Flinders University.

Executive Director People and Culture
Ms Caroline Wagner B.A. Comms, Grad Dip. Psych

Ms Caroline Wagner has been Executive Director of People and Culture since January 2010.

Previously, Caroline worked both internationally and in Australia for General Motors for 15 years in a number of Human Resources roles. Caroline started her career with General Motors working in its European Headquarters based in Zurich, Switzerland, before going on to complete assignments in Japan, India and Thailand before returning to Melbourne.

Caroline holds a Bachelor of Communication and is currently studying for a Graduate Diploma in Psychology with Monash University.

Executive Director Strategy, Planning, Performance, Aboriginal and Torres Strait Islander Health

Mr Brad McCulloch BSc, GPCompSci, MPH, JP(Qual)

Mr Brad McCulloch was appointed as the Executive Director for Strategy, Planning, Performance and Aboriginal and Torres Strait Islander Health in September 2013.

Before the establishment of Hospital and Health Services, Brad was the Senior Director for Tropical Regional Services, delivering Public Health Services for the northern half of Queensland. Prior to this, Brad was the Manager for Quality, Safety and Clinical Networks in the Northern Area Health Service.

Brad has a Bachelor of Science with majors in Chemistry and Biochemistry, a Graduate Diploma in Computer Science and a Masters of Public Health.

Executive Director Medical Services
Dr Neil Beaton MBBS MRCGP FACRRM DA

Associate Professor Rural Medicine, James Cook University School of Medicine

Dr Neil Beaton was appointed to the Executive Director of Medical Services position in August 2010. Neil has extensive experience as an advanced practice rural generalist in North Queensland and as a former rural medical superintendent. Neil has held previous appointments in general practice education, Indigenous health and primary medical care service development.

A/Executive Director Nursing and Midwifery
Ms Jocelyn Rogers BHSc, MPH

Adjunct Associate Professor (Professional) School of Nursing Midwifery and Nutrition James Cook University

Ms Jocelyn Rogers commenced acting as the Executive Director of Nursing and Midwifery in May 2010.

Prior to this Jocelyn was acting as the Service Manager of Perioperative and Critical Care Services for the District. Substantively, Jocelyn is the Nursing Director of Critical Care and Peri-Operative Services at Cairns Hospital. She has held this senior nursing position since 1996.

Jocelyn has worked in both the public and private health sectors as a nurse for 39 years, spanning roles in various clinical environments, undergraduate teaching, health management and health leadership roles.

Jocelyn holds a Bachelor of Health Science and a Master of Public Health with a dual major in Health Service Management and Policy Sciences.

Executive Director of Nursing and Midwifery - Informatics
Ms Glynda Summers

Adjunct Associate Professor, School of Nursing Midwifery and Nutrition, James Cook University

Ms Glynda Summers commenced in the role of Executive Director of Nursing and Midwifery in February 2003 and in May 2010 was requested to be the Clinical Advisor for the eHealth Statewide program and Clinical Lead for Release One of the ieMR. Cairns Hospital was the first site to 'Go Live' in December 2013, Glynda has subsequently returned to her position within the Hospital and Health Service.

Prior to her role in Cairns, Glynda was the Executive Director of Nursing for Redcliffe- Caboolture District and has gained diverse experience over 44 years including: corporate office, rural, remote, regional and metropolitan in Australia and overseas.

Glynda holds a Master of Health Administration, Master of Public Policy, Bachelor of Arts, Diploma of Administration (nursing) and is also a JP (Qual). Glynda is a Director on the Board of Australasian College of Health Service Management (ACHSM), and Senior Vice President of the Queensland Branch of the ACHSM, as well as a member of the governing Queensland Branch of the Health Informatics Society of Australia.

Executive Director Allied Health
Dr Donna Goodman B.Psych (Hons), Ph.D., MAPS

Dr Donna Goodman commenced acting in the role of Executive Director Allied Health in July 2011 and was permanently appointed to the position in June 2013.

Prior to this, she held the position of Director of Psychology for the Cairns and Hinterland Hospital and Health Service. Donna is a registered Psychologist who spent 14 years working in both public and private sector health settings in clinical, management and research roles.

Donna is a Member of the Australian Psychological Society, holds a Specialist endorsement with the Australian Psychological Society College of Health Psychologists and is currently completing a Masters in Clinical Psychology with James Cook University.

The Clinical Council

Clinical Council Chair
Dr Jenny Sando RN RM PhD MRCNA

Adjunct Senior Lecturer School of Nursing, Midwifery & Nutrition James Cook University

The Cairns and Hinterland Hospital and Health Service Clinical Council was established in 2012 to represent the views of the clinicians with regards to strategic planning and service delivery.

Following a period of formation, the Clinical Council has now becoming a recognised point of contact for clinicians within our Service and issues are being formally addressed and referred to Executive Management Team and/or the Board as relevant. The Clinical Council operates according to the Clinical Council Charter which was endorsed on 27 July 2012.

The Chair of the Clinical Council sits on the Executive Management Team as the representative of Council and provides regular reports on Council activities. The Chair also has an open invitation to the Cairns and Hinterland Hospital and Health Board and provides clinical advice to the Board.

Council agreed to include an additional professional position for Oral Health/Dentistry to acknowledge the importance of this area within the Cairns and Hinterland Hospital and Health Service.

Highlights of the Clinical Council for 2013-14 include:

- Development of robust Terms of Reference and a Clinical Council Charter, dedicated webpage and Clinical Council column in the Cairns and Hinterland Hospital and Health Service's monthly newsletter, Health Up North;
- Recruitment of a diverse representative group of clinicians from the Public Sector, Academic partners, General Practice and Medicare Local representatives;
- Development of the Cairns and Hinterland Hospital and Health Service Clinician Engagement Strategy,
- Continued development of the Communication Strategy for Clinicians;
- Provision of clinical advice and opinion to the Executive Management Team on clinical issues.

Our people

We have been focused on building and rebuilding our current workforce this financial year. We continue to focus on deploying the right people to the right service at the right place at the right time.

The Cairns and Hinterland Hospital and Health Service continues to be the largest employer in the Far North with nearly 5000 full-time, part-time and casual employees delivering services across the health service. Our clinical and non-clinical staff work within a matrix structure across six multi-disciplinary operational divisions within the health service.

This year, we had a focus on making sure that our people have the rights skills and the right attitude to deliver the best possible health service to our community. A key challenge in ensuring we have the right people and skills for the future is addressing the risks associated with an ageing workforce. 64 per cent of our workforce is aged over 40 and we expect the currently high retention rate within our organisation of 92 per cent to be affected in future years as our older employees decide to retire.

The focus on right people, right service, right place, and right time' has been actioned through the development and implementation of our Strategic Workforce Plan.

CHHHS Workforce Profile

47% Nursing and Midwifery
9% Medical
34% Non Clinical (op svcs, admin etc)
10% Health Practitioners

CHHHS Staff Age and Gender Profile

1% Female 0-19
0% Male 0-19
26% Female 20-39
9% Male 20-39
43% Female 40-59
11% Male 40-59
8% Female 60-79
2% Male 60-79

The Strategic Workforce Plan 2014 - 2019 is structured around six key strategies:

- Develop workforce planning capability and practice;
- Diversity;
- Succession planning and knowledge transfer;
- Develop valued partnerships;
- Leadership; and
- Cultural Renewal.

We have been busily building the foundations to embed our strategic workforce plan in the coming years. Key areas of focus have been the introduction of the Queensland Public Sector values, succession planning through the development of a critical roles register, and adopting the Health Workforce Australia leadership (LEADS) model as the leadership framework for our Hospital and Health service.

Organisation Development Framework

In 2013-14 we considered and committed to the Queensland Public Sector values:

Customer first

This is demonstrated by knowing our customers, delivering what matters, and making decisions with empathy. Examples of how our staff have demonstrated these values include changing and adding services to meet the changing demands of the community, and reducing our surgical long wait list from 769 in September 2013 to zero by 30 June 2014.

Ideas into action

This is demonstrated by challenging the norm and suggesting solutions, encouraging and embracing new ideas, and working across boundaries. Examples of how our staff have demonstrated these values include starting the introduction of the integrated electronic medical record, our continued support to deliver outreach support in neighbouring health services and our new fresh and healthy menu plan.

Unleash potential

This is demonstrated by expecting greatness, leading and setting clear expectations, and seeking, providing and acting on feedback. Examples of how our staff have demonstrated these values include the introduction of a new senior leadership 360 instrument

based on the LEADs leadership framework and the continued rollout of the performance and development process for all staff.

Be courageous

This is demonstrated by owning our actions, successes and mistakes, taking calculated risks, and acting with transparency. Examples of how our staff have demonstrated this value includes their successful response to managing multiple natural disasters, and taking on extremely challenging stretch targets such as the NEST Project.

Empower people

This is demonstrated by leading, empowering and trusting, playing to everyone's strengths, and developing oneself and others. Examples of how our staff have demonstrated these values include participation of our staff in leadership development programs, professional development and ongoing management and employee development initiatives.

Our employee recognition program is now recognising staff's behaviour and performance in regard to the new values.

New staff orientation and induction

We commit to a personalised approach when inducting our new employees and provide them with all the information necessary to engage and assist them in building a successful career in their new role.

The Chief Executive and other members of the Executive team welcomes all new employees by attending our Hospital and Health Service wide generic orientation at the Cairns Hospital on a monthly basis.

Mandatory training

In order to meet legislative and compliance obligations, our employees are strongly encouraged and supported to participate in mandatory training which including: induction, orientation, key health and safety programs, driver Safety, Code of Conduct, ethics, Cultural Practice Program and fire safety training.

To increase efficiency, consistency and availability, online learning options for mandatory subjects have been developed and are available to all employees.

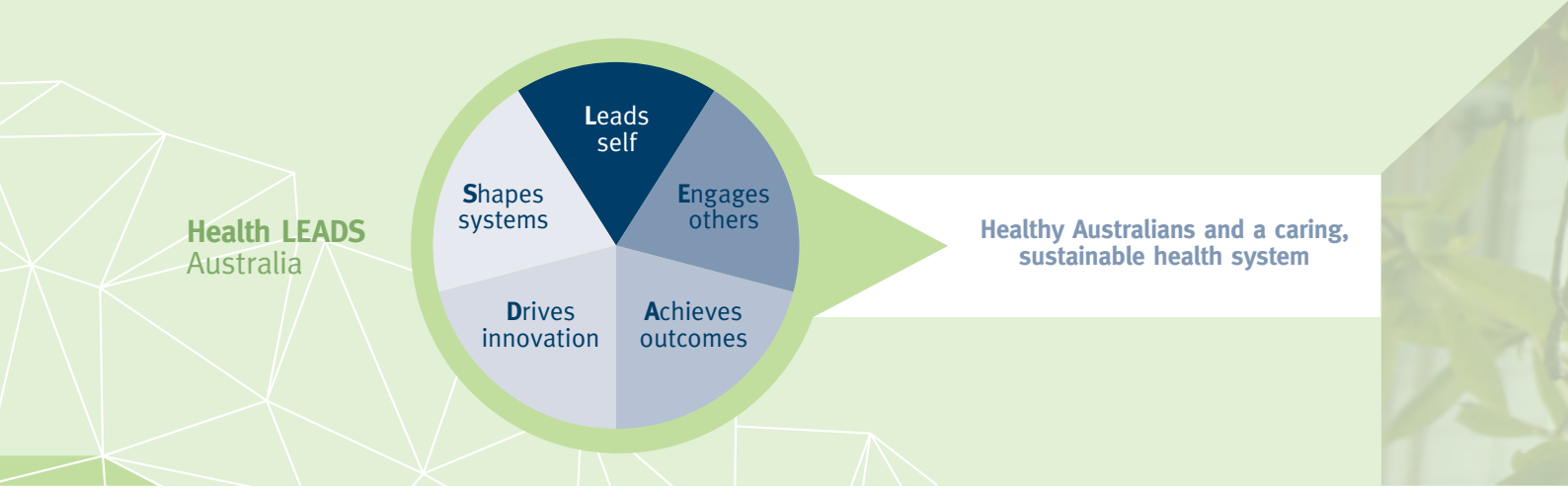
Talent Management and Recognition

We commit to attracting and retaining highly competent, innovative and successful people with the right skills and the right attitude. We present our employees with on-the-job assignments and opportunities, and foster career progression and development professional, management, and leadership opportunities, as well as structured team development activities.

An Environmental Scan was conducted to showcase our employee talent and the recognition they have achieved in local, state, national and international fields. This document includes all facets of our organisation such as clinical work and education and research activities, as well as organisational, people, and performance achievements.

Leadership and Management

We continue to build on our existing leadership and management strengths by participating in the Department of Health leadership programs such as the Emerging Clinical Leaders course, Medical Leaders into Action course, as well as the development and delivery of locally designed leadership and management programs aligned to the LEADS framework.



LEADS framework

The Health Workforce Australia LEADS framework is designed around five areas of focus: Leads self, Engages others, Achieves outcomes, Drives innovation, and Shape systems. (L-E-A-D-S). Leadership requires reflection and improvement of self (Leads self), fostering growth in and influencing others (Engages others), and communicating a vision for the future and enabling decisions to align with the goals of the organisation (Achieves outcomes).

We cultivate our leaders, to embrace the spirit of change and innovation and strategically understand and align complex systems with the goals to achieve outcomes.

Leaders in the health industry need knowledge and skills relating to all five areas of LEADS to be successful in generating and sustaining improvement within the Health Service.

Local Program

Responding to the needs of our managers, our Learning and Development team have developed an action learning, blended training program to support the LEADS competencies. The People and Performance Pulse (PPP) program provides managers with the personal insight, skills and knowledge they need to successfully lead individuals and teams.

It explores the nature of team effectiveness and how they can positively motivate, coach and performance manage their team. Delivered over 5 modules, each of the modules encompasses pre work, learning new knowledge and an action plan.

Employee Performance and Development (PaD) reviews

The Performance and Development Agreement process assists our managers, team leaders and employees to have meaningful and productive performance and development discussions.

We encourage active participation and investment of time by all of our employees in the performance management process to build better and more productive working relationships. Further, managers, team leaders and employees are supported to regularly engage in performance and development conversations outside of these formal PaD meetings, so that performance or behavioural concerns can be discussed if and when they occur.

Flexible working arrangements

We are committed to the provision of flexible work arrangements such as part-time work and job sharing. Information in regard to our flexible work practices are communicated to employees within the initial vacancy advertising package, during orientation and induction processes. This is also supported by direct enquires from individuals to line managers and the human resource department.

Flexible work practices are addressed on a case by case basis taking in to account the requirements of the staff member balanced against the operational service delivery needs of the health service.

Industrial and employee relations framework

Our industrial and employee relations are conducted under the provision of the Service Agreement with the Department of Health.

