ANNUAL REPORT 2015–2016

Cairns and Hinterland Hospital and Health Service

Queensland Government

Acknowledgment to Traditional Owners

The Cairns and Hinterland Hospital and Health Service respectfully acknowledges the Traditional Owners and Custodians both past, present and future of the land, air and waters which we service; and declare the Cairns and Hinterland Hospital and Health Service's commitment to reducing inequalities between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander health outcomes in line with the Australian Government's 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 Communications team on (07) 4226 3243.

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Interpreter Service Statement

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on (07) 4226 3290 and we will arrange an interpreter to effectively communicate the report to you.

LETTER OF COMPLIANCE

The Honourable Cameron Dick MP
Minister for Health and Minister for Ambulance Services
Member for Woodridge
Level 19, 147-163 Charlotte Street
Brisbane Qld 4000

Dear Minister

I am pleased to present the Annual Report and financial statements 2015-16 for the Cairns and Hinterland Hospital and Health Service.

I certify that this Annual Report complies with:

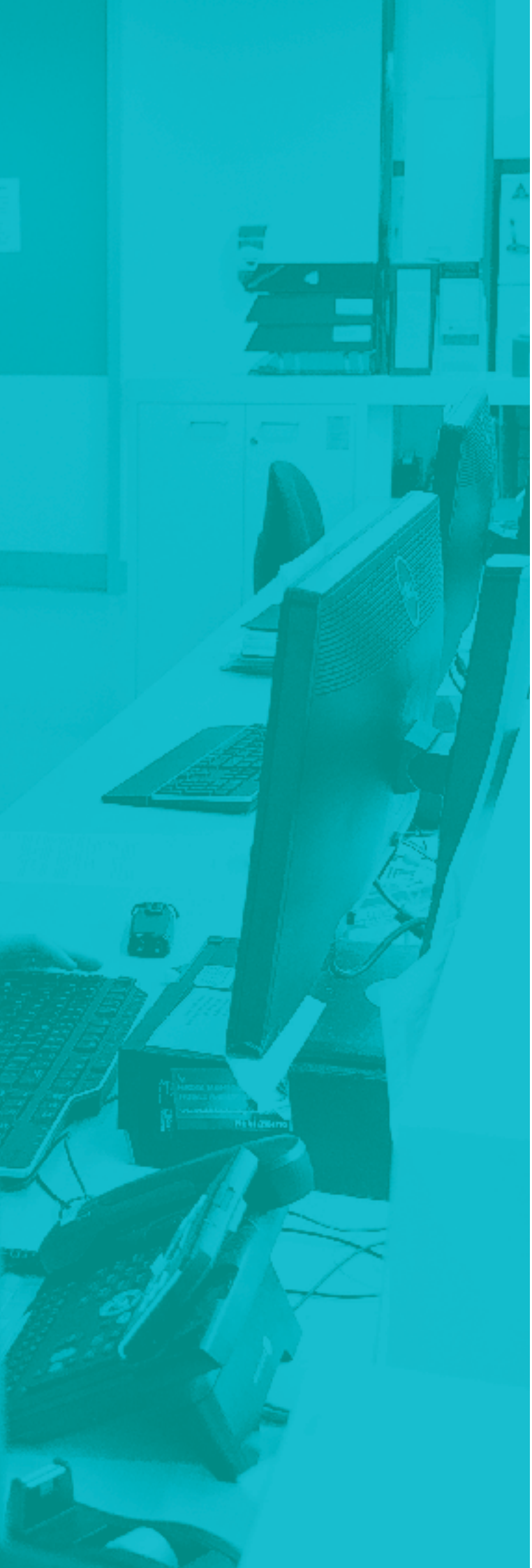
- the prescribed requirements of the *Financial Accountability Act 2009 and the Financial and Performance Management Standard 2009*, and
- the detailed requirements set out in the *Annual report requirements for Queensland Government agencies for the 2015-16 reporting period*.

A checklist outlining the annual reporting requirements can be found at page 110 of this Annual Report or accessed at http://www.health.qld.gov.au/cairns_hinterland/

Yours sincerely

Carolyn Eagle
Chair
Cairns and Hinterland Hospital and Health Board

15 September 2016



ANNUAL REPORT
2015-2016

Contents

MESSAGE FROM OUR CHAIR AND CHIEF EXECUTIVE

In our 2015-16 Annual Report we reflect on a year of integration and innovation as the Cairns and Hinterland Hospital and Health Service (the Health Service) looks toward the future. We highlight the milestones and achievements as well as the challenges of caring for an ageing population, unprecedented demand for health services across the region, all while working to become Australia's first regional Digital Hospital.

First regional Digital Hospital

One of the biggest milestones of the year saw Cairns Hospital become Australia's first large scale, regional digital hospital, with the transition to electronic patient medical records early in 2016.

The roll out of the Digital Hospital Project allows doctors, nurses and other members of the healthcare team to record and access a patient's medical information directly using digital devices, instead of relying on paper files and hard copy charts. Going digital means patient care will be more efficient, allowing our doctors, nurses and other clinical team members to have clinical information at their fingertips which ensures better decision making relating to treatment.

The team at Cairns Hospital and some community health services spent months preparing for the project, with more than 3492 staff trained and the integration of more than 1000 new digital devices across the hospital.

As a leader in digital healthcare, Cairns Hospital is the first Australian hospital to use Cerner maternity digital records and the first Queensland health service to scan clinical records and information. Real time patient information is now available instantly to healthcare staff across the hospital, providing access to critical data such as test results, allergies and medication directly via the secure electronic medical record.

In 2016-17 and beyond, the Health Service will focus on embedding and optimising the functionality of the Digital Hospital to ensure that it continues to benefit our patients and enhance quality of care.

Building for the future

The year also saw the completion of the Cairns Hospital redevelopment with all stages now operational, and only a few final improvements to be completed.

In December 2015, the Far North Queensland Hospital Foundation, and our entire community realised the vision for a state of the art all abilities paediatric playground at Cairns Hospital. This $1.285M playground has come after almost nine years of planning and over five years of fundraising. The Health Service continues to be bolstered by the support of the community and the Foundation in funding these essential projects to benefit our local community.

Over the next twelve months, key priorities for infrastructure development include investment in the refurbishment of Atherton Hospital as well as the development of a business case to assess the requirements of the hospital going into the future; the replacement of the Dimbulah Primary Health Care Centre; initial planning for a health facility in South Cairns and progression of the proposed Youth Prevention and Recovery Care (YPARC) mental health facility in Cairns.

The development of the YPARC is another strategic initiative in improving our mental health care delivery. Our Health Service is committed to providing care for mental health clients in the most appropriate setting possible. The development of the YPARC will follow on from the successful opening and operation in November 2015 of our Community Care Unit, which is a step down residential facility that supports adult mental health clients who are returning to independent living.

The ever-increasing demand

Growing demand for services remains a challenge for our Health Service in meeting its key performance areas. As a Health Service, we are all focused on achieving these targets which support better patient experiences and outcomes.

In 2015-16 our performance against key performance indicators for emergency department access, elective surgery and waiting times improved and we will continue our focus to maintain these results in 2016-17.

In 2015-16, the number of patients moving through our Emergency Department (ED) within four hours reached 80.1 per cent. The Health Service is treating 97 per cent of patients requiring elective surgery within the clinically recommended time.

The demand for outpatient services has increased significantly in recent years with almost 257,099 people attending Specialist Outpatient Clinic appointments across the Health Service as at 30 June 2016.

One of the key challenges still facing the Health Service is the growing and ageing population in the region. An extra 67,000 people are expected to live in our catchment area by 2026, and close to one in five will be aged over 65. The Board and Hospital and Health Service are committed to providing services for this increased demand including focus on organisational performance and sustainability going forward into 2016-17 and beyond.

Living within our means

During the past year, we have experienced some financial challenges. The Health Service is committed to enhancing organisational sustainability and has developed a number of strategies to focus on our financial performance and to ensure that the health needs of our community and our patients will be met in a safe, effective, equitable and sustainable way today and into the future.

The safety of our patients and staff remains our number one priority as we give due regard to improving efficiencies and organisational practices.

Board and Executive movements

In October 2015, Mr Bob Norman resigned as Chair of the Hospital and Health Board. Mr Norman joined the Health Service as Board Chair on 1 July 2012 and worked tirelessly to improve health outcomes and services to the people of the Far North. Many of the enhancements to services and infrastructure were progressed during his time as Chair. We also said goodbye to Board Members, Mr Mario Calanna and Mr Bruce Peden, and wish to recognise these board members' contribution and dedication to serving the health needs of the people of Far North Queensland.

In May 2016, we welcomed Ms Gillian Shaw, Ms Joann Schmider and Ms Anita Veivers to the Board, and look forward to their enthusiastic contribution. Our new members are supported by Chair, Ms Carolyn Eagle, and current Board Members, Ms Leeanne Bou-Samra, Dr Felicity Croker and Dr Peter Smith.

After more than seven years as Chief Executive of the Health Service, Ms Julie Hartley-Jones left the Health Service in June 2016 to take up an opportunity in South Australia Health. During her time in the role, Ms Hartley-Jones was a passionate advocate for our Health Service and delivered some key projects including the Cairns Hospital redevelopment and the implementation of the Digital Hospital. We also welcomed Interim Chief Executive, Ms Clare Douglas to the Health Service whilst the Board undertakes a global search for a Chief Executive.

Everything we do

Everyday our workforce does amazing things. Their contribution to the community cannot be overstated, and we would like to recognise our employees for their dedication and commitment to the Health Service. From our clinical staff, to our operational and administrative staff, from the volunteers and consumers, to the leadership of Board members, the Executive Management Team and Divisional Directors, we could not do this without you. Together, all the things we do every day make a profound difference in the lives of our patients, our community and each other.

Carolyn Eagle
Chair

Clare Douglas
Interim Chief Executive

It is with great pleasure that we present to you the Cairns and Hinterland Hospital and Health Service's 2015-2016 Annual Report.

Fast facts

Cairns and Hinterland Hospital and Health Service by numbers

80.10%
Proportion of **people admitted or treated and discharged within 4 hours of presentation** to an emergency department

3,024
Number of babies born

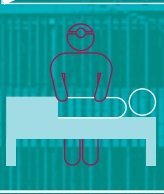
487
Number of
Hospital in the Home admissions

3.77
Average **number of days that patients stayed in our hospitals**
(acute overnight patients only)

257,099 Number of
outpatient clinic attendances

ELECTIVE SURGERY

6,526
Number of
elective surgery patients treated



97%
Percentage of **elective surgery patients treated in time**

158,739 Number of
emergency presentations

44,746
Number of **overnight admissions**

52,434 Number of
same day admissions

97,180
Total number of admissions


Cairns Hospital

ABOUT THE CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

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

Manner of establishment

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

The functions of a Hospital and Health Service are outlined in the *Hospital and Health Board Act,* 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 consolidating our 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, Hinchinbrook Shire Council and Yarrabah Aboriginal Shire Council.

Our vision

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 North East Australian Region.

With a geographical area of 142,900 square kilometres spanning from 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, Hinterland and north east Australian regions. The outer western region of our Health Service encompasses extremely remote communities.

Our Health Service supports a population of 283,197 which is forecast to grow by nine per cent by 2026. The highest level of growth will occur within the 65 and over age group. Tourism is a key industry and contributes to a relatively high transient population. It is estimated that almost 13 per cent of our population are Aboriginal and Torres Strait Islander Australians, compared to 3.5 per cent for Queensland as a whole.

Our Health Service delivers health services across the continuum of care and also provides services to the Torres and Cape Hospital and Health Service. Some high level acute services are provided outside of our Hospital and Health Service, in both Townsville and Brisbane.

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; and**
- **engage and understand our communities' culturally diverse needs.**

Our hospital facilities

Atherton Hospital
Babinda Multi-Purpose Health Centre
Cairns Hospital
Gurriny Yealamucka Health Centre (Yarrabah)
Gordonvale Hospital
Herberton Hospital
Innisfail Hospital
Mareeba Hospital
Mossman Multi-Purpose Health Centre
Tully Hospital

Primary Health Centres

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; home care services; immunisation services; oral health (dental clinics); Positive Parenting Program; school health; and child health clinics.

Location of Community Health Centres

Atherton Primary Health Care Centre
Cairns Community Health (Cairns North 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

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 of whom are not able to be specifically 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 and Minister for Ambulance Services, the Honourable Cameron Dick MP, the Queensland Government, and the Federal Government for their support.

The Board has identified further opportunities to collaborate with stakeholders, the community and consumers. These are detailed in the Cairns and Hinterland Hospital and Health Service Consumer and Community Engagement Strategy July 2015 – July 2017.

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 assists the activities and services of the Cairns Hospital and our regional facilities.

Fundraising

The Foundation raised $1.2 million through its fundraising efforts during the year. The Foundation's biggest annual fundraiser, the Mount Franklin Cardiac Challenge bike ride from Cairns to Cooktown, attracted 270 riders and raised $246,000.

Friends of the Foundation

The Foundation also benefits from the tireless efforts of regionally-based fundraising volunteers, known as Friends of the Foundation. These groups, based at Innisfail, Cooktown, Mareeba, Gordonvale and Cow Bay, have collectively raised $113,000 towards the improvement of healthcare facilities within their communities.

Funding achievements

In addition to funding the Cairns Hospital paediatric playground which opened in December 2015, the Foundation contributed $1.3 million to health services during the year – its second largest annual handover to date. That sum is made up of $362,000 for a Brainlab navigation system for spine and trauma navigation for the Operating Theatres, $361,000 for patient televisions, $58,000 for a Midas Rex Drill for the Operating Theatres, $68,000 for an X-Porte ultrasound kiosk system with stand and three transducers for the Emergency Department and $43,000 for a telemetry system to assist with cardiac monitoring in the Paediatric Ward at Cairns Hospital.

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, about 95 Foundation volunteers contributed more than 24,056 hours of unpaid service to the Cairns Hospital. Hundreds more Foundation volunteers lent their support to fundraising events.

North Queensland Primary Health Network

The Primary Health Network works to improve the coordination and delivery of primary healthcare and commenced operations on 1 July 2015. The Network works with primary health providers including general practice, pharmacy, allied health practitioners and non-government organisations to identify and address service gaps through analysis, planning, working closely with service providers and listening to the community. Key to its function is the desire to improve collaboration and integration between primary health and the Hospital and Health Services across North Queensland.

COUCH

Cairns COUCH (Committee for Oncology Unit at Cairns Hospital) has continued with its efforts to establish a Cancer Health and Wellness Centre in Manoora. The centre will include facilities for respite and complementary therapies, providing a holistic approach to cancer treatment in tandem to patient's clinical therapies.

Gurriny Yealamucka Health Services

The Health Service continues to work with Gurriny Yealamucka Health Services (GYHS) to strengthen the support and capacity for community control of health services in Yarrabah. At this time, GYHS operates Primary Health Care, including General Practice services, with the Health Service offering Emergency, Dialysis, Dental and Specialist Outreach services. Ongoing collaboration with GYHS is targeted towards achieving a more integrated experience for consumers with information flowing between providers to ensure patients receive the best care possible without frequent repetition of histories and symptoms. In addition, the Health Service and GYHS continue to collaborate to ensure the best local use of available resources.

Queensland Ambulance Service and Queensland Police Service

We have continued to build a strong relationship with the Queensland Ambulance Service (QAS) and Queensland Police Service (QPS) for both operational and strategic planning in the area of disaster management and other ongoing projects and operations. We wish to recognise the contributions of these responders in supporting our Health Service.

James Cook University

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

Highlights 2015-2016

BUILDING ON HEALTH CARE SERVICE DELIVERY INITIATIVES

Digital Hospital

Cairns Hospital is Australia's first large-scale regional digital hospital, joining Princess Alexandra Hospital (PAH) in Brisbane as partner exemplar Digital Hospital sites through the Digital Hospital journey.

Cairns Hospital had a successful go live in early 2016 including new systems for the Emergency Department, theatres, and outpatient scheduling. The Cairns Hospital is also leading Queensland in implementing digital records in maternity, paediatrics and community health.

Over time, the Digital Hospital program will provide Queensland Health with the opportunity to improve the patient experience. This includes providing clinicians with up-to-date patient records to enable informed clinical decision making, so patients don't have to repeat their history every visit.

Digital Hospital highlights at Cairns Hospital include:

- Access to real-time data
- First digital multi-trigger early warning tool in the world
- First Maternity build in Australia
- First Community and Paediatric build in Queensland.

Some of the benefits experienced by clinicians thus far include:

- Patient care is enhanced through care plans and task lists
- Streamlining patient information
- Enables multiple teams to work on a patient's care simultaneously
- Instantaneous access to patient care information across the hospital
- Improves workflow, care delivery and efficiency.

Advancements in Cardiac Care

In June 2016, staff from past and present celebrated the 30th anniversary of Cardiac Services at Cairns Hospital. There have been many achievements over the years including the expansion in April 2015 of the Cardiac Catheter Laboratory Services from four days a week to a 24/7 service enabling it to provide emergency care to heart attack patients around the clock. Due to the expansion in services there has been a significant increase in presentations with 441 angioplasties in 2015-16, compared to 241 back in 2012.

Ear, Nose and Throat (ENT) service

The demand for Ear, Nose and Throat specialist outpatient appointments continued to be a challenge for the Health Service this year and in October 2015, we welcomed the Queensland Government's commitment to an additional $5 million over the next two years to reduce the number of patients waiting longer than clinically recommended.

Mental Health

Providing care for mental health clients in a more appropriate setting than in to the Emergency Department has been a key priority for the Cairns and Hinterland Hospital and Health Service. There has been significant growth in community based mental health services with two residential recovery services and the expansion of acute in-home support services in 2015-16.

In 2015-16 the first Prevention and Recovery Care Service (PARC) delivered its first full year of service to the Cairns region. The PARC – a partnership model with the non-government organisation MIND Australia - provides short-term support in a residential setting for adults who require intensive support to help them transition out of an acute mental health facility (step down care) or to help them avoid hospitalisation (step up care).

Additionally in November 2015, the Community Care Unit opened offering a longer-term residential service consisting of 20 self-contained one-bedroom units with 24-hour support. This residential service is an option for people who need medium to long-term residential rehabilitation support to help them regain their independence.

A research project based around a day program to support mums and their babies is also now underway. The 'Perinatal Day Program' for mums with mental health issues is being implemented via an inter-service partnership.

Increased theatre capacity

An additional operating theatre opened at Cairns Hospital during this year thanks to the hospital redevelopment project, bringing the total number to nine. The additional capacity has enabled extra elective surgery to be scheduled as well as increased flexibility so that elective surgery sessions are less likely to be cancelled due to emergencies. In 2016 the Queensland Audit Office released a performance report on theatre utilisation across the health service sector. The recommendations from that report are being considered to ensure that our Health Service effectively uses our additional theatre capacity to meet the needs of the community.

Women and Children

The redevelopment of the women's health unit and new birthing centre at Cairns Hospital was a highlight, as was the establishment of a new maternity consumer group to inform service delivery.

In 2016, Cairns Hospital announced a new Family Birthing Centre with three suites which will give Far Northern women the option to give birth in a home-like setting and go home just six hours later. Women with low-risk pregnancies have welcomed the opportunity to have a more natural, home-style birth with less medical intervention.

The availability of Midwifery Group Practice was also increased to 800 women per year to improve continuity of care for pregnant women before, during, and after the birth of their child. The major benefit of Midwifery Group Practice is that expectant mothers have a known midwife throughout their pregnancy, who takes primary responsibility for the care of the expectant mother. The midwife ensures the expectant mother has access to services 24 hours a day, seven days a week and strives to be in attendance at the birth. The midwife also provides pre and post birth education and assistance with documenting any referrals that may be required. The Midwifery Group Practice has received overwhelmingly positive feedback on this service from patients.

Stroke Unit

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. Each year between 250-300 patients are admitted to Cairns Hospital with acute stroke. Aboriginal and Torres Strait Islanders are over-represented in this figure.

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 in 2013.

The care of stroke patients in Far North Queensland has been further enhanced by the commencement of the Acute Stroke Unit in 2014 as part of the Cairns Hospital redevelopment.

Expertise in Disaster Preparedness

In June 2015 our Health Service experienced the largest burns mass casualty event in Queensland, as a result of the tragic Ravenshoe explosion. No one could have predicted such an event, and our Health Service can be proud of the way our staff responded on that day and the many days afterwards.

With such events, there are always opportunities to learn, and a review was conducted by a former Queensland Ambulance Service Commissioner with a number of clear actions to improve future disaster responses across Queensland. Our Health Service is committed to improving medical incident training, with 15 staff trained in Advance Major Incident Medical Management and Support (MIMMS) in 2015-16. We continue our work to develop a mass casualty plan and enhance our disaster plan and exercise framework.

