ANNUAL REPORT 2016–2017

Cairns and Hinterland Hospital and Health Service

Queensland Government

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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Enquiries to

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CHHHS_Board@health.qld.gov.au
(07) 4226 3266

LETTER OF COMPLIANCE

4 September 2014

The Honourable Cameron Dick MP
Minister for Health and Minister for Ambulance Services
GPO Box 48
Brisbane, Queensland 4001

Dear Minister

I am pleased to present the Annual Report and financial statements 2016-17 for the Cairns and Hinterland Hospital and Health Service.

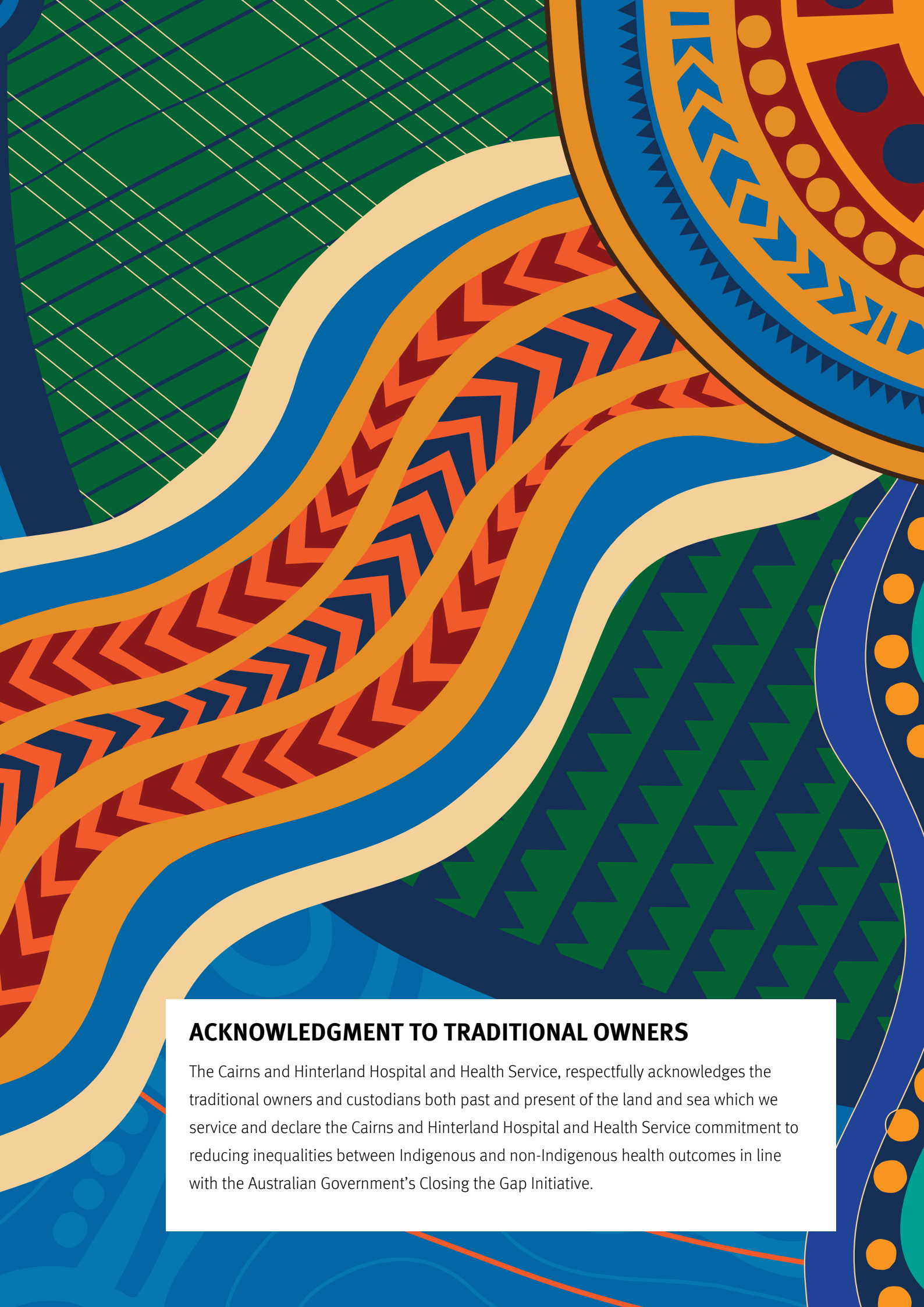
I certify that this Annual Report complies with:

- 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 2016-17 reporting period.

A checklist outlining the annual reporting requirements can be found at page 139 of this Annual Report or accessed at http://www.health.qld.gov.au/cairns_hinterland/

Yours sincerely

Clive Skarott AM
Chair
Hospital and Health Board



ACKNOWLEDGMENT TO TRADITIONAL OWNERS

The Cairns and Hinterland Hospital and Health Service, respectfully acknowledges the traditional owners and custodians both past and present of the land and sea which we service and declare the Cairns and Hinterland Hospital and Health Service commitment to reducing inequalities between Indigenous and non-Indigenous health outcomes in line with the Australian Government's Closing the Gap Initiative.


Welcome

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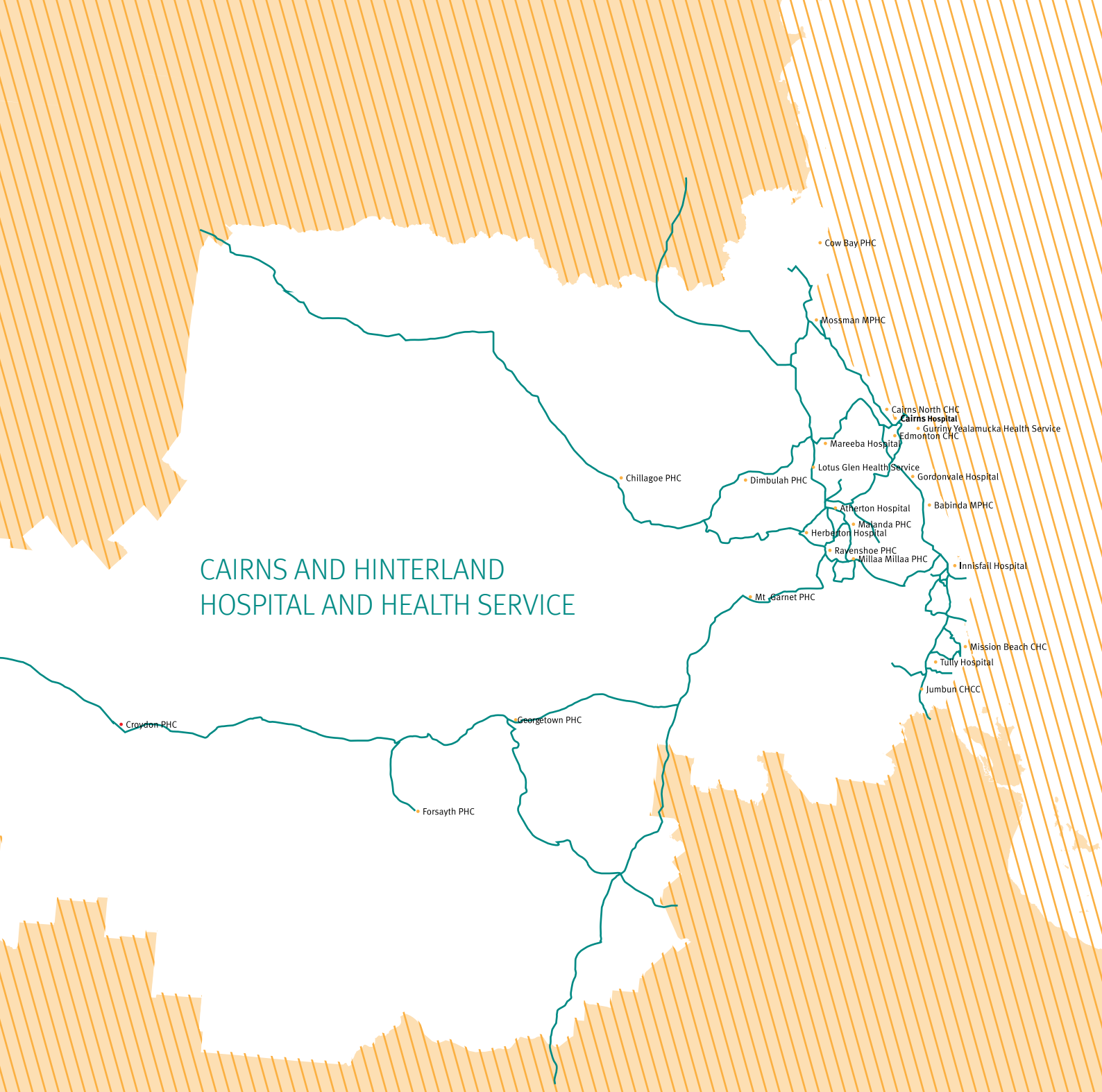


Staff	**5,837 individuals (headcount); 4,849.78 full time equivalent staff**
Population	**253,000 (approx)**
Geographic Area	**142,900 square kilometres**
Density	**1.77 people per square kilometre**
Investment in Care	**$853.70 million**
Sites	**10 Hospitals, 10 Primary Health Care Centres, 8 Community Health Care Centres and a number of mental health, oral health and other facilities**

AT A GLANCE

2,907
Babies welcomed into the world

1,498 Boys

1,409 Girls

10% increase
in Outpatient clinic attendances

7,270
Elective Surgeries

96.4%
Elective surgery patients treated in time

6,803
Emergency Surgeries

130,728
Emergency Department Presentations

35,765 via Ambulance

422 via Helicopter

745 via Flying Doctor

77%
Admitted and treated within 4hrs of presentation in ED

Telehealth Consults
4,962

45,559
Overnight Admissions

54,438
Same Day Admissions

606
Hospital in the Home Admissions
up 24%

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

99,997
Total admissions

From the Chair and Chief Executive

In our 2016-17 Annual Report we reflect on what has been a challenging year for the Cairns and Hinterland Hospital and Health Service. A focus on consolidating the expansion of services over the previous period has resulted in solid foundations being laid for a bright future ahead.

During this time our staff have continued to provide exceptional care for the people of Far North Queensland. In addition, there has been much work behind the scenes to improve the financial position of the Health Service during the past 12 months.

Faced with increased demand for services across the region, our Health Service has experienced growth of 15 percent across the region. This includes presentations to Cairns Hospital's Emergency Department increasing by four percent with 68,634 presentations and 35,244 ambulances arriving in 2016-17, another three percent increase.

Following the resignation of the previous Board in September 2016, the Health Service welcomed the Queensland Health Director-General Michael Walsh as Interim Administrator prior to the appointment of Terry Mehan to the role. The Director-General worked with the Executive Management Team to develop a seven-point plan, *Embracing a Healthier Future*, which Terry Mehan then worked to implement with our staff. The new Board has continued with the same focus since its appointment on 16 May 2017.

Embracing a Healthier Future is based on seven areas – quality and safety; governance continuity; financial sustainability; workforce development; digital systems; clinical services planning; engagement and communication. The plan was developed on the principles of patient safety, respect for staff, openness and transparency.

The implementation of Embracing a Healthier Future was the catalyst for a number of the key achievements throughout the year.

Strengthening clinical and corporate governance

We have made significant strides towards strengthening our clinical and corporate governance frameworks, as well as improving the reporting, monitoring, oversight and processes required to ensure the Health Service is operating to its full potential and with due diligence.

Clinical governance is crucial to ensure continuous improvement in the safety and quality of care offered across the Health Service, while our corporate governance ensures we are able to continue to deliver this health care in the best interests of all members of the community and stakeholders.

Periodic Review - Australian Council on Healthcare Standards

After much hard work and preparation by staff, the Health Service was successful in meeting the mandatory criteria for the Periodic Review, which was assessed by the Australian Council on Healthcare Standards surveyors in March 2017.

A 'Met with Merit' rating was awarded for Emergency and Disaster Management, demonstrating the great advances our Health Service has made in its disaster preparedness.

The ever-increasing demand

It was a very busy year with an overall increase of 15 percent in activity. A significant proportion of this increase related to new services opened in the previous year.

In 2016-17, our performance against key performance indicators for emergency department access, elective surgery and waiting times continued to perform well, even with this increase in activity and we will continue our focus to maintain these results in the coming year.

In 2016-17, the number of patients moving through Emergency Departments across the region within four hours was 77 percent and Patient Off Stretcher Time (POST) was 84 percent. The Health Service is treating 96.4 percent of patients requiring elective surgery within the clinically recommended time. The delivery of elective surgical services to the Far North also increased by 11 percent during the year.

The demand for outpatient services has increased significantly in recent years with more than 313,658 people attending specialist outpatient clinic appointments across the Health Service as at 30 June 2017. Waiting lists of people who had been waiting longer than clinically recommended for an outpatient appointment were reduced to zero and waiting lists for specialist outpatient appointments have been reduced by 34.3 percent.

Building for the future

During 2016-17 we saw the commencement of several infrastructure projects as well as the $70 million funding announcement in the State Budget for the development of a new mental health unit for inpatient and community services in Cairns. This unit will be a step towards positioning the Health Service as a leader in regional mental health care delivery.

Project planning commenced for the redevelopment of Atherton Hospital including the Emergency Department and operating theatres; construction of the new Dimbulah Primary Health Care Centre commenced in March and

planning and engagement for a health facility in South Cairns all commenced in 2016-17. Progress towards the establishment of a Youth Prevention and Recovery Centre (YPARC) was made, with the Health Service seeking an alternative site for the facility.

Our new Board

In May, we welcomed the announcement of the new Hospital and Health Board, consisting of a mix of individuals with clinical, business and community backgrounds, who bring broad experience and expertise to the Health Service.

The new Board members possess a strong understanding of both clinical and corporate governance and have already demonstrated they will exercise the necessary diligence, accountability and passion for health care required to ensure the Health Service will continue to grow and deliver high quality care for the people of Far North Queensland.

Clinical Services Plan and Strategic Plan

During the second half of 2016-17, the Health Service has been engaged in the development of its new Clinical Services Plan.

Clinical Services Planning provides a strategic overview of how the Health Service will continue to meet the health needs of the region and –more broadly –the Far North Queensland population over the next five years, and includes a 10-year forecast. The plan has been developed through identifying the existing and anticipated health needs of our communities, and considering the key service changes that will be required to deliver safe and sustainable health services into the future, in light of these health needs.

Sitting alongside the Clinical Services Planning, in 2017-18 the Board and Executive will develop a new strategic plan to shape the future direction of the Health Service. Since the development of the current strategic plan, significant organisational changes have occurred in the internal and external environment, and accompanying influencing factors have also changed.

Throughout the past 12 months, the organisation has been laying solid foundations to support our strategic direction, including:

- Clinical Services Planning: This includes extensive consultation on current and future health needs with each service area and the communities we serve.
- *Your voice, our values*: Staff and community engagement to define the values and behaviours that unify our organisation.
- Leadership Pipeline: Engagement-based process to define the core functions of leadership at each layer of the Health Service.
- Financial sustainability: Achieved through our organisational sustainability plan.

Board engagement

Our Board has committed to ensuring that every second meeting is held in a facility other than Cairns Hospital, ensuring that Board members have the opportunity to familiarise themselves with our facilities and the communities we serve.

The way forward

During the past year, we have experienced significant financial challenges but a huge effort from each and every one of our staff, together with the strategies implemented through the Embracing a Healthier Future plan, saw our commitment to enhancing organisational sustainability rewarded. The Health Service ended the 2016-17 year with a $32.07 million deficit but it was a significantly improved position from the original $80 million forecast. The effort to improve our financial performance has focussed on managing our increased activity while being diligent in our handling of costs. This has ensured we have been able to minimise the deficit position while continuing to meet the health needs of our community and our patients in a safe, effective, equitable and sustainable way into the future.

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

Our staff are our heartbeat

Everyday our staff do amazing things. The contribution they make to our community and to the lives of our patients 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, technical and administrative staff, to the volunteers and consumers, it has been a challenging year, but we have come through it stronger together. To our staff, what may seem like 'just another day' may literally mean the gift of life to our patients and we never forget that.

It is with great pleasure that we present to you the Cairns and Hinterland's 2016-2017 Annual Report.

Clive Skarott AM
Chair
Hospital and Health Board

Clare Douglas
Chief Executive
Cairns and Hinterland Hospital and Health Service

1 ABOUT US

About the Cairns and Hinterland Hospital and Health Service

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

The Health Service provides a range of health services in Cairns and in our rural and regional facilities across a geographical area of 142,900 square kilometres ranging from Cairns to Tully in the south, Cow Bay in the north and Croydon in the west.

Our Health Service supports a population of approximately 253,000, which is forecast to grow by 15 percent by 2027. 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 as well as demand for health services. It is estimated that almost 13 percent of our population is Aboriginal and Torres Strait Islander Australians, compared to four percent for Queensland as a whole.

The Health Service is highly self-sufficient with only a small amount (five percent) of high-level acute services being provided outside of our Health Service, in both Townsville and Brisbane. Our Health Service also provides some services to the Torres and Cape Hospital and Health Service.