Employment terms and conditions are in accordance with the relevant industrial awards and agreements. Grievances and disputes are managed in accordance with the Award grievance resolutions provisions and the Cairns and Hinterland Hospital and Health Service Human Resources Policies.

We are steadfast in our commitment to meet the requirements of relevant industrial awards and are cognisant of the benefits of maintaining a robust relationship with key stakeholder groups. To achieve this, we conducted the following regular consultative forums in 2013-14: Health Service Consultative Forum, Local Consultative Forums, Medical Consultative Forum, Nursing and Midwifery Consultative Forum and Redevelopment Consultative Forum.

Senior Medical Officers and Visiting Medical Officers will transition on to new high income contracts on August 4, 2014. To support the implementation of these new arrangements, the Medical Contracts Advisory Committee was formed in May 2014 to provide advice to the Chief Executive. This Committee is chaired by the President of the Senior Medical Staff Association, Dr Roxanne Wu and membership consists of Senior Medical Officers, Senior Medical Staff Association members, Union representation and Senior Management representation.

Education and training

Our Education and Learning and Development departments have been evolving as we continue to foster and develop learning support that fits the requirements of knowledge workers – that is, embedded in day-to-day activity, supporting development of professional networks and ultimately ensuring that the business has the knowledge and skills to deliver on our Strategic Plan.

Learning and Development as a function is responding to the needs of our organisation by expanding the learning offerings available to our employees, having an increased focused on online learning, encouraging and supporting collaborative learning, and using micro-modules to provide a more focused learning experience.

There are currently a number of Queensland Health Programs available to our employees:

- Leadership Development Program
- Management Development Program
- Administration Professional Program
- Operational Officers Program
- Human Error and Patient Safety Program

Financial support for professional development is accessible for targeted employees through the following avenues;

- Administration Professional Program
- Operational Officers Program

Professional development support such as finance and leave is available to all of our employees through the Study and Research Assistance Scheme. This scheme is designed to assist our employees to participate in further education, with the intention of improving their capability in a wide range of disciplines and study areas.

Nurse education

The Cairns and Hinterland Hospital and Health Service Nurse Education & Research Unit (NERU) comprises 17 Nurse Educator positions and the Nursing Director Education/Research. Our NERU team works collaboratively in consultation with service delivery teams and the Nursing Executive.

Whilst much of the education service delivery is focused on clinical practice areas, the team is also responsible for delivering a number of generically focused programs including: orientation, preceptor training and mandatory competency workshops. One portfolio is specifically focused on the management of clinical placements for undergraduate nursing students and TAFE nursing students across the Cairns and Hinterland Hospital and Health Service.

Student Support

Students increasingly contribute to our workforce and our NERU team facilitate the learning pathways within a variety of programs, including:

- Graduate support programs
- Undergraduate nursing programs
- Postgraduate nursing programs
- TAFE Enrolled Nursing Diploma programs
- Work experience programs for school students

Allied Health

In 2013-14 we re-established our Clinical Educators Network for Allied Health and preparations have commenced to develop an Allied Health Education Sub-Plan, which will form part of our Education and Research Strategic Framework.

Other achievements for Allied Health education and training include:

- Successful completion of the SPEED Project, which investigated the education and training requirements for an Advanced Physiotherapist to gain endorsement to practice within an Extended Scope of Practice in the Emergency Department;
- Introduction of clinical placements for Anaesthetic Technicians from Southbank TAFE

Staff Reward and Recognition

In 2013-2014 we saw the addition of five new categories to the Patsy Bjerregaard Award for Clinical Excellence in Allied Health, including Early Career, Research, Rural and Remote Practitioner, Innovation and Supervision/Training Awards.

This year also saw the introduction of Staff Recognition BBQs across the health service facilities, where the Executive and Divisional Directors visit a facility each month to thank our employees for their commitment to excellent patient care.

These informal events present an ideal opportunity for Executives to get to know individual staff members and to learn first-hand about the great patient centred work they are delivering.

Occupational Health and Safety

In January 2014, the Cairns and Hinterland Hospital and Health Service was audited by Deloitte Touche Tohmatsu by an internal audit process to assess whether we had implemented the Queensland Health Occupational Health and Safety Management System in accordance with the standards AS/NZS4801:2001 and the prescribed Queensland Government "Whole of Government elements". The Health Service did not receive any non-conformance ratings against 25 audit criteria and received an overall rating of 84%.

Minimum Obligatory Human Resource Information

Minimum Obligatory Human Resource Information (MOHRI) is a Whole of Government methodology for producing Occupied Full Time Equivalent (FTE). As at 30 June 2014, the Cairns and Hinterland Hospital and Health Service MOHRI occupied FTE was 4047.86.

Early retirement, redundancy and retrenchment

Due to some small departmental restructures, 55 employees received redundancy packages in 2013-14, at a total cost of $2,593,495.44. During the 2013-2014 period, no employees were provided with retrenchment packages.

Our partners

We foster partnerships within the community to develop valuable connections, build trust and to raise awareness.

We have collaborated with a range of partners and stakeholders within our community. The resolute support of these stakeholders, auxiliaries, volunteers and community groups, many not mentioned in this Annual Report, allow us to continue to provide excellent care for our community.

We recognise all of the organisations with whom we have ongoing, productive, collaborative relationships with, as well as the leadership team of the Department of Health. We also thank the Minister for Health; the Honourable Lawrence Springborg MP, the Queensland Government, and the Federal Government for their support.

Far North Queensland Hospital Foundation

The Cairns and Hinterland Hospital and Health Service continue to be grateful to the Board, staff and volunteers of the Far North Queensland Hospital Foundation, a charitable organisation that endeavours to assist the activities and services of the Cairns Hospital and our regional facilities.

Fundraising

The Foundation raised the sum of $1.295 million (revenue before direct costs) in 2013-14. The Foundation's biggest annual fundraiser, the Cardiac Challenge bike ride from Cairns to Cooktown, attracted a record 352 riders, who set a new fundraising record for the event, $374,000.

Friends of the Foundation

The Foundation also benefits from the tireless efforts of regionally-based, and focused fundraising volunteers, known as Friends of the Foundation (FOF). FOF groups based at Innisfail, Cooktown, Mareeba, Gordonvale and Cow Bay have collectively raised more than $181,000.

Funding achievements

The Foundation spent a total of $902,000 on the purchase of up-to-date health care equipment, training and research for health care professionals, both targeted to address important health issues in this region.

The Foundation's major purchases for the year were; a $100,000 STORZ navigation system to aid ear, nose and throat surgeries at Cairns Hospital, a $78,000 point of care ultrasound tool for the Cairns Hospital Cardiology Unit, $68,000 of cardiac monitoring equipment for the East Ward at Mareeba Hospital, 3 VersaCare and 2 CareAssist beds at a cost of $47,000 for the Oncology Unit at Cairns Hospital and 2 dialysis machines for the Cooktown Renal Service at a cost of $31,000.

Twelve health care professionals engaged in research on health issues particularly relevant to Far North Queensland also shared the benefit of around $33,000 in Foundation grants.

Volunteer services

Foundation volunteers are the quiet achievers and many people are unaware of the sheer volume and scale of their efforts to maintain and improve health care services in this region.

Last year, around 140 Foundation volunteers contributed more than 23,506 hours of unpaid labour to the Cairns Hospital. Hundreds more Foundation volunteers leant their support to fundraising events during the year, devoting a total of around 6,972 hours.

Queensland Police Service

We have continued to build a strong relationship with the Queensland Police Service (QPS) for both operational and strategic planning in the area of disaster management and other ongoing projects and operations. The QPS works closely with network agencies in an effort to minimise alcohol fuelled violence and injuries which subsequently impact on hospital Emergency Departments. Other projects include the Mental Health Co-Responder Team in which Police and Queensland Health work together to ensure people with mental illness receive the appropriate support and assistance from all Government and Non-Government organisations.

COUCH

Stage 1 of the $5 million COUCH Cancer Health and Wellness Centre in Manoora is complete and construction will commence in 2015. COUCH has been pleased to receive input and support from the Cairns and Hinterland Hospital and Health Service on the on-going planning of this project. The Cancer Health and Wellness Centre will include facilities for respite and a range of complementary therapies providing a holistic approach to cancer treatment, which will work in tandem with the patient's clinical therapies.

The COUCH cancer shuttle, which has been supplied by COUCH, is in ongoing use by the Cairns Hospital to connect to the Liz Plummer Cancer Care Centre.

Cairns Safer Streets Taskforce (CSST)

The Cairns Safer Streets Task Force is dedicated to developing and implementing an overarching strategy for addressing crime issues on the ground in Cairns. The task force is responsible for addressing immediate concerns such as juvenile offending, accessibility of alcohol, homelessness, Indigenous offending and victimisation, community resistance and resilience building and interagency coordination.

The Cairns Safer Streets Task Force has a diverse range of stakeholders, and the Cairns and Hinterland Hospital and Health Service is pleased to represent health at this important forum. Together with Torres and Cape York Hospital and Health Service, we jointly fund a Liaison Officer to develop and implement collaborative, targeted and effective responses to crime and homelessness in Cairns.

James Cook University

Students from James Cook University's (JCU) disciplines of medicine, nursing, dentistry, allied health psychology and social work complete clinical placements within the Cairns and Hinterland Hospital and Health Service each year.

In 2013, 555 James Cook University medical students across years 1 to 6 undertook placements in Cairns and Hinterland Hospital and Health Service facilities, including 212 at Cairns Hospital. Eight dentistry students completed placements at Cairns North Community Health Facility, and a further four at Mareeba Hospital.

Over the financial year 41 physiotherapy students undertook placements at Cairns Hospital, five at Cairns Community Health Cardio Vascular and Pulmonary Education Rehabilitation & Self Management (CAPERS), two at Innisfail Hospital and four at Tully Hospital.

More than 80 occupational therapy students were placed in Cairns and Hinterland Hospital and Health Service facilities across the region in 2013, including 37 at Cairns Hospital.

568 JCU nursing students completed placements at Cairns Hospital in 2013 and about 190 nursing students completed placements at other Cairns and Hinterland Hospital and Health Service facilities across the region.

Nine speech pathology students completed placements at Cairns and Hinterland Hospital and Health facilities in the same year. Two psychology students and six social work students undertook placement at the Cairns Hospital.

Simulation facilities play an important role in teaching nursing and medical students. With funding from a QH-HWA SLE project, a simulation coordinator has been employed to work between Cairns Hospital and James Cook University.

A number of infrastructure developments in the region are enhancing clinical placement capacity. Block A in Cairns Hospital was rebuilt in 2013 to provide expanded placement capacity for JCU medical students. At JCU in Cairns, redevelopment of laboratories has strengthened clinical placement preparation capacity for nursing and medical students, and has provided an emergency facility for community use in case of natural disasters. Outside of Cairns, dental chairs have been built at Mareeba and Tully to support the training needs of JCU dental students in the region.

The Joint Inter-professional Planning Committee for Education, Training and Research was established in 2013 to strengthen the positive relationships between key stakeholders involved in the education, clinical training and research in the region.

Red Cross

Red Cross has opened a new accommodation centre 'Pat Gosper Place' in Cairns, providing a welcome home away from home for people from some of the most remote parts of the state who are receiving medical treatment in Cairns.

The $7 million centre offers quality, affordable accommodation in an inclusive, healing and culturally appropriate environment. The centre with 44 ensuite double rooms provides accommodation for 88 people at no cost if they are eligible for the Queensland Government Patient Travel Subsidy Scheme. Construction of Pat Gosper Place has been funded by Queensland Health ($5 million) and the Australian Government's Health and Hospitals Fund ($1.9 million).

Cairns and Hinterland Hospital and Health Service
Financial statements 2013-2014

Contents

General Information

These financial statements cover the Cairns and Hinterland Hospital and Health Service as an individual entity.

The Cairns and Hinterland Hospital and Health Service (HHS) is controlled by the State of Queensland which is the ultimate parent.

The head office and principal place of business of the HHS is:

Cairns Hospital
165 - 171 The Esplanade
Cairns QLD 4870

A description of the nature of the HHS operations and its principal activities is included in the notes to the financial statements.

For information in relation to the HHS financial statements, email Jodie-Lee.Johnson@health.qld.gov.au or visit the website at www.health.qld.gov.au/cairns_hinterland/.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Statement of Comprehensive Income for the year ended 30 June 2014

	Note	2014 $'000	2013 $'000
Income			
User charges and fees	4	619,286	595,985
Grants and other contributions	5	20,441	18,007
Interest		138	55
Other revenue	6	16,886	12,940
Total revenue		656,751	626,987
Gains on disposal / remeasurement of assets	7	-	63
Total income		656,751	627,050
Expenses			
Employee expenses	8	1,604	946
Health service employee expenses	9	458,735	441,624
Supplies and services	10	162,800	145,116
Grants and subsidies	11	665	1,654
Depreciation and amortisation	12	21,587	20,120
Impairment losses	13	1,868	3,862
Revaluation decrement	14	-	159
Other expenses	15	9,606	8,203
Total expenses		656,865	621,684
Operating result for the year		(114)	5,366
Other comprehensive income			
Items that will not be reclassified subsequently to operating result			
Increase in asset revaluation surplus	25	2,732	18,378
Total other comprehensive income		2,732	18,378
Total comprehensive income		2,618	23,744

The accompanying notes form part of these statements.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Statement of Financial Position as at 30 June 2014

	Note	2014 $'000	2013 $'000
Current assets			
Cash and cash equivalents	16	35,956	17,980
Receivables	17	18,675	21,617
Inventories	18	3,850	3,339
Other current assets	19	24	390
Total current assets		58,505	43,326
Non-current assets			
Intangible assets	20	408	147
Property, plant and equipment	21	596,756	331,609
Total non-current assets		597,164	331,756
Total assets		655,669	375,082
Current liabilities			
Payables	22	51,731	36,720
Accrued employee benefits	23	63	39
Unearned revenue	24	2,175	153
Total current liabilities		53,969	36,912
Total liabilities		53,969	36,912
Net assets		601,700	338,170
Equity			
Contributed equity		575,338	314,426
Accumulated surplus		5,252	5,366
Asset revaluation surplus	25	21,110	18,378
Total equity		601,700	338,170

The accompanying notes form part of these statements.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Statement of Changes in Equity for the year ended 30 June 2014