Additional beds in ICU

Six additional beds have been opened in the Intensive Care Unit, bringing the total number of beds to 16. Opened in 2016, ICU2 has a nurse to patient ratio of 1:2, whereas ICU1 has a ratio of 1:1. The beds have been an asset in the response to an increase in not only the number of patients presenting to Cairns Hospital but those who are critically ill and in need of immediate, intensive treatment.

Patient Flow Unit

A new patient flow unit has also improved patient journeys throughout Cairns Hospital. The multidisciplinary team is focused on ensuring patients are receiving the right care in the right place in Cairns Hospital.

The team is also responsible for continuity of care, so once people have received the care they require at Cairns Hospital they have a clear way of returning to facilities closer to their homes in regional and remote parts of our Health Service and in the Torres and Cape Hospital and Health Service.

Other highlights:

- Expansion of Renal Services with three additional renal chairs to be based at Cairns Private Hospital, taking the total number to 21.

AROUND THE REGION

Nurse Navigation Service

The Health Service embraced the Queensland Health initiative to introduce Nurse Navigators in 2015-16. The program is a result of the Queensland Government's Nursing Guarantee Policy that will see 400 nursing positions introduced across the State.

Each Health Service was tasked with the responsibility of ensuring each model of care was developed and implemented in accordance with the Department of Health Nurse Navigation principles: coordination of patient centred care, creating partnerships, improving patient outcomes and facilitating system improvement.

In February 2016, Innisfail Hospital became the first hospital in the Health Service to implement a Nurse Navigator. This required the development of operational processes, integrating Queensland Health nurse navigation requirements into a model of care. Examples are the referral process, a health care summary and patient-centric care plan developed in partnership with the navigator and aimed to address holistic requirements that will support the patient with complex care needs as they move through the health system.

To date, 45 patients have benefited from the service in the Innisfail area, with the majority of the patients having had high levels of complexity. Nurse Navigation has improved the quality of life for patients. Examples of the impact the service provides include: decreased length of stay in hospital; fewer presentations to the emergency department; increased uptake in planned procedures improving patient health; reduced time to residential care placement; and greater linkage to support services. Another benefit of Nurse Navigation is an increased number of patients are now engaged with a regular General Practitioner.

The Health Service currently has 10 Nurse Navigators who are primarily cohort based; respiratory, older persons, mental health, paediatric, stroke and vascular as well as generalists in regional locations who have added value to the multi-disciplinary health team.

Atherton Oncology Service

Atherton Day Oncology Service provides regimens and supportive therapies two days a week. In the 2015/16 financial year the Atherton Day Oncology Service has seen as fifty per cent increase in the number of chemotherapy treatments.

The Atherton Day Oncology Unit provides chemotherapy regimens and supportive therapies two days per week. Care is provided utilising an integrated service model in partnership with the Cairns Cancer Centre to patients across the Atherton Tablelands and western gulf region. The Atherton Day Oncology Unit is supported by both Medical Oncologists and a Haematologist who oversee care utilising a Telehealth model of care.

Gordonvale Transitional Care

The Transitional Care program provides short term rehabilitation for older people when being discharged from hospital. The residential care component of Transition Care commenced in December 2015 at Gordonvale Hospital, and provides residential beds for clients who are not quite ready or able to go home but are medically stable. With the aim of delaying or preventing nursing home admission for the elderly, the program facilitates early discharge from hospital and provides a total of 38 different transitional packages.

Telehealth

Telehealth provides an innovative response to patient care with an integrated and sustainable service. The service strives to address the community's diverse needs and to work with patients to ensure that the service is providing solutions that ensure the best possible outcome for patients.

In July 2015, virtual Telehealth ward rounds were established between Mareeba Hospital and Cairns Hospital's General Medicine department. In the 12 months to June 2016, 1059 inpatients ward rounds were conducted via Telehealth in consultation with Senior Medical Officers; delivering speciality support from Cairns to medical officers in Mareeba and enabling them to make informed clinical decisions, improve patient outcomes and potentially reduce transfers of patients to Cairns Hospital.

Atherton Hospital has joined other sites like Mareeba Hospital in embracing Telehealth, identifying opportunities to encourage and expand the use of the service.

In 2015-16 the Endoscopy Unit at Atherton integrated Telehealth appointments within normal clinic practice. The clinic nurses, who organise and run the clinic, unreservedly supported the decision and to date it has proven to be an extremely positive experience, not only for patients but also for our clinical staff.

Atherton Hospital aims to develop Telehealth further and this development will also benefit other districts including many patients from western rural communities and as far north as Mossman.

Atherton Hospital offers recipient Telehealth appointments for provider sites of Cairns, Townsville and Brisbane, reducing patient travel costs and allowing rural patients to more easily obtain speciality services.

The Haematology clinic now sees up to 20 patients fortnightly, ensuring patients stay within their community while their disease management is closely monitored. Atherton Hospital has offered this service to patients for some years and considering the first Haematology Telehealth clinics only started in Queensland in 2014, Atherton Hospital is constantly proving to be progressive when it comes to the delivery of patient care.

Remote health facilities

The Health Service operates remote primary health care facilities in locations such as Georgetown, Forsayth, Croydon and Cow Bay which are staffed by a nurse and operational staff. These facilities responded exceptionally well to a number of major motor vehicle accidents last year with work that is largely unrecognised. Their role included responding with the hospital based ambulance, stabilising patients, managing emergency evacuations, working with the police, operating the morgue and providing social support to patients and families.

INFRASTRUCTURE AND CAPITAL WORKS

In 2015-16, Cairns Hospital Redevelopment was completed with the refurbishment of blocks A,B and C. The $446.3 million redevelopment commenced in 2008.

Other significant investments included:

- The replacement of air conditioning at the Mareeba Hospital worth $2.4 million
- Innisfail Hospital air conditioning ($2.7 million)
- Tully Hospital air conditioning ($3.1 million)
- Fire service upgrades at Mossman, Herberton and Babinda Hospitals at a cost of $3.5 million
- Patient bathroom upgrades at Mareeba Hospital for $563,000
- Mossman Hospital kitchen upgrade for $600,000
- Upgrade to Cairns Hospital theatres for $400,000
- Electrical switchboards were upgraded at Herberton Hospital for $400,000 and replaced at Cairns Hospital at a cost of $1.5 million.

Aboriginal and Torres Strait Islander health

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Why an Aboriginal and Torres Strait Islander Indigenous perspective is important

First Nation Status

Within the Health Service catchment there are at least nine Aboriginal language family group nations including Yalanji, Djabugay, Yidinji, Gunggandji, Dyirbalngan, Mbabaram, Warungu, Ewamian and Tagalaka. These language nations comprise 21 tribal groups each with up to six clan groups. These Traditional Owner custodian groups have a history of around 2000 generations of relationship and custodianship responsibility for Country across the Health Service footprint. Additionally, there are at least a further 60 Aboriginal and Torres Strait Islander Traditional Owner groups in Cape York and Torres Strait Islands whose members access care and services within the Health Service. They do so either as local residents within the area or as a transfer from their primary residence, as well as individuals from the broader 250 or so Aboriginal and Torres Strait Islander language family group Nations across Australia.

In addition to the diversity of cultures and languages amongst the Aboriginal and Torres Strait Islander residents and visiting clients who access services, a significant proportion are diagnosed with co-morbidity of chronic conditions in the context of systemic poor social determinants and geographic remoteness.

To improve the equity in health between Aboriginal and Torres Strait Islander Peoples and non-Indigenous Australians, *Close the Gap Health Targets* were developed by the Council of Australian Governments. Reaching these targets requires specific Aboriginal and Torres Strait Islander engagement, and a holistic strengths-based approach which recognises the unique traditional knowledges, cultures, and connections to Country in order to overcome the current circumstances, reduce risks factors, improve early access to health services, and optimise chronic disease management.

Close the Gap Health Targets

- Halving the mortality gap in infants 0-4 years by 2018
- Closing the life expectancy gap by 2031

Traditional Owners

Facility	Traditional Owners/ Custodians at language nation, tribal or clan group (as self-determined)
Atherton Hospital	Ngadjon-Jii, close with Wadjanbarra Yidinji
Babinda MPHS	Wanyurr Majay Yidini
Cairns Hospital	Yirrganydji in the north and Gimuy Walubura Yidinji in the south
Chillagoe PHC	Wagaman, close with Kuku Djungan
Cow Bay PHC	Kuku Yalanji, Jalun clan
Croydon PHC	Tgalaka
Dimbulah PHC	Mbabaram / Bar Barrum
Forsayth PHC	Ewamian
Georgetown PHC	Ewamian
Gordonvale Hospital	Malanbarra Yidinji
Gurriny Yealamucka HS	Gunggandji and Mandingalbay Yidinji
Herberton Hospital	Jirrbal
Innisfail Hospital	Mamu
Jumbun CHC	Gulnay
Kuranda PHC	Djabugay
Lotus Glen HS	Muluridji
Malanda PHC	Ngadjon-Jii
Mareeba Hospital	Muluridji
Millaa Millaa PHC	Mamu
Mission Beach CHC	Djiru
Mossman MPHS	Kuku Yalanji
Mount Garnet PHC	Bar Barrum / Mbabaram
Ravenshoe PHC	Jirrbal
Tully Hospital	Gulnay

Aboriginal and Torres Strait Islander engagement across the catchment

After consultation with Aboriginal and Torres Strait Islander communities and a review of the Health Service governance structure, the formation of the Aboriginal and Torres Strait Islander Community Consultative Committee (CCC) was endorsed by the Board in August 2015. An extensive recruitment process was undertaken, resulting in a diverse range of membership from across the Cairns and Hinterland area including the Elders Justice Group, Aboriginal and Torres Strait Islander media, arts and Local Government.

This process of Aboriginal and Torres Strait Islander engagement is underpinned by international best practice as outlined within United Nations Declaration on the Rights of Indigenous Peoples.

This diversity in engagement through the Aboriginal and Torres Strait Islander CCC helps take into account broader demographic, cultural and social issues in relation to health care.

Younger Population Age

36 per cent of Aboriginal and Torres Strait Islander residents were aged between zero and fourteen years in 2014, compared with 19 per cent of non-Indigenous residents.

Less than 4 per cent of Aboriginal and Torres Strait Islander residents were aged 65 years or older (n=1,066), compared with 15 per cent of non- Indigenous residents.

This reflects both a higher fertility rate as well as a lower life expectancy among Indigenous people.

The Aboriginal and Torres Strait Islander population within the catchment

The Cairns and Hinterland Hospital and Health Service is the largest hospital and health service provider within a region that has a large percentage of Aboriginal and Torres Strait Islander Peoples in comparison to other areas of Queensland.

Aboriginal and Torres Strait Islander residents (n=31,326) accounted for 12.6 per cent of the total estimated resident population within the Health Service footprint in 2014, and 15.4 per cent of the total estimated Aboriginal and Torres Strait Islander population of Queensland.

The distribution of the Aboriginal and Torres Strait Islander people across the Health Service is illustrated in Figure 1, and shows a higher percentage of Aboriginal and Torres Strait Islander residents (>20%) in the inner western and inner southern statistical area of Cairns, including Manoora, Manunda, Woree and White Rock. The Atherton Tableland and Douglas and Daintree statistical areas had a relatively high percentage of Aboriginal and Torres Strait Islander residents (16-20%). The highest percentage of Aboriginal and Torres Strait Islander residents observed in the Health Service was in the Yarrabah statistical area, at 98.2 per cent.

Aboriginal and Torres Strait Islander Peoples have similar demographic characteristics to other overseas countries with developing status - young population age, high unemployment, progressing toward urbanisation, lower individual and household income, Aboriginal and Torres Strait Islander Peoples living in remote areas, within small vulnerable economies experience higher costs of living and reduced access to transport, broader markets, technology, reduced essential services (housing, water, sewerage) as well as access to community services (health, welfare, education).

Some of these factors are referred to as social determinants and can impact on health outcomes as risk factors which increase the chance of diseases, infections or injury. However, Aboriginal and Torres Strait Islander Peoples also have a huge wealth of protective factors, such as traditional knowledge and the Aboriginal and Torres Strait Islander unique perspectives of Health which can reduce the chances of getting diseases, infections or injury.

Figure 1: Per cent Indigenous population by statistical area, Cairns and Hinterland HHS, 2014.

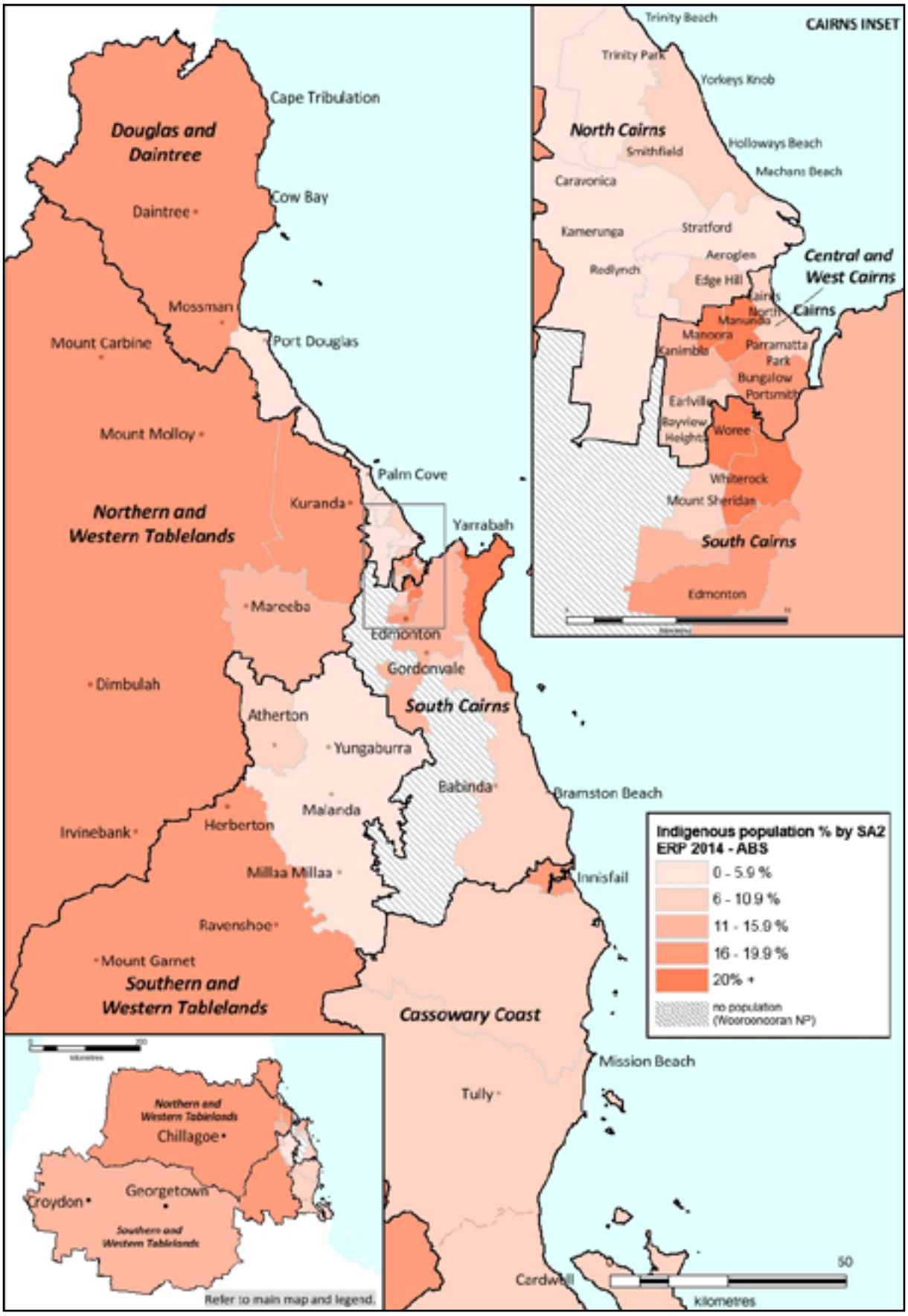
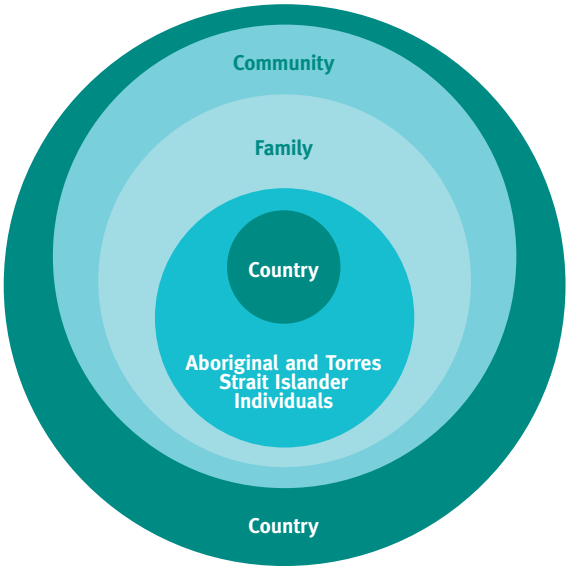


Figure 2: Aboriginal and Torres Strait Islander perspectives of health



Aboriginal and Torres Strait Islander Perspectives of Health

Aboriginal and Torres Strait Islander Peoples view Country as encompassing and, at the same time, central to health.

Country is a concept which describes connections, spirituality, physical resources, and connections to land, sea, water, animals, each other, ecology, and more.

An example of Country is when air, waterways and soil are clean and healthy, then people can eat healthy and plentiful food, drink clean water and breathe fresh air. Ceremony, songs and dances can hand down knowledge through generations about how Country looks after those in its care, the living and non-living, how to care for Country, and how systems work together to care for Country. These knowledge systems and ways of transferring knowledge also put strong value and give a strong emotional connection within people to care for Country. For tens of thousands of years and some 2000 generations, cultural practices have reinforced that Country is important, so today Aboriginal and Torres Strait Islander Peoples still believe and practice their culture.

Western science refers to these concepts of the connection between peoples and communities as an Ecological - Social determinant model of health. Modern influences of Western society have brought challenges to Aboriginal and Torres Strait Islander lifestyles, and how Australia needs to systemically merge Aboriginal and Torres Strait Islander perspectives with Western perspectives through schooling, universities, research, and other institutions such as hospitals and health services.

Leadership

The Health Service board and executive management are actively showing leadership in progressing Aboriginal and Torres Strait Islander health through participation in various forums such as the North Queensland Optimal Health Meeting, and progressing integration of service delivery and care coordination including with Aboriginal Community Controlled Health Organisations (ACCHOs).

How do we know if we're on track?

The Health Service has two main key performance indicators in Aboriginal and Torres Strait Islander Health i) Discharge Against Medical Advice (DAMA); and ii) Potentially Preventable Hospitalisation (PPH).

Significant activities to addressing DAMA and PPH performance include:

- developing a culturally responsive service;
- targeted services; and,
- progressing specific Aboriginal and Torres Strait Islander research and development.

Table 1: Cairns and Hinterland HHS Summary of PPH and DAMA Indicators 2014-15 and 2015-16

Key Performance Indicator		PPH [a]	DAMA [b]
2014-15	Q1	21.6% (576/2,662)	110/3,022 (3.6%)
	Q2	17.6% (527/2,998)	120/3,408 (3.5%)
	Q3	20.7% (581/2,805)	117/3,232 (3.6%)
	Q4	18.0% (553/3,076)	130/3,415 (3.8%)
	Total	19.4% (2,237/11,541)	477/13,077 (3.6%)
2015-16	Q1	22.2% (671/3,027)	121/3,353 (3.6%)
	Q2	19.3% (593/3,068)	133/3,426 (3.9%)
	Q3	18.8% (582/3,100)	137/3,504 (3.9%)
	Q4	19.1% (548/2,871)	96/3,266 (2.9%)
	Quarterly Target	16.3%	72
	Annual Target	16.3%	288
	Year-to-date	**19.8% (2,394/12,066)**	**487/13,548 (3.6%)**

(a) Aboriginal and Torres Strait Islander potentially preventable hospitalisations (PPH): % and PPH count/total episodes.
(b) Aboriginal and Torres Strait Islander count of discharge against medical advice (DAMA).
Note: Q = quarter

PPH 2015-16		DAMA 2015-16	
	Less than or equal to target		Less than or equal to target or less than or equal to count of 5
	Target + 1 percentage point		Target + 5% of target
	Greater than (target + 1 percentage point)		Greater than (target + 5% of target)

Note: This report uses latest data updated from the relevant databases.
As a result there may be small differences in the data compared to previous reports.