OUR ROLE

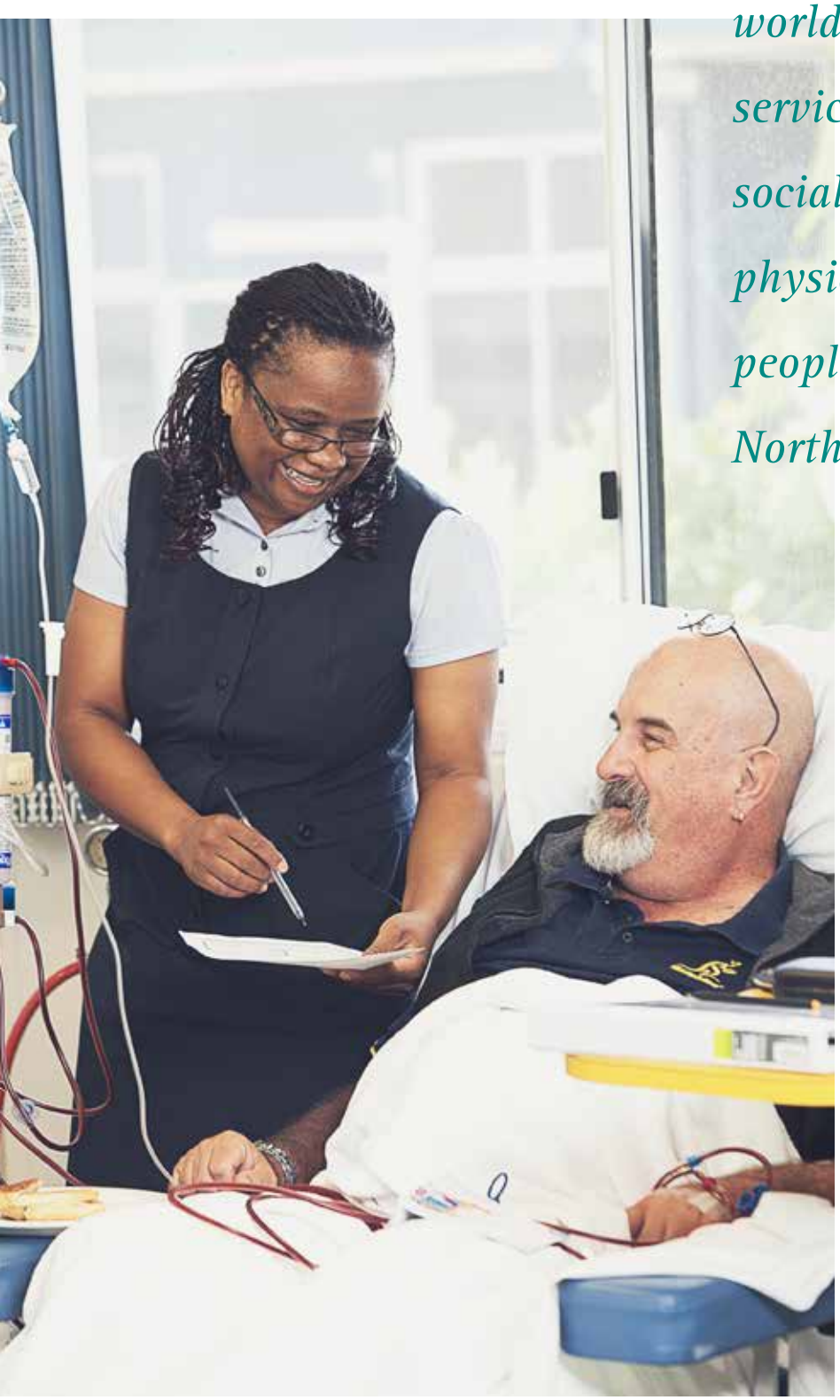
Established on 1 July 2012, the Health Service is an independent statutory body overseen by a local Hospital and Health Board under *the Hospital and Health Boards Act 2011*.

The functions of a Hospital and Health Service are outlined in the Act, with the main functions being to deliver the hospital services, other health services, teaching and research as stated in our Service Agreement.

The 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.

The Cairns and Hinterland Hospital and Health Service strives to provide world-class health services to improve the social, emotional and physical wellbeing of people in the and the Far North Queensland region.

Our Vision



OUR PURPOSE

To achieve our vision, our objectives are 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 VALUES

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

During 2016-17 the Health Service worked in consultation with staff, patients and the community to establish a new set of local values. During 2017-18 the Health Service will see the launch of the new organisational values - Compassion, Accountability, Integrity, and Respect.

OUR FACILITIES

A comprehensive and diverse range of health services are delivered across the Health Service from:

- Cairns Hospital, which provides specialist care, and is the major referral centre for Far North Queensland.
- Major regional hospitals, located at Atherton, Innisfail, and Mareeba with regional community hospitals at Mossman, Babinda, Yarrabah, Gordonvale, Herberton and Tully.
- Ten primary health care centres, which are located across the region, often in remote areas, provide services to local communities.
- Community health centres, which are located at Cairns North, Edmonton, and Smithfield as well as at regional hospitals and towns. Services can 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 baby clinics.
- Mental Health, Oral Health, and Community, Indigenous and Subacute Services, are provided from many sites including hospitals, community health centres, primary health care centres, residential and extended care facilities and mobile service teams.
- Tropical Public Health Services (Cairns), which is focussed on preventing disease, illness and injury as well as providing limited health promotion to targeted groups.
- Lotus Glen Health Service, which provides offender health services.

OPERATING ENVIRONMENT

Growth in population

The population of the Health Service has grown by six percent over the past five years, with further growth of 15 percent (1.4 percent average annual growth), projected over the next 10 years. The majority of population growth is expected to occur in the Cairns southern corridor, which will account for 59 percent of the Health Service's population growth over the next 10 years.

Approximately 20 percent of the Health Service's population was over the age of 60 in 2015, and this demographic is projected to grow by 14 percent in 2026. This represents an increase of almost 20,000 people from 2015 population numbers. Much of the aged population increase is projected to occur largely in the Health Service's rural areas, with the age structure of Cairns city expected to remain largely unchanged.

Accordingly, it is necessary for the Health Service to plan for an increased demand on services in both central and rural areas.

High-risk factors

Residents within the Health Service has a higher prevalence of known health risk factors such as alcohol consumption, smoking and obesity. This is expected to translate to a higher burden of disease for the population, and potential demand for health services in the future.

Indigenous population

The Cairns and Hinterland region has the largest absolute population number (n=31,172) of Aboriginal and Torres Strait Islander people of any Health Service in Queensland, with 12.6 percent of the resident population identifying as Aboriginal and Torres Strait Islander, compared to only four percent for Queensland as a whole. This is projected to increase for the Health Service to 16 percent by 2026.

Partnerships in service delivery

Highly specialised services are accessed outside the Health Service facilities, providing an opportunity to develop formalised patient pathways with other Health Services such as Townsville and Children's Health Queensland, including the development of shared service models to increase sustainability and reduce patient travel where possible.

Burden of Disease

Based on National Health Survey data, the self-reported prevalence of selected chronic health conditions for the Health Services is in line with Queensland and Australia more broadly in the rate of prevalence of chronic diseases, with the exception being mental health, where prevalence rates are above Queensland and Australian averages.

Major issues impacting service delivery

The Health Service has a growing and ageing population that is also socioeconomically disadvantaged compared to the rest of Queensland.

People in some parts of the Health Service have difficulty accessing primary care, community health and aged care in terms of providers, bulk-billing availability (primary care) and/or after-hours services. This often results in the Health Service taking on a greater role as the primary care and community health service provider in these areas.

The Health Service's population is dispersed across a large geographic area, resulting in the need to achieve an appropriate balance between providing local access to services, and centralising services to ensure their quality and sustainability.

Cairns Hospital is the only major referral hospital for Far North Queensland, with the nearest tertiary hospital in Townsville, 350 kilometres south or Brisbane.

Tourist numbers are expected to grow from 2.8 million visitors in 2015-16, to 3.8 million in 2021-22 (5.5 percent per annum), thereby increasing the demand on services.

Building for the future

During the year, planning and work continued on a number of key infrastructure priorities.

Atherton Hospital Redevelopment: Planning for the redevelopment of Atherton Hospital has been a key focus of 2016-17. Once complete, the redevelopment will deliver a new purpose-built clinical services building with an emergency department and operating theatres, medical imaging and inpatient ward. The redevelopment will also refurbish one inpatient ward within the existing hospital building, and improve outpatient and community health facilities.

Cairns Southern Corridor Health Precinct:

The Cairns Southern Corridor Health Precinct was announced in the 2016-17 Queensland State Budget, as part of the $230 million Advancing Queensland's Health Infrastructure Program. Funding has been allocated for facility planning which has commenced.

Located on Walker Road, Edmonton, the Cairns Southern Corridor Health Precinct will have a dual purpose. In times of a potential disaster event, the facility will be used to provide interim acute and emergent patient care if Cairns Hospital is evacuated. During ordinary day-to-day operations, the facility will provide community health services to residents within the southern corridor of Cairns.

Cairns Mental Health Services: The next twelve months will see planning commence on the replacement of mental health infrastructure in Cairns to improve both inpatient and community mental health facilities. The $70 million project was announced in the 2017/18 Queensland State Budget, as part of the Rural and Regional Infrastructure Package.

Dimbulah Primary Health Centre: A new primary health centre was under construction during 2016-17 with completion expected in September 2017. The original facility at Dimbulah was built in the 1960-70s and no longer meets current service needs. The new clinic is purpose-built and has been designed to deliver nurse-led clinics, child health, twice-weekly General Practitioner (GP) clinics, immunisation, health promotion, school screening and visiting specialist mental health services.

Capital Infrastructure Projects

In 2016-17, the Health Service has undertaken the following major capital improvement projects at a cost of just over $17 million.

Cairns Hospital cooling towers: Replacement of all five cooling towers on B Block, which has improved serviceability to blocks A, B and C.

Babinda Hospital high voltage air-conditioning upgrade: Replacement of the existing individual single split-system air-conditioners with a new central plant unit to improve air quality and supply, while reducing energy consumption.

High Voltage air-conditioning upgrades: At Mareeba, Innisfail and Tully Hospitals, the installation of new air-conditioning systems has increased capacity, air quality, and compliance with infection control requirements. These improvements have also reduced the energy consumption compared to the previous systems through the installation of thermal storage tanks that minimise the running time in peak demand times.

Atherton Hospital air-conditioning: Prior to this project being completed, there was limited or no air-conditioning available throughout the general wards area. This project has seen the installation of a new air conditioning and precondition system providing cooling to the ward areas as well as ensuring compliance with infection control requirements.

Cairns North Community Health Centre air conditioning: Upgrade of the existing high voltage air-conditioning system to meet current requirements of the facility.

Cairns Hospital Paediatric Isolation Rooms upgrade: Construction of three new isolation rooms within the Paediatric Ward to meet current health requirements; completed in July 2017.

ENGAGING WITH OUR COMMUNITY

The Health Service fosters partnerships within the community to develop valuable connections, build trust and to raise awareness. We collaborate with a range of partners and stakeholders within our community. The Health Service recognises support of the many stakeholders, auxiliaries, volunteers and community groups who help us to continue to provide excellent care for our community.

The Board has identified further opportunities to collaborate with our stakeholders, the community and consumers. These are detailed in the *Cairns and Hinterland Hospital and Health Service Consumer and Community Engagement Strategy July 2017 – July 2020*.

In response to the legislative requirement for community engagement, and the desire of the Health Board to involve the community in local healthcare 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 Committees.

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

Community Consultation Committees

During 2016-17, the Community Consultation Committees have utilised their networks to provide direct input into health service planning and delivery. Examples include: the process of specialist outpatient appointments; communication after patients have been discharged from hospital; the use of Telehealth; the patient experience in the transit lounge, and the development of the Consumer and Community Engagement Strategy 2017-2020.
They have also provided input into the development of printed client information materials, such as pamphlets, newsletters and fact sheets, for different health teams within the Health Service.

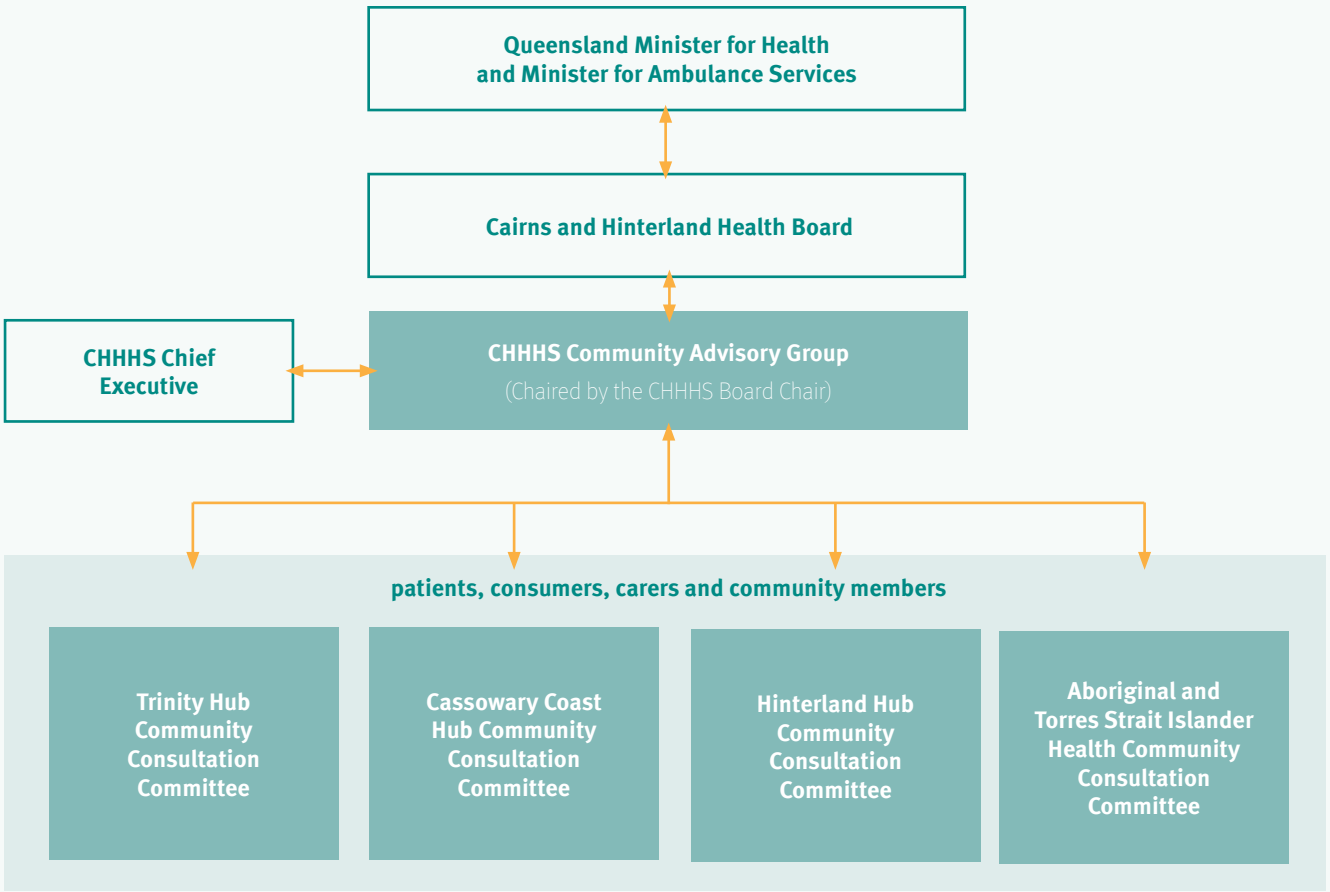
Membership at 30 June 2017

Cassowary Coast Hub:
(rotating chair)
John O'Brien, Community Representative
Jean Vallianos, Community Representative
Juliette Edwards, Community Representative
Rick Taylor, Local Government Representative
Heather Dizcbalis, Health Service Representative

Hinterland Hub:
(chair) Robyn Boundy, Community Representative
Jo Barnes, Community Representative
Ivan Bright, Community Representative
Sandy Kelly, Community Representative
Amy Philips, Community Representative
Michelle Rothwell, Health Service Representative

Trinity Hub:
(chair) Kristy Strout, Community Representative
Rosemary Iloste, Community Representative
Michael Friganiotis, Community Representative
Tracey John, Community Representative
Jessie Richardson, Local Government Representative
Kelly May, Health Service Representative

Aboriginal and Torres Strait Islander Health:
(chair) Jason Leon, Community Representative
Eslyn Wargent, Community Representative
Louise Lawrie, Community Representative
Joy Harris, Community Representative
Trevor Tim, Community Representative
Gudju Gudju Fourmile, Community Representative
Colin Cedric, Local Government Representative
Simon Costello, Health Service Representative



Community Consultation Committee governance structure and reporting relationships

HIGHLIGHTS 2

Admitted Patient Denise Caroll receiving a tele-ward round consultation with the support of the Senior Medical Officer, Merilee Frankish, at Mareeba Hospital.

TELEHEALTH INCREASED ACTIVITY

Cairns and Hinterland Hospital and Health Service reported a 29 percent growth in activity in Telehealth outpatient appointments, exceeding the state-wide target by nine percent and improving access to specialists for patients in rural and remote areas.