	Accumulated surplus / (deficit)	Asset revaluation surplus (Note 25)	Contributed equity	Total equity
	$'000	$'000	$'000	$'000
Balance as at 1 July 2012	-	-	-	-
Operating result from continuing operations	5,366	-	-	5,366
Other comprehensive income:				
Increase in asset revaluation surplus	-	18,378	-	18,378
Total comprehensive income for the year	5,366	18,378	-	23,744
Transactions with owners as owners:				
Net assets received (transferred under Administrative Arrangement at 1 July 2012) Note 3	-	-	305,469	305,469
Non appropriated equity injections (Minor capital works) Note 3	-	-	29,541	29,541
Non appropriated equity withdrawals (Depreciation funding) Note 3	-	-	(20,584)	(20,584)
Net transactions with owners as owners	-	-	314,426	314,426
Balance as at 30 June 2013	5,366	18,378	314,426	338,170
Balance as at 1 July 2013	5,366	18,378	314,429	338,170
Operating result from continuing operations	(114)	-	-	(114)
Other comprehensive income:				
Increase in asset revaluation surplus	-	2,732	-	2,732
Total comprehensive income for the year	(114)	2,732	-	2,618
Transactions with owners as owners:				
Non appropriated equity asset transfers	-	-	272,169	272,169
Non appropriated equity injections (Minor capital works) Note 3	-	-	10,303	10,303
Non appropriated equity withdrawals (Depreciation funding) Note 3	-	-	(21,560)	(21,560)
Net transactions with owners as owners	-	-	260,912	260,912
Balance as at 30 June 2014	5,252	21,110	575,338	601,700

The accompanying notes form part of these statements.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Statement of Cash Flows as at 30 June 2014

	Note	2014 $'000	2013 $'000
Cash flows from operating activities			
Inflows:			
User charges and fees		601,536	565,837
Grants and other contributions		19,880	17,399
Interest receipts		138	55
GST input tax credits from Australian Tax Office		10,176	6,370
GST collected from customers		641	413
Other receipts		16,887	12,939
		649,258	603,013
Outflows:			
Employee expenses		(1,581)	(907)
Health service employee expenses		(452,887)	(427,663)
Supplies and services		(154,187)	(140,959)
Grants and subsidies		(665)	(1,654)
GST paid to suppliers		(10,646)	(7,803)
GST remitted to Australian Tax Office		(637)	-
Other		(9,219)	(7,936)
		(699,822)	(586,922)
Net cash provided by (used in) operating activities	26	19,436	16,091
Cash flows from investing activities			
Inflows:			
Sales of property, plant and equipment		-	100
Outflows:			
Payments for property, plant and equipment		(11,763)	(7,959)
Net cash provided by (used in) investing activities		(11,763)	(7,859)
Cash flows from financing activities			
Inflows:			
Equity injections		10,303	9,748
Net cash provided by (used in) financing activities		10,303	9,748
Net increase in cash and cash equivalents		17,976	17,980
Cash and cash equivalents at the beginning of the financial year		17,980	-
Cash and cash equivalents at the end of the financial year	16	35,956	17,980

The accompanying notes form part of these statements.

Notes to and Forming Part of the Financial Statements 2013-14

Index of Notes

1. Objectives and principal activities of the Hospital and Health Service

Cairns and Hinterland Hospital and Health Service (HHS) was established on 1 July 2012, as a not-for-profit statutory body under the *Hospital and Health Boards Act 2011* (refer Note 3). It is governed by a Hospital and Health Board that is accountable to the local community and the Queensland Minister for Health for its performance.

The HHS is responsible for providing primary health, community and public health services in the Cairns and Hinterland Health Service area under the *Hospital and Health Boards Regulation 2012*. The HHS covers an area of 141,000 square kilometres in Far North Queensland, and services a resident population of approximately 283,197 which is culturally diverse and dispersed over a wide geographical area.

This includes responsibility for direct management of the facilities within its geographical boundaries which include Atherton Hospital, Innisfail Hospital, Babinda Multipurpose Health Centre, Mareeba Hospital, Cairns Hospital, Mossman Multi-Purpose Health Service, Gordonvale Hospital, Tully Hospital and Herberton Hospital/Aged Care Unit. The HHS operates a number of Community Health Centres and Primary Health Care Centres.

The HHS strategic priorities for 2013-14 are:

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

These principal themes inform and guide the planning, coordination and delivery of services throughout the HHS.

Funding is obtained predominantly through the purchase of health services by the Department of Health on behalf of both the State and Australian Governments. In addition, health services are provided on a fee for service basis mainly for private patient care.

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

2. Summary of significant accounting policies

(a) Statement of compliance

The HHS has prepared these financial statements in compliance with section 43 of the *Financial and Performance Management Standard 2009*.

These financial statements are general purpose financial statements, and have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations. In addition, the financial statements comply with Queensland Treasury and Trade's *Minimum Reporting Requirements* for the year ending 30 June 2014, and other authoritative pronouncements.

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

(b) The reporting entity

The financial statements include the value of all income, expenses, assets, liabilities and equity of the HHS. The HHS does not have any controlled entities. The major activities of the HHS are disclosed in Note 3.

(c) Trust and agency transactions and balances

Patient fiduciary fund transactions

The HHS undertakes patient fiduciary fund account transactions as trustee. These funds are received and held on behalf of patients with the hospital having no discretion over the use of monies.

2. Summary of significant accounting policies (continued)

(c) Trust and agency transactions and balances (continued)

As such they are not part of the HHS assets recognised in the financial statements. Patient funds are not controlled by the HHS but trust activities are included in the annual audit performed by the Auditor-General of Queensland and disclosed in Note 31(a).

Agency transactions - Right of Private Practice (RoPP) scheme

Under the Australian Government's National Health Reform Agreement with the states and territories, patient choice is facilitated by the right of private practice (RoPP) scheme, which provides for senior medical officers (SMOs) who are employed in the public health system to also treat those patients who come into the public system and elect to be treated as private patients. The Queensland RoPP scheme was approved to capture privately insured patients receiving treatment as public patients in a cost neutral manner; and additionally to assist in the recruitment and retention of full time specialist staff in the public hospital system. Public patients were not to be affected adversely by the introduction of scheme options.

Under the scheme, SMOs receive a private practice allowance as well as a base salary. In exchange for being paid this allowance, these SMOs assign all the private practice revenue they generate to the hospital and health service facility where they are working. In turn, the hospital and health service fully absorbs the direct and indirect costs (facility, administrative and other overheads) associated with these services including, for example, the cost of billing and collection of revenue. This scheme is called Option A. It is also referred to as the 'assignment' model.

The other major scheme variant allows SMOs to retain a proportion of the private fees they earn, with the balance being paid into a trust account for the hospital and health service facility to apply to research by, and education of, all staff at the facility referred to as SERTA funds. The hospital and health service recovers a facility charge and administration fee from each participating SMO to defray the overhead costs of service provision. At 30 June, this scheme is called Option B. It is also referred to as the 'retention and revenue sharing' model.

The HHS acts in an agency role in respect of the transactions and balances of the Private Practice (RoPP) bank account. Transactions relating to Option B revenue are managed in an agency capacity, except for payments to the HHS for recoverable costs which are recognised as controlled revenue in the HHS accounts and payment of SERTA funds to the General Trust. At balance date any monies remaining in the RoPP bank account that represent the HHS revenue is accrued as revenue in the HHS accounts. As such, the right of private practice funds are not controlled by the HHS but the activities are included in the annual audit performed by the Auditor-General of Queensland and disclosed in Note 31(b).

(d) User charges and fees

User charges and fees primarily comprises Department of Health funding, hospital fees, reimbursement of pharmaceutical benefits and sales of goods and services. There has been a change in the recognition of Department of Health funding from grants and other contributions in 2012-13 to user charges and fees this year, refer Note 4 for details.

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

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

2. Summary of significant accounting policies (continued)

(d) User charges and fees (continued)

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

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

Hospital fees mainly consist of private patient hospital fees, interstate patient revenue and Department of Veterans' Affairs revenue. Interstate patient revenue and Department of Veterans' Affairs revenue are recognised as revenue in the year in which the HHS obtains control over the non-reciprocal funding. Allocated revenue is based on previous actual activity experienced by the HHS and future funding allocations are adjusted on an annual basis to reflect the updated activity levels.

(e) Grants and contributions

Grants, contributions, donations and gifts that are non-reciprocal in nature are recognised as revenue in the year in which the HHS obtains control over them. Where grants are received that are reciprocal in nature, revenue is progressively recognised as it is earned, according to the terms of the funding arrangements.

Contributed assets are recognised at their fair 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 an expense.

(f) Other revenue

Other revenue primarily reflects recoveries of payments for contracted staff from third parties such as universities and other government agencies and travel and inventory management services provided on behalf of other hospital and health services.

(g) Special payments

Special payments include ex gratia expenditure and other expenditure that the HHS is not contractually or legally obligated to make to other parties. In compliance with the *Financial and Performance Management Standard 2009*, the HHS maintains a register setting out details of all special payments exceeding $5,000. The total of all special payments (including those of $5,000 or less) is disclosed separately within Other expenses (Note 15). However, descriptions of the nature of special payments are only provided for special payments greater than $5,000.

(h) Cash and cash equivalents

For the purpose of the *Statement of Financial Position and the Statement of Cash Flows*, cash assets include all cash and cheques receipted but not banked as at 30 June as well as deposits at call with financial institutions. Refer to Note 30 for restricted assets.

In accordance with 31(2) of the Statutory Bodies Financial Arrangements Act 1982, the HHS obtained approval by Queensland Treasury and Trade for a bank overdraft facility on its main operating bank account. This arrangement is forming part of the whole-of–government banking arrangements with the Commonwealth Bank of Australia and allows the HHS access to the whole-of-government debit facility up to its approved limit. Refer to Note 32(d).

(i) Receivables

Trade debtors are recognised at the amounts due at the time of sale or service delivery. Trade receivables are generally settled within 120 days.

The collectability of receivables is assessed periodically with provision being made for impairment. All known bad debts are written off when identified. Increases in the allowance for impairment are based on loss events disclosed in Note 32(c).

(j) Inventories

Inventories consist mainly of medical supplies held for distribution in hospitals and are provided to

2. Summary of significant accounting policies (continued)

(j) Inventories (continued)

public admitted patients free of charge except for pharmaceuticals which are provided at a subsidised rate. Inventories are measured at weighted average cost, adjusted for obsolescence. These supplies are expensed once issued from the HHS.

(k) Non-current assets classified as held for sale

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

In accordance with AASB 5 *Non-current Assets Held for Sale and Discontinued Operations*, when an asset is classified as held for sale, its value is measured at the lower of the asset's carrying amount and fair value less costs to sell. Any restatement of the asset's value to fair value less costs to sell (in compliance with AASB 5) is a non-recurring valuation. Such assets are no longer amortised or depreciated upon being classified as held for sale.

Land and buildings under the operational control of the HHS were transferred from the Department of Health under a Deed of Lease. As the Department continues to be the registered owner, the HHS has a legal impediment to selling these assets. Where land and buildings are identified as held for sale by the HHS, the Deed of Lease is partially surrendered and the assets are returned to the Department for sale. The HHS, under the partial leasing arrangement is required to effectively maintain and operate these assets until their disposal.

(l) Acquisition of assets

Actual cost is used for the initial recording of all non-current physical and intangible asset acquisitions. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use, including architects' fees and engineering design fees.

However, any training costs are expensed as incurred. Items or components that form an integral part of an asset are recognised as a single (functional) asset.

Where assets are received free of charge from another Queensland Government entity (whether as a result of a machinery-of-government change or other involuntary transfer), the acquisition cost is recognised as the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation. Assets acquired at no cost or for nominal consideration, other than from an involuntary transfer from another Queensland Government entity, are recognised at their fair value at the date of acquisition in accordance with AASB 116 *Property, Plant and Equipment*.

(m) Property, plant and equipment

The HHS holds property, plant and equipment in order to meet its core objective of providing quality healthcare that Queenslanders value.

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

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

**Land improvements undertaken by the HHS are included with buildings.*

On 1 July 2012, the Minister for Health approved the transfer of land and buildings via a three year concurrent lease (representing its right to use the assets) to the hospital and health services from the Department of Health. AASB 17 *Leased Assets* is not applicable as under the terms of the lease no consideration in the form of a lease or residual payment by the hospital and health services is required therefore failing to meet the criteria in section 4 of this standard for recognition.

2. Summary of significant accounting policies (continued)

(m) Property, plant and equipment (continued)

While the Department of Health retains legal ownership, effective control of these assets was transferred to the HHS. Under the terms of the lease the HHS has full exposure to the risks and rewards of asset ownership.

The HHS has the full right of use, managerial control of land and building assets and is responsible for their maintenance. The Department of Health generates no economic benefits from these assets.

In accordance with the definition of control under Australian Accounting Standards, the HHS recognises the value of these assets in the Statement of Financial Position.

(n) Revaluations of non-current physical and intangible assets

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

In respect of the abovementioned asset classes, the cost of items acquired during the financial year has been judged by management to materially represent their fair value at the end of the reporting period.

Plant and equipment, is measured at cost in accordance with the Non-Current Asset Policies. The carrying amounts for plant and equipment at cost should not materially differ from their fair value.

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

In 2013-14 the HHS engaged the State Valuation Service to provide indices for all land holdings as at 30 June 2014. Indices are based on actual market movements for each local government area issued by the Valuer-General. An individual factor change per property has been developed from review of market transactions, having regard to the review of land values undertaken for each local government area. SVS provides assurance of the robustness of the indices, validity and appropriateness for application to the relevant asset.

Buildings are measured at fair value by applying either a revised estimate of the individual asset's depreciated replacement cost or interim indices which approximate movements in market prices for labour and other key resource inputs as well as changes in design standards at the reporting date. These estimates are developed by independent quantity surveyors.

In 2013-14, the HHS engaged Davis Langdon Australia Pty Ltd (Davis Langdon) to value the remaining approximately 33 per cent of the building portfolio not valued in the prior two years (by the HHS in 2012-13 or Department of Health in 2011-12). In addition assets previously revalued that had material additional works performed in the current financial year were also revalued in 2013-14.

Revaluations using independent professional valuers or independent expert appraisals are undertaken to achieve 80% coverage every three years. However, if a particular asset class experiences significant volatile changes in fair value, that class is subject to specific appraisal in the reporting period, where practicable, regardless of timing of the last specific appraisal.

The fair values reported by the HHS are based on appropriate valuation techniques that maximise the use of available and relevant observable inputs and minimise the use of unobservable inputs (refer Note 2(o)).

Where assets have not been specifically appraised in the reporting period, their previous revaluations are materially kept up-to-date via the application of relevant indices and /or assessment by Davis Langdon confirming their fair value at balance date.

2. Summary of significant accounting policies (continued)

(n) Revaluations of non-current physical and intangible assets (continued)

The HHS ensures that the application of such indices results in a valid estimation of the assets' fair values at reporting date.

Assets under construction are not revalued until they are ready for use. Construction of major health infrastructure is managed by the Department of Health. Upon practical completion of a project, assets under construction are assessed at fair value by the Department of Health through the engagement of an independent valuer prior to the transfer of those assets to the HHS, affected via an equity adjustment. Refer Note 21 for more details.