Cultural Responsive Service

The Cairns and Hinterland Hospital and Health Service Cultural Capability Program improved significantly, after recruitment to a dedicated full time position in February 2015. Since then, multi-disciplinary staff uptake of foundation and intermediate cultural capability training increased (see Figure 3).

Evaluation of the training shows nearly all staff who attended the training gained valuable insights into Aboriginal and Torres Strait Islander cultures and were keen to improve the cultural responsiveness of their work areas. In the evaluation we asked a sample of staff three months after they had completed the training to reflect on the cultural safety of their practice. The majority of these staff said they regularly utilised Aboriginal and Torres Strait Islander Liaison Officers and Health Workers to improve cultural effectiveness, and applied the skills, knowledge and behaviours learnt at cultural capability training into their work practice, and they update their knowledge of major health concerns and issues of Aboriginal and Torres Strait Islander populations residing in the Health Service catchment or accessing services.

This year, in collaboration with various branches, we developed 10 specialised cultural capability training activities, which included various professional streams and service delivery areas such as occupational therapists, geriatric medicine registrars, mental health and emergency department. The content for this specialist training is developed in collaboration with professional streams or service delivery areas. The training content can include case based scenarios and explores in detail how to improve the cultural safety of their work area systems and practices. This work will continue to be developed next year with pharmacy and medication management and other areas.

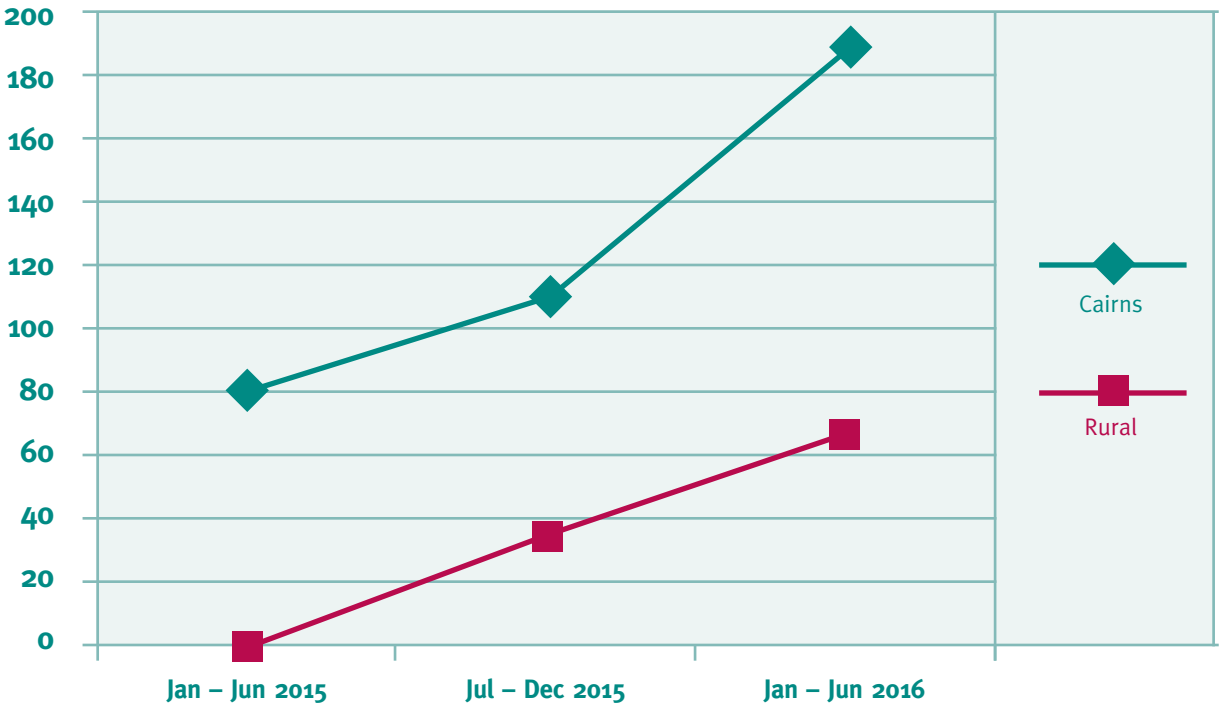
Making Tracks Indigenous Health Investment Initiatives

In 2015-16 the Health Service implemented 10 Indigenous Health Investment Projects which are funded through Aboriginal and Torres Strait Islander Health Branch of Queensland Health. These included:

- The Aboriginal and Torres Strait Islander Stroke Unit at Cairns Hospital – a culturally specific rehabilitation and secondary prevention service for Aboriginal and Torres Strait Islander stroke survivors.
- Aboriginal and Torres Strait Islander Liaison Services Renal Unit – offering contact services for patients to ensure Fail to Attend rates are decreased, patients are encouraged to utilise services such as Telehealth and home therapy options offered so patients do not have to relocate for treatment.

- Chronic Kidney Disease – Clinical Pharmacy and Telehealth Service to increase the delivery of pharmacy consultations through Telehealth from Cardwell up to the Torres Strait.
- Statewide Rheumatic Heart Disease Register and Control Program – based at Tropical Public Health Services (Cairns), this Statewide program coordinates the Rheumatic Heart Disease (RHD) register and RHD program including patient education and resources for local health service providers to raise awareness of RHD and Acute Rheumatic Fever.
- Enhanced Diabetes Outreach Service; Chronic Kidney Disease – Clinical Pharmacy and Telehealth. Delivery of nurse-led clinics in ten locations providing endocrinology and diabetes outreach so people with diabetes can receive specialist support closer to home.
- Indigenous Alcohol Tobacco and Other Substances (ATODS) Youth Program – ongoing partnerships with schools and other organisations to provide intervention and diversion activities aimed at youth at risk. For example, a bicycle maintenance course at Innisfail High School.
- Sexual Health in Corrective Settings – information, education and service support to offenders and those involved in violent relationships.
- Youth Sexual Health Service – through strong partnerships with identified schools such as Djarragun College, this program provides support and education on sexual health issues to meet the needs of youth in the community.
- Remote Sexual Health Service and the North Queensland Aboriginal and Torres Strait Islander Sexually Transmitted Infections (STI) Action Plan – aims to eliminate congenital syphilis, control syphilis outbreaks and reduce the prevalence of STIs among Aboriginal and Torres Strait Islander people in North Queensland.
- Aboriginal and Torres Strait Islander Cultural Capability Program (CCP) – building the cultural understanding and knowledge of our staff to improve delivery of care.

Figure 3: Numbers of Health Service staff completing cultural capability training



Aboriginal and Torres Strait Islander Cultural Capability Audit and Compliance Framework Pilot Project

In 2015-16 the Health Service developed the Aboriginal and Torres Strait Islander Cultural Capability Audit and Compliance framework. Three services volunteered to pilot the framework: Liz Plummer Oncology Unit, North Cairns Community Health Chronic Conditions Management Unit, and Mareeba Hospital (Maternity and Paediatrics, Community Health and East Ward).

The framework aims to provide a standardised internal audit tool which teams can use to assess the cultural safety of their work units. The framework is used to ask whether a service has gauged Aboriginal and Torres Strait Islander patient satisfaction, the number of team members accessing the Cultural Practice Program and more.

Preliminary results from the pilot will be delivered at the Cairns and Hinterland Hospital and Health Service research and quality symposium next year with the final report scheduled to be completed by November 2016.

Research and Development Activities

Aboriginal and Torres Strait Islander Stroke Unit

The Aboriginal and Torres Strait Islander Stroke Unit at Cairns Hospital provided a culturally specific rehabilitation and secondary prevention service for Aboriginal and Torres Strait Islander stroke survivors. The model of service provision focused on care coordination and development of tools for providing culturally responsive services and care including: speech pathology across different verbal and non-verbal language and linguistic sounds, nutrition advice based upon Aboriginal and Torres Strait Islander food preferences and sources, and occupational and physiotherapy aids for rural and remote built environments and to suit harsh climates such as wheelchairs for fishing locations.

Aboriginal and Torres Strait Islander Successful Ageing

In a potential landmark research project, the Health Service Health Ageing research team received a project grant of $365,000 from the National Health and Medical Research Council to gain an understanding of the rate of dementia and other diseases of ageing amongst people in the Torres Strait. Clinical Director of the Older Persons Health Services, Dr Eddy Strivens, is one of three local chief investigators on the project along with Dr Sarah Russell and Dr Gavin Miller. Previous studies have found high rates of dementia in Aboriginal communities but this will be the first time the issue has been addressed in the Torres Strait.

Key to the success of this and previous studies by the team, has been the partnership model with local health workers, community Elders and emerging Aboriginal and Torres Strait Islander researchers, with associate investigators including Betty Sagigi and Vonda Moor Malone, combined with ongoing capacity building, community engagement, training opportunities and ongoing clinical support.

Dr Russell, Rachel Quigley and Dr Strivens have also been working with local teams in Cairns and Yarrabah to validate a culturally safe and appropriate dementia screening tool for Aboriginal and Torres Strait Islander people via Telehealth.

Aboriginal and Torres Strait Islander International Women's Day Event – Workforce Development

The 2016 Aboriginal and Torres Strait Islander Women's Health Leadership Yarning Circle provided practical advice and strategies for women's leadership excellence and career advancement in the health sector, focusing on strategies to improve recruitment and retention of Aboriginal and Torres Strait Islander Workers. The forum provided a rare opportunity for Aboriginal and Torres Strait Islander women leaders and senior high school students to interact, mentor and share stories of career progression balanced with the lived experience of poor community outcomes.

Our organisation

OUR ORGANISATION

During 2015-16, we consolidated 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 Health Service are aligned with the Queensland Government Department of Health Strategic Plan 2016-2020 and the Government's objectives for the community to deliver better infrastructure and planning and revitalise frontline services.

The Queensland Government's objectives for the community:

The Queensland Government's objectives for the community

Creating jobs and a diverse economy

Our Health Service remains the largest employer in Far North Queensland, with 5821 individuals employed as at 30 June 2016.

Our Health Service is dedicated to delivering new infrastructure and investment to improve the healthcare of patients living within our region.

During 2015-16, locally available service delivery was enhanced with the opening of a Community Care Unit, offering a step down residential facility for adults recovering from mental illness who are returning to independent living.

Significant capital works continued in the 2015-16 financial year with $28 million allocated to the Cairns Hospital Redevelopment and $3.3 million for backlog maintenance across our Health Service. Other highlights included upgrades to fire services at Mossman, Herberton and Babinda Hospitals at a cost of $3.5 million, patient bathroom upgrades at Mareeba Hospital for $563,000, Mossman Hospital kitchen upgrade for $600,000 and an upgrade to Cairns Hospital theatres for $400,000. Electrical switchboards were upgraded at Herberton Hospital for $400,000 and replaced at Cairns Hospital at a cost of $1.5 million.

Delivering quality frontline services

The Health Service is committed to strengthening the public health system and strives to continually improve patient care, safety and outcomes.

Our contribution to the delivery of quality frontline services was exemplified in 2015-16 through the establishment of 10 specialised Nurse Navigator Complex Care Coordinator positions, established to facilitate the journey of a complex care patient through the health system. The Health Service implemented the Senior Intervention for Triage model into the Cairns Hospital Emergency Department, which aims to commence diagnostic tests and treatment early in the patient's presentation.

There has been considerable growth in Telehealth for clinical services. Patients are currently able to access and receive services with the use of video conferencing from their closest Queensland Health facility, with plans to extend the service to 'in home' video conferencing solutions to patients in the future.

In 2015-16 the Health Service reported 3,841 non-admitted patient Telehealth service events. This is a 34 per cent increase on the previous 2014-15 financial year where 2,860 non-admitted patient Telehealth service events were reported. The Health Service also reported 1,189 admitted patient Telehealth events in 2015-16. In 2014-15 there were 26 admitted patient telehealth events.

Building safe, caring and connected communities

The introduction of health technology is providing our Health Service with more opportunities to connect communities and collaborate with external partners. Locally, there has been strategic investment in ICT initiatives to improve clinical access to integrated and readily available patient information. The Digital Hospital solution is focused on improving patient safety and quality of care by providing the right information, at the right place, at the right time.

Supported by the Commonwealth of Australia's Health and Hospital Fund, the Regional eHealth Project intends to facilitate clinical and information sharing electronically between Queensland Health facilities and with external healthcare partners across Cairns and Hinterland Hospital and Health Service and Torres and Cape Hospital and Health Service. The proposed implementation of this solution further demonstrates how the Health Service supports patient focused, integrated care and collaborative service delivery as quickly and as closely to the patient as possible.

Patients living in remote areas within Northern Queensland also benefit from eHealth initiatives through the introduction of the MyHealth Record System. In collaboration with the Northern Queensland Primary Health Network, the initiative is expected to have a positive impact on the community's interaction with the health system by providing access to a patient's latest health information, test results, prescriptions, appointment cards, medication summaries and treatment plans.

OUR STRATEGIC OBJECTIVES

Strategic objective	Strategies	Progress in 2015-16
We will strive to continually improve patient care, safety and outcomes.	Maintain compliance requirements with all 15 Australian Council Healthcare Standards, including management and recording of quality improvement activities.	In 2015-16, the Health Service has undertaken a review of the Clinical Governance function, with the development of a draft Strategic Plan for Clinical Governance. The HHS is due for a periodic review for accreditation in 2016-17.
	Meet all Service Agreement KPIs.	The Health Service recorded improvements in KPIs including achieving zero patients waiting longer than clinically recommended for surgery, and improvements in a range of quality KPIs.
	Meet all Health Ombudsman reporting requirements.	Met all Health Ombudsman reporting requirements for 2015-16.
We will provide integrated and coordinated health care services that are patient-focussed and culturally appropriate.	That the Cairns and Hinterland Hospital and Health Service use population health data to guide the strategic and operational planning, facility utilisation and determination of actual service needs and priorities.	In 2015-16 service planning has been focussed on the proposed Atherton Hospital redevelopment. Data was used in the development of the Business Case for refurbishment of Atherton Hospital. In principle approval for this work was received in the May 2016 State Budget.
	Use the Health Services Plan to develop and implement mechanisms to provide integrated and co-ordinated health care services, with an action plan and timelines.	The Health Service has continued to work with the Primary Health Network and other service providers to improve the continuity of service provision, including the development of a number of clinical pathways, defining the most effective processes for outpatient referral. The Health Service has been actively involved in the Opt-Out trial of My Health Record led by the Primary Health Network.
We will actively engage stakeholders and consider their input in the delivery of healthcare services.	Policies and structures (including stakeholder map) are in place to ensure robust engagement processes, including feedback mechanisms, exist and are operationalised with respect to: • Community, • Workforce, • Clinicians, • Partners and • Other stakeholders	In 2015-16 the Health Service has strengthened its commitment to community engagement through the establishment of a specific Aboriginal and Torres Strait Islander Community Consultative Committee. The Committee's purpose is to collaborate with consumers and advocates on ways to address the health outcome inequalities experienced by Aboriginal and Torres Strait Islander people. This group is additional to the three pre-existing region-based Community Consultative Committees, which have been successfully raising community issues, and providing feedback on services.

Strategic objective	Strategies	Progress in 2015-16
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.	Each Division has a workforce plan that identifies current and future workforce requirements.	The Health Service has maintained a workforce plan, and undertaken targeted national and international recruitment
	Succession plans to be prepared for 100% of roles identified as 'critical' and identify gaps in active recruitment for business critical roles with a view to decreasing time for recruitment by 25 per cent.	One hundred and twenty-five (125) critical roles were identified as at June 2016, with succession plans in place for 76 per cent of these roles. The Health Service has reviewed recruitment processes to improve the quality and timeliness of recruitment.
	Support and facilitate innovative models of placement, and best practice quality frameworks for education and research.	The Health Service has continued to work with University and vocational providers, including a significant increase in Aboriginal and Torres Strait Islander trainees and student placements in 2015-16.
	Rebuild and reenergise our organisation by considering the results of the Employee Opinion Survey and actioning positive changes.	The Health Service has seen ongoing improvements in its Employee Opinion Survey results, and participation.
We will ensure fiscally responsible decision making while providing stable and sustainable health services.	Our expenditure will be within 1 per cent of our budget.	The Health Service will end the 2015-16 Financial Year with an overall deficit position of $20M. Organisation sustainability is a strong focus for the Board and Health Service in the coming years.
	That we remain a case-mix efficient service.	In 2015-16, the Health Service operated at a cost per weighted activity unit within 1 per cent of the state average.
We will establish engaged, consistent and timely decisions making processes at all levels of the organisation and at the closest point to service delivery.	The Performance and Accountability Framework has been implemented and operationalised including: • Development and implementation of communication and training mechanisms for all staff that clearly outline the Human Resource and Finance delegations within their line of management. • Evidence that decisions are being made within delegations closest to the point of service delivery.	The Performance and Accountability framework has been supported further over the 2015-16 FY through the development of Cairns and Hinterland Analytical Intelligence (CHAI), a sophisticated drill-down dashboard allowing better decision support closer to the front line of service delivery. The Health Service has undertaken substantial training, in both cost centre management and Human Resource management in 2015-16. The Health Service has reviewed all HR and financial delegations, to ensure that decisions can be made appropriately and responsively. Evidence from the Employee Opinion Survey indicates that the Health Service can do more to ensure front line team members are more aware of where decisions are made and the processes to inform and influence these.

Strategic objective	Strategies	Progress in 2015-16
We will establish engaged, consistent and timely decisions making processes at all levels of the organisation and at the closest point to service delivery.	Evidence of the systematic management of Corporate, Strategic and Clinical Risk.	The Health Service regularly reviews risk at a Board, Executive and Divisional level.
We will build, develop and implement information technology and systems that support integrated health care delivery and enhance organisational performance.	Implementation of Integrated Electronic Medical Record (ieMR) and the Digital Exemplar Hospital releases on time and on budget with full clinical engagement and functionality.	In February 2016, additional modules of the Digital Hospital went live, with a successful full implementation in March 2016. During the go-live period, there were no adverse patient safety events recorded that were attributed to Digital Hospital.
	Established and monitored compliance with minimum standards of access to ICT systems and infrastructure, across the HHS.	The Health Service upgraded infrastructure at Cairns Hospital to increase bandwidth availability and actively monitors compliance with minimum access standards. Regional sites have access issues due to bandwidth availability.
	Strategically invest in ICT initiatives to pursue integrated and accessible medical records across the sector to improve outcomes.	Across the Health Service, in 2015-16, computers in use in clinical and non-clinical settings have been upgraded to a contemporary operating system, with approximately half the fleet of computers replaced.
We will recognise and promote our standing and our achievements – locally, nationally and internationally.	Development and implementation of the communications strategy to capture and celebrate our achievements.	The Health Service has actively engaged with its internal and external community throughout 2015-16. The Health Service and its members have received numerous awards and recognitions, and the Health Service congratulates all involved.

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 Board appointed by the Governor in Council, as recommended by the Queensland Minister for Health and Minister for Ambulance Services.

Cairns and Hinterland Hospital and Health Board

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*. 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.

Board Members are conscious of the honour and responsibility of serving the health and wellbeing needs of the communities in Far North Queensland.

During the reporting period, the Cairns and Hinterland Hospital and Health Board members were:

Ms Carolyn Eagle

B.Com, FCA, CIA, CGAP, CRMA

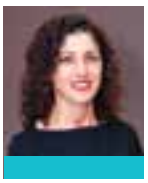
Date of appointment: 1 July 2012

Current term of office: 18 May 2014 to 17 May 2017

- Chair of the Cairns and Hinterland Hospital and Health Board (appointed 11 December 2015)
- A/Chair of the Cairns and Hinterland Hospital and Health Board (1 October 2015 to 11 December 2015)
- Deputy Chair of the Cairns and Hinterland Hospital and Health Board (1 July 2012 to 1 October 2015)
- Member, Audit and Risk Management Committee
- Chair, Finance and Performance Committee
- Member, Safety and Quality Committee

Other professional positions

- Director, Pacifica Pty Ltd
- Chair of the Audit Committee of three Queensland Local Government Authorities



Ms Leeanne Bou-Samra

LLB

Date of appointment: 1 July 2012

Current term of office: 18 May 2016 to 17 May 2019

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

Other professional positions

- Lawyer, Miller Bou-Samra Lawyers

Dr Peter Smith

FRACGP

Date of appointment: 18 May 2013

Current term of office:
18 May 2016 to 17 May 2019

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

Other professional positions

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

Dr Felicity Croker

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

Date of appointment: 23 August 2013

Current term of office:
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

Other 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.