In 2016-17, the Health Service provided an estimated 4962 telehealth outpatient appointments, exceeding the target of 4623.

Telehealth is used to support the delivery of services to admitted and non-admitted patients, provide emergency management support and advice, and aeromedical retrieval coordination across Queensland, enabling the provision of more than 50 specialty and sub-specialty services which help to improve timely access to care in regional, rural and remote communities.

Heath Service Telehealth Coordinator Sharon Young said in 2016-17 the Cairns Hospital Medical Assessment Unit expanded their tele-inpatient ward round services to include Weipa and Thursday Island Hospitals.

“This means that weekly specialist inpatient support and advice is now available to Mareeba, Atherton, Babinda, Mossman, Cooktown, Weipa and Thursday Island hospitals,” said Ms Young.

REDUCED OUTPATIENT WAITING LISTS

Waiting lists for specialist outpatient appointments in the Health Service have been reduced by 34.3 percent in the past year.

Health Service Executive Director Medical Services, Dr Nicki Murdock, said a number of initiatives had contributed to shorter wait times.

"In Cairns, we held extra clinics to guarantee we were seeing more patients; we scheduled extra surgery to get patients off both the outpatient and surgical waitlists, and we have elected to work with private providers in some specialities to ensure patients were seen," Dr Murdock said.

Debbie Doidge, and her 14-year-old daughter Zoe, from Malanda, had nothing but praise for the strategy, as well as the staff at Cairns Hospital.

"We had been prepared to wait quite a while for Zoe to be seen, and had actually made a private appointment when we got the call from Cairns Hospital to book us in," Mrs Doidge said.

"The lady on the phone to schedule our appointment was just so professional, efficient and well-mannered, and on the day the service at the hospital was efficient and all the staff so caring.

"We were really impressed with the whole experience, particularly as we know how much pressure there is on everyone in the health system to make things happen quickly, and they all just do such a wonderful job."

"WE HAD BEEN PREPARED TO WAIT QUITE A WHILE FOR ZOE TO BE SEEN, AND HAD ACTUALLY MADE A PRIVATE APPOINTMENT WHEN WE GOT THE CALL FROM CAIRNS HOSPITAL TO BOOK US IN," MRS DOIDGE SAID.

AWARD FOR CYCLONE DEBBIE EFFORTS

Following Tropical Cyclone Debbie in March 2017, the Cairns and Hinterland Hospital and Health Service deployed a number of mental health, public health, nursing and other staff to help its southern counterparts in the aftermath and clean-up.

The Health Service received a certificate of recognition from the Chief Health Officer Jeanette Young for the tireless work of not only those deployed and those who worked in the Health Emergency Operations Centre (HEOC), but those who did additional hours, shifts and in many cases additional duties in order to either boost local capacity or to enable fellow staff members to be deployed.

ORGANISATIONAL SUSTAINABILITY PLAN

During 2016-17 the Health Service introduced an Organisational Sustainability Plan where a series of projects was undertaken to improve the efficiency of the Health Service while maintaining the highest level of safety and quality, with no reduction in activity or staffing levels. Initiatives involved both financial savings and capability building to ensure continuous improvement was front and centre for all staff.

EXPANSION OF NEUROLOGY AND STROKE CARE

Cairns Hospital has expanded its provision of specialist services in Neurology and Acute Stroke Care through hiring a third neurologist.

Professor Christian Gericke joined Doctors Andrew McNabb and Ian Wilson, and stroke physician Dr Ramesh Durairaj to help further reduce the waiting times for outpatient neurology and clinical neurophysiology services in Far North Queensland. Professor Gericke has also been appointed as the Director of Research and will develop a research strategy for the Health Service.

There has been a virtual absence of private neurology services within the region. Cairns Hospital provides the only neurology specialist service for the entire population from Tully in the South to the Torres Strait in the North.

This will also allow the hospital to expand the activities of the Acute Stroke Unit that was commenced in 2014, as part of the Cairns Hospital redevelopment, as well as inpatient neurology services on the Rehabilitation Ward.

In line with this expansion, Cairns Hospital has for the first time been successful in obtaining a core advanced training position in neurology accredited by the Royal Australasian College of Physicians starting in 2017-18.

CAIRNS HOSPITAL HELPS TRAINEES ACHIEVE GOALS

In 2016, the Cairns Hospital employed four school-based trainees with a disability to work within operational services including food services, cleaning, porterage, waste, bed washing and linen.

For 17-year-old Zac Sallur who has autism, nodding and rarely speaking was the extent of his communication.

After a year of undertaking a workplace traineeship at the Cairns Hospital, Zac is now speaking in full sentences with great confidence.

“It’s been great to see Zac come so far in just over a year,” said Cairns Hospital Acting Training Coordinator Tamie Lenord.

“Two of our students have intellectual disabilities, one is autistic and the other has a hearing impairment.

“All four have been committed and eager to learn life skills.”

They ended their traineeship on 30 August 2016, having gained a nationally accredited certificate I or II in Hospitality.

Not only was the program beneficial for the trainees, but working with the students also helped staff.

“The staff rapidly connected with the trainees and enhanced their own skills as mentors. The staff in Operational Services worked exceptionally well with the trainees and the trainees thrived having access to their knowledge and support,” said Tamie.

THEY ENDED THEIR TRAINEESHIP ON 30 AUGUST 2016, HAVING GAINED A NATIONALLY ACCREDITED CERTIFICATE I OR II IN HOSPITALITY

From left: Ethan Woodley (fellow trainee), Adam Quinlivan (staff mentor/support) and Zac Sallur.

DIETITIANS WIN AWARD FOR RESEARCH PRESENTATION

Dietitians from Cairns Hospital and Cairns Diabetes Centre have won an award as part of a multi-centre trial for their research project implementing a full scope of dietetic practice in gestational diabetes mellitus (GDM).

Along with Mater Mothers' Hospital and Toowoomba Hospital, Cairns Diabetes Centre won the *Research into Practice Award* at the 2017 Dietitians Association of Australia National Conference.

The project evaluated how well a best practice model of care for patients with GDM could be implemented as an 'Off the Shelf' program in regional facilities. The model of care had been successfully developed and implemented at Mater Mothers' Hospital in Brisbane.

Cairns had 70-90 women present during the trial and the number of women who received best practice care as defined by the number of visits increased significantly by 84.3 percent in Cairns with small clinically significant decreases in medication use.

CARDIAC SERVICES CELEBRATES 30TH ANNIVERSARY

Cairns Hospital's Cardiac Services celebrated 30 years of operation in the Far North in November 2016.

Cardiac services started operation in 1986 with a four-bed Cardiac Care Unit in Cairns Hospital's B block.

Now, the service comprises an eight-bed cardiac care unit with the capacity to increase by four more beds when there is high demand. There is also a 12-bed cardiac ward, a fully operational 24/7 cardiac catheter laboratory, a cardiac investigations unit and a cardiac research unit.

"WE'VE HAD MANY NURSES WORK THEIR WHOLE CAREERS HERE SO THAT SAYS A LOT ABOUT WHAT A WONDERFUL PLACE IT IS TO WORK," CARDIAC SERVICES NURSE UNIT MANAGER MIDGE BALODIS SAID.

"It's also been a wonderful breeding ground for specialists with many undertaking their training here with us."

Cairns Hospital Director of Cardiology Dr Greg Starmer said the anniversary was a terrific reminder of how far the service had come in 30 years.

"Cardiac services in the Far North have even come a long way in the past decade. Prior to 2010, the Cardiac Catheter Laboratory did not offer angioplasty and patients were referred to southern hospitals, usually Townsville," Dr Starmer said.

"The commencement of the 24/7 on-call service was another big milestone during my own time here and has become a crucial part of Cardiac Services here in Cairns.

Previously, the Cardiac Catheter Laboratory was only open five days a week and anyone experiencing a heart attack on a weekend would need to go to Townsville or Brisbane for treatment.

FEWER LONG-STAY PATIENTS AT CAIRNS HOSPITAL

The Health Service has implemented various strategies to reduce the waiting time for patients eligible for residential care placement, resulting in only 31 elderly patients waiting for aged care placements on 30 June 2017 compared to 52 in July 2015, and 39 patients overall waiting to be discharged from hospital to more appropriate accommodation.

The strategies have included working with the Federal Government to ensure further aged care places were allocated to Far North Queensland. It also included working closely with representatives of the residential aged care facilities in the region to ensure all allocated places were offered to suitable applicants.

Employing a Social Worker to assist elderly patients and their families to navigate the complex application process and to advocate on behalf of patients awaiting placement has also reduced the number of patients who wait in hospital for aged care placements.

The Health Service has also enhanced sub-acute services over the last two years to minimise any decline in function in older people admitted to hospital, as well as maximising their potential to return home.

PROTECTING PEOPLE FROM HIV

Cairns is one of 20 sites around Queensland to be involved in a $6 million State Government funded trial to help protect people from HIV.

A total of 1640 people at risk of acquiring human immunodeficiency virus (HIV) have been enrolled in the expanded Queensland Pre-exposure Prophylaxis (QPrEPd) study, with a further 1824 people screened, including 13 participants in Cairns, where HIV infections doubled in 2016.

Cairns Sexual Health Service Director Dr Darren Russell said there has been an outbreak in Indigenous Australians in Cairns, which has also been associated with the syphilis outbreak in Cairns.

“Those two infections often go together and that’s one of the things we think has contributed to increased numbers in 2016,” said Dr Russell.

Dr Russell said the outbreak made his team’s work even more relevant.

“Clearly, there are people at risk and our job is to try to engage those individuals and to offer them the best prevention that we can, and the QPrEP study is a very good form of HIV prevention,” he said.

PrEP is an acronym for Pre Exposure Prophylaxis and refers to the use of anti-HIV medication – an oral pill taken once a day by HIV-negative people to stop the virus becoming established in the body. The QPrEPd study is a state-wide project coordinated and led by the Health Service Sexual Health Team.

Tropical Public Health Services

As one of the largest public health units in the state, Tropical Public Health Services (Cairns) provides a range of disease, illness and injury prevention services across Far North Queensland.

Some of the highlights for the public health team during 2016-17 are as follows.

RHEUMATIC HEART DISEASE REGISTER (RHD) AND CONTROL PROGRAM

Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD) occur at very high rates among Aboriginal and Torres Strait Islander people, refugees and migrant groups that have experienced poverty and overcrowding. Both diseases are completely preventable.

The Rheumatic Heart Disease Register (RHD) and Control Program is a state-wide program that is hosted by Cairns and Hinterland Hospital and Health Service. As at 30 June 2017, the RHD Register and Control program had 2017 active clients on the register from across Queensland, a 75 percent increase since commencement of the register in 2009, with much of the increase attributable to the program's active case finding activities. Almost 80 percent of all clients on the register reside in North Queensland (Mackay to the Torres Strait) and 85 percent of all clients identify as Aboriginal and/or Torres Strait Islander.

COMMUNICABLE DISEASE CONTROL

The “Are all your bubbas jabs up to date” campaign was developed by the Cairns immunisation public health team in 2010 with the aim of promoting childhood immunisations in Aboriginal and Torres Strait Islander people. Following the successful implementation across Far North Queensland, the health promotion campaign is being rolled out across Queensland in 2017.

HEALTH SURVEILLANCE

The Health Surveillance team has released Short Health Indicator Reports profiling the population, maternal and child health status of residents of the Health Service. The Short Health Indicator Report Series profile the health status of populations in sub-regions of the Health Service for selected health indicators, and comprehensively report on the health status of Indigenous and non-Indigenous residents by age group and sex. Additional reports in this series to be released include: health-related behaviours, leading causes of death, injury and poisoning, and cardiovascular health.

SEXUAL HEALTH

The Sexual Health team at Tropical Public Health Services comprises two services. The first is enhanced syphilis surveillance for the northern half of Queensland through the Queensland Syphilis Surveillance Service (QSSS). The QSSS continues to provide advice and education to clinicians on all aspects of sexually transmitted infections and contributes to syphilis notification and management reporting.

The second is an Action Plan team, responsible for clinical leadership and the regional coordination of the Queensland Health North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infection (STI) Action Plan 2016-2021. Activities during 2016-17 include:

- foundation Action Plan activities related to governance, performance reporting and communication;
- an ‘increase STI testing’ campaign in the Health Service in March 2017, involving Aboriginal Medical Services, Sexual Health, General Practitioners and other services;
- clinical and health promotion support for community screens undertaken in two Cape York communities in partnership with Torres and Cape Health Service;
- work with Townsville Public Health and Education Queensland to implement a sexual health and relationships school curriculum in three pilot sites in Indigenous-majority schools in North Queensland, participation in pilot evaluation, and consultation with other Far North Queensland communities for future roll out;
- development of a regional Guide to offering STI testing to people aged less than 16 years in clinical settings;
- development and trial of syphilis point-of-care test guidelines for community screens.

MAREEBA HOSPITAL USING TAI CHI IN FALLS PREVENTION

Mareeba residents are enjoying the health benefits of Tai Chi, now with the weekly classes run by the Mareeba Hospital being more popular than ever.

Mareeba Community Health's Clinical Nurse Mal Fraser said the Tai Chi program has been a huge success among the elderly.

"We can't keep up with the demand, and now have a waitlist," he said.

Studies show that Tai Chi is found to reduce falls in older adults and is one of Mareeba Hospital's strategies in falls prevention.

"The impact of just one fall in the community can be quite significant and can cost the public health system around fifteen thousand dollars," said Mr Fraser.

"If this program helps prevent just one fall, then we have done our job right for that person's quality of life and for the community."

Mareeba resident and Tai Chi enthusiast Jeanette Hartley said she has been attending the Mareeba classes for two years now.

"It's great for us oldies and helps us tremendously in our ageing process. Tai Chi isn't just for the bones and balance, but when you're learning and remembering the moves, it helps with your mind and your memory too."

Tai Chi is a gentle form of exercise focusing on slow, controlled movements. Studies show benefits can include improvements in strength, posture, balance, mental relaxation and breath control.

PALLIATIVE CARE IN RURAL AREAS

Patients at Atherton Hospital and the surrounding rural and remote areas as far as Croydon are benefiting from the dedicated teams who are passionate about providing the best possible palliative care.

Palliative care is the multidisciplinary approach to specialised medical care for patients with serious life threatening illness. It focuses on providing patients with relief from the symptoms, pain, physical stress and mental stress of a serious illness – whatever the diagnosis.

Atherton Hospital Director of Nursing Ann Aitken said the goal of palliative care is to improve quality of life for both the patient and the family.

"At Atherton Hospital, our multidisciplinary team has the privilege to develop an ongoing and caring relationship with many of our palliative patients, who may spend time in the hospital on numerous occasions during their illness," she said.

"OUR SKILLED TEAM ENSURES THAT PATIENT WISHES IN RELATION TO THEIR END-OF-LIFE CARE ARE CONSIDERED AT ALL TIMES."

Rural and remote facilities including Malanda, Millaa Millaa, Georgetown, Forsayth and Croydon Primary Health Centres, have highly skilled and resourceful nursing staff who help to provide palliative care.

"These nurses work in consultation with general practitioners, hospital staff and the Royal Flying Doctor Service to support patients to successfully stay at home if they wish, often in very isolated and difficult circumstances," said Ms Aitken.

"Through flexibility and at times utilising plain ingenuity, these nurses demonstrate great advocacy for their patients and their families, often going above and beyond in support of patient care needs."

LOTUS GLEN – AUSTRALIA'S FIRST HEP C FREE PRISON

Lotus Glen Correctional Centre has made history by becoming the first prison in Australia to be free of Hepatitis C.

The facility passed the milestone in early 2017 after the Health Service staff introduced new medications to treat the infectious blood-borne virus, which only became available early last year.

Hepatitis C is a blood-borne virus that causes inflammation of the liver and is present in the blood of an infected person and can be spread through blood-to-blood contact, including through sexual intercourse.

Lotus Glen Health Service Clinical Nurse Harris said Hepatitis C is commonly spread by the sharing of drug injecting equipment.

"In prison the men often use the same homemade machines to tattoo each other, which spreads the virus," said Mr Cabatingan.

"It has been our goal for quite some time to be the first gaol in Australia to be Hep C free, and now with this new treatment we have a 99.9 percent success rate."

NURSE NAVIGATOR SERVICE IN CASSOWARY HUB

Innisfail, Tully and Babinda Hospitals continue to embrace the Nurse Navigator service where a specialist nurse provides individual assistance to patients with complex health conditions to manage their health care and direct them to the right service, at the right time and in the right place.

The Nurse Navigator service is now in its second year in the Cassowary Hub. The pre- and post- data of the twelve months since implementation show significant improvements at the Innisfail Hospital.

Nurse Navigator for the Cassowary Coast Helen Kulas said there was a 65 percent decrease in Emergency Department presentations by 'nurse navigated' patients.

"There was also an 83 percent decrease in bed days for navigated patients, a 68 percent reduction in failure to attend outpatient appointments for navigated patients, 68 percent of patients who showed an increase in uptake in necessary procedures (planned interventions) that had not been able to achieve these prior to navigation, and there were 78 percent of patients (and their main carers/ decision makers) who demonstrated an increase in health literacy post navigation (measured by the Health Literacy Questionnaire from Deakin University)," said Ms Kulas.