Reflecting the specialised nature of health service buildings and on hospital-site residential facilities, fairvalue is determined using depreciated replacement cost methodology, due to there not being an active market for such facilities. Depreciated replacement cost is determined as the replacement cost less the cost to bring an asset to current standards. The methodology applied by the valuer is a financial simulation in lieu of a market based measurement as these assets cannot be bought and sold on the open market.

In determining the replacement cost of each building, the estimated replacement cost of the asset, or the likely cost of construction including fees and on costs if tendered on the valuation date, is assessed. This is based on historical and current construction contracts. Assets are priced using Brisbane rates with published industry benchmark location indices. Revaluations are then compared and assessed against current construction contracts for reasonableness. The valuation assumes that a replacement building will replace the current function of the building with a building of the same form (size and shape) but built to meet current design standards. The key measurement quantities used in the determination of the replacement cost were:

- Asset type
- Gross floor area
- Number of floors
- Girth of the building
- Height of the building
- Numbers of lifts and staircases
- Location

Estimates of area were obtained by measuring floor areas from Project Services e-Plan room or drawings from the HHS. Refurbishment costs have been derived from specific projects and are therefore indicative of actual costs.

The 'cost to bring to current standards' is the estimated cost of refurbishing the asset to bring it to current standards and a new condition. This estimated cost is linked to the condition assessment rating of the building evaluated by the quantity surveyor during site inspection. The condition rating is also determined using asset condition data provided by the HHS, information from asset managers and previous reports and inspection photographs (where available) to show the change in condition over time.

The following table outlines the condition assessment rating applied to each building which assists the valuer in determining the current depreciated replacement cost.

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

2. Summary of significant accounting policies (continued)

(n) Revaluations of non-current physical and intangible assets (continued)

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

The standard life of a health facility is generally 30 to 40 years and is adjusted for those assets in extreme climatic conditions that have historically shorter lives.

Estimates of remaining life are based on the assumption that the asset remains in its current function and will be maintained. No allowance has been provided for significant refurbishment works in the estimate of remaining life as any refurbishment should extend the life of the asset. Buildings have been valued on the basis that there is no residual value.

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

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

(o) Fair value measurement

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

Observable inputs are publicly available data that are relevant to the characteristics of the assets being valued, and include, but are not limited to, published sales data for land and residential dwellings.

Unobservable inputs are data, assumptions and judgements that are not available publicly, but are relevant to the characteristics of the assets being valued. Significant unobservable inputs used by the HHS include, but are not limited to, subjective adjustments made to observable data to take account of the specialised nature of health service buildings and on hospital-site residential facilities, including historical and current construction contracts (and/or estimates of such costs), and assessments of physical condition and remaining useful life. Unobservable inputs are used to the extent that sufficient relevant and reliable observable inputs are not available for similar assets/liabilities.

A fair value measurement of a non-financial asset takes into account a market participant's ability to generate economic benefit by using the asset in its highest and best use or by selling it to another market participant that would use the asset in its highest and best use.

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

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

None of the HHS valuations of assets are eligible for categorisation into level 1 of the fair value hierarchy. As 2013-14 is the first year of application of AASB 13 by the HHS, there were no transfers of assets between fair value hierarchy levels during the period.

More specific fair value information about the HHS property, plant and equipment is outlined in Note 21.

2. Summary of significant accounting policies (continued)

(p) Intangibles

Intangible assets with a cost or other value equal to or greater than $100,000 are recognised in the statement of financial position. Items with a lesser value are expensed. Each intangible asset, less any anticipated residual value, is amortised over its estimated useful life to the HHS. The residual value is zero for all the HHS intangible assets.

It has been determined that there is not an active market for any of the HHS intangible assets. As such, the assets are recognised and carried at cost less accumulated amortisation and accumulated impairment losses.

No intangible assets have been classified as held for sale or form part of a disposal group held for sale.

Costs associated with the development of computer software have been capitalised and are amortised on a straight line basis over the period of expected benefit to the HHS.

The amortisation rates for the HHS software are between 10 per cent and 20 per cent. Expenditure on research activities relating to internally-generated intangible assets is recognised as an expense in the period in which it is incurred.

(q) Depreciation of property, plant and equipment

Land is not depreciated as it has an unlimited useful life.

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 HHS.

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

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.

In accordance with Queensland Treasury and Trade's *Non-current Asset Policy Guideline 2*, the HHS has determined material specialised health service buildings are complex in nature. The components should be separately depreciated if the overall depreciation effect of doing so would be material to the associated class of asset.

The HHS has assessed its material complex assets through testing a sample of buildings and applying different useful life scenarios to the various elements of each building. It was found that there was no material impact on the depreciation rate from this review and componentisation of buildings is not required.

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. Major spares purchased specifically for particular assets are capitalised and depreciated on the same basis as the asset to which they relate.

The depreciable amount of improvements to or on leasehold land is allocated progressively over the shorter of the estimated useful lives of the improvements or the unexpired period of the lease. The unexpired period of leases includes any option period where exercise of the option is probable.

The estimated useful lives of the assets are reviewed annually and where necessary, are adjusted to better reflect the pattern of consumption of the asset. In reviewing the useful life of each asset factors such as asset usage and the rate of technical obsolescence are considered.

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

2. Summary of significant accounting policies (continued)

(q) Depreciation of property, plant and equipment (continued)

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

(r) 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 HHS 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, in which case the impairment loss is offset against the asset revaluation surplus of the relevant class to the extent available.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of its recoverable amount, but so that the increased carrying amount does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset in prior years. A reversal of an impairment loss is recognised as income, unless the asset is carried at a revalued amount, in which case the reversal of the impairment loss is treated as a revaluation increase. Refer also Note 2(n).

(s) Leased property, plant and equipment

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

The HHS has no assets subject to finance lease. AASB 117 *Leased Assets* is not applicable to land and buildings, currently under a Deed of Lease with the Department of Health, as no consideration in the form of lease payments are required under the agreement.

Operating lease payments are representative of the pattern of benefits derived from the leased assets and are expensed in the periods in which they are incurred. Refer to Note 28(a).

(t) Payables

Trade creditors are recognised upon receipt of the goods or services ordered and are measured at the nominal amount i.e. agreed purchase/contract price, gross of applicable trade and other discounts. Amounts owing are unsecured and generally settled on 30 day terms.

(u) Financial instruments

Recognition

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

Classification

Financial instruments are classified and measured as follows:

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

The HHS does not enter into transactions for speculative purposes, nor for hedging. Apart from cash and cash equivalents, the HHS holds no financial assets classified at fair value through profit or loss. All other disclosures relating to the measurement and financial risk management of financial instruments held by the HHS are include in Note 32.

2. Summary of significant accounting policies (continued)

(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 counted in an employee's total remuneration package. They are not employee benefits and are not recognised separately as employee related expenses.

The HHS employment arrangements are in accordance with the *Hospital and Health Boards Act 2011* (HHBA). Part five of the HHBA outlines the conditions for the health service employees to continue to be employed by the Department of Health and health executives to be directly engaged by the hospital and health services. The information below outlines the terms relevant to these arrangements.

Health service employees

In accordance with HHBA section 67, the employees of the Department of Health are referred to as health service employees. Pursuant to section 80 of the HHBA they remain employees of the Department of Health and are taken to be employed by the HHS on the same terms, conditions and entitlements.

Under this arrangement:

- The health service employees remain as Department of Health employees.
- The HHS is responsible for the day to day management of these Department of Health employees.
- The HHS reimburses the Department of Health for the salaries, on-costs and other employee related expenses (payroll tax and workers' compensation premium) relating to these Department of Health employees. These reimbursements are shown under Note 9.

Health executives

Health executives are directly engaged in the service of the HHS in accordance with section 70 of the HHBA. The basis of employment for health executives is in accordance with section 74 of the HHBA.

The information detailed below relates specifically to these directly engaged employees only.

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 salary rates. As the HHS expects liabilities to be wholly settled within 12 months of reporting date, the liabilities are recognised at undiscounted amounts.

Prior 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.

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, commercial business units, shared service providers and selected not for profit statutory bodies. The HHS was admitted into this arrangement effective 1 July 2012. Under this scheme, a levy is made on the HHS 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. The Department of Health centrally manages the levy and reimbursement process on behalf of the HHS.

No provision for annual leave is recognised in the HHS financial statements as the liability is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting.*

2. Summary of significant accounting policies (continued)

(v) Employee benefits (continued)

Long service leave

Under the Queensland Government's Long Service Leave Scheme, a levy is made on the HHS to cover the cost of employees' long service leave. The levies are expensed in the period in which they are payable. Amounts paid to employees for long service leave are claimed from the scheme quarterly in arrears. The Department of Health centrally manages the levy and reimbursement process on behalf of the HHS.

No provision for long service leave is recognised in the HHS financial statements as the liability is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting.*

Rostered days off

No provision for rostered days off is recognised in the HHS financial statements as the liability is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 Whole of Government and General Government Sector Financial Reporting.

Superannuation

Employer superannuation contributions are paid to QSuper, the superannuation scheme for Queensland Government employees, at rates determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are paid or payable and the HHS obligation is limited to its contribution to QSuper.

The QSuper scheme has defined benefit and defined contribution categories. The liability for defined benefits is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 Whole of Government and General Government Sector Financial Reporting.

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

Key management personnel and remuneration

Key management personnel and remuneration disclosures are made in accordance with section 5 of the Financial Reporting Requirements for Queensland Government Agencies issued by Queensland Treasury and Trade. Refer to Note 33 for the disclosures on key executive management personnel and remuneration.

(w) Insurance

The HHS is covered by the Department of Health insurance policy with Queensland Government Insurance Fund (QGIF) and pays a fee to the Department of Health as a fee for service arrangement. Refer to Note 15.

QGIF covers property and general losses above a $10,000 threshold and health litigation payments above a $20,000 threshold and associated legal fees. Premiums are calculated by QGIF on a risk assessment basis.

(x) Services received free of charge or for nominal value

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

The HHS receives corporate services support from the Department of Health for no cost. Corporate services received include payroll services, accounts payable services, accounts receivable services, finance transactional services, taxation services, supply services and information technology services. As the fair value of these services is unable to be estimated

2. Summary of significant accounting policies (continued)

(x) Services received free of charge or for nominal value (continued)

reliably, no associated revenue and expense is recognised in the Statement of Comprehensive Income.

(y) 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.

Transactions with owners as owners include equity injections for non-current asset acquisitions and non-cash equity withdrawals to offset non-cash depreciation funding received under the Service Agreement with the Department of Health.

(z) Taxation

The HHS is a State body as defined under the *Income Tax Assessment Act 193*6 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 taxes accounted for by the HHS.

The Australian Taxation Office has recognised the Department of Health and the seventeen hospital and health services as a single taxation entity for reporting purposes. All FBT and GST reporting to the Commonwealth is managed centrally by the Department of Health, with payments/receipts made on behalf of the HHS reimbursed to/from the Department on a monthly basis. GST credits receivable from, and GST payable to the ATO, are recognised on this basis. Refer to Note 17.

(aa) Issuance of financial statements

The financial statements are authorised for issue by the Chairman of the HHS, the Chief Executive and the Chief Finance Officer at the date of signing the Management Certificate.

(ab) Accounting estimates and judgements

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

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

- Impairment of Receivables – Note 2(i) and Note 32(c);
- Valuation of Property, Plant and Equipment – Notes 2(n) - (o) and Note 21;
- Contingencies – Note 29; and
- Depreciation and Amortisation – Note 2(q) and Note 12

(ac) Rounding and comparatives

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

Comparative information has been restated where necessary to be consistent with disclosures in the current reporting period. In particular, the HHS has changed the classification of State Government funding received from the Department of Health

2. Summary of significant accounting policies (continued)

(ac) Rounding and comparatives (continued)

from 'Grants and contributions' to 'User charges' as outlined in Note 2(ad).

(ad) New and revised accounting standards

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

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

To align with this basis of funding provided by the Department of Health under a service agreement, the HHS now recognises the 2013-14 funding of $566.189 million as user charges and fees revenue for 2013-14 rather than as grants revenue which occurred in 2012-13. The main effect is that the revenue is now recognised under the criteria detailed in AASB 118 *Revenue* for 2013-14, rather than under AASB 1004 *Contributions* in 2012-13. The revenue recognition criteria is described in Notes 2(d) User charges and fees and Note 2(e) Grants and contributions.

This change in accounting policy has been applied retrospectively with the effect that grants and contributions revenue for 2012-13 has reduced by $554.46 million and user charges and fees revenue has increased by the same amount.

The only Australian Accounting Standard changes applicable for the first time as from 2013-14 that have had a significant impact on the HHS financial statements are those arising from AASB 13 *Fair Value Measurement*, as explained below.

AASB 13 *Fair Value Measurement* became effective from reporting periods beginning on or after 1 January 2013. AASB 13 sets out a new definition of 'fair value' as well as new principles to be applied when determining the fair value of assets and liabilities. The new requirements apply to all of the HHS assets that are measured and/or disclosed at fair value or another measurement based on fair value. The impact of AASB 13 relates to the fair value measurement methodologies used and financial statement disclosures made in respect of such assets.

The HHS reviewed its fair value methodologies (including instructions to valuers, data used and assumptions made) for land and buildings measured at fair value to assess whether those methodologies comply with AASB 13. To the extent that the methodologies didn't comply, changes were made and applied to the valuations. None of the changes to valuation methodologies resulted in material differences from the previous methodologies.

AASB 13 has required an increased amount of information to be disclosed in relation to fair value measurements for both assets and liabilities. For those fair value measurements of assets or liabilities that substantially are based on data that is not 'observable' (i.e. accessible outside the HHS), the amount of information disclosed has significantly increased. Note 2(o) explains some of the principles underpinning the additional fair value information disclosed. Most of this additional information is set out in Note 21 Property, plant and equipment.

A revised version of AASB 119 *Employee Benefits* became effective for reporting periods beginning on or after 1 January 2013 with the majority of changes to be applied retrospectively. Given the HHS circumstances, the only implications for the HHS were the revised concept of 'termination benefits' and the revised recognition criteria for termination benefit liabilities. If termination benefits meet the timeframe criterion for 'short-term employee benefits' they will be measured according to the AASB119 requirements for 'short-term employee benefits'. Otherwise,

2. Summary of significant accounting policies (continued)

(ad) New and revised accounting standards (continued)

termination benefits need to be measured according to the AASB 119 requirements for 'other long-term employee benefits'. Under the revised standard, the recognition and measurement of employer obligations for 'other long-term employee benefits' are accounted for according to most of the requirements for defined benefit plans.