Incoming Board Members

On 12 May 2016, His Excellency the Governor, acting on the advice of the Executive Council approved appointments to Queensland Hospital and Health Boards for terms commencing 18 May 2016. Board renewal is important to capture the past, present and future of the organisation and to ensure Board Members have the skills and expertise necessary to drive the organisation forward.

In addition to the reappointment of Ms Bou-Samra and Dr Smith we are pleased to welcome Ms Joann Schmider, Ms Gillian Shaw and Ms Anita Veivers to the Cairns and Hinterland Hospital and Health Board.

Ms Joann Schmider

B.Ed

Date of appointment: 18 May 2016

Current term of office:
18 May 2016 to 17 May 2017

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

Other professional positions

- Managing Director of ComUnity ACETs Pty Ltd
- Project Management, Rainforest Aboriginal People's Alliance
- Director, Mullen Bun Goon
- Director, Central Wet Tropics Institute for Country and Culture Aboriginal Corporation
- Board Member, Queensland State Library Aboriginal and Torres Strait Islander Advisory Committee
- Committee Member, Regional Development Australia Far North Queensland and Torres Strait Inc.
- Board Member, The Cairns Institute, International Advisory Board
- Director and Treasurer, National Aboriginal and Torres Strait Islander Women's Alliance

Ms Gillian Shaw

BCom, CA, MAICD

Date of appointment: 18 May 2016

Current term of office:
18 May 2016 to 17 May 2017

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

Other professional positions
- Business Manager and Company Secretary, Tropical Queensland Centre for Oral Health

Ms Anita Veivers

Date of appointment: 18 May 2016

Current term of office:
18 May 2016 to 17 May 2017

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

Other professional positions
- Executive Director of Centacare Cairns
- Chair, Far North Queensland Regional Disability Advisory Council
- Deputy Chair, Queensland Disability Advisory Council

Outgoing Board Members

Mr Robert (Bob) Norman

Fellow of the Australian Institute of Company Directors

Originally appointed 1 July 2012,
resigned from office 1 October 2015

- 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

Mr Bob Norman resigned as Chair and Member of the Cairns and Hinterland Hospital and Health Board on 1 October 2015. Mr Norman was the inaugural Board Chair, and with the support of the Board worked tirelessly over three and a half years to improve health outcomes and services to our community.

Mr Mario Calanna

B.Pharm. FAIM FACP MACID MAACP

Originally appointed 18 May 2013,
retired from office 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

Mr Bruce Peden

FCA (Fellow of the Institute of Chartered Accountants in Australia)

Originally appointed 18 May 2013,
retired from office 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

Mr Mario Calanna and Mr Bruce Peden did not seek reappointment to the Cairns and Hinterland Hospital and Health Board. We would like to thank Mr Calanna and Mr Peden for their dedication and commitment to serving the health needs of our community whilst on the Cairns and Hinterland Hospital and Health Board.

Board attendance

The Board meets monthly with 11 meetings typically scheduled each financial year, and an extraordinary Board meeting in August to approve the annual Cairns and Hinterland Hospital and Health Service Financial Statements. The attendance at 2015-16 Board meetings and prescribed committees was exemplary:

	Board Meeting	Resolution out of Session	Audit and Risk Management	Finance and Performance	Safety and Quality
Robert Norman*	4 of 4	3 of 3	1 of 1	1 of 1	1 of 1
Carolyn Eagle	12 of 12	17 of 21	4 of 5	2 of 3	2 of 3
Leeanne Bou-Samra	11 of 12	20 of 21	5 of 5	2 of 3	3 of 3
Mario Calanna**	11 of 11	19 of 19	4 of 4	3 of 3	3 of 3
Felicity Croker	11 of 12	17 of 21	5 of 5	3 of 3	3 of 3
Bruce Peden**	11 of 11	15 of 19	4 of 4	3 of 3	3 of 3
Peter Smith	12 of 12	20 of 21	5 of 5	3 of 3	3 of 3
Joann Schmider ***	0 of 1	2 of 2	0 of 1	-	-
Gillian Shaw***	1 of 1	2 of 2	1 of 1	-	-
Anita Veivers***	1 of 1	1 of 2	1 of 1	-	-

* Resigned on 1 October 2015
** Tenure concluded on 17 May 2016
*** Tenure commenced on 18 May 2016

Our board committees

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

The Board has established those prescribed committees required under the *Hospital and Health Boards Act 2011* 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 officers 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 2015-16 as the functions were subsumed by the Board Meeting.

Summary of out-of-pocket expenses

Out of pocket expenses paid to Board Members during the reporting period totalled $64.30.

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's 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 and its long term financial viability.

The Finance and Performance Committee convened on three occasions during 2015-16.

Community Advisory Group

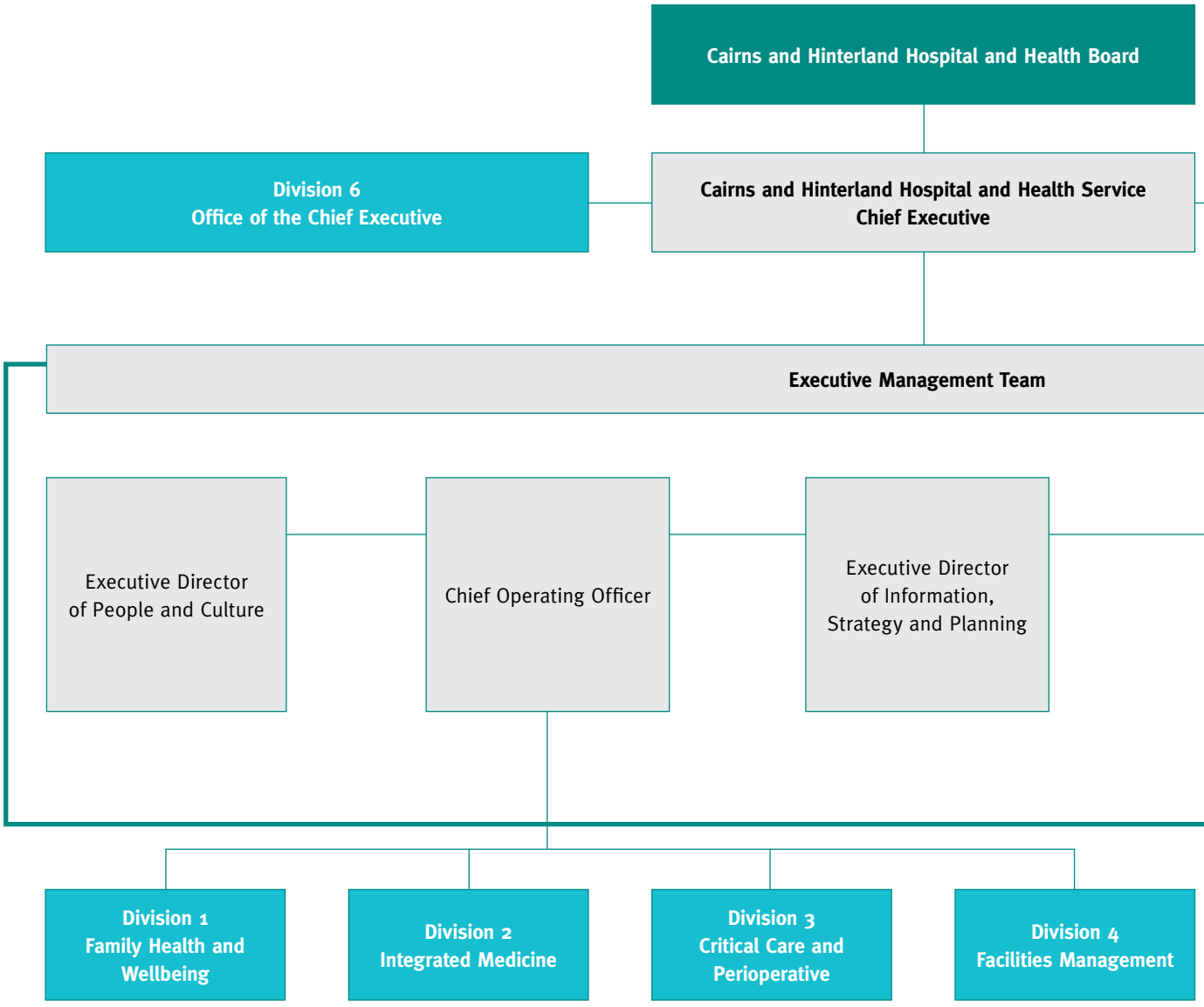
In response to the legislative requirement for community engagement and the desire of the Cairns and Hinterland Hospital and Health Board to involve the community in local health care delivery the Board established four Community Consultation Committees – the first Queensland Aboriginal and Torres Strait Islander Health Community Consultation Committee, together with Trinity, Hinterland and Cassowary Committtees.

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 which meets quarterly at a centrally located Health Service facility. The four Community Consultation Committees also meet quarterly throughout the year at regionally based Health Service facilities.

ORGANISATIONAL STRUCTURE

Cairns and Hinterland Hospital and Health Service Executive Organisation Chart



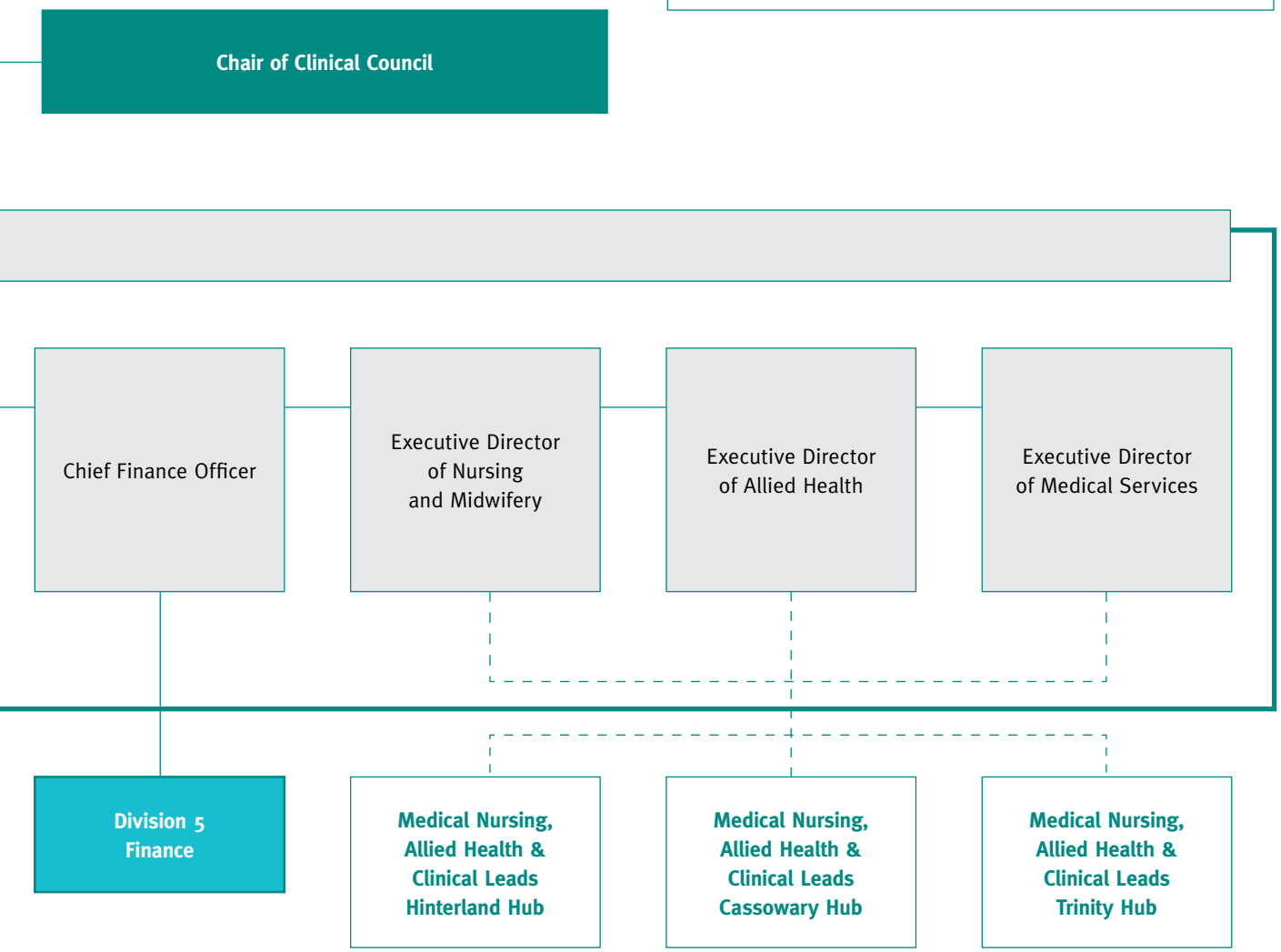
Note: Operational Accountability refers to day to day management and Professional Accountability refers to technical leadership.

Legend:

Operational accountability	———
Professional accountability	- - - - -

Colour key to hierarchy:

- Tier 1 = light grey (Executive)
- Tier 2 = red (Division)
- Other = maroon (Professional Leads)
- Other = white (Clinical Leads)



EXECUTIVE MANAGEMENT

Ms Clare Douglas
Interim Chief Executive

BAppSc (Nursing), GDipHlthA, MMgt, GAICD

Ms Clare Douglas was appointed as the interim Chief Executive for Cairns and Hinterland Hospital and Health Service commencing in June 2016. Clare is the substantive Chief Executive for the Mackay Hospital and Health Service, taking up this position on 15 September 2014.

Clare has over 15 years' experience as a senior executive in acute public health, private health and aged care sectors. She has a proven ability to liaise with a variety of stakeholders including Boards, State and Local Governments. Clare has a demonstrated capacity to develop effective teams to deliver financial and operational outcomes whilst maintaining quality services.

Clare has a background in nursing with post-graduate management qualifications.

Ms Julie Hartley-Jones, CBE
Former Chief Executive

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 left the Health Service in June 2016.

Mr Stephen Thacker
Chief Financial Officer

BA PGDip MA ACCA

Mr Stephen Thacker was appointed as Chief Finance Officer of the Cairns and Hinterland Hospital and Health Service in December 2015.

He is a born and bred North Queenslander having grown up in Townsville. Stephen started his career with local insurance, exhibition providers and remote and rural communities, before making his way overseas. Prior to accepting the appointment here as CFO, he spent the past six years working as a Senior Finance Manager with the National Health Service in the United Kingdom. Stephen brings to the role more than 25 years' experience across health and government sectors.

He is a member of the Association Chartered Certified Accountants and Member of the Institute of Directors.

Ms Tina Chinery
Chief Operating Officer

EMPA, DipEd, BAppSc (Nursing), AICD

Tina started her career as a nurse in Western Australia. Much of her recent career has been in leadership roles in country WA, including Regional Director for the Pilbara Region and Chief Operating Officer Southern for WA Country Health Service. In late 2014 Tina was asked by the Director General to oversee the commissioning of the Perth Children's Hospital as the Executive Director, Commissioning. Tina oversaw the commissioning program and ICT implementation for Perth Children's Hospital; the development and commissioning of three regional hospitals in country WA, developed the WA Country Health Services Mental Health Strategic Plan, and established a disaster response framework in the Pilbara that was utilised across country health. Tina received a Western Australian Premier's award for Enhancing the Pilbara Health Partnership a joint initiate between industry and Government, which included programs that increased Aboriginal employment in health and improving emergency services.

Dr Neil Beaton
Executive Director Medical Services

MBBS MRCGP FACRRM DA

Associate Professor Rural Medicine, James Cook University School of Medicine

Dr Neil Beaton is the Executive Director of Medical Services for the Cairns and Hinterland Hospital and Health Service. He was appointed to his position permanently in August 2010. He was previously the Medical Superintendent at Atherton Hospital and continues to practice anaesthetics and rural generalist practice.

Neil graduated from the University of Newcastle Upon Tyne Medical School in the UK in 1980 and emigrated to Australia in 1984, practicing in the Northern Territory, Victoria, New Zealand, Vanuatu, Cape York and Cairns. He has 10 years' experience in Aboriginal and Torres Strait Islander health services and primary medical care and service development and led the development of the Aboriginal and Torres Strait Islander health curriculum for ACRRM and RACGP. As Executive Director Medical Services he is responsible for patient safety and clinical governance, medical workforce and medical education in the Cairns and Hinterland Hospital and Health Service.

Dr Donna Goodman
Executive Director Allied Health

B.Psych (Hons), Ph.D., MAPS

Donna has been Executive Director of Allied Health for the Cairns and Hinterland Hospital and Health Service since July 2011, permanently appointed in July 2013. Prior to this, Donna worked as a Psychologist for 14 years in both public and private sector health settings in clinical, management and research roles before becoming the Director of Psychology for the Hospital and Health Service in 2008. Donna holds a Bachelor of Psychology and completed a Ph.D. in 2002 which investigated psychosocial adjustment to chronic illness. She completed a Masters in Clinical Psychology in 2015. Clinically, Donna's interests include chronic condition self-management adjustment to illness and disability, health behaviour change and chronic pain.

Ms Glynda Summers
Executive Director Nursing and Midwifery

MHA, MPub Pol., BA, Dip Admin (Nsg), CHIA, RN, RM, JP (Qual).

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.

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 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.

Ms Caroline Wagner
Executive Director People and Culture

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 recently completed a Graduate Diploma in Psychology with Monash University.

Mr Brad McCulloch
Executive Director Information, Strategy and Planning

BSc, GPCompSci, MPH, JP(Qual)

Mr Brad McCulloch was appointed as the Executive Director for Information, Strategy and Planning in September 2013. Before the establishment of the Health Service, 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.

The Clinical Council

The Cairns and Hinterland Hospital and Health Service Clinical Council is the peak representative body for clinicians within the Health Service. The Council provides a mechanism for clinician involvement and input into strategic and governance matters aimed at improving health care delivery in the Health Service.

The Council takes an active role in the planning of future clinical services, the improvement of current services, service standards, and the progression of clinical ideas or issues, by providing expert clinical knowledge to the Executive and the Board.

The Council strives to be the peak source of expert clinical knowledge, so that it can continue to provide advice for evidence based, clinician driven, high value care in order to maximise the beneficial use of health resources across the Health Service.

The Council comprises representatives who reflect the diversity of professional groups and facilities across the organisation.

The Chair of the Clinical Council sits on the Executive Management Team as the representative of the Council (and clinicians across the service), and reports on Council activities. The Chair of the Council also has an open invitation to the Cairns and Hinterland Hospital and Health Board to provide clinical advice to the Board, and meets with the Board Safety and Quality Committee quarterly to discuss current priorities and ongoing work activities.

Highlights of the Clinical Council for 2015 – 2016 include:

- Endorsed Clinician Engagement Strategy 2016-2019
- Endorsed Clinical Council Terms of Reference 2016-2017
- Re-alignment of top four work activities:
  1. Oral Health Pilot Trial
  2. Tropical Australian Academic Health Centre
  3. Review of Education, Training, and Research across the Health Service
  4. Clinician Engagement with Digital Hospital
- Appointment of a Coordinator to manage and support the Council's projects and top work activities.
- Developed relationship with the new North Queensland Primary Health Network Clinical Council.

- Queensland Clinical Senate members nominated/ endorsed. They are Dr Jenny Sando (Nursing), Dr Tjaart Grobbelaar (Medical) and Andree Malpas (Allied Health).
- Representatives from the Senior Medical Staff Association have a standing invitation to Council meetings as ex-officio members. This has progressed to full membership for 2016-2017.

Leadership of Council

Dr Jenny Sando, and Dr Eddy Strivens completed their final terms as Chair, and Deputy Chair. Dr Malcolm Donaldson (Chair) and Rudi De Faveri (Deputy Chair) were elected as interim leaders, and the new membership will vote to the positions permanently in December 2016.

Membership of Council

The Council expanded its membership and led a successful campaign to recruit to all of the vacant positions, which includes representatives from Cairns, the Community, and Rural Sites for Allied Health, Indigenous Health, Nursing, Medical, and Oral Health. The Council will begin the 2016-2017 term with a strong new membership, eager to contribute to the discussions and activities of the Council.

Members reviewed and provided feedback on the Strategic Plan, Operational Plan, Clinical Governance Framework, Seven Day Health Care Referral Paper, Open Disclosure Procedure, and Physician Assistant's Discussion Paper.

The Council reinstated the newsletter 'The Clinicians Voice', refreshed the intranet site, and are working to develop strategies for greater engagement with clinicians throughout the service.

Risk Management

Risk management practices are continuing to be developed within both corporate and clinical functions at all levels of the Health Service. Integrated risk management practices underpin the organisation's operational governance structure and processes.