The Nurse Navigator role has also benefited the multidisciplinary team by giving all local healthcare providers insight into available support services and organisations and formed new networks with local services.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

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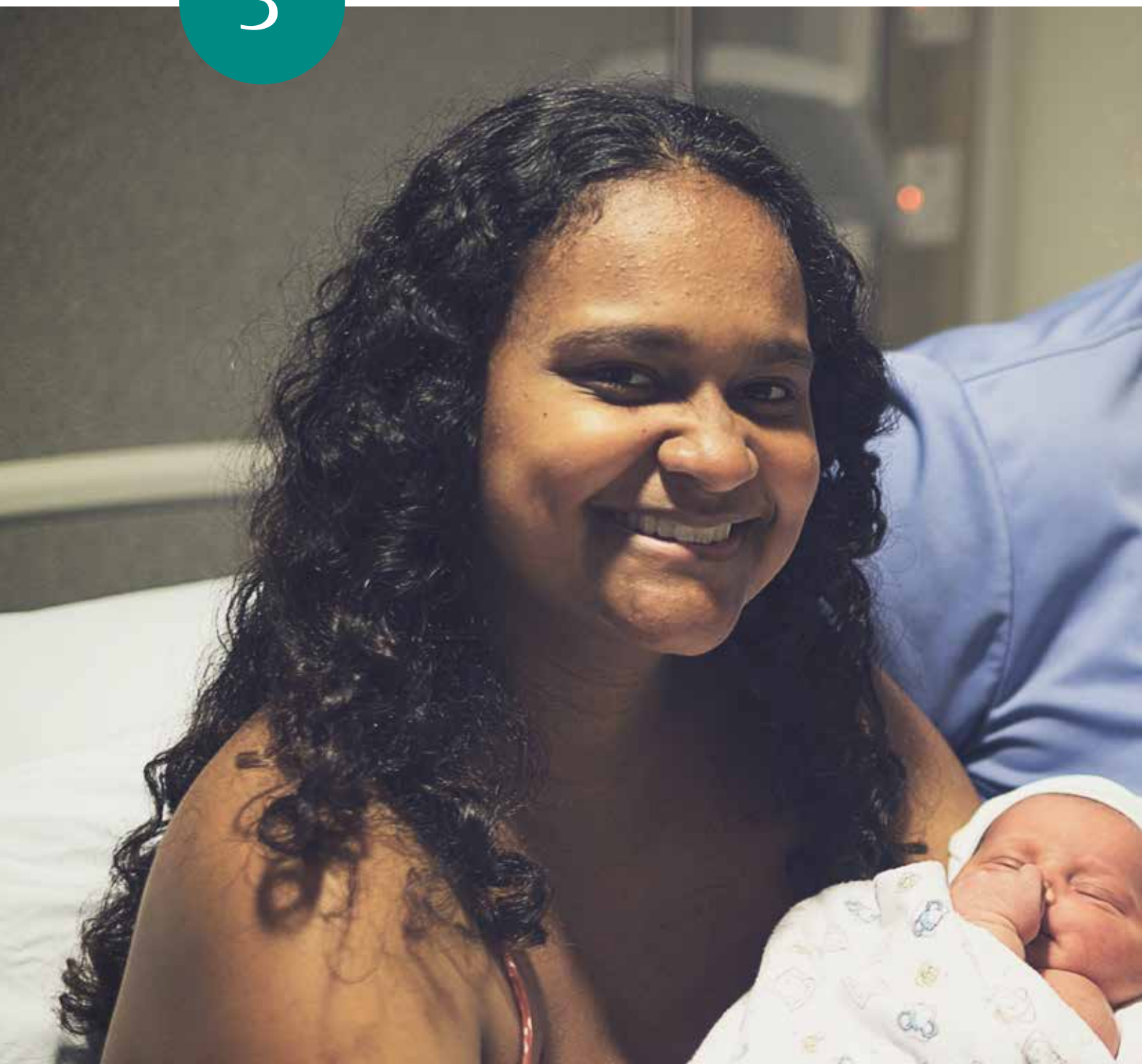


Why an Aboriginal and Torres Strait Islander Indigenous Perspective is important

First Nation Status

Within the Health Service catchment there are at least nine Aboriginal language nations including Kuku Yalanji, Djabugay, Yidinji, Gunggandji, Dyirbalngan, Mbabaram, Warungu, Ewamian and Tagalaka. These language nations comprise approximately 20 tribal groups, each with up to six clans. 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 60 Aboriginal and Torres Strait Islander Traditional Owner groups in Cape York and the Torres Strait Islands whose members access care and services within the Health Service. Individuals from the broader 250 or so Aboriginal and Torres Strait Islander language Nations across Australia visit the health service catchment and access care whilst in the area.

ABORIGINAL AND TORRES STRAIT ISLANDER POPULATION

The Health Service is home to the highest number (n=31,172) of Aboriginal and Torres Strait Islander people in comparison to other Health Services across Queensland. In 2014, Aboriginal and Torres Strait Islander people accounted for 12.6 percent of the total estimated resident population of the Health Service and 15.4 percent 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 A, and shows a higher percentage of Aboriginal and Torres Strait Islander residents (›20 percent) in the inner western and inner southern statistical areas of Cairns, including Manoora, Manunda, Woree and White Rock. On the Atherton Tablelands, the Tablelands and Douglas and Daintree statistical areas had a relatively high percentage of Aboriginal and Torres Strait Islander residents (16-20 percent). The highest percentage of Aboriginal and Torres Strait Islander residents observed in communities across the Health Service was in Yarrabah at 98.2 percent.

In addition to the diversity of cultures and languages amongst the Aboriginal and Torres Strait Islander residents and visitors to the region, a significant number presenting to the Health Service are diagnosed with co-morbidity of chronic conditions, often the result of geographic remoteness and low socio-economic circumstances.

To improve equity in health outcomes between Aboriginal and Torres Strait Islander Peoples and non-Indigenous Australians, the Council of Australian Governments developed and committed to achieving Close the Gap Health Targets. Achieving these targets requires specific Aboriginal and Torres Strait Islander engagement, and adopting a holistic strengths-based approach which recognises the unique cultures, knowledge and connections to Country in order to reduce risk factors, improve early access to health services, and optimise care through best practice chronic disease management.

Aboriginal and Torres Strait Islander peoples have a huge wealth of protective factors which can help reduce the chances of getting diseases or infections. These protective factors include Traditional Ecological Knowledges (TEK), cultural practices, and ceremonies for building interdependence, and Aboriginal and Torres Strait Islander unique perspectives of health.

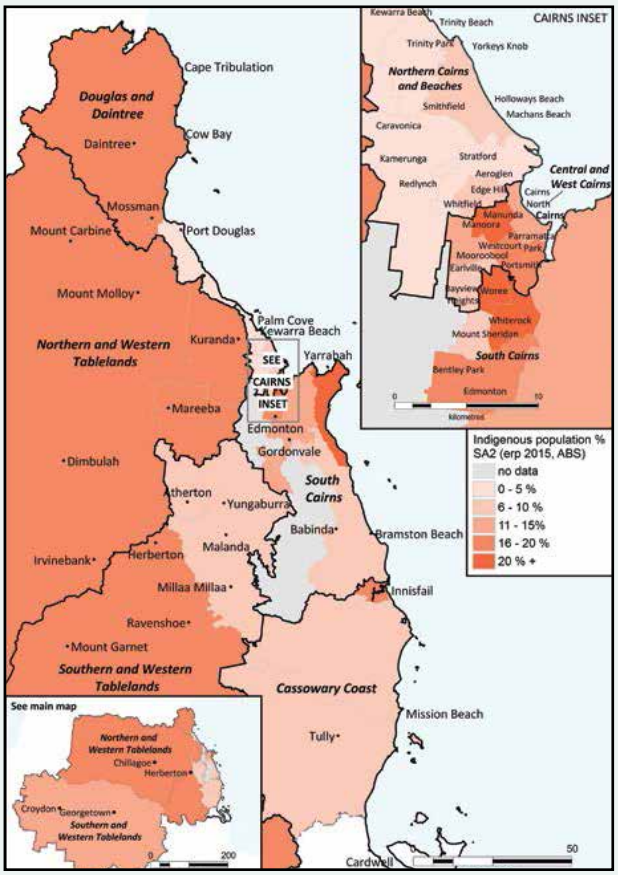


Figure A: Percent Indigenous population by SA2, Cairns and Hinterland HHS, 2014.

Close the Gap - Health Targets

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

LEADERSHIP

The Hospital and Health Board and Executive Management team actively show leadership in implementing the four principles of Aboriginal and Torres Strait Islander Cultural Capability:

- Cultural respect and recognition;
- Communication;
- Relationships and Partnerships;
- Capacity Building.

Smoking Ceremony Performed by Gimuy Walaburra Yidinji at Cairns Hospital to welcome the new Hospital and Health Board.

The display of Making Tracks artwork within Cairns Hospital's Emergency Department was launched by Jeanette Singleton, Yirrganydji. Making Tracks symbolises how we are all working together on a journey to Close the Gap.

The artwork is also displayed on digital way-finding signs throughout Cairns Hospital.

ABORIGINAL AND TORRES STRAIT ISLANDER ENGAGEMENT

The **Aboriginal and Torres Strait Islander Community Consultative Committee (CCC)** has been actively contributing to our governance for nearly two years. Chaired by Jason Leon (pictured), the Committee consists of a diverse range of members from across the area, including Elders Justice Groups, Aboriginal and Torres Strait Islander media, arts and Local Government. This diversity in membership helps our Health Service to canvass the unique demographic, social and cultural perspectives of our local communities.

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

Jason Leon Chair Aboriginal and Torres Strait Islander Community Consultation Committee, Norma Soloman and Karen Philp (Cluster Coordinators) and Simon Costello (Senior Project Officer).

HOW DO WE KNOW IF WE'RE ON TRACK?

The Health Service monitors two main key performance indicators (KPIs) in Aboriginal and Torres Strait Islander Health:

i. Potentially Preventable Hospitalisation (PPH);

ii. Discharge Against Medical Advice (DAMA).

Aboriginal and Torres Strait Islander PPH and DAMA key performance indicators help us to measure equity and effectiveness of access to our Health Service for Aboriginal and Torres Strait Islander peoples. These measures show if people are able to access services easily and if they feel comfortable seeking out healthcare.

Table: Cairns and Hinterland Hospital and Health Service summary of PPH and DAMA indicators over three years for Aboriginal and Torres Strait Islander patients

	Target	2014-15	2015-16	2016-17
Potentially preventable hospitalisations	17.4%	2,242/19.4%	2398/19.9%	2378/18.3%
DAMA	1.0%	477/3.6%	487/3.6%	474/3.3%

Indigenous PPH: count and % (PPH count / total episodes) **Indigenous DAMA:** count and % (DAMA count / total DAMA)

Potentially Preventable Hospitalisation

Potentially Preventable Hospitalisations (PPHs) are conditions where admission to hospital is believed to be avoidable through the provision of timely and adequate primary health care.

In 2016-17, 12.5 percent of the episodes of care were provided to Indigenous people and contributed 22.4 percent to the PPH count.

Top 4 Potentially Preventable Hospitalisation conditions

1. **Diabetes complications**
2. **Cellulitis**
3. **Urinary Tract Infections**
4. **Convulsions and epilepsy**

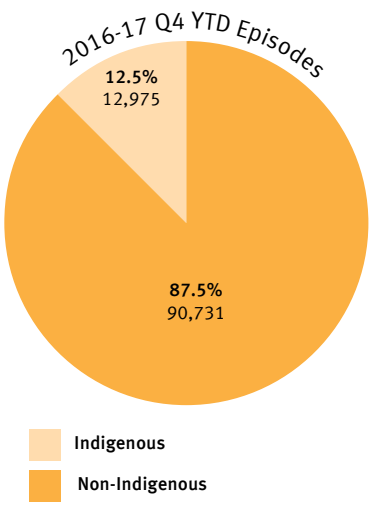


Figure: 2016-17 episodes of care provided to Indigenous and non-Indigenous people

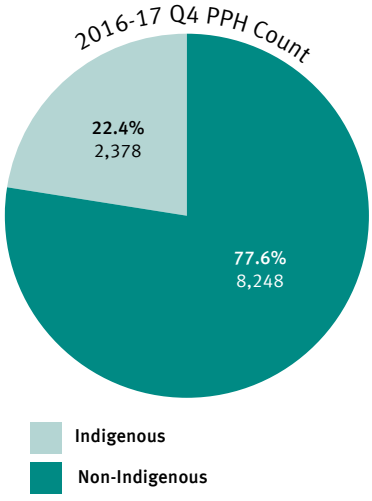


Figure: Comparison of the number of potentially preventable hospitalisations between Indigenous and non-Indigenous people

Discharge Against Medical Advice (DAMA)

The target for Aboriginal and Torres Strait Islander DAMA is one percent. Currently the Health Service's performance is 3.3 percent. Our performance is showing that there is a slight downward trend in DAMA. This improvement in DAMA rates can be attributed in part to the implementation of the DAMA action plan which was introduced in February 2017.

Key Activities to improve DAMA and PPH key performance indicators include:

- developing a culturally responsive service;
- targeted services;
- progressing specific Aboriginal and Torres Strait Islander Research and Development;
- workforce development.

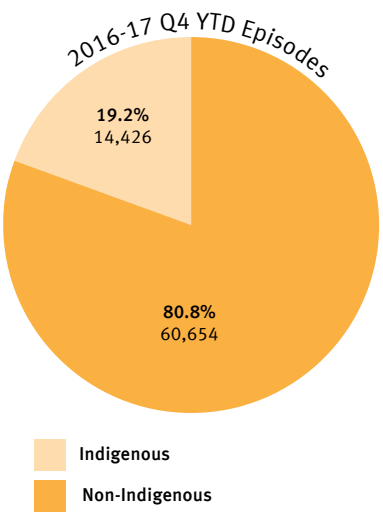


Figure: 2016-17 episodes of care provided to Indigenous and non-Indigenous people

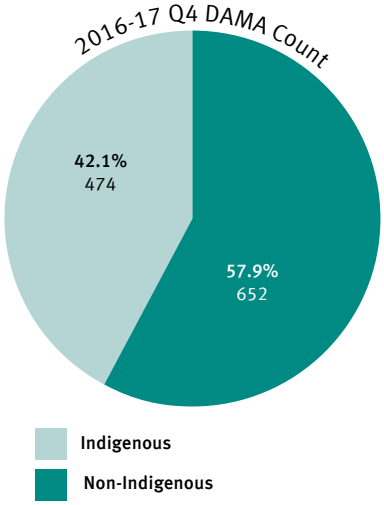


Figure: 2016-17 comparison of the number of Indigenous and non-indigenous people who discharge against medical advice

MAKING TRACKS INDIGENOUS HEALTH INVESTMENT INITIATIVES

In 2016/17, the Health Service implemented a number of targeted Indigenous Health Investment Projects, which were funded through the Aboriginal and Torres Strait Islander Health Branch of Queensland Health.

These projects include:

- Aboriginal and Torres Strait Islander Liaison Services Renal Unit;
- Chronic Kidney Disease – Clinical Pharmacy and Telehealth;
- State-wide Rheumatic Heart Disease Register and Control Program;
- Enhanced Diabetes Outreach Service;
- Indigenous Alcohol Tobacco and Other Drugs Service (ATODS) Youth Program;
- Sexual Health in Corrective Settings;
- Youth Sexual Health Service;
- North Queensland Aboriginal and Torres Strait Islander Sexually Transmitted Infection (STI) Action Plan;
- Remote Sexual Health Service;
- Indigenous Complex Care Coordinator;
- Aboriginal and Torres Strait Islander Cultural Capability Program.

Indigenous Traineeship Program

Throughout 2016-17, there has been a sustained emphasis on Indigenous employee development with the continuation of the Indigenous Traineeship Program.

Our 2016-17 Indigenous Traineeship cohort graduated on 4 July 2017, with a 100 percent success rate – the best our Health Service has seen to date. Outcomes and achievements have been highly regarded, including:

- Five trainees retained in temporary full-time positions within our Health Service and the Torres and Cape Hospital and Health Service; and
- Five trainees nominated for VTEC Trainee of the Year 2016; two of which were awarded Trainee of the Year and Runner-up Trainee of the Year;
- Three Trainees applied for and were accepted into Bachelor Degrees with James Cook University.

Our goal for 2017-18 is to replicate this highly successful traineeship model and achieve similar success rates and outcomes with a new cohort of eight trainees.

The success of the trainees can be attributed to not only their commitment and hard work, but also the support and mentorship they received from senior staff within the Health Service, and external mentors such as Gill Mailman (pictured with trainees).

Research and Quality Symposium 2016

Theme "Promoting Aboriginal and Torres Strait Islander Health and Wellbeing":

More than 130 health professionals, researchers and community members attended the 2016 Research and Quality Symposium.

In its fifth year, the symposium featured 26 podium and 10 poster presentations on the theme Promoting Aboriginal and Torres Strait Islander Health and Wellbeing.