The revised AASB 119 includes changed criteria for accounting for employee benefits as 'short-term employee benefits'. However, as the HHS is a member of the Queensland Government central schemes for annual leave and long service leave this change in criteria has no impact on the HHS financial statements as the employer liability is held by the central scheme. The revised standard also includes changed requirements for the measurement of employer liabilities/assets arising from defined benefit plans, and the measurement and presentation of changes in such liabilities and assets. The HHS makes employer superannuation contributions only to the QSuper defined benefit plan, and the corresponding QSuper employer benefit obligation is held by the State. Therefore, those changes to AASB119 will have no impact on the HHS.

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

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

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

At the date of authorisation of the financial report, the following new or amended Australian Accounting Standards are expected to impact on the HHS in future periods. The potential effect of the revised Standards and Interpretations on the HHS financial statements is not expected to be significant but a full review has not yet been completed.

Standards effective for annual periods beginning on or after 1 July 2014:

- AASB 1055 *Budgetary Reporting* applies to reporting periods beginning on or after 1 July 2014. The HHS will need to include in its 2014-15 financial statements the original budgeted figures from the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity, and Statement of Cash Flows as published in the 2014-15 Queensland Government's Service Delivery Statements. The budgeted figures will need to be presented consistently with the corresponding (actual) financial statements, and will be accompanied by explanations of major variances between

2. Summary of significant accounting policies (continued)

(ad) New and revised accounting standards (continued)

the actual amounts and the corresponding original budgeted figures.

The following new and revised standards apply as from reporting periods beginning on or after 1 January 2014:

- AASB 10 *Consolidated Financial Statements*;
- AASB 11 *Joint Arrangements*;
- AASB 12 *Disclosure of Interests in Other Entities*;
- AASB 127 (revised) *Separate Financial Statements*;
- AASB 128 (revised) *Investments in Associates and Joint Ventures*;
- AASB 2011-7 *Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 1023 & 1038 and Interpretations 5, 9, 16 & 17]*; and
- AASB 2013-8 *Amendments to Australian Accounting Standards - Australian Implementation Guidance for Not-for-Profit Entities - Control and Structured Entities*.

AASB 10 redefines and clarifies the concept of control of another entity, and is the basis for determining which entities should be consolidated into an entity's financial statements. AASB 2013-8 applies the various principles in AASB 10 for determining whether a not-for-profit entity controls another entity. On the basis of those accounting standards, the HHS has reviewed the nature of its relationships with entities that the HHS is connected with to determine the impact of AASB 2013-8. Currently the HHS does not have control over any other entities.

AASB 11 deals with the concept of joint control and sets out new principles for determining the type of joint arrangement that exist, which in turn dictates the accounting treatment. The new categories of joint arrangements under AASB 11 are more aligned to the actual rights and obligations of the parties to the arrangement. The HHS has assessed its arrangements with other entities to determine whether a joint arrangement exists in terms of AASB 11. Based on present arrangements, no joint arrangements exist. However, if a joint arrangement does arise in the future, the HHS will need to follow the relevant accounting treatment specified in either AASB 11 or the revised AASB 128, depending on the nature of the joint arrangement.

AASB 9 *Financial Instruments* and AASB 2010-7 *Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Interpretations 2, 5, 10, 12,19 & 127]* will become effective for reporting periods beginning on or after 1 January 2018.

The main impacts of these standards on the HHS are that they will change the requirements for the classification, measurement and disclosures associated with the HHS financial assets. Under the new requirements, financial assets will be more simply classified according to whether they are measured at amortised cost or fair value. Pursuant to AASB 9, financial assets can only be measured at amortised cost if two conditions are met. One of these conditions is that the asset must be held within a business model whose objective is to hold assets in order to collect contractual cash flows.

The other condition is that the contractual terms of the asset give rise to cash flows that are solely payments of principal and interest on the principal amount outstanding. The only financial asset currently disclosed at amortised cost is receivables and as they are short term in nature, the carrying amount is expected to be a reasonable approximate of fair value so the impact of this standard is minimal. For financial liabilities which are designated as at fair value through profit or loss, the amount of change in fair value that is attributable to changes in the liability's credit risk will be recognised in other comprehensive income.

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

3. Major activities and services

(a) Major activities

Administrative arrangements under the National Health Reform

Government funding - National Health Reform

Funding revenue is received in accordance with service agreements with the Department of Health. The Department of Health purchases delivery of health services based on nationally set funding and efficient pricing models determined by the Independent Hospital Pricing Authority (IHPA). The majority of services are funded on an activity unit basis. State funding is also provided for depreciation and minor capital works.

IHPA was established to develop and specify national classifications for activity in public hospitals for the purposes of Activity Based Funding.

It determines the national efficient price for services provided, on an activity basis, in public hospitals and develops data and coding standards to support uniform provision of data. In addition to this, IHPA determines block funded criteria and what other public hospital services are eligible for Commonwealth funding.

The Commonwealth and State contribution for activity based funding is pooled and allocated transparently via a National Health Funding Pool. The Commonwealth and State contribution for block funding and training, teaching and research funds is pooled and allocated transparently via a State Managed Fund. Public Health funding from the Commonwealth is managed by Department of Health.

The National Health Funding Body and National Health Funding Pool have complete transparency in reporting and accounting for contributions into and out of pool accounts. The Administrator is an independent statutory office holder, distinct from Commonwealth and State departments.

Depreciation funding

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

Transfer of net asset balances

In 2012-13, certain balances were transferred from the Department of Health to the HHS. This was effected via a transfer notice signed by the Minister for Health, designating that the transfer be recognised as a contribution by owners through equity. The transfer notices were approved by the Director-General of the Department of Health and the Chairman and Chief Executive of each hospital and health board.

The value of assets and liabilities transferred to the HHS were as follows:

	1 July 2012 $'000
Cash and cash equivalents	1,673
Receivables	14,586
Inventories	4,888
Other current assets	77
Property, plant and equipment, including intangibles	303,822
Payables	(19,577)
Total net assets; contributed equity	305,469

Other administrative arrangements

Transfer of assets

In 2013-14 the Minister for Health has issued a Designation of Transfer notice authorising transfer of Relevant Assets from the Transferor to the Transferee. This Notice is enduring until otherwise determined by the Minister for Health in writing. The Transferor and Transferee may be the Department of Health and/or any of the Hospital and Health Services as listed in Schedule 1 of the *Hospital and Health Boards Regulation 2012* as amended from time to time. This Designation of Transfer applies to all Relevant Assets which include assets of land, buildings, work in progress, plant and equipment and intangible assets. This Notice provides that any

3. Major activities and services (continued)

(a) Major activities (continued)

transfer authorised by the Chief Finance Officer of the Transferor and the Transferee is to be accounted for in accordance with AASB Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities and Accounting Policy Guideline (APG) 9 Accounting for Contributions by Owners and Distributions to Owners*:

- as a non-reciprocal transfer;
- as capital contribution by owners (in the records of the Transferee);and
- capital distribution to owners (in the records of the Transferor) by way of an adjustment against equity;
  (a) to the extent that this would cause the Transferor's contributed equity to reduce below $0, the balance is to be adjusted against the Transferor's accumulated surplus;
  (b) to the extent that this would cause the Transferor's accumulated surplus to reduce below $0,
- the balance is to be recognised as an expense; and the value attributed to the relevant assets is to be the carrying value of the item as recorded in the accounts of the entity immediately prior to the effective date of transfer.

Minor capital works

The HHS manages purchases of plant and equipment complimenting the State capital program funded by the State through the Department of Health as equity injections as part of the service agreement with the Department of Health. See Note 2(y).

(b) Major services

The HHS delivers a full suite of speciality health services, including:

Prevention, promotion, protection

Aims to prevent illness or injury, promote and protect good health and well-being of the population and reduce the health status gap between the most and least advantaged in the community.

Primary health care

Aims to 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. This incorporates the activities of public hospital and outpatient departments as well as emergency medical services provided in the public hospital emergency departments.

Acute services

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 services in Queensland hospitals.

Rehabilitation and extended care

Aims to improve the functional status of patients with an impairment or disability and to 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.

4. User charges and fees

	Share of funding		2014	2013
Funding for the provision of public health services*	*State*	*Australian Government*	**$'000**	**$'000**
Activity based funding	268,830	174,503	443,333	369,729
Block funding	39,324	22,250	61,574	71,425
Teacher Training funding	2,249	1,481	3,730	17,239
General purpose funding	57,552	-	57,552	96,067
Total government funding			566,189	554,460
Pharmaceutical Benefits Scheme subsidy			20,593	9,609
Hospital fees			27,747	29,094
Rental income			8	19
Other			4,749	2,803
Total			**619,286**	**595,985**

* State government funding and Australian government contribution received as part of the National Health Reform Funding Pool arrangement has been reclassified from Grants and contributions to User charges representing service procurement funding from the Department of Health. Comparatives have been adjusted, refer Note 2(ad).

5. Grants and other contributions

	2014	2013
Australian government grants		
Nursing home grants	2,498	2,047
Specific purpose - capital grants	607	961
Specific purpose payments	13,272	11,728
Total Australian government grants	16,377	14,736
Other		
Donations other	88	114
Donations non-current physical assets	561	608
Other grants	3,415	2,551
Total	**20,441**	**18,007**

6. Other revenue

	2014 $'000	2013 $'000
Sale proceeds for assets	6	22
Licences and registration charges	29	27
Recoveries from other agencies and other hospital and health services	16,654	12,878
Other	197	13
Total	**16,886**	**12,940**

7. Gains on disposal/remeasurement of assets

Net gains from disposal of property, plant and equipment	-	63
Total	**-**	**63**

8. Employee expenses*

Employee benefits		
Wages and salaries	1,279	761
Annual leave levy	129	76
Employer superannuation contributions	137	80
Long service leave levy	27	16
Termination benefits	-	-
Employee related expenses		
Workers compensation premium	17	10
Payroll tax	15	3
Other employee related expense	-	-
Total	**1,604**	**946**

	No.	No.
Number of employees**	8	4

* Employee expenses include the health executives and divisional directors. Refer to Note 2(v) and Note 33.

** The number of employees include full-time and part-time employees measured on a full-time equivalent basis (reflecting Minimum Obligatory Human Resource Information (MOHRI)).The number of employees does not include the Chair or the Deputy Chair of the Board or the Board members.

9. Health service employee expenses

Health service employee expenses represent the cost of Department of Health employees contracted to the HHS to provide public health services. As established under the *Hospital and Health Boards Act 2011*, the Department of Health is the employer for all health service employees (excluding persons appointed as a Health Executive) and recovers all employee expenses and associated on-costs from hospital and health services.

	2014 $'000	2013 $'000
Health service employee expenses	450,163	433,932
Health service employee related expenses*	7,235	6,310
Other health service employees related expenses	1,337	1,382
Total	458,735	441,624

	No.	No.
Number of health service employees**	4,040	3,736

* The health service employee related expenses include $6.102 million of workers' compensation insurance premium and $0.908 million payroll tax.

** The number of health service employees reflects full-time employees and part-time health service employees measured on a full-time equivalent basis (reflecting Minimum Obligatory Human Resource Information (MOHRI)). Also refer Note 2(v).

10. Supplies and services

	2014 $'000	2013 $'000
Agency fees	964	951
Electricity and other energy	6,570	5,620
Patient travel	16,074	14,714
Other travel	4,945	5,153
Building services	1,346	1,382
Computer services	3,727	2,575
Motor vehicles	804	658
Communications	6,289	5,857
Repairs and maintenance	10,176	8,456
Minor works including plant and equipment	2,356	818
Operating lease rentals	5,930	4,471
Inventories held for distribution		
Drugs	31,498	28,249
Clinical supplies and services	40,218	39,196
Catering and domestic supplies	11,957	9,791
Pathology, blood and parts	11,566	12,541
Other	8,380	4,684
Total	162,800	145,116

11. Grants and subsidies

Mental health services	351	585
Medical research programs	208	913
Home and community health services	106	156
Total	665	1,654

12. Depreciation and amortisation

Depreciation and amortisation were incurred in respect of:		
Buildings and land improvements	14,255	12,793
Plant and equipment	7,297	7,285
Software purchased	35	42
Total	21,587	20,120

13. Impairment losses

	2014 $'000	2013 $'000
Impairment losses on receivables	248	158
Bad debts written off	1,620	3,704
Total	1,868	3,862

14. Revaluation decrement

Land	-	159
Total	-	159

The asset revaluation surplus represents the net effect of upwards and downwards revaluations of assets to fair value. The decrement in 2012-13, not being a reversal of a previous revaluation increment in respect of the same class of assets, has been recognised as an expense in the Statement of Comprehensive Income.

15. Other expenses

External audit fees*	210	206
Insurance premiums - QGIF	7,748	6,995
Insurance premiums - Other	70	18
Net losses from the disposal of non-current assets	230	167
Special payments - ex-gratia payments	6	-
Other legal costs	168	52
Advertising	193	118
Interpreter fees	237	228
Other	744	419
Total	9,606	8,203

*Total audit fees paid to the Queensland Audit Office relating to the 2013-14 financial year are estimated to be $0.210 million (2013: $0.206 million) including out of pocket expenses. There are no non-audit services included in this amount.

16. Cash and cash equivalents

	2014	2013
	$'000	$'000
Cash at bank and on hand	34,533	16,615
24 hour call deposits	1,423	1,365
Total	**35,956**	**17,980**

The HHS bank accounts are grouped within the whole-of-government set-off arrangement with the Queensland Treasury Corporation. The HHS does not earn interest on surplus funds and is not charged interest or fees for accessing its approved cash debit facility. Interest earned on the aggregate set-off arrangement accrues to the Consolidated Fund.

Cash deposited at call with Queensland Treasury Corporation earns interest, calculated on a daily basis reflecting market movements in cash funds. Rates achieved throughout the year range between 3.3% to 4.2% (2013: 3.5% to 5%).

17. Receivables

Current		
Trade debtors	19,636	11,229
Other debtors	-	11,569
Less: Allowance for impairment loss	(2,450)	(2,202)
	17,186	20,596
GST input tax credits receivable	1,525	1,053
GST payable	(37)	(33)
	1,488	1,020
Sundry debtors	1	1
Total	**18,675**	**21,617**

Refer to Note 32(c) Financial Instruments (Credit Risk Exposure) for an analysis of movements in the allowance for impairment loss.

18. Inventories

Inventories held for distribution:		
Drugs	3,011	2,426
Clinical supplies and services	704	773
Catering and domestic supplies	135	140
Total	**3,850**	**3,339**

19. Other current assets

	2014 $'000	2013 $'000
Current		
Prepayments	24	390
Total	24	390

20. Intangible assets

Software purchased: At cost		
Gross	533	238
Less: Accumulated amortisation	(125)	(91)
Total	408	147

	Software purchased $'000	Total $'000
Intangibles reconciliation		
Carrying amount at 1 July 2012	-	-
Transfers in from other Queensland Government entities*	189	189
Amortisation	(42)	(42)
Carrying amount at 30 June 2013	147	147
Carrying amount at 1 July 2013	147	147
Acquisitions	296	296
Amortisation	(35)	(35)
Carrying amount at 30 June 2014	408	408

* Net assets transferred pursuant to the *Hospital and Health Boards Act 2011* to the HHS from the Department of Health. Refer to Note 3.