We operate in a complex and challenging environment, balancing efficient service delivery with high quality health outcomes for patients. To achieve this, we utilise a balanced decision making approach, taking into account safety, quality, cost and activity using a risk management approach.

The Board's Audit and Risk Committee has oversight of the risk register and all high and medium organisational risks are presented quarterly.

The Health Service is participating in a collaborative initiative with the Department of Health to replace the current risk management system with an Integrated Safety Information System designed to collect, integrate, manage and report clinical incidents, workplace incidents, consumer feedback, staff feedback and risk.

The proposed web-based system will have the ability to integrate with selected existing Queensland Health enterprise systems. This improvement will increase the ability to report and evaluate effectiveness of risk management practices as well as enable incident reports and complaints to be linked to associated risks and enable all information to be viewed in the one system.

Internal Audit

The Health Service has an internal audit function to facilitate the maintenance and development of a strong internal control environment through reviews of prioritised risk areas and key activities.

For the year ended 30 June 2016, this function was undertaken using a co-sourced model, with an in-house team including a Director of Internal Audit and Senior Internal Auditor and further arrangements for external contractors as required. The Internal Audit team are members of professional bodies including the Institute of Internal Auditors and CPA Australia.

The Internal Audit function operates in accordance with a Board-approved Internal Audit Charter, which is reviewed annually, and with the Institute of Internal Auditors Professional Practices Framework. The Internal Audit Charter identifies the role and responsibility of the function, along with how it ensures independence and objectivity by reporting functionally to the Chief Executive and having a direct reporting line to the Audit and Risk Management Committee. The Internal Audit function is independent of management and the external auditors.

An Annual Internal Audit Plan is prepared and approved by the Executive Management Team, Audit and Risk Management Committee and Board at the start of each financial year. Internal Audit provides quarterly updates to the Executive Management Team and Audit and Risk Management Committee on the progress towards the plan.

All audit reports are presented to the relevant operational manager for management responses and then submitted to the Chief Executive and Audit and Risk Management Committee. Internal Audit follows up implementation of all review recommendations and presents a quarterly update on implementation to senior management, the Chief Executive and Audit and Risk Management Committee.

External scrutiny

The Health Service's operations are subject to regular scrutiny from external oversight bodies. These include, but are not limited to:

- Australian Council on Healthcare Standards (ACHS)
- Australian Health Practitioner Regulation Authority
- Coroner
- Crime and Corruption Commission
- Medical Colleges
- National Association of Testing Authorities Australia
- Office of the Health Ombudsman
- Postgraduate Medical Education Council of Queensland
- Queensland Audit Office

In 2015-16, the Queensland Audit Office (QAO) conducted cross-service audits which included coverage of our Health Service. Those relevant to our Hospital and Health Service were:

- Report 15: 2015-16 Queensland public hospital operating theatre efficiency
- Report 10: 2015-16 Queensland State Government: 2014-15 financial statements
- Report 5: 2015-16 Hospital and Health Services: 2014-15 financial statements

The Health Service considered the findings and recommendations contained in these reports and, where appropriate, has commenced taking action to implement recommendations or address issues raised.

Public Interest Disclosure

In accordance with section 160 of the *Hospital and Health Board Act 2011*, the Cairns and Hinterland Hospital and Health Service is required to include a statement in the annual report detailing the disclosure of confidential information in the public interest.

During 2015-16, there were no requests for public interest disclosure.

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

The 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: https://www.health.qld.gov.au/system-governance/contact-us/access-info/rti-application/

2015-16 Right to Information and Information Privacy data	
RIGHT TO INFORMATION	**TOTAL**
Total applications received	74
Applications Completed within timeframe	63
Applications not completed within timeframe	1
Applications currently in progress (still within legislative timeframe)	10

INFORMATION PRIVACY	**TOTAL**
Total applications received	101
Applications completed within timeframe	83
Applications not completed within timeframe	2
Applications currently in progress (still within legislative timeframe)	16

EXTERNAL REVIEW	**TOTAL**
This matter was resolved through the informal resolution process	2
This matter remains ongoing; currently undergoing informal resolution process with Office of the Information Commissioner	2

2014-15 Access data	
Administrative Access (Which includes MAI Act, medico legal reports, PIPA, subpoena etc, Work Cover Queensland, other e.g. certificates, insurance forms)	**TOTAL**
	1,753

Public Records Act 2002 (Qld)

The 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 Health Service seeks to comply with the General Retention and Disposal Schedule for Administrative Records, Version 7, Queensland State Archives (26 March 2014). Administrative records are only created, stored and maintained for some of the business activities undertaken.

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

Medical Records

The Health Service manages medical records through two key mechanisms: digital and paper-based.

Cairns Hospital, in February to March 2016, implemented a Digital Hospital system, as one of two exemplar facilities. Within Cairns Hospital, the majority of information that was previously collected on paper-based systems is now electronically collected. This allows for information to be available to multiple providers at a time and assists in the coordinated care of patients. All access to the system is controlled and logged.

Health Information Services, within the Health Service manages the paper records across the facilities and where required, scans information from paper records into the electronic medical record. Health Information Services is currently accredited by the Australian Council of Healthcare Standards. Systems are in place to ensure paper records are appropriately stored, secured from unauthorised access and protected from environmental threats. In addition Health Information Services have procedures and work instructions in place that ensure compliance with the Health Sector (Clinical Records) Retention and Disposal Schedule, QDAN 683 Version 1.

Our performance

An outline of the non-financial performance of the Cairns and Hinterland Hospital and Health Service delivery standards

	Notes	2015-2016 Target/est.	2015-2016 Est.Actual	2016-2017 Target/est.	2015-2016 Actual
Effectiveness measures					
Percentage of patients attending emergency departments seen within recommended timeframes:					
Category 1 (within 2 minutes)	1-3	100%	100%	100%	99.5%
Category 2 (within 10 minutes)		80%	76%	80%	79.3%
Category 3 (within 30 minutes)		75%	73%	75%	74.8%
Category 4 (within 60 minutes)		70%	78%	70%	79.9%
Category 5 (within 120 minutes)		70%	94%	70%	95.6%
All categories			79%		81.1%
Percentage of emergency department attendances who depart within four hours of their arrival in the department	1, 2	90%	80%	›80%	80.1%
Percentage of elective surgery patients treated within clinically recommended times:					
Category 1 (30 days)	4	›98%	93%	›98%	95%
Category 2 (90 days)		›95%	97%	›95%	98%
Category 3 (365 days)		›95%	100%	›95%	100%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	5	‹2.0	0.3	‹2.0	0.41
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit	6	›65%	56.9%	›65%	64.7%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	7	‹12%	17.5%	‹12%	17.4%
Percentage of specialist outpatients waiting within clinically recommended times:					
Category 1 (30 days)	8		54%	55%	58.1%
Category 2 (90 days)			27%	35%	33.5%
Category 3 (365 days)			48%	50%	57.8%
Median wait time for treatment in emergency departments (minutes)	1, 2	20	16	20	17
Median wait time for elective surgery (days)	4	25	23	25	22
Efficiency measures					
Average cost per weighted activity unit for Activity Based Funding facilities	9	$4,774	$4,983	$4,598	$5,083
Other measures					
Total weighted activity units:					
Acute Inpatient	10	60,659	65,383	62,902	63,809
Outpatients		14,189	13,406	14,117	14,417
Sub-acute		8,887	8,915	9,963	10,366
Emergency Department		15,325	17,845	15,920	19,372
Mental Health		7,779	7,107	8,077	6,744
Interventions and Procedures		10,425	11,580	10,504	12,102
Ambulatory mental health service contact duration (hours)	11	›77,500	79,341	›80,135	79,488

NON-FINANCIAL PERFORMANCE SUMMARY

The Cairns and Hinterland Hospital and Health Service strives to be a leader in innovation with an emphasis on effectively meeting the community's health needs 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. This year's performance has seen an improvement in outpatient referral wait times, Queensland Emergency Access Target (QEAT), National Elective Surgery Target (NEST) and Patient Off Stretcher time (POST).

This improved performance has been supported by the establishment of a Patient Flow Unit and a focus on improving the management of outpatient referrals through the Scheduled Care Unit project.

The past year saw the completion of the redevelopment of Cairns Hospital. This has resulted in increased bed capacity and self-sufficiency. In 2015-16, the overall number of Health Service patients able to be cared for close to home increased, particularly cardiology services by three per cent and urology services by seven per cent. Inpatient activity is up 14 per cent and Cairns Hospital Emergency Department presentations 6.2 per cent with the highest day being 226 presentations seen in one day.

The rural health facilities continue to provide excellent care close to home and in 2015-16 saw an increase in inpatient admissions of three per cent, and Emergency Department attendances of five per cent.

The Key Performance Indicators tables on the previous page provide a summary of our performance against major key performance indicators described in the Cairns and Hinterland Hospital and Health Service's Service Delivery Statement.

Notes:

1. The 2015-16 Estimated Actual figures are based on ten months of actual performance from 1 July 2015 to 30 April 2016. From 2015-16, Queensland Health expanded the centrally collected dataset from 26 emergency departments to include an additional 32 emergency services in regional and rural areas around Queensland. This expansion to 58 facilities provides a broader representation of the patients who require emergency services.
2. This information is sourced from the Queensland Health Emergency Data Collection (EDC). The EDC does not include attendances at the Cairns Hospital for March 2016 due to a temporary inability to report during the transition to a new electronic information system. Reporting functions for this facility will commence once the transition to the new electronic system is complete.
3. A Target/Estimate for percentage of emergency department patients seen within recommended timeframes is not included for the 'All Categories' as there is no national benchmark. The included triage category targets 2015-16 are based on the Australasian Triage Scale.
4. 2015-16 Estimated Actual figures are based on ten months of actual performance from 1 July 2015 to 30 April 2016.
5. Staphylococcus aureus are bacteria commonly found on around 30 per cent 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. The Target/Estimate for this measure aligns with the national benchmark of 2 cases per 10,000 acute public hospital patient days. The 2015-16 Estimated Actual figures are based on eight months of actual performance from 1 July 2015 to 29 February 2016.
6. Whilst overall Queensland has made significant progress in improving the rate of community follow up over the past five years, the department continues to work with HHSs regarding improvements in this area.
7. Whilst overall Queensland has made significant progress in reducing readmission rates over the past five years, with continued incremental improvements towards the nationally recommended target, the department continues to work with HHSs regarding improvements in this area. The 2016-17 Target/Estimate is the nationally recommended target.
8. The 2015-16 Estimated Actual figures are based on an average of ten months actual performance from 1 July 2015 to 30 April 2016 with the following exceptions due to a temporary inability to report for some facilities during the transition to a new electronic information system: no data has been included for the Cairns Hospital for the period February to April 2016. Reporting functions for this facility will commence once the transition to the new electronic system is complete. The 2015-16 Service Delivery Statement did not include a 2015-16 Target/Estimate as the target was under review. The review has been completed and has enabled HHS specific targets to be set for 2016-17.
9. The 2015-16 and 2016-17 Target/Estimate costs reflect the finance and activity schedules of the 2016-17 Round 2 Service Agreements Contract Offers (V3.10). The 2015-16 Target/Estimate is recalculated based on the funding provided in the Hospital and Health Service Agreements as at the March 2016 Deed of Amendment and the activity recalculated based on the Activity Based Funding (ABF) model Q19 Round 2 2016-17 Contract Offers to enable comparison with 2016-17 Target/Estimate figures. An adjustment for the full year reconciliation of ABF cost by the Hospital and Health Services has been reflected in the 2016-17 figures.
10. The weighted activity units reflect the finance and activity schedules of the 2016-17 Round 2 Service Agreements Contract Offers (v3.10). The 2015-16 Target/Estimate and the 2015-16 Estimated Actual figures have been recalculated as per the finance and activity schedules of the 2016-17 Round 2 Service Agreements Contract Offers (v3.10) to enable comparison.
11. This measure counts the number of in-scope service contact hours attributable to each HHS, based on the national definition and calculation of service contacts and duration. The target for this measure is determined using a standard formula based upon available clinical staffing, HHS rurality, and historical performance.

FINANCIAL PERFORMANCE SUMMARY

Services are commissioned by the Queensland Department of Health through the purchaser-provider model whereby services are purchased from the Health Service, facilitated and monitored through a service level agreement and underpinned by a performance framework.

The Cairns and Hinterland Hospital and Health Service ended the financial year with an operating deficit of $20.0 million, compared with an operating surplus of $8.84 million in the previous financial year.

Financial highlights

The deficit position of $20.0 million represents a 2.4 per cent over spend variance against the base revenue of $839.19 million for the year ended 30 June 2016. Although the Health Service has higher expenses compared with the revenue recorded, this is against a backdrop of increasing demand for services, increasing the self-sufficiency of services for the local community and improving delivery against key performance indicators.

In 2015-16, the Health Service delivered better access to services, improved flow within and across facilities, as well as greater ability to meet the needs of our community.

Where the funds came from

The Health Service's income from all funding sources for 2015-16 was $839.186 million and was principally derived from the ABF (Activity Based Funding) model with the Queensland Department of Health.

TOTAL INCOME COMPRISED

$735.72 million
Funding from State and Australian Government for **provision of health services**

$71.73 million
Other user **charges and fees**

$15.21 million
Australian Government **contributions**

$16.53 million
Donations, other revenue, interests, other grants and recoveries

CHART 1: Income by revenue sources

87.7% Funding for provision of health services

8.5% Other user charges and fees

1.8% Australian Government contributions

2.0% Donations, other revenue, interests, other grants and recoveries

Where funding was spent

Total expenses were $859.19 million, averaging $2.35 million per day to provide public health services. This is up from an average $1.97 million per day in 2014-15.

Expenditure has increased by $140.25 million on 2014-15 levels. Expenditure increased primarily due to Digital Hospital implementation, commencement of new and expanded services to address demand and improve our performance relating to access to services.

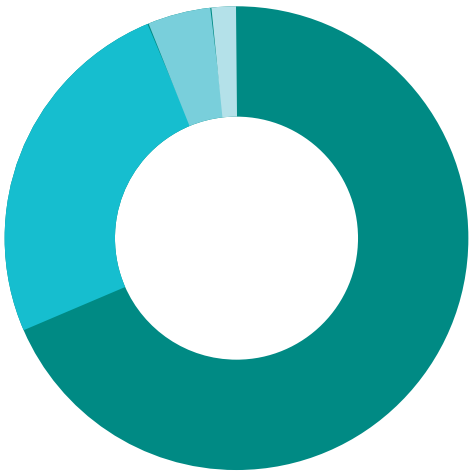
Cash and investments

As at balance date, the Health Service had $1.382 million in cash and investments. Utilisation of the existing debt facility in operation at year end results in an overall cash position of -$5.7 million. This balance is largely a result of the timing of outgoings including payroll.

Asset revaluation

During 2015-16 there was a revaluation of a remaining cohort of Land and Building Assets, leading to an increase to the Asset revaluation Surplus of $18.082 million, bringing the surplus balance to $71.361 million. This was due to an increase in the market value of the land and building subject to the revaluation.

Chart 2: The Health Service's expenditure areas



68.7% Employee expenses and Health Service employee expenses

25.6% Supplies and services

4.3% Depreciation and amortisation of the Health Service's assets

1.4% Other

Our people

Workforce planning and performance

The Health Service continues to be the largest employer in the Far North. As at 30 June 2016, there were 5821 full-time, part-time and casual employees delivering services across the Health Service. Our clinical and non-clinical staff work across six multidisciplinary operational divisions within the Health Service.

The focus on ensuring our people are aligned, capable and committed to delivering the best possible health care to our community continues by deploying the right people to the right service at the right place at the right time. A key challenge in having the right people and skills for the future is addressing the risks associated with an ageing workforce. Currently, 61 per cent of our workforce is aged over 40 and we expect the number of staff leaving our workforce to increase by 11 per cent as our workforce approaches retirement.

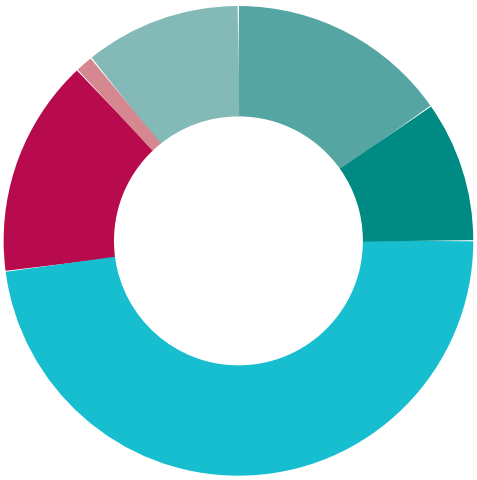
Early retirement, redundancy and retrenchment

During 2015-16, one employee received a redundancy package at a cost of $106,458.00. The Health Service remains committed to maximising permanent employment and employees will not be forced into unemployment as a result of organisational change or changes in agency priorities other than in exceptional circumstances and with the approval of the Chief Executive, Public Service Commission.

Employees affected by organisational change will be offered employment opportunities within the government, including retraining, deployment and redeployment.

Separation Type	Separation FTE	Separations
Changed to Casual	14.15	18
Separated Queensland Health	185.61	226

CHHHS Workforce Profile



48% Nursing

11% Professional and Technical

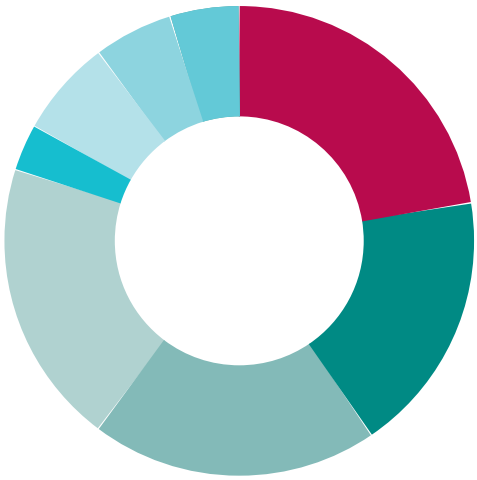
15% Operational

15% Managerial and Clerical

1% Trade and Artisans

10% Medical incl. VMOs

CHHHS Staff Age and Gender Profile



21.88% Female <19

3.13% Male <19

18.52% Female 20-39

6.48% Male 20-39

19.78% Female 40-59

5.22% Male 40-59

20.26% Female 60-79

4.74% Male 60-79

The development and implementation of our Strategic Workforce Plan has supported our focus on ensuring we have the right people, right service, right place, and right time.

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.

2015-2016 has seen the Health Service implement LinkedIn as a tool for attracting highly skilled employees to hard-to-fill positions. Testing using the Saville Wave psychometric suite of assessments continues to be integrated into senior level recruiting to ensure the best chance of recruiting a candidate with the right skills and organisational fit.

Staff orientation and induction

We commit to a personalised approach when inducting our new employees and provide them with all of 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 welcome all new employees by attending our Health Service-wide orientation at the Cairns Hospital on a monthly basis. During the year 2015-16, we welcomed 768 new employees into our Health Service through our orientation days.

Mandatory training

In order to meet legislative and compliance obligations, our employees are supported to participate in mandatory training. Mandatory training includes: induction, orientation, key health and safety programs, driver safety, code of conduct, ethics, the Cultural Practice Program and fire safety training.

To increase efficiency, consistency and availability, some of our mandatory training is available through our online learning platform, iLearn.

This allows for flexible delivery of training with online learning available to all employees. As we move into 2017, many more role-specific training options will become available through iLearn.

Our employees are given access to appropriate education and training about public sector ethics as part of our induction and continued learning.

Our procedures and management practices have proper regard to the ethics, principles and values of the Public Sector Code of Conduct.

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.

Recognition Week is about recognising those employees that reach significant tenure milestones and celebrating teams and individuals that display the core values in their everyday effort. Our Health Service will celebrate Recognition Week with divisions and facilities hosting local celebrations to recognise the contribution of their staff and congratulate those nominated for a recognition award.

Life Styles Inventory (LSI)

Our Health Service utilises the Life Styles Inventory (LSI) assessment tool which is designed to promote constructive change helping our leaders more clearly understand what is currently supporting and hindering their personal effectiveness.

We cultivate our leaders, to embrace the spirit of change and innovation and to strategically understand and align complex systems with the goal to achieve constructive outcomes. Leaders in the health industry require knowledge and skills relating to their LSI in order to be successful in generating and sustaining improved outcomes within the Health Service.