Presenters were from a range of partners including Apunipima Cape York Health Council, Gurriny Yealamucka Health Service, James Cook University (JCU) and Cairns and Hinterland Hospital and Health Service.

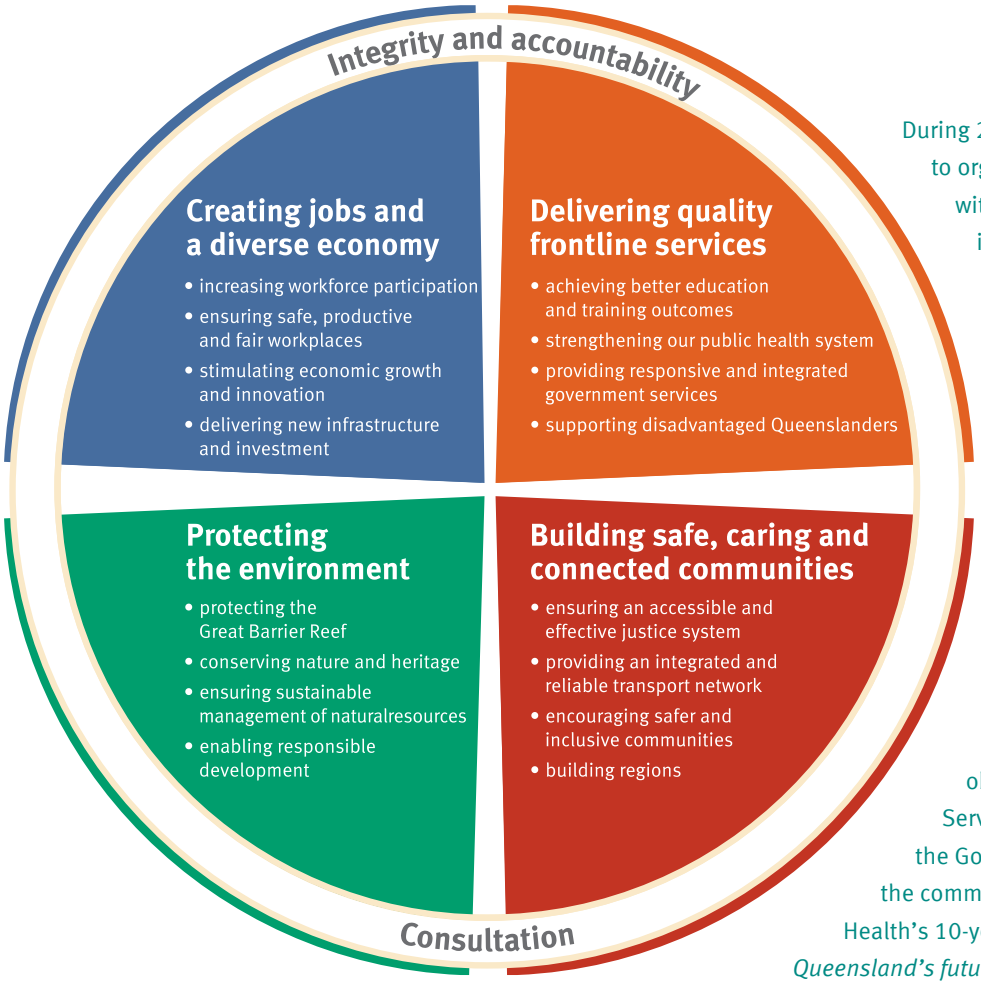
Presenter Dr Sarah Russell, Cairns Hospital Clinical Neuropsychologist and Post-Doctoral Research Fellow at JCU, said she thoroughly enjoyed the day and was very pleased to see so many Aboriginal and Torres Strait Islander health workers from other organisations at the event.

"It was also very useful for networking and we have made some great connections that will benefit the Health Service," she said.

A highlight of the symposium was the keynote address by then Associate Professor Noel Hayman, Clinical Director of the Inala Indigenous Health Service in Brisbane, who spoke on "Striving towards a Centre of Excellence in Indigenous primary health care: The Inala experience".

Cleveland Fagan and Dr Alan Ruben from Apunipima Cape York Health Council and Professor Yvonne Cadet-James from James Cook University were also invited speakers at the event.

4 OUR ORGANISATION



During 2016-17, our focus shifted to organisational sustainability, with a number of strategies implemented to improve the way we deliver health services to ensure that we meet the health needs of our community and patients, now and into the future.

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 also aligned with the Government's objectives for the community and Queensland Health's 10-year strategy *My health, Queensland's future: Advancing health 2026.*

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 5837 full-time, part-time and casual employees as at 30 June 2017.

Our Health Service recognises the importance of delivery of new infrastructure and investment to improve the health care of patients living within our region, as well as the need to sufficiently maintain the facilities that we currently have. Significant upgrades to air-conditioning facilities have been made at a number of rural sites including Babinda, Tully, Innisfail, Mareeba and Atherton, at a cost of $10.4 million. The cooling towers at Cairns Hospital B Block, which were also nearing the end of their lifecycle, have been replaced.

Works continue on the replacement of the Dimbulah Primary Health Care Centre and the planning for the redevelopment of Atherton Hospital.

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 has been strengthened, with the increase of Nurse Navigator Complex Care Coordinators from 10 to 15 positions during 2016-2017. These coordinators act as guides for patients with complex care needs, ensuring patients are seen by the right person, at the right time and in the right place.

The Health Service has continued to focus on reducing ultra-long waits (those waiting more than two years) for Specialist Outpatient appointments. We achieved a 90 percent reduction in the total number of patients waiting longer than two years for an appointment. This is a significant achievement and an excellent outcome for the 2,653 patients who were seen by a specialist.

Protecting the environment

The Health Service is committed to a clean energy future. Where possible, all new hospital and major construction projects within the Health Service are designed to achieve a low carbon footprint, to reduce facility energy costs and the impact on the local environment.

As an example, the Dimbulah Primary Health Care Centre has been architecturally designed to allow more natural lighting into the centre with the view to reducing energy consumption. Other energy-efficient features of the facility include solar power, the fitting of LED lighting throughout, timer-controlled air-conditioning systems, and additional thermal insulation. Inclusion of these features resulted in the Health Centre being awarded a six-star energy-efficiency rating and further demonstrates the Health Service's commitment to ensuring sustainable use of natural resources.

HealthPathways

Patients in the Far North are benefiting from a new era of digitalised healthcare with the launch of Cairns HealthPathways, a joint venture between the Health Service, and Northern Queensland Primary Health Network (NQPHN).

Ruth Fisher, Dr Melanie Stuttgen, Andy Froggatt, Director-General Michael Walsh, Dianne Shkurka, Anthony Elliot, and Helen Stoelhorst at the launch of HealthPathways.

HealthPathways is a web-based information portal aimed at supporting primary care clinicians to plan patient care through primary, community and secondary healthcare systems across the Far North.

GP Clinical Editor for the Cairns HealthPathways project, Dr Melanie Stuttgen, said the system had been compared to a "care map", so that all members of a healthcare team – whether they worked in a hospital or in the community - can be on the same page when it comes to looking after a particular patient.

"The aim of HealthPathways is to improve the referral process for GPs by providing clear information about who to refer, when to refer, and the process in the local area, which should result in patients who are more informed from the get-go about their journey," Dr Stuttgen said.

"One of the main benefits of HealthPathways will be the assistance it offers GPs in the assessment, management and referral of patients to community-based and specialist care.

"Through this, there will be improved consistency in patient care, increased appropriateness of referrals, and enhanced integration of care between primary healthcare and hospital services or other health service providers."

HealthPathways incorporates Clinical Prioritisation Criteria (CPC), which are clinical decision support tools that help ensure patients referred for public specialist outpatient services in Queensland are assessed in order of clinical urgency.

"The inclusion of CPC will enable GPs to make complete and appropriate referrals for their patients, ensuring those who require the most urgent care are seen in the clinically recommended time," Dr Stuttgen said.

Building safe, caring and connected communities

The continuing improvements in implementing health technology are providing our Health Service with the opportunity to connect with other healthcare providers and collaborate with external partners to improve the coordination of care for our patients.

During 2016-17, the Health Service:

- Introduced General Practitioner access to view electronic patient summary information held by the Health Service through the service known as 'The Viewer'.
- Launched *HealthPathways* in conjunction with Torres and Cape Hospital and Health Service and Northern Queensland Primary Health Network. HealthPathways is a web-based health information site that assists clinicians to guide patients through the healthcare system. HealthPathways will also provide support in assessing and managing patients, and clear referral pathways to community and secondary care services. There were 118 pathways launched in 2016-17 and work continues to expand this to more than 550 medical conditions.
- Continued detailed planning and the appointment of a contractor for the Regional eHealth Project, which aims to implement an electronic health record system for primary and community care. This initiative will enhance the quality of, and access to, patient and clinical information across Far North Queensland. The system will support patient-focussed, integrated healthcare services delivered as close to the patient's home as possible.
- Embedded the digital hospital solution across Cairns Hospital and related facilities.

Regional eHealth Project

The Regional eHealth Project aims to deliver an electronic health record system that enables access to secure and reliable patient information in 58 primary, community and hospital-based healthcare facilities across Far North Queensland. It is intended that this information is shared with healthcare partners from public, private and the not-for-profit healthcare sector. This solution will support patient-focussed integrated care and collaborative service delivery as quickly and as closely to the patient's home as possible.

The new system will be designed to meet the local needs of healthcare providers and enhance the delivery of comprehensive primary care to their patients. Replacing paper-based processes, it will ensure that all the clinical information about a patient is immediately available to all their healthcare providers. During 2017, the Regional eHealth Project is undertaking detailed planning activities in partnership with contractor ISA Healthcare Solutions, whose intuitive software will be adapted to meet the region's unique needs. This will consist of working with healthcare providers so the software can be tailored and ensure a smooth transition from how clinical information is accessed now to how it will be accessed via an integrated electronic health record system. It is expected that the project will commence the implementation in mid-2018.

Ultimately the system will ensure that clinicians have access to all the clinical information needed to provide high quality, comprehensive primary care for their patients as well as empowering patients to have greater involvement in their own health and wellbeing.

The Regional eHealth Project is a joint initiative between the Cairns and Hinterland Hospital and Health Service and the Torres and Cape Hospital and Health Service utilising funding from the Commonwealth of Australia's Health and Hospital Fund and in-kind funding from the State Government.

OUR STRATEGIC OBJECTIVES

The Hospital and Health Service's objectives and strategic priorities are guided by the National Health Reform Agreement and the vision and 10 year strategy for health in Queensland – *My health, Queensland's future: Advancing health 2026.*

QUALITY AND SAFETY

We will strive to continually improve patient care, safety and outcomes.

STRATEGIES

Maintain compliance requirements with all 15 Australian Council Healthcare Standards, including management and recording of quality improvement activities.

PERFORMANCE INDICATORS

Meet all Service Agreement KPIs and Health Ombudsman reporting requirements.

PROGRESS IN 2016-17

Following an Organisation-wide survey in 2014, the Health Service was awarded four years' accreditation through to the end of 2018. In March 2017, a periodic review was conducted, with it subsequently being confirmed that the organisation had maintained its accreditation status through to the end of 2018.

INTEGRATION

We will provide integrated and coordinated healthcare services that are patient-focussed and culturally appropriate.

STRATEGIES

Implement the Health Service Plan to provide integrated and coordinated healthcare

PERFORMANCE INDICATORS

Demonstrated use of population health data to guide the strategic and operational planning, facility utilisation, and determination of actual service needs for health service delivery.

PROGRESS IN 2016-17

The development of a new *Clinical Services Plan 2017-2022* has been itentified as a priority for the Health Service to ensure that future service delivery priorities align with community health needs, integrates care across the region, as well as to inform longer-term infrastructure master planning.

During 2017, the development of the Clinical Services Plan has been undertaken incorporating extensive data analysis and consultation with staff and with external key stakeholders to validate health service needs and issues.

Population health data was also utilised in the development of business cases for the Atherton Hospital redevelopment and the establishment of the Cairns Southern Corridor Health Precinct.

ENGAGEMENT

We will actively engage stakeholders and consider their input in the delivery of healthcare services.

STRATEGIES

Recognise that the voices of our community, clinicians and patients are important. Build systems to support active engagement and responsiveness.

PERFORMANCE INDICATORS

Implement the Consumer and Community Engagement Strategy and demonstrate that community input is considered during healthcare planning and service delivery.

PROGRESS IN 2016-17

The Health Service has continued to strengthen its commitment to community engagement with quarterly meetings of the Community Consultative Committees taking place. The committees have provided feedback on a variety of patient-centred topics.

Clinical and non-clinical user groups were established during planning for infrastructure development for the Atherton Hospital redevelopment and the Cairns Southern Corridor Health Precinct.

WORKFORCE

We will create and maintain a positive workplace culture that will enable our workforce to be fully engaged, productive, educated and supported. The right people will be deployed to the right service at the right time.

STRATEGIES

Attract and retain the best available talent for every role in the Health Service, and provide an environment for talent and extension.

PERFORMANCE INDICATORS

Reenergise our organisation by considering the results of the Employee Opinion Survey and actioning positive changes. Identification of gaps in active recruitment for business critical positions.

PROGRESS IN 2016-17

The Leadership Pipeline project commenced in 2016-17 and is being rolled out which will support and align leadership principles and standards with a framework to deliver more clarity, accountability and ownership across all levels and streams.

SUSTAINABILITY

We will ensure fiscally responsible decision-making, while providing stable and sustainable health services.

STRATEGIES

Approach every decision from a perspective that ensures sustainability and safety of our services, customers and workforce.

PERFORMANCE INDICATORS

We will implement our agreed plans to reach and maintain sustainable service delivery.

PROGRESS IN 2016-17

In September 2016, an independent audit identified a projected operating deficit of $80 million for the 2016-17 financial year. Through the identification of cost savings, including improved controls, an actual deficit of $32.07M was achieved at year end without a reduction in services.

DECISION-MAKING

We will establish engaged, consistent and timely decision-making processes at all levels of the organisation.

STRATEGIES

Inform, empower and drive a commitment to accountability for performance through effective decision-making at all levels of the organisation.

PERFORMANCE INDICATORS

Develop and implement communication and training mechanisms for all staff that clearly outline the human resource and finance delegations within their line of management.

PROGRESS IN 2016-17

The Health Service conducted a review of all human resources and financial delegations to ensure that decisions could be made appropriately and responsively. Training of 504 staff members who currently hold such delegations took place during 2016-17.

Risk management processes have been improved through the development of a framework document which clarifies responsibilities for managing risks across the Health Service. Systems, structures, processes, policies, roles and support functions all form part of the risk management framework.

INFORMATION TECHNOLOGY

We will build, develop and implement information technology and systems that support integrated healthcare delivery and enhance organisational performance.

STRATEGIES

Improve ICT and support information sharing electronically between Queensland Health facilities and external partners across the FNQ region, where possible.

PERFORMANCE INDICATORS

Strategically invest in initiatives to pursue integration of ICT across the sector to improve outcomes. Establish and monitor compliance with minimum standards of access to ICT systems and infrastructure across the Health Service.

PROGRESS IN 2016-17

In an effort to address ICT access issues, the Health Service has received approval to upgrade the bandwidths across all seven of the rural sites as part of the Regional eHealth Project.

The Health Information Group (HIG) was established to ensure clinical input and advice into integrated electronic medical record (ieMR) improvements.

In April 2017, the Northern Queensland Primary Health Network and the Cairns and Hintelrand Hospital and Health Service launched a web-based health information site, HealthPathways. HealthPathways assists clinicians to guide patients through the healthcare system.

RECOGNITION

We will recognise and promote our standing and our achievements; locally, nationally and internationally.

STRATEGIES

Development and implementation of the Communication Strategy, which incorporates traditional and collaborative communication models.

PERFORMANCE INDICATORS

Successful implementation of the Communications Strategy.

PROGRESS IN 2016-17

The Health Service updated the Consumer and Community Engagement Strategy 2017-2020, which was approved by the Board in June 2017.

During staff recognition week, the Health Service held events and acknowledged the contribution of staff through awards and length-of-service presentations.

5

OUR GOVERNANCE

CAIRNS AND HINTERLAND HOSPITAL AND HEALTH BOARD

The Cairns and Hinterland Hospital and Health Service is a statutory body as defined by the *Hospital and Health Boards Act 2011*('the Act') 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.

The Cairns and Hinterland Hospital and Health Board ('the Board') must perform its functions and exercise its powers in accordance with the provisions of the Act.

The Board has responsibility for ensuring that the Health Service discharges its functions in accordance with Section 19 of the Act. This includes, but is not limited to, the obligation to develop statements of priorities and strategic plans for the corporate governance of the Service and to monitor compliance with those statements and plans. The Board also has the responsibility for the appointment of the Health Service Chief Executive.

Throughout 2016-17, there were some significant changes to the governance of the Health Service. On 19 September 2016, the full Board resigned. Shortly afterwards, on the 23 September 2016, an Administrator was appointed to oversee the Health Service.