21. Property, plant and equipment

	2014 $'000	2013 $'000
Land: at fair value		
Gross	30,108	28,681
Buildings: at fair value		
Gross	787,319	497,254
Less: Accumulated depreciation	(263,740)	(234,239)
	523,579	263,015
Plant and equipment: at cost		
Gross	84,842	75,748
Less: Accumulated depreciation	(42,089)	(36,211)
	42,753	39,537
Capital works in progress		
At cost	316	376
Total	**596,756**	**331,609**

Land

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

In 2013-14, the HHS engaged the State Valuation Service (SVS) to provide indices for all land holdings at 26 May 2014 excluding properties under Deed of grant (recorded at nominal value of $1.00). Management has assessed the indices provided by the SVS as appropriate for the HHS and has endorsed the use of the indices.

State Valuation Service (SVS) supplied indices and provided an assurance of their robustness, validity and appropriateness for application to the relevant assets. Indices supplied were tested by SVS for reasonableness by applying the indices to a sample of assets and comparing results to similar assets that have been valued.

The use of market based indices are observable inputs that are developed using market data and publicly available information on market transactions. These indices fall into a hierarchy level 2. The SVS provides the following methodology for the interim indexation of land and buildings not comprehensively valued in the particular year:

- The State Valuation Service provides an individual factor change per property derived from the review of market transactions (Observable Market Data). These market movements are determined having regard to the review of land values undertaken for each local government area issued by the Valuer- General Department of Natural Resources and Mines.

21. Property, plant and equipment (continued)

Land (continued)

- The State Valuation Service undertakes investigation and research into each factor provided for the interim land asset indexation. All local government property market movements are reviewed annually by market surveys to determine any material change in values. For local government areas where the Valuer-General has issued land values, an index will be provided. Ongoing market investigations undertaken by SVS assist in providing an accurate assessment of the prevailing market conditions and detail the specific market movement applicable to each property.

The revaluation program for 2013-14 resulted in a net increment of $1.427 million (2012-13: decrement of $0.158 million) to the carrying amount of land.

Buildings

An independent valuation of 33 per cent of the gross value of the building portfolio (55 buildings) was valued in 2013-14 by Davis Langdon. This has concluded the valuation of the building portfolio over three financial years, with 63 per cent of the gross value of the building portfolio performed in the prior two financial years by the HHS or the Department of Health. As redevelopment at Cairns Hospital was capitalised in June 2014, the acquisition cost was assumed to materially equate to fair value and this asset was not revalued in 2013-14. The acquisition cost for Block D of $241.804 million has therefore been excluded when calculating the valuation coverage achieved across the building portfolio.

Reflecting the specialised nature of health service buildings and on hospital-site residential facilities, fair value is determined using a depreciated replacement cost approach, due to there not being an active market for such facilities. The depreciated replacement cost was based on a combination of internal records of the original cost, adjusted for more contemporary design/construction approaches and current construction contracts. Significant judgement is also used to assess the remaining service potential of the facility, given local climatic and environmental conditions and records of the current condition of the facility.

The independent valuation in 2013-14 resulted in a net increment to the building portfolio of $1.305 million (2012-13: increment of $18.378 million).

Plant and equipment

The HHS has plant and equipment with an original cost of $1.132 million and a written down value of zero still being used in the provision of services. 0.5% percent of these assets with a gross cost of $5,963 are expected to be replaced in 2014-15 with a further 1.0% expected to be replaced in the 2015-16 financial year.

The HHS has plant and equipment with an original cost of $83.711 million that has been written down to a residual value of $42.753 million still being used in the provision of services. 2.7% of these assets with a gross cost of $2.273 million are expected to be replaced in 2014-15 with a further 2.8% to be replaced in the 2015-16 financial year.

21. Property, plant and equipment (continued)

Property, plant and equipment reconciliation

	Land	Buildings	Plant & equipment	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000
Carrying amount at 1 July 2012	-	-	-	-	-
Acquisitions	-	21,527	7,372	532	29,431
Transfers in from other Queensland Government entities*	28,839	234,419	38,890	1,484	303,632
Donations received	-	-	608	-	608
Disposals	-	-	(204)	-	(204)
Transfers between asset classes	-	1,484	156	(1,640)	-
Net revaluation increments/(decrements)	(158)	18,378	-	-	18,220
Depreciation	-	(12,793)	(7,285)	-	(20,078)
Carrying amount at 30 June 2013	28,681	263,015	39,537	376	331,609

* Net assets transferred pursuant to the *Hospital and Health Boards Act 2011* to the HHS from the Department of Health. Refer to Note 3(a).

	Land*		Buildings**		Plant & equipment	Work in progress	Total
	Level 2	Level 3	Level 2	Level 3			
	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Carrying amount at 1 July 2013	28,681	-	5,527	257,488	39,537	376	331,609
Acquisitions	-	-	-	3,913	7,614	(60)	11,467
Transfers in from other Queensland Government entities	-	-	-	271,194	1,103	-	272,297
Donations received	-	-	-	-	561	-	561
Disposals	-	-	-	-	(230)	-	(230)
Transfers out to other Queensland Government entities	-	-	-	(128)	-	-	(128)
Transfers between asset classes	-	-	-	(1,465)	1,465	-	-
Net revaluation increments	1,427	-	-	1,305	-	-	2,732
Depreciation	-	-	(223)	(14,032)	(7,297)	-	(21,552)
Carrying amount at 30 June 2014	30,108	-	5,304	518,275	42,753	316	596,756

* Land level 2 assets represent vacant land in an active market whereas level 3 assets are land parcels with no active market and/or significant restrictions.

** Buildings level 2 assets represent offsite residential dwellings in an active market whereas level 3 are special purpose built buildings with no active market.

21. Property, plant and equipment (continued)

Categorisation of fair values recognised as at 30 June 2014 (refer to note 2 (o)).

	Level 2	Level 3	Total
	$'000	$'000	$'000
Land	30,108	-	30,108
Buildings	5,304	518,275	523,579

Level 3 significant valuation inputs and relationship to fair value

The fair value of health service site buildings is computed by quantity surveyors. The methodology is known as the Depreciated Replacement Cost valuation technique. The following table highlights the key unobservable (Level 3) inputs assessed during the valuation process and the relationship to the estimated fair value.

Description	Fair value at 30 June 2014 $'000	Significant unobservable inputs used in valuation	Possible alternative values for level 3 inputs	Unobservable inputs - general effect on fair value measurement
Building - special purpose hospital facilities	518,275	Replacement cost estimates.	10% or $467m - $570m	Replacement cost is based on tender pricing and historical building cost data. An increase in the estimated replacement cost would increase the fair value of the assets. A decrease in the estimated replacement cost would reduce the fair value of the assets.
		Remaining lives estimates.	3% or $503m - $534m	The remaining useful lives are based on industry benchmarks. An increase in the estimated remaining useful lives would increase the fair value of the assets. A decrease in the estimated remaining useful lives would reduce the fair value of the assets.
		Condition rating.	3% or $503m - $534m	The condition rating is based on the physical state of the assets. An improvement in the condition rating (possible high of 1) would increase the fair value of the assets. A decline in the condition rating (possible low of 5) would reduce the fair value of the assets.

21. Property, plant and equipment (continued)

Level 3 significant valuation inputs and relationship to fair value (continued)

Description	Fair value at 30 June 2014 $'000	Significant unobservable inputs used in valuation	Possible alternative values for level 3 inputs	Unobservable inputs - general effect on fair value measurement
Building - special purpose hospital facilities	518,275	Cost to bring to current standard.	1% or $513m - $524m	Costs to bring to current standards are based on tender pricing and historical building cost data. An increase in the estimated costs to bring to current standards would reduce the fair value of the assets. A decrease in the estimated costs to bring to current standards would increase the fair value of the assets.

For further information on condition ratings, refer Note 2(n).

Usage of alternative level 3 inputs (as per the above table) that are reasonable in the circumstances as at the revaluation date would be unlikely to result in material changes in the reported fair value. Whilst there is some minor correlation between costs to bring to standard and condition rating, either measure in isolation does not directly and materially affect the other.

There are no other direct or significant relationships between the unobservable inputs which materially impact fair value.

22. Payables

	2014 $'000	2013 $'000
Current		
Trade creditors	7,266	4,395
Accrued expenses	11,786	7,791
Department of Health payables*	32,679	24,533
Total	51,731	36,720

* Department of Health payables are due to outstanding payments for payroll and other fee for service charges.

23. Accrued employee benefits

Salaries and wages accrued	52	51
Other employee entitlements payable	11	(12)
Total	63	39

24. Unearned revenue

	2014 $'000	2013 $'000
Current		
Revenue in advance	2,175	153
Total	2,175	153

25. Asset revaluation surplus by class

Land		
Balance at the beginning of the financial year	-	-
Revaluation increment/(decrement)	1,427	-
Balance at the end of the financial year	1,427	-
Buildings		
Balance at the beginning of the financial year	18,378	-
Revaluation increment/(decrement)	1,305	18,378
Balance at the end of the financial year	19,683	18,378
Total	21,110	18,378

The asset revaluation surplus represents the net effect of revaluation movements in assets. Refer to Note 21.

26. Reconciliation of operating result to net cash flows from operating activities

	2014 $'000	2013 $'000
Operating surplus/(deficit)	(114)	5,366
Depreciation and amortisation expense	21,587	20,120
Equity funding for depreciation and amortisation	(21,560)	(20,584)
Net (gain)/loss on disposal of non-current assets	230	111
Revaluation decrement	-	159
Write up of non-current asset	-	(7)
Donated assets received	(561)	(608)
Change in assets and liabilities:		
(Increase)/decrease in receivables	3,410	(6,010)
(Increase)/decrease in inventories	(511)	1,549
(Increase)/decrease in prepayments	366	(313)
Increase/(decrease) in payables	15,011	17,137
Increase/(decrease) in accrued employee benefits	24	39
Increase/(decrease) in GST refund due	(468)	(1,020)
Increase/(decrease) in unearned revenue	2,022	152
Net cash from operating activities	**19,436**	**16,091**

27. Non-cash financing and investing activities

Assets and liabilities received or transferred by the HHS are set out in the Statement of Changes in Equity.

28. Expenditure commitments

(a) Non-cancellable operating leases

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

No later than one year	3,240	2,773
Later than one year and not later than five years	1,604	2,724
Total	**4,844**	**5,497**

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

28. Expenditure commitments (continued)

(b) Capital expenditure commitments

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

	2014 $'000	2013 $'000
Capital works	479	-
Repairs and maintenance	841	-
	1,320	-
No later than one year	1,320	-
Total	1,320	-

29. Contingencies

(a) Litigation in progress

As at 30 June 2014, the following cases were filed in the courts naming the State of Queensland acting through the HHS as defendant:

	2014 Number of cases	2013 Number of cases
Supreme Court	2	2
Magistrates Court	1	1
Tribunals, commissions and boards	-	1
Total	3	4

It is not possible to make a reliable estimate of the final amount payable, if any, in respect of the litigation before the courts at this time.

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). The HHS liability in this area is limited to an excess per insurance event. Refer to Note 2(w).

As of 30 June 2014, there were 35 claims (2013: 1 claim) managed by QGIF, some of which may never be litigated or result in payments to claim. The maximum exposure to the HHS under this policy is up to $20,000 for each insurable event.

(b) Native title

As at 30 June 2014, the HHS does not have legal title to properties under its control. Refer to Note 3 regarding the Health Reform information. The Department of Health remains the legal owner of health service properties.

29. Contingencies (continued)

(b) Native title (continued)

The Queensland Government's Native Title Work Procedures were designed to ensure that native title issues are considered in all land and natural resource management activities. All dealings pertaining to land held by or on behalf of the department must take native title into account before proceeding. These dealings include disposal, acquisition, development, redevelopment, clearing, fencing and the granting of leases, licences or permits and so on. Real property dealings may proceed on department owned land where native title continues to exist, provided native title holders or claimants receive the necessary procedural rights.

Queensland Health undertakes native title assessments over real property when required and is currently negotiating a number of Indigenous Land Use Agreements (ILUA) with native title holders. These ILUAs will provide trustee leases to validate the tenure of current and future health facilities. The National Title Tribunal reported that there are no native title claims against property under the control of the HHS.

30. Restricted assets

The HHS receives cash contributions primarily from private practice clinicians and external entities to provide for education, study and research in clinical areas. Contributions are also received from benefactors in the form of gifts, donations and bequests for stipulated purposes. At 30 June 2014, amounts of $1.440 million (2013: $1.372 million) in General Trust and $1.225 million (2013: $1.223 million) for research projects are set aside for the specified purpose underlying the contribution.

31. Agency and fiduciary trust transactions and balances

The HHS acts in a custodial role in respect of these transactions and balances. As such, they are not recognised in the financial statements, but are disclosed below for information purposes. The activities of trust accounts are audited by the Queensland Audit Office (QAO) on an annual basis. The fee for this service is incorporated in the total fee charged by the QAO for the full audit of the annual financial report.

(a) Patient trust receipts and payments

	2014 $'000	2013 $'000
Trust receipts and payments		
Receipts	617	504
Payments	(618)	(539)
Increase/(decrease) in patient funds	(1)	(35)
Trust assets and liabilities		
Current assets		
Cash held and bank deposits*	60	61
Total current assets	60	61

* Represents patient trust funds and refundable deposits

31. Agency and fiduciary trust transactions and balance (continued)

(b) Right of private practice receipts and payments

	2014 $'000	2013 $'000
Receipts		
Private practice receipts*	6,050	6,333
Total receipts	6,050	6,333
Payments		
Payments to doctors	57	1
Payments to HHS for recoverable costs	6,103	6,457
Total payments	6,160	6,458
Increase/(decrease) in net right of private practice assets	(110)	(125)
Right of private practice assets		
Current assets		
Cash	1,183	1,293
Total current assets	1,183	1,293

* Private practice receipts include receipts for RoPP, Option A of $5.969 million.

32. Financial instruments

(a) Categorisation of financial instruments

The HHS has the following categories of financial assets and financial liabilities:

Category	Note		
Financial assets			
Cash and cash equivalents	16	35,956	17,980
Receivables	17	18,675	21,617
Total		54,631	39,597
Financial liabilities			
Financial liabilities measured at amortised cost:			
Payables	22	51,731	36,720
Total		51,731	36,720

32. Financial instruments (continued)

(b) Financial risk management

The HHS activities expose it to a variety of financial risks - credit risk, liquidity risk and market risk.