Leadership and Local Programs

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 and Step Up programs. In response to the recognised needs of our managers, the Organisational Development team have developed an action learning, blended training program to support LSI. Our middle management leadership program, Motivating and Managing for Performance (MMP), was designed especially for the unique challenges of managing a diverse workforce in a constantly changing environment, and has a strong emphasis on personal leadership.

During the 2015-16 year, 33 of our leaders participated through four cohorts, made up of differing disciplines creating shared learning experiences. The program explores the nature of team effectiveness and how managers can positively motivate, coach and performance manage their team. Our program has been highly successful in helping leaders identify their areas for growth and implement personal change. The program continues to evolve and attracts a high demand for places.

Employee Performance and Development (PaD) reviews

The Performance and Development (PaD) review process assists our managers, team leaders and employees to have meaningful and productive performance and development discussions. We encourage active participation and investment from all our employees in the performance management process to build better and more productive working relationships.

Flexible working arrangements

Our Health Service is committed to the provision of flexible work arrangements including part-time work and job sharing. Currently, 36 per cent of the Health Service workforce is part-time.

Information on our flexible work practices is communicated to employees within the initial vacancy advertising package and during orientation and induction as well as responding to direct enquiries from individuals to line managers and the human resource department.

Education and training

Our Education, Learning and Development teams have been evolving as we continue to foster and develop learning support. Learning support is embedded in day-to-day activity, supports development of professional networks and ultimately ensures the business has the knowledge and skills to deliver our Strategic Plan.

The Organisational Development team is responding to the needs of our organisation by expanding the learning offerings available to our employees, having an increased focus on online learning, and by encouraging and supporting collaborative learning.

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

- Administration Officers Education Incentive Fund
- Administrative Professional Program
- Operational Officers Program

Professional development support including finance and leave assistance is available to all of our employees through the Study and Research Assistance Scheme (SARAS). 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. Fifty-three of our Health Service employees accessed this support throughout 2015-16.

Point in Time Job History

54% Full time: 3,131

36% Part time: 2,091

10% Casual: 599

Indigenous Traineeship Program

In 2016 there has been a sustained emphasis on Indigenous employee development with the continuation of the school-based indigenous trainee program. Eight full time Indigenous Trainees worked in different departments throughout the Health Service, including Oral Health, Human Resources, Speech Pathology, Nutrition and Dietetics, Learning and Development, Nursing Administration, Aboriginal and Torres Strait Islander Health Unit and Rural and Health Support Services.

The Traineeship program not only benefits the trainee in gaining access to real work experience and career pathways, but it also benefits the Health Service by having our Indigenous Trainees welcome and assist our local Indigenous community accessing our services.

Our goal is that the trainees successfully complete their traineeship and either gain positions within our Health Service or go onto University, gain the relevant qualifications and come back to our Health Service to better serve our community.

Employee Opinion Survey

Our annual Employee Opinion Survey (EOS) gained a record participation rate for our Health Service of 48 per cent this year. With the purpose of the EOS being to explore employee perceptions of our workplace climate and wider organisational performance outcomes, our Employees are taking the opportunity to have their say about their engagement with the Health Service and wider organization. The Board and Executive are fully supportive of coordinated action plans that have been formulated from the survey feedback and cascaded up and down all levels of the organisation that better engage employees to the business.

Workplace Health and Safety

In order to meet legislative compliance, the Health Service has implemented a detailed Safety Management System in accordance with AS4801 that continues to evolve to meet the changing workplace requirements. This was proven in March 2016 when the Health Service again successfully passed its AS4801 compliance audit. The Workplace Health and Safety team continues to embed a Workplace Health and Safety culture within the HHS by partnering with our divisional colleagues to implement a robust and flexible Safety Management System that ensures the safety, health and wellbeing of all staff.

Injury numbers for staff have remained consistent with previous years despite the growth in staff numbers. As a consequence the Health Service has again had a decrease to the WorkCover premium rate for 2016/17 (see table below).

Year	13/14	14/15	15/16	16/17
CHHHS Premium rate	1.446	1.207	1.061	1.035
Industry Premium rate	1.297	1.087	1.154	TBD

Injury Management

Changes are occurring in the Rehabilitation and Injury Management team to improve early return to work outcomes for staff and for the Health Service.

Patient Handling

Improved capacity through increased support to the ward unit trainers is starting to see a cultural change at the grass roots level. Additional upskilling of more ward staff in Train the Trainer skills together with new equipment will lead to less physical intervention and fewer injuries from manual handling.

Occupational Violence Prevention

The new Occupational Violence Prevention program has been running for over 18 months now and the response to the program has been very positive from the staff attending. Demand for the program continues to increase in response to challenging behaviours exhibited by patients and consumers.
The Health Service has zero tolerance for occupational violence and continues to explore ways to reduce risks to our workforce.

Our financial statements

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE
FINANCIAL STATEMENTS – 30 JUNE 2016

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

For more 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 2016

	Notes	2016 $'000	2015 $'000
Income			
User charges and fees	2	807,453	693,427
Grants and other contributions	3	20,418	24,385
Interest		80	100
Other revenue	4	11,235	9,869
Total revenue		839,186	727,781
Total income		839,186	727,781
Expenses			
Employee expenses	5	(82,076)	(71,449)
Health service employee expenses	6	(507,942)	(434,938)
Supplies and services	7	(219,543)	(167,834)
Grants and subsidies		(32)	(2,602)
Depreciation and amortisation	8	(37,251)	(29,360)
Impairment losses	9	(1,971)	(3,149)
Other expenses	10	(10,371)	(9,609)
Total expenses		(859,186)	(718,941)
Operating result for the year		**(20,000)**	**8,840**
Other comprehensive income			
Items that will not be reclassified subsequently to operating result			
Increase in asset revaluation surplus	18	18,082	32,169
Total other comprehensive income		18,082	32,169
Total comprehensive income for the year		**(1,918)**	**41,009**

The accompanying notes form part of these statements.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Statement of Financial Position as at 30 June 2016

	Notes	2016 $'000	2015 $'000
Current assets			
Cash and cash equivalents	11	1,382	24,785
Receivables	12	34,913	26,485
Inventories	13	4,852	3,988
Other current assets		327	333
Total current assets		41,474	55,591
Non-current assets			
Intangible assets	14	649	5,104
Property, plant and equipment	15	711,524	628,017
Total non-current assets		712,173	633,121
Total assets		753,647	688,712
Current liabilities			
Bank overdraft	11	7,084	-
Payables	16	43,153	40,940
Accrued employee benefits	17	2,600	1,794
Unearned revenue		293	3,198
Total current liabilities		53,130	45,932
Total liabilities		53,130	45,932
Net assets		700,517	642,780
Equity			
Contributed equity		635,064	575,409
Accumulated surplus		(5,908)	14,092
Asset revaluation surplus	18	71,361	53,279
Total equity		700,517	642,780

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 2016

	Contributed equity	Accumulated surplus	Asset revaluation surplus (Note 18)	Total equity
	$'000	$'000	$'000	$'000
Balance as at 1 July 2014	575,338	5,252	21,110	601,700
Operating result for the year	-	8,840	-	8,840
Other comprehensive income:				
Increase in asset revaluation surplus	-	-	32,169	32,169
Total comprehensive income for the year	-	8,840	32,169	41,009
Transactions with owners as owners:				
Correction of prior year error – assets not previously recognised	1,855	-	-	1,855
Non appropriated equity asset transfers	10,578	-	-	10,578
Non appropriated equity injections	16,991	-	-	16,991
Non appropriated equity withdrawals (Depreciation funding)	(29,353)	-	-	(29,353)
Net transactions with owners as owners	71	-	-	71
Balance as at 30 June 2015	**575,409**	**14,092**	**53,279**	**642,780**
Balance as at 1 July 2015	575,409	14,092	53,279	642,780
Operating result for the year	-	(20,000)	-	(20,000)
Other comprehensive income:				
Increase in asset revaluation surplus	-	-	18,082	18,082
Total comprehensive income for the year	-	(20,000)	18,082	(1,918)
Transactions with owners as owners:				
Non appropriated equity asset transfers	74,884	-	-	74,884
Non appropriated equity injections	22,023	-	-	22,023
Non appropriated equity withdrawals (Depreciation funding)	(37,252)	-	-	(37,252)
Net transactions with owners as owners	59,655	-	-	59,655
Balance as at 30 June 2016	**635,064**	**(5,908)**	**71,361**	**700,517**

The accompanying notes form part of these statements.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Statement of Cash Flows for the year ended 30 June 2016

	Note	2016 $'000	2015 $'000
Cash flows from operating activities			
Inflows:			
User charges and fees		756,268	655,699
Grants and other contributions		19,879	24,012
Interest receipts		80	100
GST input tax credits from Australian Tax Office		16,528	13,451
GST collected from customers		575	489
Other receipts		11,774	8,439
Outflows:			
Employee expenses		(83,633)	(69,719)
Health service employee expenses		(504,097)	(446,975)
Supplies and services		(219,338)	(168,863)
Grants and subsidies		(32)	(2,602)
GST paid to suppliers		(17,008)	(13,302)
GST remitted to Australian Tax Office		(581)	(454)
Other		(9,754)	(9,352)
Net cash provided by (used in) operating activities	19	**(29,339)**	**(9,077)**
Cash flows from investing activities			
Outflows:			
Payments for property, plant and equipment		(23,152)	(14,270)
Payments for intangibles		(19)	(4,815)
Net cash provided by (used in) investing activities		**(23,171)**	**(19,085)**
Cash flows from financing activities			
Inflows:			
Equity injections		22,023	16,991
Net cash provided by (used in) financing activities		22,023	16,991
Net increase / (decrease) in cash and cash equivalents		(30,487)	(11,171)
Cash and cash equivalents at the beginning of the financial year		24,785	35,956
Cash and cash equivalents at the end of the financial year	11	**(5,702)**	**24,785**

The accompanying notes form part of these statements.

Notes to the Financial Statements 30 June 2016

Index of Notes

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

1. Summary of significant accounting policies

(a) Statement of compliance

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

These financial statements are general purpose financial statements, and have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations. In addition, the financial statements comply with Queensland Treasury's *Minimum Reporting Requirements* for the year ending 30 June 2016, 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 revenues, expenses, assets, liabilities and equity of the HHS. The HHS does not have any controlled entities.

(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 HHS having no discretion over the use of monies. As such they are not part of the HHS's 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 are disclosed in Note 24(a).

Right of Private Practice arrangement

The HHS has a Right of Private Practice (ROPP) arrangement in place.

On 4 August 2014 new private practice arrangements were made available at the HHS's discretion. Hospital and Health Services now hold the prerogative to grant a clinician limited rights to conduct private practice on the terms and conditions of the private practice schedule within the employment contract (granted private practice). These new arrangements introduced two new contract options replacing Options A/B/P and R. Private practice during employed time is integrated into the employment contract as a schedule and will no longer be a separate contract.

The contract options are:

1. Assignment where all revenue is assigned to the HHS
2. Retention where a clinician engaging in private practice during employed time can retain private practice revenue after paying service fees and GST to the HHS. Amounts over a ceiling cap are split 1/3 to the doctor and 2/3 to the Private Practice Trust Fund.

Private Practice in Queensland public hospitals is supported by the Health Service Directive#QH-HSD-044:2014 Private Practice in the Queensland Public Health Sector (http://www.health.qld.gov.au/directives/docs/hsd/qh-hsd-044.pdf)

The Private Practice Trust Fund has been established to fund various educational, study and research programmes for HHS staff. A Study, Education, Research, Training and Administration (SERTA) committee approves the expenditure of this Fund.

Recoverables (administration costs etc.) in respect of the retained revenue, which the HHS is entitled to, are recorded in the statement of comprehensive income.

The only asset of the arrangement is cash, the balance of which is held in the Private Practice bank account. This account does not form part of the cash and cash equivalents of the HHS. As at 30 June 2016 the balance was $1.636 million ($1.266 million as at 30 June 2015).

(d) User charges and fees

Funding is provided predominantly by the Department of Health for specific public health services purchased by the Department in accordance with a service agreement. The Department of Health receives its revenue for funding from the Queensland Government (majority of funding) and the Commonwealth. Activity based funding is based on an agreed number of activities, per the service agreement and a state-wide price by which relevant activities are funded.

1. Summary of significant accounting policies (continued)

(d) User charges and fees (continued)

Block funding is not based on levels of public health care activity. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered. The funding from the Department is received fortnightly in advance. At the end of the financial year, a financial adjustment may be required where the level of service provided is above or below the agreed level.

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

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 10. 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 23. for restricted assets.

In accordance with section 31(2) of the *Statutory Bodies Financial Arrangements Act 1982*, the HHS obtained approval by Queensland Treasury 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 25. (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 25. c).

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

1. Summary of significant accounting policies (continued)

(j) Inventories

Inventories consist mainly of clinical supplies and pharmaceuticals held for distribution in hospital and health service facilities. Inventories are measured at weighted average cost, adjusted for obsolescence. These supplies are expensed once issued from the HHS.

(k) 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*.

(l) Property, plant and equipment

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

(m) Revaluations of non-current physical 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's Non-Current Asset Policies for the Queensland Public Sector*. These assets are reported at their revalued amounts.

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

Land and buildings are measured at fair value each year using independent revaluations, desktop market revaluations or indexation. Independent revaluations are performed with sufficient regularity to ensure assets are carried at fair value.

In 2015-16 the HHS engaged Davis Langdon Australia Pty Ltd (Davis Langdon), an AECOM company, to value a selected sample of buildings and Knight Frank to value land as at 30 June 2016. In accordance with Queensland Treasury Non-Current Asset Policy the independent revaluations occur at least every five years. In the off cycle years indexation is applied where there is no evidence of significant market fluctuations in land and building prices. Davis Langdon provided building indexation for 2015-16.

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 1.n).

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 15 for more details.

Reflecting the specialised nature of health service buildings and on hospital-site residential facilities, fair value 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.

1. Summary of significant accounting policies (continued)

(m) Revaluations of non-current physical assets (continued)

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
- Number 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 per cent of capital replacement cost)
4	Requires renewal	Complete renewal of the internal fit out and engineering services required (up to 70 per cent of capital replacement cost)
5	Asset unserviceable	Complete asset replacement required

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.

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.

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.

(n) 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

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

inputs or estimated using another valuation technique.

1. Summary of significant accounting policies (continued)

(n) Fair value measurement (continued)

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

Unobservable inputs are data, assumptions and judgements that are not available publicly, but are relevant to the characteristics of the assets/liabilities being valued. Significant unobservable inputs 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 and there were no transfers of assets between fair value hierarchy levels during the period.

(o) 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.

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 percent and 20 percent. Expenditure on research activities relating to internally-generated intangible assets is recognised as an expense in the period in which it is incurred.

(p) 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.

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:

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

1. Summary of significant accounting policies (continued)

(q) Impairment of non-current assets

A review is conducted annually in order to isolate indicators of impairment in accordance with AASB 136 *Impairment of Assets*. If an indicator of impairment exists, the HHS determines the asset's recoverable amount (the higher of value in use or fair value less costs of disposal). Any amount by which the asset's carrying amount exceeds the recoverable amount is considered an impairment loss.

(r) 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.

(s) 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
- Receivables – held at amortised cost
- Payables – held at amortised cost

The HHS does not enter into transactions for speculative purposes, nor for hedging. All other disclosures relating to the measurement and financial risk management of financial instruments held by the HHS are included in Note 25.

(t) Employee benefits

Employer superannuation contributions, annual leave levies and long service leave levies are regarded as employee benefits. Workers' compensation insurance is a consequence of employing employees, but is not counted in an employee's total remuneration package. It is not an employee benefit and is recognised separately as an employee related expense.

Health service employees

In accordance with the *Hospital and Health Boards Act 2011* (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 and on-costs of these employees.
- From August 2014, Senior Medical Officers entered into individual contracts with the HHS.

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.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

1. Summary of significant accounting policies (continued)

(t) Employee benefits (continued)

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.*

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.*

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 W*hole 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 26 for the disclosures on key executive management personnel and remuneration.

(u) 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 10.

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.

1. Summary of significant accounting policies (continued)

(v) 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, finance transactional services, taxation services, supply services and information technology services. As the fair value of these services is unable to be estimated reliably, no associated revenue and expense is recognised in the Statement of Comprehensive Income.

(w) Contributed equity

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.

(x) Taxation

The HHS is a State body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). FBT and GST are the only taxes accounted for by the HHS.

The Australian Taxation Office (ATO) has recognised the Department of Health and the sixteen Queensland 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 12.

(y) 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.

(z) 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. Revisions to accounting estimates are recognised in the period in which the estimate is revised and in future periods as relevant.

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

- Impairment of receivables – Note 1.i) and Note 25.
- Valuation of property, plant and equipment – Note 1.m) - n) and Note 15.
- Contingencies - Note 22.
- Depreciation and amortisation – Note 1.p) and Note 8.

aa) Other presentation matters

Currency and rounding

Amounts included in the financial statements are in Australian dollars and have been rounded to the nearest $1,000.

Comparatives

Comparative information has been restated where necessary to be consistent with disclosures in the current reporting period.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

ab) New and revised accounting standards

First year application of new standards or change in policy

Changes in accounting policy

The HHS did not voluntarily change any of its accounting policies during 2015-16.

Accounting Standards early adopted for 2015-16

Two Australian Accounting Standards have been early adopted for the 2015-16 year as required by Queensland Treasury. These are:

AASB 2015-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101 [AASB 7, AASB 101, AASB 134 & AASB 1049]

The amendments arising from this standard seek to improve financial reporting by providing flexibility as to the ordering of notes, the identification and location of significant accounting policies and the presentation of sub-totals, and provide clarity on aggregating line items. It also emphasizes only including material disclosures in the notes.

AASB 2015-7 Amendments to Australian Accounting Standards – Fair Value Disclosures of Not-for-Profit Public Sector Entities [AASB 13]

This standard amends AASB 13 *Fair Value Measurement* and provides relief to not-for-profit public sector entities from certain disclosures about property, plant and equipment that is primarily held for its current service potential rather than to generate future net cash inflows. The relief applies to assets under AASB 116 *Property, Plant and Equipment* which are measured at fair value and categorised within Level 3 of the fair value hierarchy.

As a result, the following disclosures are no longer required for those assets. In early adopting the amendments, the following disclosures have been removed from the 2015-16 financial statements:

- disaggregation of certain gains/losses on assets reflected in the operating result;
- quantitative information about the significant unobservable inputs used in the fair value measurement , and
- a description of the sensitivity of the fair value measurement to changes in the future unobservable inputs.

Accounting Standards applied for the first time in 2015-16

No new Australian Accounting Standards effective for the first time in 2015-16 had any material impact on this financial report.

Future impact of Accounting Standards not yet effective

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

AASB 124 Related Party Disclosures

From reporting periods beginning on or after 1 July 2016, the HHS will need to comply with the requirements of AASB 124 *Related Party Disclosures*. That accounting standard requires a range of disclosures about the remuneration of key management personnel, transactions with related parties/entities, and relationships between parent and controlled entities. The HHS already discloses information about the remuneration expenses for key management personnel (refer to Note 26) in compliance with requirements from Queensland Treasury. Therefore, the most significant impact of AASB 124 for the HHS's financial statements will be the disclosures to be made about transactions with related parties, including transactions with key management personnel or close members of their families.

AASB 15 Revenue from Contracts with Customers

This Standard will become effective from reporting periods beginning on or after 1 January 2018 and contains much more detailed requirements for the accounting for certain types of revenue from customers. Depending on the specific contractual terms, the new requirements may potentially result in a change to the timing of revenue from sales of the HHS's goods and services, such that some revenue may need to be deferred to a later reporting period to the extent that the HHS has received cash but has not met its associated obligations (such amount would be reported as a liability (unearned revenue) in the meantime). The HHS is yet to complete its analysis of current arrangements for sale of its goods and services, but at this stage does not expect a significant impact on its present accounting practices.

1. Summary of significant accounting policies (continued)

ab) New and revised accounting standards (continued)

AASB 9 Financial Instruments and AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)

These Standards will become effective from 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, impairment and disclosures associated with the HHS's financial assets. AASB 9 will introduce different criteria for whether financial assets can be measured at amortised cost or fair value.

The HHS is yet to fully assess the impact of these standards, however, given the nature of and limited extent of financial instruments held, the impact is expected to be minimal.

AASB 16 Leases

This Standard will become effective for reporting periods on or after 1 January 2019. When applied, the standard supersedes AASB 117 *Leases*, AASB Interpretation 4 *Determining whether an Arrangement contains a Lease*, AASB Interpretation 115 *Operating Leases – Incentives* and AASB Interpretation 127 *Evaluating the Substance of Transactions Involving the Legal Form of a Lease*. The HHS has not yet quantified the impact on the Statement of Comprehensive Income or the Statement of Financial Position of applying AASB 16 to its current operating leases, including the extent of additional disclosure required.