On 16 May 2017, the Governor of Queensland, the Honourable Paul de Jersey AC, acting on the advice of the Executive Council and on the recommendation of the Minister for Health and Minister for Ambulance Services, the Honourable Cameron Dick MP, approved the appointment of a new Hospital and Health Board. The Board is supported in its efforts by two advisors for its first six months.

Our Board members have a mix of qualifications, skills and experience, and contribute to the governance of the Health Service collectively as a Board through attendance at Board meetings, participation in committes and other public, staff and consumer activites.

Front (L-R): Nancy Long, Clive Skarott AM (Chair), Luckbir Singh, Lee Stewart. Rear (L-R): Jodi Peters, Sean McManus, Tracey Wilson, Chris Boland.

Mr Clive Skarott AM (Chair)

DipFinSvcs, FAICD, FAMI, JP (Qual.)

15 May 2017 – 17 May 2019

Mr Skarott is the Chair of JCU Dental and President of the Cairns Historical Society and Museum. He was Chair of Ergon Energy and a director of Energy Queensland Ltd as well as being Chair of the Cairns Port Authority until June 2010. Mr Skarott has also served in a number of other positions including as a director of Advance Cairns; Treasurer of the Regional Development Australia Committee (Far North Queensland and Torres Strait); and director and Chief Executive Officer of the Electricity Credit Union.

Mr Skarott holds the following positions:

- Chair, Board
- Member, Finance and Performance Committee
- Member, Safety and Quality Committee
- Member, Audit Committee
- Member, Executive Committee

Mr Luckbir Singh (Deputy Chair)

LLB, GAICD

15 May 2017 – 17 May 2020

Mr Singh has been a corporate lawyer for 17 years and became a partner of MacDonnell's Law in 2007 - the youngest modern-day partner appointment in the firm's 130 year-plus history. He has been recognised for his legal skills and client outcomes by Lawyer's Weekly as a finalist in the 2016 Australian Partner of the Year Awards. Mr Singh is also a director and chair of the Nominations Committee for Northern Queensland Primary Health Network; director of Cairns COUCH Limited (COUCH); board member of the Australian Institute of Company Directors Queensland Council; and chair of the Chamber of Commerce and Industry Far North Queensland Regional Council.

Mr Singh holds the following positions:

- Deputy Chair, Board
- Chair, Executive Committee

Ms Nancy Long

ADip Bus, Dip Bus.

15 May 2017 – 17 May 2020

Ms Long is an Indigenous health executive, holding various positions with Wuchopperen Health Service from 1989, including Chief Executive Officer, director of Primary Health Care, and Director of Business Development. Ms Long was inducted into the Queensland Aboriginal and Islander Health Council's Hall of Fame in 2010.

Mrs Long holds the following positions:

- Member, Safety and Quality Committee

Professor Lee Stewart

DipTch(Nsg), BHlthSc(Nsg),PGCertEd, MDispute Resolution, PhD, RN, RM

15 May 2017 – 17 May 2020

Professor Stewart worked as a Clinical Governance Consultant to the Fiji Minister of Health and has written a variety of publications related to clinical governance and healthcare leadership. She has been Dean of the College of Healthcare Sciences at James Cook University (JCU) since 2014. The college includes the disciplines of exercise physiology, nursing, midwifery, occupational therapy, physiotherapy, psychology, speech pathology and sport and exercise science. Professor Stewart was previously Associate Professor and Head of the School of Nursing, Midwifery and Nutrition at JCU, and has held a variety of senior lecturer and director positions across the university since 2003. She started her career at Ipswich General Hospital, where she received her General Nursing Certificate in 1975.

Professor Stewart holds the following positions:

- Chair, Safety and Quality Committee

Mr Christopher Boland

B.E.(Hons), GAICD

15 May 2017 – 17 May 2020

Mr Boland has been Chief Executive Officer of the Far North Queensland Ports Corporation (Ports North) since 2009,

and previously the General Manager Seaport for Cairns Ports (formerly Cairns Port Authority). Mr Boland has two adult children, both practising as doctors in Brisbane and Mackay.

Mr Boland holds the following positions:

- Chair, Finance and Performance Committee
- Chair, Audit Committee

Dr Sean McManus

MBBS FCICM FANZCA MAICD

15 May 2017 – 17 May 2020

Dr McManus is a Consultant Intensivist and Anaesthetist in the Department of Anaesthesia, Perioperative Medicine and Intensive Care at Cairns Hospital. Dr McManus started his medical career as an intern at the Royal Brisbane Hospital in 1994, before moving to Innisfail Hospital in 1996 as Principal House Officer, then undertaking his Anaesthesia/ICU traineeship at Cairns Hospital from 1998, giving him 20 years of experience working in the Cairns and Hinterland Hospital and Health Service. Dr McManus has been on the Board of the Australian and New Zealand College of Anaesthetists since 2014.

Dr McManus holds the following positions:

- Member, Safety and Quality Committee
- Member, Executive Committee

Ms Jodi Peters

B Bus (USQ), GAICD

15 May 2017 – 17 May 2019

Ms Peters is a founder and Managing Director of The 20/20 Group, a North Queensland strategic consultancy specialising in business and marketing planning. Through that business Ms Peters primarily advises on strategic planning, governance, and major tendering projects. She holds a Bachelor of Business, has an extensive background managing law firms and is presently the Business Manager of Peters Bosel Lawyers. Ms Peters has chaired, sat on, and consulted for several not-for-profit boards, giving her a strong knowledge of governance, executive reporting, financial and performance management. She presently holds current directorships on the Boards of Community Enterprise Queensland and Trinity Anglican School Limited.

Ms Peters holds the following positions:

- Member, Finance and Performance Committee
- Member, Audit Committee

Ms Tracey Wilson

MSustDev, ProfDipHRM,CAHRI

15 May 2017 – 17 May 2019

Ms Wilson is owner and director of Working Visions, a Queensland consulting firm specialising in strategy, communications and engagement, with particular emphasis on public participation, facilitation, stakeholder engagement, and issues management. Ms Wilson has experience as a crisis communications and engagement specialist, and commenced her communications career in political offices.

Ms Wilson holds the following positions:

- Member, Audit Committee
- Member, Executive Committee

Advisors

Mr Ian Langdon
Chair, Gold Coast Hospital and Health Service
15 May 2017–
14 November 2017

Mr Terry Mehan
Previous Administrator, Cairns and Hinterland Hospital and Health Service
15 May 2017–
14 November 2017

Administrators

Mr Michael Walsh
19 September 2016 –
7 November 2016

Mr Terry Mehan
14 November 2016 –
15 May 2017

Previous Board

Ms Carolyn Eagle
1July 2012 –
19 September 2016

Ms Joann Schmider
18 May 2016 –
19 September 2016

Ms Leeanne Bou-Samra
1July 2012 –
19 September 2016

Ms Gillian Shaw
18 May 2016 –
19 September 2016

Dr Peter Smith
17 May 2013 –
19 September 2016

Ms Anita Veivers
18 May 2016 –
19 September 2016

Dr Felicity Croker
23 August 2013 –
19 September 2016

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. Attendance for the current* Hospital and Health Board:

	Board Meeting	Audit and Risk Management	Finance and Performance	Safety and Quality
Clive Skarott	1 of 1	1 of 1	1 of 1	1 of 1
Luckbir Singh	1 of 1	1 of 1	1 of 1	-
Nancy Long	1 of 1	1 of 1	1 of 1	1 of 1
Lee Stewart	0 of 1	0 of 1	0 of 1	-
Chris Boland	0 of 1	0 of 1	0 of 1	-
Sean McManus	1 of 1	1 of 1	1 of 1	1 of 1
Jodi Peters	1 of 1	1 of 1	1 of 1	-
Tracey Wilson	1 of 1	1 of 1	1 of 1	-
Ian Langdon (Advisor)	1 of 1	1 of 1	1 of 1	1 of 1
Terry Mehan (Advisor)	1 of 1	1 of 1	1 of 1	1 of 1

**Attendance record for Board appointed on 16 May 2017.*

Total out-of-pocket expenses paid to board members during the reporting period was $135.15.

Our Board committees

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

The Board has established those prescribed committees required under the Act 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 legislative requirements, the needs of the Health Service and the skill and experience of individual board members. The Board has sole responsibility for the appointment to committees.

During the 2016-17 year the following committees of the Board were noted:

- Audit Committee;
- Safety and Quality Committee;
- Finance and Performance Committee;
- Executive Committee (did not meet in 2016-17).

Audit Committee

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

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

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

The Audit 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*, and performs the functions described under Part 7, Section 32 of the Hospital and Health Boards Regulations 2012.

The purpose of the Safety and Quality Committee is to assist the 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.

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* and performs the functions described under part 7, Section 33 of the Hospital and Health Boards Regulation 2012.

The purpose of the Finance and Performance Committee is to assist the 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.

Executive Committee

The Executive Committee may, at the direction of the Board:

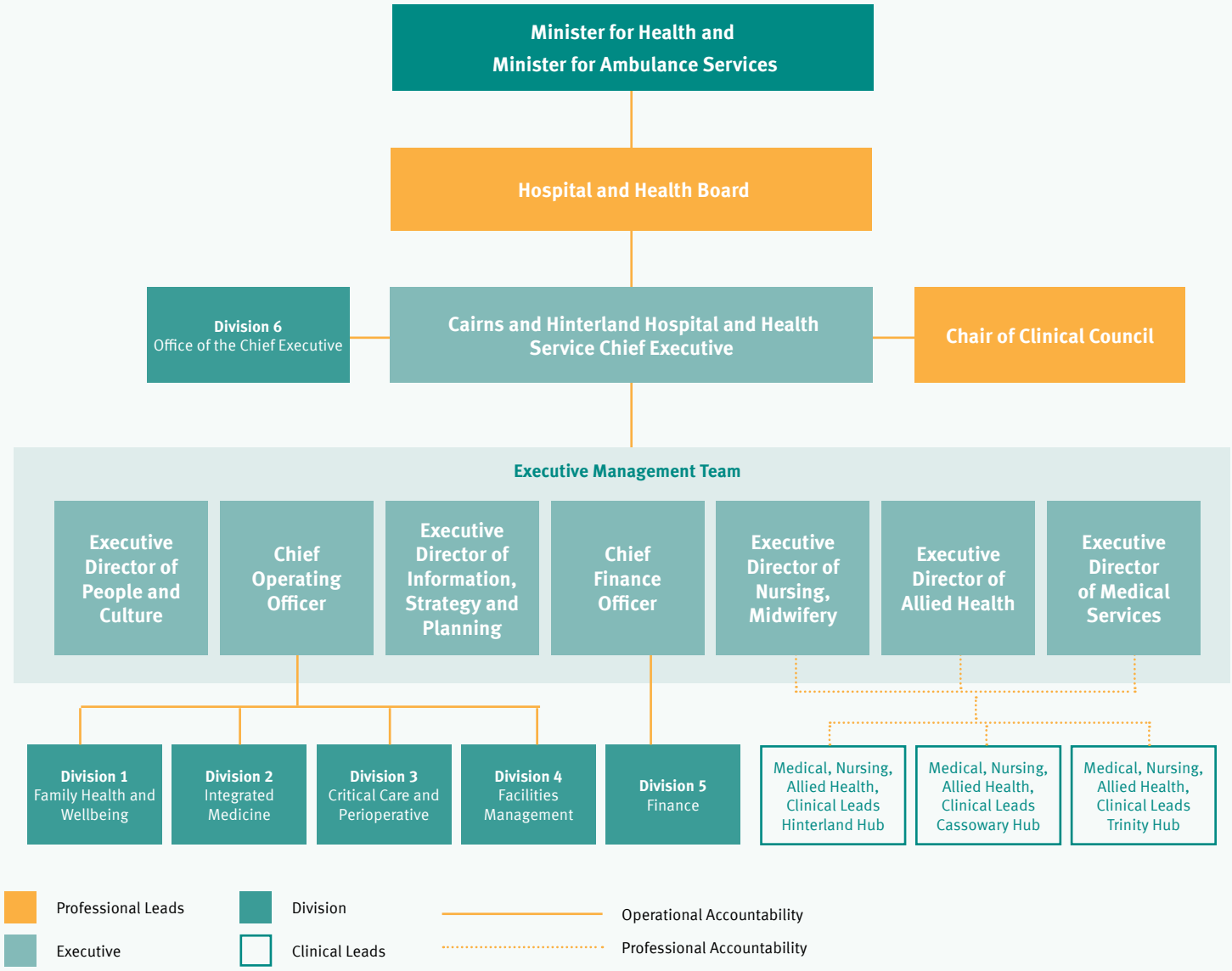
- oversee the performance of the Health Service against the performance measures stated in the service agreement;
- support the Board in the development of engagement strategies and protocols with primary healthcare organisations, monitor their implementation, and address issues that arise in their implementation;
- support the Board in the development of service plans and other plans for the Health Service and monitor their implementation;
- work with the Health Service Chief Executive in responding to critical emergent issues in the Health Service; and
- perform other functions given to the committee by the Board.

The specific functions of the committee will vary from year to year and will be contained in a work plan and calendar of activities to be proposed by the committee and approved by the Board annually in May of each year.

Approval by the Board of the above mentioned work plan ensures that the committee is working towards providing directed advice to the Board to assist it in discharging its duties under the Act.

ORGANISATIONAL STRUCTURE

As at 30 June 2017



During 2016-17, the Health Service commenced an executive realignment as part of the workforce development priorities under the *Embracing A Healthier Future* plan to ensure the executive portfolios support clear accountabilities, effective collaboration and a focus on the right priorities.

Consultation with staff on the realignment started in November 2016 with a body of work completed in 2017 to ensure the newly aligned structure was ready for implementation early in 2017-18.

The Executive Realignment results in a shifting of portfolios between executives and the creation of a new Executive Director of Aboriginal and Torres Strait Islander Health role.

EXECUTIVE MANAGEMENT

As at 30 June 2017

Ms Clare Douglas

Chief Executive

BAppSc (Nursing), GDipHlthA, MaMgt, GAICD

Ms Clare Douglas was appointed as the Chief Executive of Cairns and Hinterland Hospital and Health Service commencing in December 2016. She was interim Chief Executive between June and December 2016. Previously Clare was the 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.

Mr Steve Thacker

Chief Financial Officer

BA PGDip MA ACCA

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

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

He is a member of the Association Chartered Certified Accountants, a member of the Institute of Directors and a member of the Association for Project Management.

Ms Tina Chinery

Chief Operating Officer

EMPA, DipEd, BAppSc (Nursing), GAICD

Ms Tina Chinery has extensive experience in health service management in acute, primary health and aged care sector, including service reform and has overseen the development and commissioning of three regional hospitals in Western Australia (WA).

Tina started her career as a nurse and in the last 15 years has been in leadership roles including Regional Director for the Pilbara Region WA and Chief Operating Officer Southern for the WA Country Health Service. Prior to commencing as the Chief Operating Officer , Tina was asked by the then WA Health Director General to oversee the commissioning of the Perth Children's Hospital as the Executive Director Commissioning.

This role included development of the commissioning program and ICT implementation for Perth Children's Hospital.

Dr Donna Goodman

Executive Director Allied Health

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

Dr Donna Goodman has been Executive Director of Allied Health for the 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 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.

Dr Nicki Murdock

Executive Director Medical Services

FRACP, FRACMA, FRACGP, FAICD, EMBA

Dr Nicki Murdock has specialist qualifications in general practice, paediatrics and medical administration. As well as being the Executive Director of Medical Services, Cairns and Hinterland Hospital and Health Service, she is a past President of the Paediatrics and Child Health Division of the Royal Australasian College of Physicians (RACP).

Nicki has been a Director of not-for-profit companies (NFP) in Australia for over 10 years including service as Chair of the Capricornia Division of General Practice in 2008. For six years Nicki was a Board Director of CSQTC, then the largest GP training organisation and served a stint as Company Secretary.

Nicki was on the Board of the RACP and chaired the Board Risk Management Committee and the Board International Strategy working group for four years. Nicki has been a Fellow of the Australian Institute of Company Directors since 2011.

Corporate governance in health care organisations is a particular interest of Nicki's and she has been part of senior leadership teams in the Royal Children's Hospital and Central Queensland Hospital and Health Service, concentrating on quality and risk management. Nicki is foundation Chair of Health Leaders Australia (HLA). This not-for-profit (NFP) organisation provides IT and facility management services for health and education NFPs. HLA holds the Queensland Health contract for intern accreditation and has developed an IT platform for staff performance management.

A/Prof Denise Paterson

Executive Director Nursing and Midwifery

A/Professor, MscMid, GDipHlthM, GDipHospRed, RN, RM

Associate Professor Denise Paterson has had an extensive career in health both nationally and internationally, including senior nursing and midwifery and operational roles in the United Kingdom, New South Wales and Victoria. She has also held numerous board and committee positions, including chair Victorian Metro Executive Directors of Nursing & Midwifery.

Denise holds an Honorary Clinical Associate Professorship with Deakin University, a Masters of Midwifery, Graduate Diploma in Health Management and a Graduate Diploma in Hospital Redesign.

In her most recent role before commencing at the Health Service, Denise developed and implemented Western Health Links, a pilot program to improve the outcomes for patients with complex and chronic disease and led Western Health's Closing the Gap strategy.