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

The HHS measures risk exposure using a variety of methods as follows:

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

(c) Credit risk exposure

Credit risk exposure refers to the situation where the HHS may incur financial loss as a result of another party to a financial instrument failing to discharge their obligation. Exposure to credit risk is managed through regular analysis of the counterparty's ability to meet payment obligations.

The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any provision for impairment. As such, the gross carrying amount of cash and receivables represent the maximum exposure to credit risk.

The following table represents the maximum exposure to credit risk based on the carrying amounts of financial assets at the end of the reporting period.

Maximum exposure to credit risk	Note	2014 $'000	2013 $'000
Cash and cash equivalents	16	35,956	17,980
Receivables	17	18,675	21,617
Total		54,631	39,597

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

No financial assets and financial liabilities have been offset and presented net in the Statement of Financial Position.

Cash and cash equivalents

The HHS may be exposed to credit risk through its cash and cash equivalents which are compised predominantly of its investment in the QTC Cash Fund and accounts with a 'Big 4' Australian bank. The QTC Cash Fund is an asses management portfolio that invests with a wide range of high credit rated counterparties. Deposits with the QTC Cash Fund are capital guaranteed therefore the likelihood of the counterparties having capacity to meet their financial commitments is strong.

32. Financial instruments (continued)

(c) Credit risk exposure (continued)

Trade and other receivables

Throughout the year, the HHS assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes financial difficulties of the debtor, changes in debtor credit ratings and current outstanding accounts over 90 days. The allowance for impairment reflects the HHS assessment of the credit risk associated with receivables balances and is determined based on historical rates of bad debts (by category) and loss events mainly relating to unrecoverable debts from private businesses and patients ineligible for Medicare.

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

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

	Not past due	Past due but not impaired			
	Less than 30 days	30 - 60 days	61 - 90 days	More than 90 days	Total
2014 financial assets past due but not impaired					
Receivables	14,871	1,499	710	1,595	18,675
Total	**14,871**	**1,499**	**710**	**1,595**	**18,675**
2013 financial assets past due but not impaired					
Receivables	19,808	912	593	304	21,617
Total	**19,808**	**912**	**593**	**304**	**21,617**
2014 individually impaired financial assets					
Receivables (gross)	81	70	9	2,290	2,450
Allowance for impairment	(81)	(70)	(9)	(2,290)	(2,450)
Carrying amount	-	-	-	-	-
2013 individually impaired financial assets					
Receivables (gross)	225	165	140	1,672	2,202
Allowance for impairment	(225)	(165)	(140)	(1,672)	(2,202)
Carrying amount	-	-	-	-	-

32. Financial instruments (continued)

(c) Credit risk exposure (continued)

Movements in the allowance for impairment loss

	2014 $'000	2013 $'000
Balance at 1 July	2,202	-
Balance transferred in on establishment of HHS	-	2,044
Amounts written off during the year	(1,620)	(3,704)
Increase in allowance recognised in operating result	1,868	3,862
Balance at 30 June	**2,450**	**2,202**

(d) Liquidity risk

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

The HHS is exposed to liquidity risk through its trading in the normal course of business. The HHS 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 HHS has an approved debt facility of $6.0 million under whole-of-government banking arrangements to manage any short term cash shortfalls. No funds had been withdrawn against this debt facility as at 30 June 2014.

The following table sets out the liquidity risk of financial liabilities held by the HHS. It represents the contractual maturity of liabilities, calculated based on the undiscounted cash flows relating to the liabilities at reporting date.

		2014 Payable in			Total
	Note	<1 year $'000	1-5 years $'000	>5 years $'000	
Financial liabilities					
Payables	22	51,731	-	-	51,731
Total		51,731	-	-	51,731

		2013 Payable in			Total
	Note	<1 year $'000	1-5 years $'000	>5 years $'000	
Financial liabilities					
Payables	22	36,720	-	-	36,720
Total		36,720	-	-	36,720

32. Financial instruments (continued)

(e) Market risk

The HHS does not trade in foreign currency and is not materially exposed to commodity price changes. The HHS has minimal interest rate exposure on the 24 hour call deposits, however there is no such risk on its cash deposits. The HHS does not undertake any hedging in relation to interest rate risk.

(f) Interest rate sensitivity analysis

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

Financial instrument		2014 Interest rate risk			
		-1%		1%	
	Carrying amount	Profit	Equity	Profit	Equity
	$'000	$'000	$'000	$'000	$'000
Cash and cash equivalents	1,423	(14)	(14)	14	14
Potential impact		(14)	(14)	14	14

Financial instrument		2013 Interest rate risk			
		-1%		1%	
	Carrying amount	Profit	Equity	Profit	Equity
	$'000	$'000	$'000	$'000	$'000
Cash and cash equivalents	1,365	(14)	(14)	14	14
Potential impact		(14)	(14)	14	14

(g) Fair value

The fair value of trade receivables and payables is assumed to approximate the value of the original transaction, less any allowance for impairment.

33. Key management personnel and remuneration expenses

(a) Key management personnel

The following details for key management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of the HHS during 2013-14. Further information on these positions can be found in the body of the annual report under the section relating to Executive Management.

Position	Responsibilities	Current Incumbents	
		Contract classification and appointment authority	**Date appointed to position** (Date resigned from position)
Cairns and Hinterland Hospital and Health Board **Chair** Robert Norman **Deputy Chair** Carolyn Eagle	The HHS is independently and locally controlled by the Cairns and Hinterland Hospital and Health Service Board. The Board appoints the Health Service Chief Executive and exercises significant responsibilities at a local level, including controlling the financial management of the HHS and the management of the HHS land and buildings (section 7 *Hospital and Health Board Act 2011*).	Appointments are under the provisions of the Hospital and Health Board Act 2011 by Governor in Council. Notice is published in the Queensland Government Gazette.	29/06/2012 1/07/2012
Board Members Leeanne Bou-Samra Mario Calanna Dr Felicity Croker Bruce Peden Dr Peter Smith			1/07/2012 17/05/2013 23/08/2013 17/05/2013 17/05/2013
Chief Executive* Julie Hartley-Jones	Responsible to the Board for the efficient overall operational management of the HHS and the achievement of its strategic objectives, as determined by the Board. Acts as principal advisor to the Board and provides the leadership of and guidance to the Executive Management Team of the HHS.	s24 & s70 appointed by Board under Hospital and Health Board Act 2011 (Section 7 (3)).	1/07/2012
Executive Director Medical Services Dr Neil Beaton	Responsible to the Chief Executive as the single point of accountability for clinical governance and professional leadership and direction of medical services across the HHS. Provides medical executive leadership, strategic focus, managerial direction, authoritative counsel and expert advice on a wide range of professional and policy issues that meet safe professional practice standards.	MEDC3, Appointed by Chief Executive under Hospital and Health Board Act 2011.	1/07/2012

* Denotes directly employed by the HHS.

33. Key management personnel and remuneration expenses (continued)

(a) Key management personnel (continued)

Position	Responsibilities	Current Incumbents	
		Contract classification and appointment authority	**Date appointed to position** (Date resigned from position)
Chief Operating Officer* Robin Moore	Responsible to the Chief Executive for the day-today operational management of the HHS. The Chief Operating Officer leads the development and establishment of services consistent with the identified needs of the population, and manages, coordinates and monitors the KPIs pursuant to the service agreement.	HES2-5, Appointed by Chief Executive under Hospital and Health Board Act 2011.	1/07/2012
Chief Finance Officer* John Slaven	Responsible to the Chief Executive to ensure the financial and fiscal responsibility of the HHS are met. Provides governance arrangements to meet financial performance targets and imperatives. Provides strategic financial advice in all aspects of finance management and performance.	HES2-5, Appointed by Chief Executive under Hospital and Health Board Act 2011.	1/07/2012
Executive Director People and Culture* Caroline Wagner	Responsible to the Chief Executive for the management and resolution of people and cultural issues within the HHS. Provides strategic development and strategies to achieve maximum employee engagement, safety and productivity and to ensure the HHS's capacity to attract and retain the skilled resources required.	HES2-1, Appointed by Chief Executive under Hospital and Health Board Act 2011.	1/07/2012
Executive Director Strategy, Planning, Performance and Aboriginal & Torres Strait Islander Health* Bradley McCulloch	Responsible to the Chief Executive for the design, implementation and continuous improvement of the integrated planning, strategy management, and strategy communications frameworks and systems. Provides direction and leadership to improve the health of Aboriginal and Torres Strait Islander peoples.	HES2-1, Appointed by Chief Executive under Hospital and Health Board Act 2011.	2/09/2013

* Denotes directly employed by the HHS.

33. Key management personnel and remuneration expenses (continued)

(a) Key management personnel (continued)

Position	Responsibilities	Current Incumbents	
		Contract classification and appointment authority	**Date appointed to position** (Date resigned from position)
Executive Director Nursing & Midwifery Jocelyn Rogers	Responsible to the Chief Executive as the single point of accountability for clinical governance and professional leadership and direction of nursing and midwifery services across the HHS. Provides nursing and midwifery executive leadership, strategic focus, managerial direction, authoritative counsel and expert advice on a wide range of professional and policy issues that meet safe professional practice standards.	NRG11, Appointed by Chief Executive under Hospital and Health Board Act 2011.	1/07/2012
Executive Director Allied Health Donna Goodman	Responsible to the Chief Executive as the single point of accountability for clinical governance and professional leadership and direction of allied health services across the HHS. Provides allied health executive leadership, strategic focus and authoritative counsel on professional and policy issues that meet safe professional practice standards.	HP7-2, Appointed by Chief Executive under Hospital and Health Board Act 2011.	19/06/2013

* Denotes directly employed by the HHS.

(b) Remuneration expenses

Remuneration policy for the HHS key executive management personnel is set by the following Legislation:

- *Hospital and Health Boards Act 2011* (HHBA)
- Industrial awards and agreements

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

Remuneration policy for the HHS key executive management personnel is set by direct engagement common law employment contracts. The remuneration and other terms of employment for the key executive management

33. Key management personnel and remuneration expenses (continued)

(b) Remuneration expenses (continued)

personnel are also addressed by these common law employment contracts. The contracts provide for other benefits including motor vehicles and expense payments such as rental or loan repayments.

The following disclosures focus on the expenses incurred by the HHS during the respective reporting periods, that are attributable to key management positions. Therefore, the amounts disclosed reflect expenses recognised in the Statement of Comprehensive Income.

Remuneration expenses for key management personnel comprise the following components:

- Short-term employee benefits which include:
  - salaries, allowances and leave entitlements earned and expensed for the entire year or for that part of the year during which the employee occupied the specified position.
  - non-monetary benefits – consisting of provision of vehicle and other expenses together with fringe benefits tax applicable to the benefit.
- Long term employee expenses include amounts expensed in respect of long service leave entitlements earned.
- Post employment expenses include amounts expensed in respect of employer superannuation obligations.
- Termination benefits are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu on termination, regardless of the reason for termination.

Key management personnel so not receive performance payments as part of their remuneration package.

1 July 2013 - 30 June 2014						
Position (date resigned if applicable)	**Short Term Employee Expenses**		**Long Term Employee Benefits**	**Post-Employment Expenses**	**Termination Benefits**	**Total Expenses**
	Monetary Expenses $'000	**Non-Monetary Benefits** $'000	$'000	$'000	$'000	$'000
Chair Robert Norman	67	-	-	-	-	67
Deputy Chair Carolyn Eagle	34	-	-	-	-	34
Board Member Leeanne Bou-Samra	34	-	-	3	-	37
Board Member Mario Calanna	34	-	-	3	-	37
Board Member Dr Felicity Croker	29	-	-	2	-	31
Board Member Bruce Peden	34	-	-	3	-	37
Board Member Dr Peter Smith	34	-	-	3	-	37

33. Key management personnel and remuneration expenses (continued)

(b) Remuneration expenses (continued)

1 July 2013 - 30 June 2014						
Position (date resigned if applicable)	**Short Term Employee Expenses**		**Long Term Employee Benefits**	**Post-Employment Expenses**	**Termination Benefits**	**Total Expenses**
	Monetary Expenses $'000	**Non-Monetary Benefits** $'000	$'000	$'000	$'000	$'000
Chief Executive Julie Hartley-Jones	282	18	6	31	-	337
Executive Director Medical Services Dr Neil Beaton	437	18	5	29	-	489
Chief Operating Officer Robin Moore	189	18	4	20	-	231
Chief Finance Officer John Slaven	188	17	4	20	-	229
Executive Director People and Culture Caroline Wagner	168	13	4	18	-	203
Executive Director Strategy, Planning, Performance and Aboriginal & Torres Strait Islander Health Bradley McCulloch	136	17	3	15	-	171
Executive Director Nursing & Midwifery Jocelyn Rogers	161	17	4	19	-	201
Executive Director Allied Health Donna Goodman	147	17	4	18	-	186

33. Key management personnel and remuneration expenses (continued)

(b) Remuneration expenses (continued)

1 July 2012 - 30 June 2013						
Position (date resigned if applicable)	**Short Term Employee Expenses**		**Long Term Employee Benefits**	**Post-Employment Expenses**	**Termination Benefits**	**Total Expenses**
	Monetary Expenses $'000	**Non-Monetary Benefits** $'000	$'000	$'000	$'000	$'000
Chair Robert Norman	67	-	-	-	-	67
Deputy Chair Carolyn Eagle	29	-	-	-	-	29
Board Member Leeanne Bou-Samra	29	-	-	2	-	31
Board Member Mario Calanna	-	-	-	-	-	-
Board Member Margaret Cochrane (retired 17/05/2013)	27	-	-	2	-	29
Board Member Dr Henry Glennie (retired 17/05/2013)	27	-	-	-	-	27
Board Member Bruce Peden	-	-	-	-	-	-
Board Member Dr Peter Smith	-	-	-	-	-	-

33. Key management personnel and remuneration expenses (continued)

(b) Remuneration expenses (continued)

1 July 2012 - 30 June 2013						
Position (date resigned if applicable)	**Short Term Employee Expenses**		**Long Term Employee Benefits**	**Post-Employment Expenses**	**Termination Benefits**	**Total Expenses**
	Monetary Expenses $'000	**Non-Monetary Benefits** $'000	$'000	$'000	$'000	$'000
Chief Executive Julie Hartley-Jones	261	9	5	29	-	304
Executive Director Medical Services Dr Neil Beaton	381	10	4	25	-	420
Chief Operating Officer Robin Moore	180	9	4	18	-	211
Chief Finance Officer John Slaven	164	9	3	17	-	193
Executive Director People and Culture Caroline Wagner	143	7	3	16	-	169
Executive Director Aboriginal & Torres Strait Islander Health Linda Sexton	86	9	2	13	88	198
Executive Director Nursing & Midwifery Jocelyn Rogers	127	9	3	17	-	156
Executive Director Allied Health Donna Goodman	52	9	2	7	-	70
Acting Executive Allied Health Linda Bailey	56	9	2	8	-	75

34. Events occurring after balance date

There have been the following events that have arisen subsequent to the reporting date that may significantly affect the operation of the HHS in future financial years, and/or the results of operations in future financial years, and/or the state of affairs of the HHS in future financial years.