Impact for Lessees

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

In effect, the majority of operating leases (as defined by the current AASB 117) will be reported on the statement of financial position under AASB 16. There will be a significant increase in assets and liabilities for entities that lease assets. The impact on the reported assets and liabilities would be largely in proportion to the scale of the entity's leasing activities.

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

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

2. User charges and fees

	Share of funding		2016	2015
	State	*Australian Government*		
Funding for the provision of public health services			**$'000**	**$'000**
Activity based funding	306,965	206,234	513,199	484,139
Block funding	40,465	22,408	62,873	72,727
Teacher training funding	14,924	2,118	17,042	16,673
General purpose funding	142,607	-	142,607	63,951
Total government funding			735,721	637,490
Pharmaceutical Benefits Scheme subsidy			32,006	21,435
Hospital fees			34,125	30,451
Rental income			8	9
Other			5,593	4,042
Total			**807,453**	**693,427**

3. Grants and other contributions

	2016	2015
Australian government grants		
Nursing home grants	2,796	2,225
Specific purpose – capital grants	657	598
Specific purpose payments	11,754	14,638
Total Australian government grants	15,207	17,461
Other		
Donations other	475	2,454
Donations non-current physical assets	539	373
Other grants	4,197	4,097
Total	**20,418**	**24,385**

4. Other revenue

	2016	2015
Sale proceeds for assets	53	80
Licences and registration charges	29	42
Gains on asset stocktake write on	-	1,431
Recoveries from other agencies and other hospital and health services	11,154	8,041
Other revenue	(1)	275
Total	**11,235**	**9,869**

5. Employee expenses*

	2016 $'000	2015 $'000
Employee benefits		
Wages and salaries	70,263	61,316
Annual leave levy	5,198	4,306
Employer superannuation contributions	5,144	4,527
Long service leave levy	1,464	1,281
Employee related expenses		
Workers compensation premium	7	18
Payroll tax	-	1
Total	82,076	71,449

	No.	No.
Number of employees**	208	188

* Employee expenses include the health executives and divisional directors. Employee expenses also include senior medical officers who entered into individual contracts commencing August 2014. Refer to Note 1. t) and Note 26.

** 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.

6. 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.

	2016 $'000	2015 $'000
Health service employee expenses	500,548	427,417
Health service employee related expenses*	5,371	5,908
Other health service employees related expenses	2,023	1,613
Total	507,942	434,938

	No.	No.
Number of health service employees**	4,607	4,164

* The health service employee related expenses include $5.341 million of workers' compensation insurance premium partly offset by workcover recoveries.

** 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 1. t).

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

7. Supplies and services

	2016 $'000	2015 $'000
Agency fees	2,313	1,181
Electricity and other energy	8,781	7,264
Patient travel	14,162	13,787
Other travel	6,927	5,447
Building services	1,847	1,951
Computer services	8,081	3,956
Motor vehicles	568	591
Communications	9,111	8,259
Consultancies	9,595	(1)
Repairs and maintenance	11,999	9,773
Minor works including plant and equipment	1,811	1,300
Operating lease rentals	5,314	5,719
Pharmaceuticals and clinical supplies		
Drugs	43,376	32,684
Clinical supplies and services	49,247	39,814
Catering and domestic supplies	13,327	12,423
Pathology, blood and parts	17,104	14,266
Other	15,980	9,420
Total	219,543	167,834

8. Depreciation and amortisation

Depreciation and amortisation were incurred in respect of:		
Buildings and land improvements	27,301	21,208
Plant and equipment	9,745	8,033
Software purchased	205	119
Total	37,251	29,360

9. Impairment losses

Impairment losses on receivables	(1,115)	1,745
Bad debts written off	3,086	1,404
Total	1,971	3,149

10. Other expenses

	2016 $'000	2015 $'000
External audit fees*	190	209
Insurance premiums - QGIF	8,048	7,517
Insurance premiums - Other	57	59
Net losses from the disposal of non-current assets	372	186
Special payments - ex-gratia payments	12	5
Other legal costs	324	361
Advertising	370	246
Interpreter fees	249	284
Other	749	742
Total	**10,371**	**9,609**

*Total audit fees paid to the Queensland Audit Office relating to the 2015-16 financial year are estimated to be $190,000 (2015: $200,000 actual) including out of pocket expenses. There are no non-audit services included in this amount.

11. Cash and cash equivalents

Cash at bank and on hand	-	23,344
24 hour call deposits	1,382	1,441
Cash and cash equivalents	1,382	24,785
Bank overdraft used for cash management purposes	(7,084)	-
Cash and cash equivalents in the Statement of Cash Flows (Note 25d)	**(5,702)**	**24,785**

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 2.6% to 3.6% (2015: 2.8% to 4.2%).

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

12. Receivables

	2016 $'000	2015 $'000
Current		
Trade debtors	35,867	29,375
Other debtors	333	-
Less: Allowance for impairment loss	(3,080)	(4,196)
	33,120	25,179
GST input tax credits receivable	1,856	1,376
GST payable	(66)	(72)
	1,790	1,304
Payroll receivables	1	1
Sundry debtors	2	1
Total	**34,913**	**26,485**

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

13. Inventories

Inventories held for distribution:		
Drugs	4,183	3,202
Clinical supplies and services	572	655
Catering and domestic supplies	97	131
Total	**4,852**	**3,988**

14. Intangible assets

	2016 $'000	2015 $'000
Software purchased: At cost		
Gross	1,098	5,348
Less: Accumulated amortisation	(449)	(244)
Total	649	5,104

	Software purchased $'000	Total $'000
Intangibles reconciliation		
Carrying amount at 1 July 2015	5,104	5,104
Acquisitions	19	19
WIP transfer to operating expense - gross value	(4,269)	(4,269)
Amortisation	(205)	(205)
Carrying amount at 30 June 2016	649	649
Carrying amount at 1 July 2014	408	408
Acquisitions	4,815	4,815
Amortisation	(119)	(119)
Carrying amount at 30 June 2015	5,104	5,104

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

15. Property, plant and equipment

	2016 $'000	2015 $'000
Land: at fair value		
Gross	39,908	36,590
Buildings: at fair value		
Gross	963,913	836,057
Less: Accumulated depreciation	(357,996)	(294,682)
	605,917	541,375
Plant and equipment: at cost		
Gross	109,896	95,297
Less: Accumulated depreciation	(52,383)	(48,367)
	57,513	46,930
Capital works in progress		
At cost	8,186	3,122
Total	**711,524**	**628,017**

Land

Notwithstanding that a full comprehensive valuation of land holdings was undertaken in the previous year, the HHS decided to have a desktop valuation undertaken for the current year as land values in the area can be somewhat volatile. The HHS land was revalued based on specific appraisals by Knight Frank effective 30 June 2016.The fair value of land was based on publicly available data on sales of similar land in nearby locations in the six months prior to the date of the revaluation. In determining the values, adjustments were made to the sales data to take into account the location of the HHS land, its size, street/road frontage and access, and any significant restrictions. The extent of the adjustments made varies in significance for each parcel of land - refer to the reconciliation table in this note for information about the fair value classification of the HHS land.

The revaluation program for 2015-16 resulted in a net increment of $3.318 million (2014-15: increment of $7.970 million) to the carrying amount of land.

Buildings

In 2014-15, management took the opportunity to seek revaluations for all buildings, regardless of value or size, bringing the revaluation coverage over the last 3 years to 100 per cent.

In 2015-16, buildings identified to be re-valued only related to capital works in progress projects that were not completed at the time of the 2014-15 revaluation process. These projects are recognised as transfers in from the Health Infrastructure Branch upon practical completion. Under Australian Accounting Standard (AASB) 116, it is only permissible to have either the cost model or revaluation model applied to assets when determining their value. Further to this, AASB 116 requires a review of the remaining useful life of all assets at least once each financial year end.

For the 2015-16 building revaluations exercise, Davis Langdon again was engaged to perform independent revaluations on sites selected by the HHS.

The HHS also sought a separate internal review of the building revaluations received from BEMS to ensure that there was a robust platform on which to make decisions with regards to the capital transfer values from DoH.

15. Property, plant and equipment (continued)

Buildings (continued)

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 2015-16 resulted in a net increment to the building portfolio of $14.754 million (2014-15: increment of $24.199 million).

Property, plant and equipment reconciliation

	Land*	Buildings**		Plant & equipment	Work in progress	Total
	Level 2	Level 2	Level 3			
	$'000	$'000	$'000	$'000	$'000	$'000
Carrying amount at 1 July 2015	36,590	1,741	539,634	46,930	3,122	628,017
Acquisitions	-	-	2,752	12,857	7,543	23,152
Transfers in from other Queensland Government entities***	-	-	72,221	6,903	29	79,153
Donations received	-	-	-	539	-	539
Disposals	-	-	(19)	(354)	-	(373)
Transfers between asset classes	-	-	2,125	383	(2,508)	-
Net revaluation increments	3,318	-	14,764	-	-	18,082
Depreciation	-	(49)	(27,252)	(9,745)	-	(37,046)
Carrying amount at 30 June 2016	**39,908**	**1,692**	**604,225**	**57,513**	**8,186**	**711,524**

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

15. Property, plant and equipment (continued)

	Land*	Buildings**		Plant & equipment	Work in progress	Total
	Level 2	Level 2	Level 3			
	$'000	$'000	$'000	$'000	$'000	$'000
Carrying amount at 1 July 2014	30,108	5,304	518,275	42,753	316	596,756
Acquisitions	-	-	3,930	7,535	2,806	14,271
Transfers in from other Queensland Government entities***	-	-	14,885	1,222	-	16,107
Asset stocktake write on	-	-	547	884	-	1,431
Correction of prior year error to contributed equity	-	-	1,845	10	-	1,855
Donations received	-	-	-	373	-	373
Disposals	-	-	-	(185)	-	(185)
Transfers out to other Queensland Government entities	(1,488)	(2,533)	(366)	(1,134)	-	(5,521)
Transfers between asset classes	-	-	(3,503)	3,503	-	-
Net revaluation increments	7,970	(955)	25,154	-	-	32,169
Depreciation	-	(75)	(21,133)	(8,031)	-	(29,239)
Carrying amount at 30 June 2015	36,590	1,741	539,634	46,930	3,122	628,017

* Land level 2 assets represent vacant land in an active market.

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

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

16. Payables

	2016 $'000	2015 $'000
Current		
Trade creditors	5,466	5,849
Accrued expenses	17,894	14,726
Department of Health payables*	19,793	20,365
Total	43,153	40,940

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

17. Accrued employee benefits

Salaries and wages accrued	2,508	1,810
Other employee entitlements payable	92	(16)
Total	2,600	1,794

18. Asset revaluation surplus by class

Land		
Balance at the beginning of the financial year	9,397	1,427
Revaluation increment	3,318	7,970
Balance at the end of the financial year	12,715	9,397
Buildings		
Balance at the beginning of the financial year	43,882	19,683
Revaluation increment	14,764	24,199
Balance at the end of the financial year	58,646	43,882
Total	71,361	53,279

The asset revaluation surplus represents the net effects of revaluation movements in assets. Refer to Note 15.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

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

	2016 $'000	2015 $'000
Operating surplus/(deficit)	(20,000)	8,840
Depreciation and amortisation expense	37,251	29,360
Equity funding for depreciation and amortisation	(37,252)	(29,353)
Impairment losses on receivables	-	1,746
Net loss on disposal of non-current assets	372	186
Asset stocktake write on	-	(1,431)
Donated assets received	(538)	(373)
Change in assets and liabilities:		
(Increase)/decrease in trade and other receivables	(7,942)	(9,751)
(Increase)/decrease in GST receivables	(486)	184
(Increase)/decrease in inventories	(864)	(139)
(Increase)/decrease in prepayments	6	(309)
Increase/(decrease) in trade and other payables	2,213	(10,792)
Increase/(decrease) in salary and wages	806	1,732
Increase/(decrease) in unearned revenue	(2,905)	1,023
Net cash from operating activities	**(29,339)**	**(9,077)**

20. Non-cash financing and investing activities

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

21. Expenditure commitments

(a) Non-cancellable operating leases

Commitments under operating leases at reporting date are payable as follows:

	2016 $'000	2015 $'000
No later than one year	2,143	2,355
Later than one year and not later than five years	1,056	614
Total	3,199	2,969

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.

21. Expenditure commitments (continued)

(b) Capital and related expenditure commitments

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

	2016 $'000	2015 $'000
Capital works	3,813	1,088
Repairs and maintenance	1,090	2,592
Total	4,903	3,680
No later than one year	4,903	3,680
Total	4,903	3,680

22. Contingencies

Litigation in progress

As at 30 June 2016, the following cases were filed in the courts naming the State of Queensland acting through the HHS as defendant:

	2016 Number of cases	2015 Number of cases
Supreme Court	1	3
District Court	1	-
Tribunals, commissions and boards	3	2
Total	5	5

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 1.u)

As of 30 June 2016, there were 35 claims (2015: 30 claims) managed by QGIF, some of which may never be litigated or result in payments to claims. Tribunals, commissions and board figures represent the matters that have been referred to QGIF for management. The maximum exposure to the HHS under this policy is up to $20,000 for each insurable event.

23. 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 2016, amounts of $1.391 million (2015: $1.488 million) in General Trust and $1.702 million (2015: $1.260 million) for research projects are set aside for the specified purpose underlying the contribution.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

24. 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

	2016 $'000	2015 $'000
Trust receipts and payments		
Receipts	653	701
Payments	(693)	(668)
Increase/(decrease) in patient funds	**(40)**	**33**
Trust assets and liabilities		
Current assets		
Cash held and bank deposits*	64	103
Total current assets	**64**	**103**

* Represents patient trust funds and refundable deposits

(b) Right of private practice receipts and payments

Receipts		
Private practice receipts	15,840	14,206
Total receipts	15,840	14,206
Payments		
Payments to doctors	158	113
Payments to HHS for recoverable costs	15,311	14,010
Total payments	15,469	14,123
Increase/(decrease) in net right of private practice assets	371	83
Right of private practice assets		
Current assets		
Cash	1,636	1,266
Total current assets	**1,636**	**1,266**

There are no amounts payable for right of private practice.

25. Financial instruments

(a) Categorisation of financial instruments

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

Category	Note	2016 $'000	2015 $'000
Financial assets			
Cash and cash equivalents / Bank overdraft	11	(5,702)	24,785
Receivables	12	34,913	26,485
Total		29,211	51,270
Financial liabilities			
Payables	16	43,153	40,940
Total		43,153	40,940

(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 carrying amount of the financial asset, inclusive of any provision for impairment. As such, the carrying amount of cash and receivables represent the maximum exposure to credit risk. Refer to Note 11. and Note 12.

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 comprised predominantly of its investment in the QTC Cash Fund and accounts with a 'Big 4' Australian bank. The QTC Cash Fund is an asset 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.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

25. 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 amount exceeds the amount already allowed for impairment of that debt, the excess is recognised directly as a bad debt expense and written-off directly against receivables.

Ageing of receivables 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
2016					
Receivables	31,614	1,451	1,170	678	34,913
Total	**31,614**	**1,451**	**1,170**	**678**	**34,913**
2015					
Receivables	24,150	1,079	929	327	26,485
Total	**24,150**	**1,079**	**929**	**327**	**26,485**
2016 individually impaired financial assets					
Receivables (gross)	-	149	32	2,899	3,080
Allowance for impairment	-	(149)	(32)	(2,899)	(3,080)
Carrying amount	**-**	**-**	**-**	**-**	**-**
2015 individually impaired financial assets					
Receivables (gross)	-	300	-	3,896	4,196
Allowance for impairment	-	(300)	-	(3,896)	(4,196)
Carrying amount	**-**	**-**	**-**	**-**	**-**

Movements in the allowance for impairment loss

	2016 $'000	2015 $'000
Balance at 1 July	4,195	2,450
Amounts written off during the year	(3,086)	(1,404)
Increase in allowance recognised in operating result	1,971	3,149
Total	3,080	4,195

25. Financial instruments (continued)

(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 $7.5 million under whole-of-government banking arrangements to manage any short term cash shortfalls. $7.084 million had been withdrawn against this debt facility as at 30 June 2016.

The only financial liabilities which expose the HHS to liquidity risk are payables. All financial liabilities are current in nature and will be due and payable within twelve months. As such no discounting of cash flows has been made to these liabilities in the Statement of Financial Position. Refer to Note 16.

(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.

Sensitivity analysis indicates that the impact on revenue and expense due to interest rate swings is immaterial. The HHS has minimal interest rate exposure on the 24 hour call deposits. There is no interest rate risk on the main operating accounts including bank overdraft, as these do not earn interest. Refer to Note 11.

(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.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

26. 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 2015-16.Further information on these positions can be found in the body of the annual report under the section relating to Executive Management.

Position	Responsibilities	Contract classification and appointment authority	Date appointed to position (Date resigned from position if applicable)
Cairns and Hinterland Hospital and Health Board	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.	
Chair Carolyn Eagle			01/10/2015
Chair Robert Norman			29/06/2012 (01/10/2015)
Deputy Chair Carolyn Eagle			01/07/2012 (30/09/2015)
Leeanne Bou-Samra			01/07/2012
Mario Calanna			17/05/2013 (17/05/2016)
Dr Felicity Croker			23/08/2013
Bruce Peden			17/05/2013 (17/05/2016)
Dr Peter Smith			17/05/2013
Gillian Shaw			18/05/2016
Anita Veivers			18/05/2016
Joann Schmider			18/05/2016
I/Chief Executive* Clare Douglas	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)).	06/06/2016
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 (10/06/2016)

Position	Responsibilities	Contract classification and appointment authority	Date appointed to position (Date resigned from position if applicable)
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.	01/07/2012
Chief Operating Officer* Tina Chinery	Responsible to the Chief Executive for the day-to-day 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.	30/05/2016
A/Chief Operating Officer* Mary Streatfield	Responsible to the Chief Executive for the day-to-day 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.	12/02/2015 (30/05/2016)
Chief Operating Officer* Robin Moore	Responsible to the Chief Executive for the day-to-day 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.	01/07/2012 (04/12/2015)
Chief Finance Officer* Stephen Thacker	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.	07/12/2015
A/Chief Finance Officer Rod Margetts	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.	Appointed Oxford Associates to engage Rod Margetts as interim CFO on a consultant based arrangement.	30/06/2015 (16/12/2015)

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

Position	Responsibilities	Contract classification and appointment authority	Date appointed to position (Date resigned from position if applicable)
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.	01/07/2012
Executive Director Information Strategy, &Planning* 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.	01/07/2012
Executive Director Nursing & Midwifery Glynda Summers	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.	1/07/2014
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

26. Key management personnel and remuneration expenses (continued)

(b) Remuneration expenses

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

- *Hospital and Health Boards Act 2011*
- Industrial awards and agreements

Section 74 of the *Hospital and Health Boards 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 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 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 do not receive performance payments as part of their remuneration package.

1 July 2015 - 30 June 2016						
Position (period where less than full year)	**Short Term Employee Expenses**		**Long Term Employee Benefits**	**Post-Employment Expenses**	**Termination Benefits**	**Total Expenses**
	Monetary Expenses	**Non-Monetary Benefits**				
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Chair Carolyn Eagle (01/10/2015-present) (Deputy Chair 01/07/2015 -30/09/2015)	80	-	-	9	-	89
Chair Robert Norman (01/07/2015 - 01/10/2015)	24	-	-	1	-	25

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

26. Key management personnel and remuneration expenses (continued)

(b) Remuneration expenses (continued)

1 July 2015 - 30 June 2016						
Position (period where less than full year)	**Short Term Employee Expenses**		**Long Term Employee Benefits**	**Post-Employment Expenses**	**Termination Benefits**	**Total Expenses**
	Monetary Expenses	**Non-Monetary Benefits**				
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Board Member Leeanne Bou-Samra	50	-	-	5	-	55
Board Member Mario Calanna (01/07/2015 - 17/05/2016)	45	-	-	5	-	50
Board Member Dr Felicity Croker	49	-	-	-	-	49
Board Member Bruce Peden (01/07/2015 - 17/05/2016)	46	-	-	5	-	51
Board Member Dr Peter Smith	50	-	-	5	-	55
Board Member Gillian Shaw	5	-	-	1	-	6
Board Member Anita Veivers	5	-	-	1	-	6
Board Member Joann Schmider	5	-	-	1	-	6
A/Chief Executive Clare Douglas	-	-	-	-	-	-
Chief Executive Julie Hartley-Jones (01/07/2015 - 10/06/2016)	276	13	5	25	159	478
Executive Director Medical Services Dr Neil Beaton	416	9	9	25	-	459
Chief Operating Officer Tina Chinery	23	-	-	2	-	25
A/Chief Operating Officer Mary Streatfield (01/07/2015 - 30/05/2016)	175	9	3	16	-	203
Chief Operating Officer Robin Moore** (01/07/2015 - 04/12/2015)	(29)	10	(1)	(4)	2	(22)
Chief Finance Officer Stephen Thacker	120	-	2	12	-	134
Executive Director People and Culture Caroline Wagner	180	9	3	17	-	209

26. Key management personnel and remuneration expenses (continued)

(b) Remuneration expenses (continued)

1 July 2015 - 30 June 2016						
Position (period where less than full year)	**Short Term Employee Expenses**		**Long Term Employee Benefits**	**Post-Employment Expenses**	**Termination Benefits**	**Total Expenses**
	Monetary Expenses	**Non-Monetary Benefits**				
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Executive Director Information Strategy & Planning Bradley McCulloch	183	9	3	18	-	213
Executive Director Nursing & Midwifery Glynda Summers	222	4	4	21	-	251
Executive Director Allied Health Donna Goodman	172	9	-	19	-	200

For the period 1 July 2015 to 16 December 2015, Rod Margetts of Oxford Associates was contracted as Acting Chief Finance Officer. Oxford Associates was paid $161,000 for this contract.