Ms Rebecca Wells

Executive Director People and Culture

BA/LLB, DipLegPrac

Rebecca started her career as a lawyer specialising in Industrial Relations and Employment Law. She developed an interest in Generalist Human Resources, and for the past 15 years has held senior roles with companies such as BHP Billiton, Cement Australia, ABC Childcare and Queensland Health. Rebecca believes highly in the value of human resources as a key part of any business, and is focussed on fair and equitable processes for both employees and employers.

THE CLINICAL COUNCIL

The Clinical Council is the peak representative body for clinicians within the Hospital and Health Service. The council provides a mechanism for clinician involvement and input into strategic and governance matters aimed at improving healthcare 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 and advice the Executive and 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 in the Health Service.

In order to achieve diversity in expertise, council membership comprises representatives from a range of professional groups and facilities within the Health Service setting.

The Chair of the Clinical Council sits on the Executive Management Team as the representative of the council (and clinicians across the Health Service), and reports on council activities. The Chair of the council also has an open invitation to the 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.

Council Leadership

During 2016-17, the Chair of the Clinical Council was Dr Malcolm Donaldson; supported by Deputy Chair; Dr Roxanne Wu.

Membership of Council

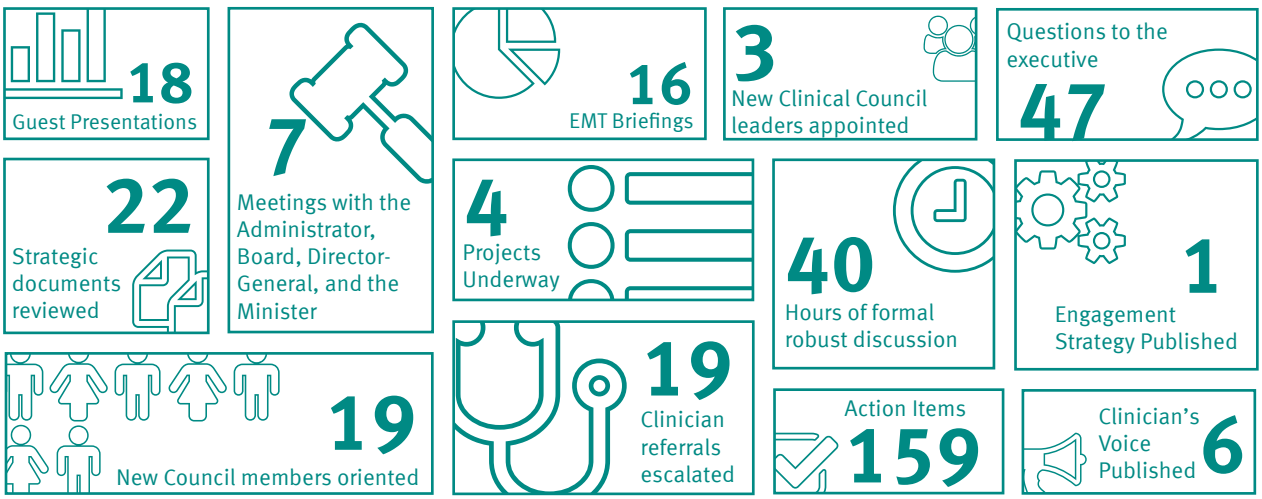
Following a successful recruitment campaign in July 2016, the council's membership grew substantially. The membership has demonstrated their passion for quality clinical care and commitment to advocating for their clinical colleagues. The council's membership continues to grow with the addition of proxy-membership, which guarantees full representation of professional groups at all meetings.

Highlights of the Clinical Council

Some of the highlights and achievements of the Clinical Council during 2016-17 include: realigning the top five priorities for the Council (Communication with Primary Care; Oral Health Project; Clinical Documentation; Equity of Distribution of Health Funding; Zero reduction of Clinical Services); securing an additional membership position for an Indigenous Health representative on the Queensland Clinical Senate; working with the General Practice Liaison Service to promote and expand secure messaging; and working with clinical coding unit to engage clinicians to improve clinical documentation. Additionally the Clinical Council awarded proxy members full voting privileges to ensure decision-making with full professional representation at every meeting; updated its terms of reference; and secured representation on the Health Informatics Group and the Clinical Services Plan Project Steering Committee.

As the key clinical representative body for the Health Service, the Clinical Council provided feedback on the executive realignment, organisational sustainability plan, clinical documentation project, draft telehealth strategy, draft quality improvement register, nurse specials project; and draft Cairns Hospital patient specials procedure, media policy, social media guidelines, clinician engagement on the Digital Hospital project, leadership pipeline, and health service values.

12 MONTHS IN NUMBERS



RISK MANAGEMENT AND ACCOUNTABILITY

Risk Management

Management of risk in the Hospital and Health Service is a key element in delivering contemporary safe and sustainable healthcare to the community of the region. The Health Service is committed to managing risk in a proactive, integrated and transparent manner.

These commitments include:

- Ensuring risk management is an integral part of all our decision-making processes;
- Using a structured risk management framework to minimise reasonably foreseeable disruptions to the provision of services, harm to people, and damage to the environment and property;
- Identifying and taking advantage of opportunities, as well as minimising adverse effects;
- Training and supporting our staff to implement risk management effectively;
- Striving to continually improve our risk management practices and;
- Integrated management of clinical, Workplace Health and Safety and enterprise risks.

Risk management processes have been improved through the development of a framework document which clarifies responsibilities for managing risks across the Health Service. Systems, structures, processes, policies, roles and support functions all form part of the risk management framework.

In 2016-2017, the Health Service improved risk management processes through the development and implementation of a new risk management framework which is consistent with the Australia New Zealand standard for risk management AS/NZS ISO: 31000:2009. The purpose of this framework is to ensure that risk is understood, managed consistently and appropriately, and to define a common language for risk management throughout the organisation.

The Health Service risk management system comprises four tiers of risk registers. The tier one risk register is termed the Cairns and Hintelrand Hospital and Health Service Risk Register. It is coordinated by the Executive Management Team and considers risks impacting on the Health Service as a whole. Risks rated “high” and “very high” on the Tier 1 Risk Register are reviewed by the Board on a quarterly basis.

Internal Audit

The Health Service has an internal audit function which provides independent, objective assurance to the Health Service’s Executive Management Team, Audit and Risk Management Committee, and Board on the state of risks and internal controls, providing management with recommendations to enhance controls.

The Internal Audit function operates in accordance with a Board-approved Internal Audit Charter, which is reviewed annually, and in accordance 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.

The Internal Audit Team is resourced with an in-house Director of Internal Audit and Senior Internal Auditor. Arrangements for the use of external contractors are made periodically as required to deliver the Internal Audit 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;
- Queensland Prevocational Medical Accreditation;
- BreastScreen Queensland;
- Pathology Queensland;
- Queensland Audit Office.

The Queensland Audit Office (QAO) conducts cross-service performance audits which include coverage of our Health Service. In 2016-2017, this included an audit of efficient and effective use of high-value medical equipment (report to Parliament 10: 2016–17).

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.

Information Systems and record keeping

Public Interest Disclosure

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

During 2016-17, there were no requests for public interest disclosure.

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* 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/

2016-17 Right to information and information privacy data

RIGHT TO INFORMATION	TOTAL
Total applications received	83
Applications Completed within timeframe	79
Applications not completed within timeframe	0
Applications currently in progress (still within legislative timeframe)	4
INFORMATION PRIVACY	**TOTAL**
Total applications received	150
Applications completed within timeframe	123
Applications not completed within timeframe	20
Applications currently in progress (still within legislative timeframe)	7
EXTERNAL REVIEW	**TOTAL**
Matters resolved through the resolution process	3
Matters currently undergoing resolution process with Office of the Information Commissioner	16
INTERNAL REVIEW	**TOTAL**
Matters resolved through the resolution process	1

2016-17 Access Data	TOTAL
Administrative Access (includes Motor Accident Insurance Act, medico legal reports, Personal Injury Proceedings Act, subpoena etc, Work Cover Queensland, other e.g. certificates, insurance forms)	2031

Public Records Act 2002

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*, 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.

In early 2016, Cairns Hospital implemented a Digital Hospital system, as one of two state-wide 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, and audit trails are regularly monitored.

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 Healthcare Standards. Systems are in place to ensure paper records are appropriately stored, easily located and accessible when required, 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*.


Anaesthetics

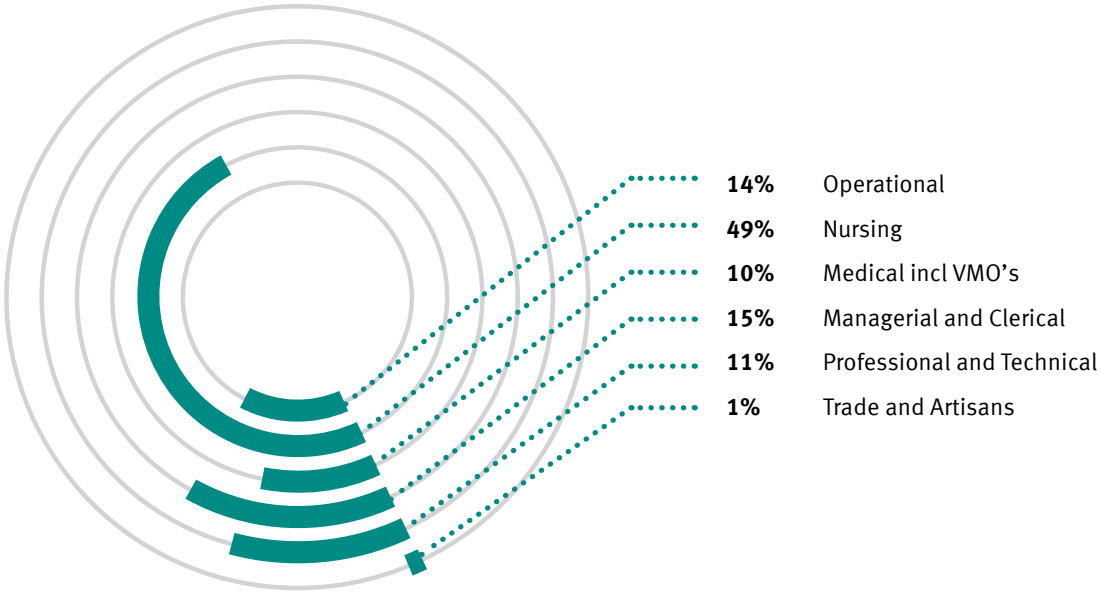
6

OUR PEOPLE

Workforce planning and performance

The Health Service continues to be the largest employer in the Far North. As at 30 June 2017, there were 5837 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 healthcare 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, 62 percent of our workforce is aged over 40.

Workforce Profile

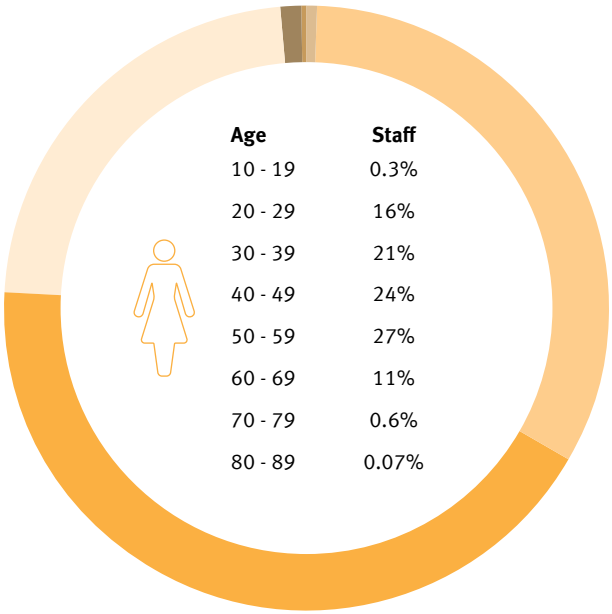


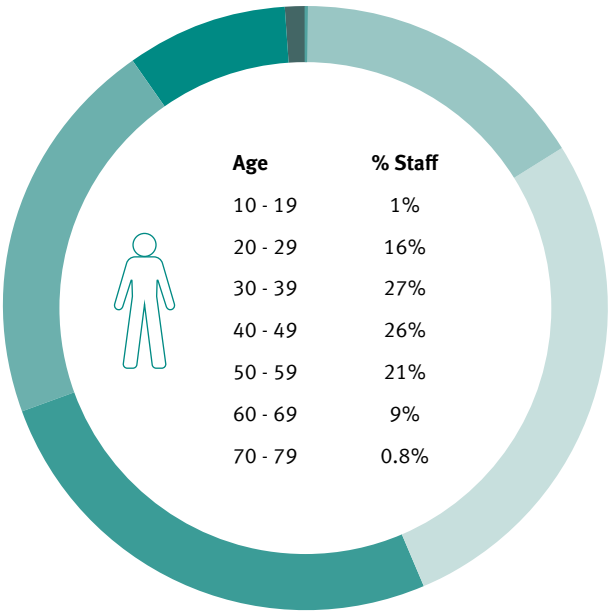
Staff age and Gender Profile

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;
- cultural renewal.





Early retirement, redundancy and retrenchment

No redundancy, early retirement or retrenchment packages were paid during the period.

Separation Type	Separations (FTE)	Separations (individuals)
Changed to casual*	58.68	80
Separated Queensland Health	342.41	397

*** 'Changed to casual' refers to staff who have moved from non-casual to casual employment.**

Queensland Public Sector Values

Cairns and Hinterland Hospital and Health Service is committed to upholding the five Queensland Public Service values of Customers First, Ideas into Action, Unleash Potential, Be Courageous and Empower People.

The implementation of the Queensland Public Service values is augmented by the Health Service's newly developed local values - compassion, accountability, integrity, and respect, which the Health Service worked towards establishing during 2016-17 for the implementation in 2017-18.

Staff orientation and induction

When new employees join our Health Service we aim to equip them with the knowledge and resources to make certain they are prepared to start building a successful career in their new role. Our monthly Generic Orientation held at Cairns Hospital is attended by our Chief Executive and other members of the Executive team to welcome our newest recruits. This day is integral to our on-boarding process, and provides insight into the many departments and services we offer with our Health Service.

The Generic Orientation information is constantly updated to be in line with changes within the Health Service and to improve the experience of new employees. We strive to make our employees feel welcome and give them the best possible start to their career. During the year 2016-17, we welcomed 505 new employees into our Health Service through our Generic Orientation Days, while other medical professionals welcomed new employees through more role specified 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.

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

Our continuing commitment is to attract and retain the best possible talent with the right skills and the right attitude. We present our employees with on-the-job projects and development opportunities that build their personal development and enhance their career progression, as well as providing leadership opportunities, along with structured team development activities that continue to enhance our great culture.

Our annual employee recognition week is about acknowledging those employees that reach significant length-of-service milestones and celebrating teams and individuals that display actions and behaviours that link to our core values. For this year's week we recognised more than 1000 staff for length-of-service awards ranging from 5 years to 45 years, with one employee retiring in 2016 after 48 years of service.

Life Styles Inventory

Our Health Service utilises the Life Styles Inventory (LSI) assessment tool which is designed to promote constructive change, helping our leaders to 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 Queensland Health-led, Manage-4-Improvement program. This year, with continued support from Queensland Health, we have commenced building leadership clarity and capability throughout the Health Service by implementing the Leadership Pipeline.

The Leadership Pipeline is an evidence-based model for building leadership capability within organisations, and has been used successfully in the health sector. Through extensive staff input and collaboration, we started by defining the 'layers' of leadership that exist in the health service, and defining what the focus of each layer should be in order to empower leaders up and down the health service to make decisions and take action to support more effective patient care.

The next stages of the Leadership Pipeline rollout maintains and builds on the momentum achieved to date. This project of work coaches a further 32 leaders in how to apply the Performance Standards to themselves and the leaders who report to them, in order to establish a best-practice approach to leadership coaching and assessment across the service. This project also embeds the Performance Standards into the refreshed Performance and Development (PaD) process, through a rollout of manager training to 20 percent of leaders and team members across the service - this embeds the Leadership Pipeline back into the yearly operating cycle of the organisation.

An Executive Leadership program has been designed to provide the newly appointed Hospital and Health Service Executive team with a structured process to establish the foundations required for high performance. This program will: a) define the shared purpose of the team; b) clarify individual roles within the team; c) develop a code of conduct; d) establish an effective operating rhythm of meetings and decision-making processes; e) understand team motivations; and, f) build capability and implement processes to manage conflict effectively.

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, 37 percent 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 resources department.

Education and training

Our Organisational Development team has a commitment to the growth and development of employees by encouraging and supporting education and learning in the workplace. Learning support is encapsulated in routine activity, aiding development of professional networks and fundamentally ensuring the business actualises the knowledge and skills necessary to deliver our Strategic Plan.

The Organisational Development team acknowledges the needs of our organisation by advancing the learning contributions available to staff, bringing together both online learning and strategic synergistic learning. Fifty-three Staff Development Days were held across our Health Service in 2016-2017, along with 60 custom-designed, team-training sessions.

All employees have access to the Study and Research Assistance Scheme (SARAS), which advocates professional development by providing assistance such as finance and leave assistance. SARAS is designed to assist employees in enhancing and developing skills and knowledge in their field, with the objective of improving their strengths and abilities in a wide range of disciplines and study areas. Seventy of our Health Service employees accessed this support throughout 2016-17.