(a) Transfer of general purpose housing to the Department of Housing and Public Works

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

As at 30 June 2014, the HHS held housing assets with a total net book value of $3.599 million under a deed of lease arrangement with the Department of Health. These housing assets initially transferred to the HHS at no cost to the HHS. Effective 1 July 2014, the deed of lease arrangement in respect of these assets will cease, and the assets will be transferred for no consideration to the Department of Health at their net book value, prior to their transfer to the DHPW.

As this transfer will be designated as a Transaction with Owners, the transfer will be undertaken through the HHS Equity account during 2014-15. Therefore, this transaction will have no impact on the Statement of Comprehensive Income in the 2014-15 Financial Year.

(b) Transfer of legal ownership of health services land and buildings

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

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

On 23 June 2014, the Minister for Health announced that the Queensland government had approved the transfer of legal ownership of health services land and buildings to hospital and health services in a staged process over the next 12 months. The transfer of legal ownership of land and buildings to the HHS will occur from December 2014. There is no material impact on the financial statements as these assets are already controlled and recognised by the HHS.

(c) Transfer of prescribed employer function

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

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

On 23 June 2014, the Minister for Health announced that the employment of existing and future staff would become the responsibility of each hospital and health service and that existing employment conditions, including pay arrangements, would remain unchanged.

The Department of Health will remain responsible for setting state-wide terms and conditions of employment, including remuneration and classification structures and for negotiating enterprise agreements.

34. Events occurring after balance date
(continued)

(c) Transfer of prescribed employer function (continued)

The HHS will become the prescribed employer of health service employees from 1 July 2015. There is no material impact on the financial statements as health service employee costs are currently recognised by the HHS.

(d) Senior Medical Officer and Visiting Medical Officer contracts

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

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

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

Non-contracted Senior Medical Officers and Visiting Medical Officers will remain employed under current award arrangements and they will continue to be employed by the Department of Health.

(e) Transfer of Yarrabah Health Service to community control

From 1 July 2014, the HHS has fulfilled a long-standing Government policy by transitioning the delivery of primary health care services in Yarrabah to Gurriny Yealamucka Health Services. Under these arrangements, primary health care services that had previously been provided by the HHS are now delivered by the community controlled organisation.

(f) Other matters

No other matter or circumstance has arisen since 30 June 2014 that has significantly affected, or may significantly affect the HHS operations, the results of those operations, or the HHS state of affairs in future financial years.

35. Related party transactions

(a) Parent entity

The HHS is controlled by the State of Queensland which is the ultimate parent entity.

(b) Key management personnel

Disclosures relating to key management personnel are set out in Note 33.

(c) Transactions with related parties

Other than transactions with the Department of Health and other hospital and health services during the ordinary course of business, there were no transactions with related parties during the financial year.

(d) Receivable from and payable to related parties

Other than balances with the Department of Health and other hospital and health services during the ordinary course of business, there were no trade receivables from or trade payables to related parties at the reporting date.

(e) Loans to/from related parties

There were no loans to or from related parties at the reporting date.

36. Economic dependency

The HHS primary source of income is from the Department of Health for the provision of public hospital, health and other services in accordance with a service agreement with the Department of Health, refer to Note 3(a). The HHS ability to continue viable operations is dependent on this funding. At the date of this report, management has no reason to believe that this financial support will not continue, particularly as the current service agreement covers the period from 1 July 2013 to 30 June 2016.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Certificate of Cairns and Hinterland Hospital and Health Service

These general purpose financial statements have been prepared pursuant to section 62(1) of the *Financial Accountability Act 2009* (the Act), section 43 of the *Financial and Performance Management Standard 2009* and other prescribed requirements. In accordance with section 62(1)(b) of the Act we certify that in our opinion:

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

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

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

Mr Robert Norman	Ms Julie Hartley-Jones	Mr John Slaven
Fellow of Australian Institute of Company Directors	RN, BSc(Hons), MBA, Adjunct Associate Professor James Cook University	B. Commerce, Member of Institute of Chartered Accountants in Australia
Chair	Chief Executive	Chief Finance Officer
Cairns and Hinterland Hospital and Health Service Board	Cairns and Hinterland Hospital and Health Service Board	Cairns and Hinterland Hospital and Health Service Board
20 August 2014	20 August 2014	20 August 2014

Independent auditor's report

To the Board of Cairns and Hinterland Hospital and Health Service

Report on the Financial Report

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

The Board's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

Independence

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

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

Opinion

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

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

(b) in my opinion –

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

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

Other Matters - Electronic Presentation of the Audited Financial Report

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

QUEENSLAND
26 AUG 2014
AUDIT OFFICE

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

Queensland Audit Office
Brisbane

Glossary

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

Best practice	Cooperative way in which organisations and their employees undertake business activities in all key processes, and use benchmarking that can be expected to lead to sustainable world class positive outcomes.
Clinical governance	A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical practice	Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/or manage illness, together with associated professional activities for patient care.
Clinical workforce or staff	Employees who are or who support health professionals working in clinical practice, have healthcare specific knowledge/ experience, and provide clinical services to health consumers, either directly and/or indirectly, through services that have a direct impact on clinical outcomes.
Emergency department waiting time	Time elapsed for each patient from presentation to the emergency department to start of services by the treating clinician. It is calculated by deducting the date and time the patient presents from the date and time of the service event.
Full-time Equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
Health outcome	Change in the health of an individual, group of people or population attributable to an intervention or series of interventions.
Health reform	Response to the National Health and Hospitals Reform Commission Report (2009) that outlined recommendations for transforming the Australian health system, the National Health and Hospitals Network Agreement (NHHNA) signed by the Commonwealth and states and territories, other than Western Australia, in April 2010 and the National Health Reform Heads of Agreement (HoA) signed in February 2010 by the Commonwealth and all states and territories amending the NHHNA.
Hospital	Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.
Hospital and Health Boards	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to governing a complex health care organisation.
Hospital and Health Service	Hospital and Health Services are separate legal entities established by Queensland Government to deliver public hospital services. Seventeen Hospital and Health Services commenced on 1 July 2012 replacing existing health service districts.
Hospital-in-the-home	Provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.

Immunisation	Process of inducing immunity to an infectious agency by administering a vaccine.
Incidence	Number of new cases of a condition occurring within a given population, over a certain period of time.
Indigenous health worker	An Aboriginal and/or Torres Strait Islander person who holds the specified qualification and works within a primary healthcare framework to improve health outcomes for Indigenous Australians.
Long wait	A 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for a category 1 patient, more than 90 days for a category 2 patient and more than 365 days for a category 3 patient.
Medicare Locals	Established by the Commonwealth to coordinate primary health care services across all providers in a geographic area. Work closely with Hospital and Health Services to identify and address local health needs.
Medical practitioner	A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.
Non-admitted patient	A patient who does not undergo a hospital's formal admission process.
Nurse practitioner	A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessing and managing clients using nursing knowledge and skills and may include, but is not limited to, direct referral of clients to other healthcare professionals, prescribing medications, and ordering diagnostic investigations.
Outpatient	Non-admitted health service provided or accessed by an individual at a hospital or health service facility.
Outpatient service	Examination, consultation, treatment or other service provided to non-admitted non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.
Overnight-stay patient (also known as inpatient)	A patient who is admitted to, and separated from, the hospital on different dates (not same-day patients).
Patient flow	Optimal patient flow means the patient's journey through the hospital system, be it planned or unplanned, happens in the safest, most streamlined and timely way to deliver good patient care.
Performance indicator	A measure that provides an 'indication' of progress towards achieving the organisation's objectives usually has targets that define the level of performance expected against the performance indicator.

Private hospital	A private hospital or free-standing day hospital, and either a hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients or insurers patients admitted to private hospitals are treated by a doctor of their choice.
Public patient	A public patient is one who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.
Public hospital	Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.
Registered nurse	An individual registered under national law to practice in the nursing profession as a nurse, other than as a student.
Statutory bodies	A non-departmental government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.
Sustainable	A health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs, for example, research and monitoring within available resources.
Telehealth	Delivery of health-related services and information via telecommunication technologies, including: • live, audio and or/video inter-active links for clinical consultations and educational purposes • store-and-forward Telehealth, including digital images, video, audio and clinical (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists • teleradiology for remote reporting and clinical advice for diagnostic images • Telehealth services and equipment to monitor people's health in their home.
Triage category	Urgency of a patient's need for medical and nursing care.
Weighted Activity Unit	A standard unit used to measure all patient care activity consistently. The more resource intensive an activity is, the higher the weighted activity unit. This is multiplied by the standard unit cost to create the 'price' for the episode of care.

Compliance checklist

The features of a quality annual report are that it:

- Complies with statutory and policy requirements
- Presents information in a concise manner
- Is written in plain English
- Provides a balanced account of performance – the good and not so good.

Financial Accountability Act 2009 (Qld)

Financial and Performance Management Standard 2009 (Qld)

Annual Report Requirements for Queensland Government agencies

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	• A letter of compliance from the accountable officer or statutory body to the relevant Minister	ARRs – section 8	3
Accessibility	• Table of contents • Glossary	ARRs – section 10.1	5 118
	• Public availability	ARRs – section 10.2	2
	• Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 10.3	2
	• Copyright notice	*Copyright Act 1968* ARRs – section 10.4	2
	• Information Licensing	*QGEA – Information Licensing* ARRs – section 10.5	2
General information	• Introductory Information	ARRs – section 11.1	8
	• Agency role and main functions	ARRs – section 11.2	7
	• Operating environment	ARRs – section 11.3	23
	• Machinery of government changes	ARRs – section 11.4	N/A
Non-financial performance	• Government's objectives for the community	ARRs – section 12.1	36
	• Other whole-of-government plans / specific initiatives	ARRs – section 12.2	36
	• Agency objectives and performance indicators	ARRs – section 12.3	36
	• Agency service areas, and service standards	ARRs – section 12.4	36
Financial performance	• Summary of financial performance	ARRs – section 13.1	31
Governance – management and structure	• Organisational structure	ARRs – section 14.1	14

Summary of requirement		Basis for requirement	Annual report reference
Governance – management and structure	• Executive management	ARRs – section 14.2	49
	• Related entities	ARRs – section 14.3	N/A
	• Government bodies	ARRs – section 14.4	N/A
	• Public Sector Ethics Act 1994	Public Sector Ethics Act 1994 (section 23 and Schedule) ARRs – section 14.5	55
	• Risk management	ARRs – section 15.1	16
	• External scrutiny	ARRs – section 15.2	17
	• Audit committee	ARRs – section 15.3	48
	• Internal audit	ARRs – section 15.4	17
	• Public Sector Renewal	ARRs – section 15.5	N/A
	• Information systems and recordkeeping	ARRs – section 15.6	19
	• Workforce planning, attraction and retention, and performance	ARRs – section 16.1	54
	• Early retirement, redundancy and retrenchment	Directive No.11/12 Early Retirement, Redundancy and Retrenchment ARRs – section 16.2	58
	• Open Data	ARRs – section 17	123
	• Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	115
	• Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	116
	• Remuneration disclosures	Financial Reporting Requirements for Queensland Government Agencies ARRs – section 18.3	109

• FAA F*inancial Accountability Act 2009*, FPMS *Financial and Performance Management Standard 2009*, ARRs *Annual Report Requirements for Queensland Government agencies*

• Open Data

In line with the Annual report requirements for Queensland Government agencies [April 2014], the following additional information applicable to statutory bodies is reported on our website, *see* http://www.health.qld.gov.au/cairns_hinterland/

- Consultancies
- Overseas travel

Contact us

Cairns and Hinterland Hospital and Health Service

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PO BOX 902, CAIRNS, QLD 4870

07 4226 0000

ABN 25 285 907 786

Atherton Hospital

Cnr Jack and Louise Streets, Atherton Qld 4883
PO Box 183, Atherton Qld 4883

07 4091 0211

Babinda Multi-Purpose Health Centre

128 Munro Street, Babinda Qld 4861
PO Box 160, Babinda Qld

07 4067 8200

Cairns Hospital

165 The Esplanade, Cairns Qld 4870
PO Box 902, Cairns Qld 4870

07 4226 0000

Chillagoe Primary Health Centre

21 Hospital Avenue Chillagoe Qld 4871
PO Box 4, Chillagoe Qld 4871

07 4094 7500

Cow Bay Primary Health Centre

69 Tea Tree Road, Diwan Qld 4873

07 4098 9296

Croydon Primary Health Centre

Sircom Street, Croydon Qld 4871
PO Box 10, Croydon Qld 4871

07 4748 7000

Dimbulah Primary Health Centre

3-5 Stephens Street, Dimbulah Qld 4872
PO Box 148, Dimbulah Qld 4872

07 4093 5333

Forsayth Primary Health Centre

Fourth Street, Forsayth Qld 4871

07 4062 5372

Georgetown Primary Health Centre

High Street, Georgetown Qld 4871
PO Box 33, Georgetown Qld 4871

07 4062 1266

Gordonvale Hospital

1-11 Highleigh Road, Gordonvale Qld 4865
PO Box 17, Gordonvale Qld 4865

07 4043 3100

Gurriny Yealamucka Health Service (Yarrabah)

1 Bukki Road, Yarrabah Qld 4871
Post Office, Yarrabah Qld 4871

07 4226 4100

Herberton Hospital

23 Grace Street, Herberton Qld 4887
PO Box 46, Herberton Qld 4887

07 4096 1000

Innisfail Hospital

87 Rankin Street, Innisfail Qld 4860
PO Box 2463, Innisfail Qld 4860

07 4061 5411

Malanda Primary Health Centre

3/15 Catherine Street, Malanda Qld 4885

07 4096 5339

Mareeba Hospital

2 Lloyd Street, Mareeba Qld 4880
PO Box 145, Mareeba Qld 4880

07 4092 9333

Millaa Millaa Primary Health Centre

45 Palm Avenue, Millaa Millaa QLD 4886

07 4097 2223

Mossman Multi-Purpose Health Service

9 Hospital Street, Mossman Qld 4873

07 4084 1200

Mount Garnet Primary Health Centre

Gelena Street, Mount Garnet Qld 4872

07 4097 9101

Ravenshoe Primary Health Centre

Kurradilla Street, Ravenshoe
PO Box 61, Ravenshoe Qld 4888

07 4097 6223

Tully Hospital

17 Bryant Street, Tully Qld 4854

07 4068 4144

Cairns and Hinterland Hospital and Health Service
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http://www.health.qld.gov.au/cairns_hinterland/