**Robin Moore took on a temporary appointment external to the HHS for a period of six months commencing 4 May 2015. Within this period there has been no expense to the HHS. A salary recovery was made for payments made from 4 May 2015 to 9 September 2015. He formally resigned on 4 December 2015.

1 July 2014 - 30 June 2015						
Position (Period where less than full year)	**Short Term Employee Expenses**		**Long Term Employee Benefits**	**Post-Employment Expenses**	**Termination Benefits**	**Total Expenses**
	Monetary Expenses	**Non-Monetary Benefits**				
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Chair Robert Norman	88	-	-	9	-	97
Deputy Chair Carolyn Eagle	50	-	-	5	-	55
Board Member Leeanne Bou-Samra	52	-	-	5	-	57
Board Member Mario Calanna	52	-	-	5	-	57
Board Member Dr Felicity Croker	52	-	-	2	-	54
Board Member Bruce Peden	53	-	-	5	-	58
Board Member Dr Peter Smith	53	-	-	5	-	58
Chief Executive Julie Hartley-Jones	299	13	6	30	-	348

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

26. Key management personnel and remuneration expenses (continued)

(b) Remuneration expenses (continued)

1 July 2014 - 30 June 2015						
Position (Period where less than full year)	**Short Term Employee Expenses**		**Long Term Employee Benefits**	**Post-Employment Expenses**	**Termination Benefits**	**Total Expenses**
	Monetary Expenses	**Non-Monetary Benefits**				
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Executive Director Medical Services Dr Neil Beaton	515	13	10	31	-	569
Chief Operating Officer Robin Moore	207	10	4	21	-	242
Chief Finance Officer John Slaven (07/04/2015)	166	10	3	16	-	195
Executive Director People and Culture Caroline Wagner	174	7	3	17	-	201
Executive Director Strategy, Planning, Performance and Aboriginal & Torres Strait Islander Health Bradley McCulloch	165	9	3	16	-	193
Executive Director Nursing & Midwifery Glynda Summers	212	-	4	18	-	234
Executive Director Allied Health Donna Goodman	152	9	3	17	-	181

27. Events occurring after balance date

There have been no material non-adjusting 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.

28. 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 26.

29. Budget vs actual comparison

A budget vs actual comparison, and explanations of major variances, has not been included for the Statement of Changes in Equity. Major variances relating to that statement have been addressed in explanations of major variances for other statements.

Statement of Comprehensive Income

	Variance Notes	Original Budget 2016 $'000	Actual 2016 $'000	Variance $'000	Variance % of Budget
Income					
User charges and fees	1	691,582	807,453	115,871	17%
Grants and other contributions		14,853	20,418	5,565	37%
Interest		96	80	(16)	(17%)
Other revenue		6,281	11,235	4,954	79%
Total revenue		**712,812**	**839,186**	**126,374**	
Total income		**712,812**	**839,186**	**126,374**	
Expenses					
Employee expenses	2	(59,654)	(82,076)	(22,422)	38%
Health service employee expenses	3	(483,943)	(507,942)	(23,999)	5%
Supplies and services	4	(128,194)	(219,543)	(91,349)	71%
Grants and subsidies		(550)	(32)	518	(94%)
Depreciation and amortisation		(35,127)	(37,251)	(2,124)	6%
Impairment losses		(1,880)	(1,971)	(91)	5%
Other expenses		(3,464)	(10,371)	(6,907)	199%
Total expenses		(712,812)	(859,186)	(146,374)	
Operating result for the year		-	(20,000)	(20,000)	-
Other comprehensive income					
Items that will not be reclassified subsequently to operating result					
Increase in asset revaluation surplus	5	4,381	18,082	13,701	313%
Total other comprehensive income		4,381	18,082	13,701	
Total comprehensive income for the year		**4,381**	**(1,918)**	**(6,299)**	

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

29. Budget vs actual comparison (continued)

Statement of Financial Position

	Variance Notes	Original Budget 2016 $'000	Actual 2016 $'000	Variance $'000	Variance % of Budget
Assets					
Current assets					
Cash and cash equivalents	6	20,903	1,382	(19,521)	(93%)
Receivables	7	19,347	34,913	15,566	80%
Inventories		1,964	4,852	2,888	147%
Other current assets		42	327	285	679%
Total current assets		**42,256**	**41,474**	**(7,866)**	
Non-current assets					
Intangible assets		338	649	311	90%
Property, plant and equipment	8	781,861	711,524	(70,337)	(9%)
Total non-current assets		782,199	712,173	(70,026)	
Total assets		824,455	753,647	(77,892)	
Current liabilities					
Bank overdraft	6	-	7,084	7,084	100%
Payables	9	38,070	43,153	5,083	13%
Accrued employee benefits		43	2,600	2,557	5947%
Unearned revenue		2,175	293	(1,882)	(87%)
Total current liabilities		40,288	53,130	5,758	
Total liabilities		40,288	53,130	5,758	
Net assets		**784,167**	**700,517**	**(83,650)**	
Equity					
Contributed equity	10	750,353	635,064	(115,289)	(15%)
Accumulated surplus	11	5,252	(5,908)	(11,160)	(212%)
Asset revaluation surplus	12	28,562	71,361	42,799	150%
Total equity		**784,167**	**700,517**	**(83,650)**	

29. Budget vs actual comparison (continued)

Statement of Cash Flows

	Variance Notes	Original Budget 2016 $'000	Actual 2016 $'000	Variance $'000	Variance % of Budget
Cash flows from operating activities					
Inflows:					
User charges and fees	13	689,465	756,268	66,803	10%
Grants and other contributions		14,853	19,879	5,026	34%
Interest receipts		96	80	(16)	(17%)
GST input tax credits from Australian Tax Office		15,770	16,528	758	5%
GST collected from customers		-	575	575	100%
Other receipts		6,281	11,774	5,493	87%
Outflows:					
Employee expenses	14	(59,676)	(83,633)	(23,957)	40%
Health service employee expenses	15	(483,943)	(504,097)	(20,154)	4%
Supplies and services	16	(143,478)	(219,338)	(75,860)	53%
Grants and subsidies		(550)	(32)	518	(94%)
GST paid to suppliers		(15,782)	(17,008)	(1,226)	8%
GST remitted to Australian Tax Office		-	(581)	(581)	100%
Other		(3,464)	(9,754)	(6,290)	182%
Net cash provided by (used in) operating activities		**19,572**	**(29,339)**	**(48,911)**	
Cash flows from investing activities					
Outflows:					
Payments for property, plant and equipment	17	(7,533)	(23,152)	(15,619)	207%
Payments for intangibles		-	(19)	(19)	100%
Net cash provided by (used in) investing activities		**(7,533)**	**(23,171)**	**(15,638)**	
Cash flows from financing activities					
Inflows:					
Equity injections	17	7,533	22,023	14,490	(192%)
Equity withdrawals	18	(35,127)	-	35,127	100%
Net cash provided by (used in) financing activities		**(27,594)**	**22,023**	**49,617**	
Net increase / (decrease) in cash and cash equivalents		(15,555)	(30,487)	(14,932)	96%
Cash and cash equivalents at the beginning of the financial year		36,458	24,785	(11,673)	(32%)
Cash and cash equivalents at the end of the financial year		**20,903**	**(5,702)**	**(26,605)**	

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

29. Budget vs actual comparison (continued)

Explanations of major variances

Statement of Comprehensive Income

The budget recorded in the financial statements above is as tabled in the annual Service Delivery Statements. These budgets were set prior to finalisation of the 2015/16 Service Agreement with the Department of Health which provided significant additional funding to provide increased services at Cairns Hospital. Final revenue and expenditure budgets for 2015/16 were therefore significantly higher than those provided for within the Service Delivery Statements.

Major variations between the 2015-16 budget and 2015-16 actual include:

1. The increase in user charges and fees relates to additional funding provided through amendments to the Service Agreement between the HHS and the Department of Health (DoH). The impact of the additional funding received from DoH, post setting of the 2015-16 budget equates to $115.9M. $27M of this additional funding, relates to the re-imbursement of Digital Hospital expenditure incurred by the HHS during 2015-16 (there was an additional increase of $3M in recoverables due to DoH invoiced at year end. This is recorded in other revenue). The remainder of the increase in funding relates to required increases in service activity in order to achieve Tier 1 KPI's set out in the Service Agreement, such as National Emergency Access Targets (NEAT), National Elective Surgery Targets (NEST) and Patients Off Stretcher Time (POST), enterprise bargaining agreements, non-labour escalation and depreciation revenue.

2 & 3. The increase in employee expenses is due to the increase in the number of staff employed compared to the funding provided for in the initial Service Agreement. Increase in staffing numbers was required to backfill and train personnel in the Digital Hospital roll out at Cairns Hospital and to address increased demand for the HHS services to improve performance against the Tier 1 KPIs set out in the Service Agreement, such as NEAT, NEST and POST.

   Also contributing to the variance against budget are the enterprise bargaining agreements which came into effect on 1 July 2015 for medical staff, as well as an increase in the recruitment of Junior Medical Officers to support increased shift and working patterns due to increased demand on services.

4. The increase in supplies and services relates to increases in expense items such as computer expenses and consultancies. These items have increased due to Digital Hospital go-live in February 2016. Also contributing to the increase is pharmaceutical expenses which relates to the introduction of new Hep C drugs distributed to patients. Clinical supplies increased due to an increase Weighted Activity Units (WAUs) year on year (6%) and above inflation increases in unit costs for clinical supplies purchased. Supplies and services also increased due to the general increase in the number of patients being seen at the services delivered by the HHS. A general increase in Acuity in ED presentations increases the supplies and services costs, and has a flow-on effect through other parts of the hospital.

   An increase in the number of beds being made available throughout the HHS to respond to increased demand for services resulted in higher than budgeted laundry and cleaning costs. Operational services and catering costs also increased as a result of more people being admitted to the HHS.

   Variance to the budget also arose due to an increase in services and supplies and other expenses due to the impact of the implementation of the digital hospital, which incurred costs in the purchase of devices. Following discussion with the Department, agreement was reached that costs would be expensed in the year rather than capitalised

5. The increase relates to the independent revaluation undertaken in 2015-16 which resulted in a net increment in both land and buildings valuations totalling $18.082m.

Statement of Financial Position

Major variations between the 2015-16 budget and 2015-16 actual include:

6. There was a net outflow of cash during the year of $30.5M as set out in the statement of cash flows. This is approximately $15M in excess of the original budget. This is in part due to the factors set out at items 2, 3 and 4 above and also due to the timing of the receipt by the HHS of DoH funding such that at 30 June 2016, there was $18M of DoH funding included in receivables (rather than having been received into the HHS bank account).

7. The increase in receivables relates predominantly to $18M of funding yet to be received from DoH for Window 3 amendments to the Service Agreement between the HHS and DoH.

29. Budget vs actual comparison (continued)

Explanations of major variances

Statement of Financial Position

8. The variance between actual and budgeted property, plant and equipment balances are due to inaccurate budget assumptions, which meant the budget was overstated by $121M and should have been $661M. The variance between the corrected budget amount and actuals is due to a portion of the additional assets of $74M transferred from the Department of Health that were not correctly budgeted for and the valuation movement of approximately $18M.

9. The variance in payables relates predominantly to payables in respect of the digital hospital go-live project.

10. The budget assumptions for contributed equity, for 2015-16, were inaccurate and should have been based on the 2014-15 actuals of $575M. The majority of this variance is attributed to $74M of assets that were transferred from the Department of Health during the year that were not correctly budgeted for.

11. At the time of preparing the budget, the HHS did not anticipate a deficit in 2015/16. The deficit result for the year was due to the expenditure increases outlined in notes 2, 3 and 4 above.

12. The budget assumptions for the asset revaluation surplus for 2015-16, were inaccurate and should have been based on the 2014-15 actuals of $53M (variance of $25M in budget process), adjusting for indexation. The increase in asset revaluation surplus of $18M is attributable to the asset revaluations undertaken during 2015-16, with the main contributors being Cairns Hospital's Block B - $8.6M and Block C - $3.7M and Cairns Hospital land - $2.0M.

Statement of Cash Flows

The variances as reported in the Statement of Comprehensive Income and explanations provided above, for the most part also reflect in the variances between budget and actual in the Statement of Cash Flows. In addition to the notes provided above, other notable differences are described below:

13. The increase relates to additional revenue provided by the DoH for increased services. The value of the difference is lower than that reported in the Statement of Comprehensive Income due to funding not received by 30 June 2016.

14. Refer to Note 2 above.

15. Refer to Note 3 above.

16. Refer to Note 4 above.

17. As indicated above, budget assumptions for acquisitions of property, plant and equipment, for 2015-16 were inaccurate and should have been based on the 2014-15 actuals, adjusting for indexation. (Note 8 above). If this methodology had been applied, the original budget for 2015-16 would have been ($14.984M). The variance relates to additional payments made for property plant and equipment with funding provided via equity injection by the DoH, as well as payments made for the digital hospital project. Total equity injections for 2015-16 equate to $22M.

18. Equity withdrawals relate to depreciation funding. As this is a non-cash transaction it should not have been included in the original budgeted cash flows.

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

Notes to the Financial Statements 30 June 2016

30. Investment in Primary Health Network

North Queensland Primary Health Network Limited (NQPHNL) was established as a public company limited by guarantee on 21 May 2015. Cairns and Hinterland Hospital and Health Service is one of six members along with Mackay Hospital and Health Service, Townsville Hospital and Health Service, Torres and Cape Hospital and Health Service, the Pharmacy Guild of Australia and the Australian College of Rural and Remote Medicine, with each member holding one voting right in the company.

The principal place of business of NQPHNL is Cairns, Queensland. The company's principal purpose is to work with general practitioners, other Primary Health Care providers, community health services, pharmacists and hospitals in North Queensland to improve and coordinate Primary Health Care across the local health system for patients requiring care from multiple providers.

As each member has the same voting entitlement, it is considered that none of the individual members has power over NQPHNL (as defined by AASB 10 *Consolidated Financial Statements*) and therefore none of the members individually control NQPHNL. Cairns and Hinterland Hospital and Health Service currently has 16.6 per cent of the voting power of the NQPHNL – below the 20 per cent at which it is presumed to have significant influence (in accordance with AASB 128 *Investments in Associates and Joint Ventures*). This is supported by the fact that each other member also has 16 per cent voting power, limiting the extent of any influence that the Cairns and Hinterland HHS may have over NQPHNL.

Each member's liability to NQPHNL is limited to $10. NQPHNL is legally prevented from paying dividends to its members and its constitution also prevents any income or property of the Company being transferred directly or indirectly to or amongst the members. As NQPNHL is not controlled by the Cairns and Hinterland HHS and is not considered a joint operation or an associate of the Cairns and Hinterland HHS, financial results of NQPHNL are not required to be disclosed in these statements.

31. Economic dependency

The HHS's 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 2. The HHS's ability to continue viable operations is dependent on this funding. At the date of this report, management has no reason to believe that this financial support will not continue, particularly as the current service agreement covers the period from 1 July 2016 to 30 June 2019.

Queensland Government

Ref:
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Office of the Chief Finance Officer
Cairns & Hinterland,
Hospital & Health Service

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 2016 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.

Ms Carolyn Eagle B.Com, FCA, CIA, CGAP, CRMA	Ms Clare Douglas B App Sci(Nursing) Grad Dip Health Admin M Management GAICD	Mr Stephen Thacker BA, PGDip, MA, ACCA
Chair **Cairns and Hinterland Hospital and Health Service Board**	**Interim Chief Executive** **Cairns and Hinterland Hospital and Health Service**	**Chief Finance Officer** **Cairns and Hinterland Hospital and Health Service**
24 August 2016	24 August 2016	24 August 2016

Level 3, GHD Building
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CAIRNS QLD 4870

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 2016, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including significant accounting policies and other explanatory information, and certificates given by the Chair, Interim 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 2015 to 30 June 2016 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.

D J OLIVE FCPA
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane

GLOSSARY

Aboriginal and Torres Strait Islander 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 Aboriginal and Torres Strait Islander Australians.
Accessible	Accessible healthcare is characterised by the ability of people to obtain appropriate healthcare at the right place and right time, irrespective of abilities, 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. 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.
Acute care	The process whereby a hospital accepts responsibility for a patient's care and/or treatment. It follows a clinical decision, based on specified criteria, that a patient requires same-day or overnight care or treatment, which can occur in hospital and/or in the patient's home (for hospital-in-the-home patients).
Admission	A patient who undergoes a hospital's formal admission process as an overnight-stay patient or a same-day patient.
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.

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.
Medical practitioner	A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.
NEAT	National Emergency Access Target. By 2015, 90 per cent of all patients will leave the Emergency Department (ED) within 4 hours through: being discharged, admitted to hospital, or transferred to another hospital for treatment.
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.
POST	Patient off stretcher time. Patients arriving at a HHS Emergency Department (ED) by ambulance will be received by HHS staff into the appropriate ED treatment area with completion of clinical handover within 30 minutes.
Primary Health Network	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.
Private hospital	A private hospital or free-standing day hospital, and either a hospital owned by a forprofit 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.
QEAT	Queensland Emergency Access Target – the number of patients leaving the emergency department within four hours of arrival. As of July 1 2016, this target has been lowered from 90 per cent to greater than 80 per cent.
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/s	ARRs – section 8	3
Accessibility	• Table of contents • Glossary	ARRs – section 10.1	5 106-109
	• 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	10-13
	• Agency role and main functions	ARRs – section 11.2	10
	• Operating environment	ARRs – section 11.3	10-20
Non-financial performance	• Government's objectives for the community	ARRs – section 12.1	28-29
	• Other whole-of-government plans / specific initiatives	ARRs – section 12.2	24-25
	• Agency objectives and performance indicators	ARRs – section 12.3	30-32
	• Agency service areas, and service standards	ARRs – section 12.4	47
Financial performance	• Summary of financial performance	ARRs – section 13.1	49
Governance – management and structure	• Organisational structure	ARRs – section 14.1	33-37
	• Executive management	ARRs – section 14.2	38-42
	• Government bodies (statutory bodies and other entities)	ARRs – section 14.3	N/A
	• *Public Sector Ethics Act 1994*	*Public Sector Ethics Act 1994* ARRs – section 14.5	53

Summary of requirement		Basis for requirement	Annual report reference
Governance – risk management and accountability	• Risk management	ARRs – section 15.1	43
	• External scrutiny	ARRs – section 15.2	44
	• Audit committee	ARRs – section 15.3	43
	• Internal audit	ARRs – section 15.4	44
	• Information systems and recordkeeping	ARRs – section 15.5	45
Governance – human resources	• Workforce planning and performance	ARRs – section 16.1	52-55
	• Early retirement, redundancy and retrenchment	Directive No.11/12 *Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	52
Open data	• Consultancies	ARRs – section 17 ARRs – section 34.1	111
	• Overseas travel	ARRs – section 17 ARRs – section 34.2	111
	• Queensland Language Services Policy	ARRs – section 17 ARRs – section 34.3	111
Financial statements	• Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	102
	• Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	104-105

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

Open Data

Additional annual report disclosures – relating to expenditure on consultancy, overseas travel and implementation of the Queensland Language Services Policy are published on the Queensland government's open data website, available via: www.data.qld.gov.au

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