There are several support schemes available to staff to enable them to enhance their professional development. They are accessible to targeted employees through:

- Administration Officers Education Incentive Fund (now open for employees up to and including AO5 level);
- Administrative Professional Program;
- Operational Officers' Program (now open for employees up to and including OO5 level).

Employee Opinion Survey

Our action plans from the 2016 Employee Opinion Survey (EOS) are well established now, with significant changes noticeable throughout the Health Service. The key priorities of organisational fairness and organisational leadership were identified as key drivers of engagement for our Health Service staff. Since the 2016 EOS, important changes have been made to ensure transparency and consistency in recruitment decisions, as well as ensuring that information from our Executive Management Team meetings are disseminated to staff in bulletins after each meeting.

With the 2017 EOS scheduled to take place in August 2017, plans are well developed to continue to drive up employee participation. The purpose of the EOS is to explore employee perceptions of our workplace climate and wider organisational performance outcomes; we continue to encourage our employees to take the opportunity to have their say about their engagement with the Health Service and wider organisation.

Workplace Health and Safety

The Cairns and Hinterland Hospital and Health Service has implemented a robust Safety Management System, which not only meets its legislative compliance requirements, but ensures a safe working environment for all our employees, patients and visitors. The successful compliance with AS4801 demonstrated in March 2016, endorses the progress we continue to make in embedding a safety culture through our work with all staff throughout the Health Service.

While the Health Service has continued to grow over the years, our injury numbers have not increased correspondingly. This is amply demonstrated by the reduction in WorkCover premium rate for the fifth successive year (see table below).

Year	13/14	14/15	15/16	16/17	17/18
CHHHS Premium rate	1.446	1.207	1.061	1.036	0.934
Industry Premium rate	1.297	1.087	1.154	1.141	1.080

Injury Management

The introduction of Riskman in late 2017 is expected to improve case management for injured workers through better electronic records and access to the incident management module in the Riskman safety information system. Early return to work is again a key focus as we try to improve rehabilitation outcomes for injured staff.

Patient Handling

Building on the early success of last year, the growth and maturity of the ward unit trainer network across the Health Service continues to improve. Prevention of injuries through less physical intervention by staff and the appropriate use of lifting equipment can be expected to lead to fewer manual handling injuries for staff.

OUR PERFORMANCE

7

SERVICE PERFORMANCE SUMMARY

	Notes	2016-17 Target/Est.	2016-17 Actual	2017-18 Target/Est.
Effectiveness measures				
Percentage of patients attending emergency departments seen within recommended time frames:				
• Category 1 (within 2 minutes)	1	100%	99%	100%
• Category 2 (within 10 minutes)		80%	74%	80%
• Category 3 (within 30 minutes)		75%	81%	75%
• Category 4 (within 60 minutes)		70%	80%	70%
• Category 5 (within 120 minutes)		70%	94%	70%
• All Categories		..	82%	..
Percentage of emergency department attendances who depart within 4 hours of their arrival in the department	2	›80%	77%	›80%
Percentage of elective surgery patients treated within clinically recommended times:				
• Category 1 (30 days)	3	›98%	95%	›98%
• Category 2 (90 days)		›95%	97%	›95%
• Category 3 (365 days)		›95%	98%	›95%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	4	‹2	0.65	‹2
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit	5	›65%	58 %	›65%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	5	‹12%	15.3 %	‹12%
Percentage of specialist outpatients waiting within clinically recommended times:				
• Category 1 (30 days)	6	55%	60%	60%
• Category 2 (90 days)		35%	38%	36%
• Category 3 (365 days)		50%	60%	65%
Percentage of specialist outpatients seen within clinically recommended times:				
• Category 1 (30 days)	7	New measure	72%	71%
• Category 2 (90 days)		New measure	58%	60%
• Category 3 (365 days)		New measure	74%	80%
Median wait time for treatment in emergency departments (minutes)	8	20	19	20
Median wait time for elective surgery (days)	9	25	29	25
Efficiency measures				
Average cost per weighted activity unit for Activity Based Funding facilities	10, 11	$4,598	$4,950	$4,587
Other measures				
Number of elective surgery patients treated within clinically recommended times				
• Category 1 (30 days)	12	New measure	2,880	2,759
• Category 2 (90 days)		New measure	2,560	2,487
• Category 3 (365 days)		New measure	1,825	1,673
Number of Telehealth outpatient occasions of service events	13	New measure	4,962	4,861
Total weighted activity units (WAUs):				
• Acute Inpatient	10, 14d	69,204	80,765	83,753
• Outpatients		18,318	18,995	19,542
• Sub-acute		9,963	9,737	10,950
• Emergency Department		15,920	19,261	19,191
• Mental Health		8,077	9,639	9,300
• Prevention and Primary Care		3,501	3,772	3,402
Ambulatory mental health service contact duration (hours)	15	›80,135	73,284	›80,135

NOTES

1. The 2016-17 Estimated Actual figures are based on actual performance from 1 July 2016 to 30 April 2017. A Target/Estimate for percentage of emergency department patients seen within recommended timeframes is not included in the 'All Categories' as there is no national benchmark.

2. This is a measure of access and timeliness of emergency department services. The 2016-17 Estimated Actual figures are based on actual performance from 1 July 2016 to 30 April 2017.

3. This is a measure of effectiveness that shows how hospitals perform in providing elective surgery services within the recommended timeframe for each urgency category. The 2016-17 Estimated Actual figures are based on actual performance from 1 July 2016 to 30 April 2017.

4. This is a National Performance Agreement indicator and a measure of effectiveness of infection control programs and services in hospitals. Staphylococcus aureus are bacteria commonly found on around 30 percent 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 methicillin resistant Staphylococcus aureus) 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 for each jurisdiction. The 2016-17 Estimated Actual figures are based on actual performance from 1 July 2016 to 31 March 2017.

5. This is a measure of access to, and timeliness of the community support system that is in place for persons who have experienced an acute psychiatric episode requiring hospitalisation. The 2016-17 Estimated Actual is for the period 1 July 2016 to 31 January 2017. Queensland has made significant progress in improving the rate of community follow up over the past five years. Increased pressure on community and inpatient mental health services has seen increases in readmission rates and is impacting the rate of follow up.

6. This is a measure of effectiveness that shows the percentage of patients who are waiting to have their first appointment (from the time of referral) with the health professional in an outpatient clinic, within the clinically recommended time. The 2016-17 Estimated Actual figure is based on patients waiting as at 30 April 2017.

7. This is a measure of effectiveness that indicates the percentage of patients seen within clinically recommended times during the reporting period. The 2016-17 Estimated Actual figures are based on actual performance from 1 July 2016 to 30 April 2017.

8. This measure indicates the amount of time for which half of all people waited in the emergency department (for all categories), from the time of presentation to being seen by a nurse or doctor (whichever was first). The 2016-17 Estimated Actual figure is based on actual performance from 1 July 2016 to 30 April 2017.

9. This is a measure of effectiveness that reports on the number of days for which half of all patients wait before undergoing elective surgery. The 2016-17 Estimated Actual figure is based on actual performance from 1 July 2016 to 30 April 2017.

10. A WAU is a measure of activity and provides a common unit of comparison so that all activity can be measured consistently. Service agreements between the Department of Health and HHSs and other organisations specify the activity to be provided in WAUs by service type.

11. The 2016-17 Estimated Actual figure reflects 1 July to 31 December 2016 activity based costs and actual activity based funded activity. The 2017-18 Target/Estimate reflects the activity based funding less Clinical Education and Training and Specified Grants and activity within the finance and activity schedules of the 2017-18 Final Round Service Agreements Contract Offers. 2017-18 Target/Estimate for cost per Queensland WAU includes HHS activity forecast over delivery in 2016-17, funded by the Commonwealth at a marginal rate of45 percent. As a result, funding per Queensland WAU in 2017-18 is generally lower than the 2016-17 Target/Estimate cost per Queensland WAU. The impact of this is partially offset in some HHSs due to changes in Own Source Revenue classification between 2016-17 and 2017-18, and non- Queensland WAU investments. 2016-17 Estimated Actual cost per Queensland WAU is a point in time measure which includes the first 6 months of HHS expenditure and activity. It includes the impact of one-off investments in 2016-17.

12. This is a measure of activity. The 2016-17 Estimated Actual figures are based on ten months of actual performance from 1 July 2016 to 30 April 2017 forecast out for 12 months.

13. This measure tracks the growth in occasions of service for Telehealth enabled outpatient services. These services support timely access to contemporary specialist services for patients from regional, rural and remote communities, supporting the reduction in wait times and costs associated with patient travel. The 2016-17 Estimated Actual figure is based on actual performance from 1 July 2016 to 30 April 2017 forecast out over 12 months.

14. The 2016-17 Estimated Actual figures are based on 2016-17 Queensland WAU forecasts as provided by HHSs. 2017-18 Target/Estimate figures are based on the 2017-18 Final Round Service Agreements Contract Offers. All activity is reported in the same phase – Activity Based Funding (ABF) model Q19. 'Total WAUs – Interventions and procedures' has been reallocated to 'Total WAUs – Acute Inpatient Care' and 'Total WAUs – Outpatient Care' service standards. 'Total WAUs – Prevention and Primary Care' is comprised of Breast Screen and Dental WAUs. Total WAUS - Prevention and Primary Care' is a new measure for the Service Delivery Statement, however, it has been included in the HHS Service Agreements since 2016-17. Purchased Queensland WAUs in 2017-18 for Prevention and Primary Care are lower due to one off investments in Oral Health in 2016-17 and NPA funding not yet allocated.

15. 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 Estimated Actuals for 2016-17 are for the period 1 July 2016 to 31 March 2017. It is important to note that not all activity of ambulatory clinicians is in-scope for this measure, with most review and some service coordination activities excluded. In addition, improvements in data quality have contributed to the result, with the data more accurately reflecting way in which services are delivered. The Target/Estimate for this measure is determined using a standard formula based upon available clinical staffing, HHS rurality, and historical performance. The targets for these measures have been set to be consistently calculated and are considered a stretch for many services.

FINANCIAL PERFORMANCE

Services are commissioned by Queensland 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.

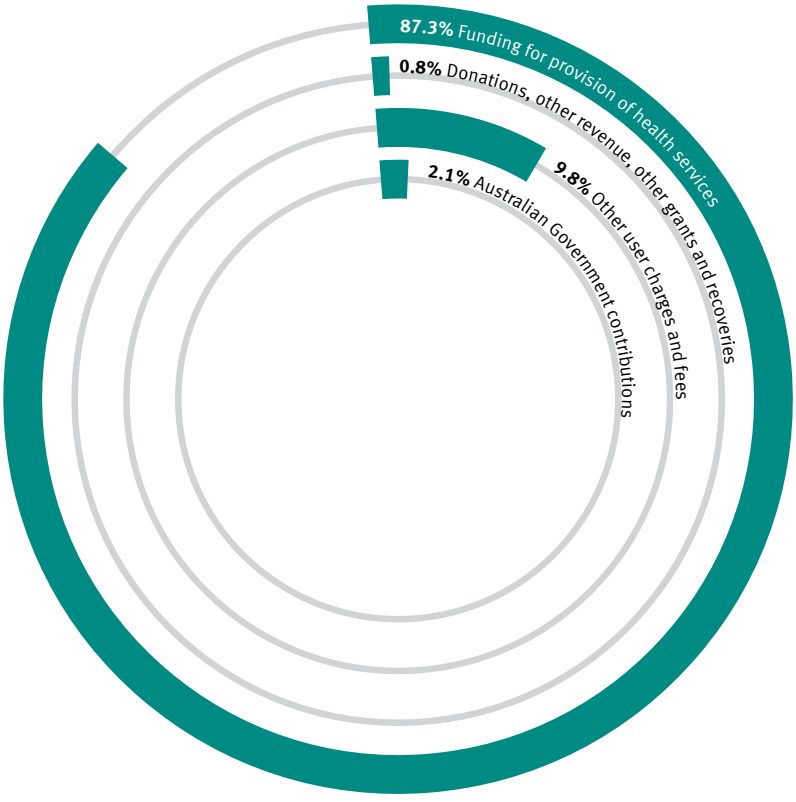
The Cairns and Hinterland Hospital and Health Service ended the financial year with an operating deficit of $32.1 million (projected budget deficit of $80.5 million), compared with an operating deficit of $20.0 million in the previous financial year.

Financial highlights

The deficit position of $32.1 million represents a 3.8 percent over-spend variance against revenue of $853.70 million for the year ended 30 June 2017. Throughout 2016-17 the Health Service has continued its journey to financial sustainability while committing to current services provided to the community with no reduction in the establishment required to safely and efficiently deliver quality care to patients. The Organisational Sustainability Plan, Project Procurement and an increase in activity growth has resulted in significant improvement in the year-end operating deficit ($32.1 million) compared to the projected budget deficit ($80.5 million). In 2016-17, the Health Service continued to deliver safe and effective services, improved flow within and across facilities, and improvements in the ability to meet the needs of our community.

Where the funds came from

The Health Service's income from all funding sources for 2016-17 was $853.70 million and was principally derived from the ABF (Activity Based Funding) model with the Queensland Health.



745.08 MILLION
Australian Government contributions

83.42 MILLION
Other user charges and fees

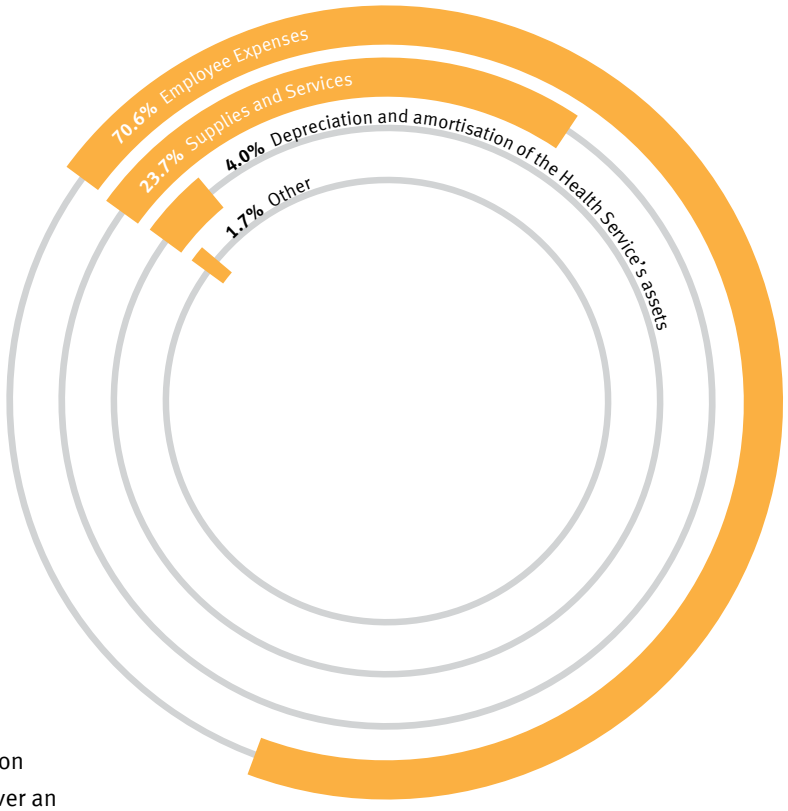
18.00 MILLION
Funding for provision of health services

7.20 MILLION
Donations, other revenue, other grants and recoveries

Where funding was spent

Total expenses were $885.77 million, averaging $2.41 million per day to provide public health services. This is up from an average $2.35 million per day in 2015-16.

Expenditure has increased by $25.95 million on 2015-16 levels. Expenditure increased primarily due to the 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 $11.872 million in cash and investments. This balance is largely a result of an equity contribution from the Queensland Health $40.0 million to cover an anticipated year-end deficit of $39.9 million; however the actual year-end deficit of $32.1 million has contributed to a favourable cash balance.

Asset revaluation

The revaluation program for 2016-17 of land and building assets led to an increase to a revaluation surplus of $23.696 million for the year, bringing the accumulated surplus balance to $95.057 million. This was due to an increase in the market value of the land and buildings subject to the revaluation.

FINANCIAL STATEMENTS

8

STATEMENT OF COMPREHENSIVE INCOME

For the year ended 30 June 2017

	Notes	2017 $'000	2016 $'000
Income			
User charges and fees	B1-1	**828,497**	807,453
Grants and other contributions	B1-2	**18,002**	20,418
Interest		**71**	80
Other revenue	B1-3	**7,126**	11,235
Total Income		**853,696**	839,186
Expenses			
Employee expenses	B2-1	**(87,795)**	(82,076)
Health service employee expenses	B2-2	**(537,824)**	(507,942)
Supplies and services	B2-3	**(209,513)**	(219,543)
Grants and subsidies		**(45)**	(32)
Depreciation and amortisation	C4-2, C5	**(35,303)**	(37,251)
Impairment losses	B2-4	**(3,741)**	(1,971)
Other expenses	B2-5	**(11,544)**	(10,371)
Total expenses		**(885,765)**	(859,186)
Operating result for the year		**(32,069)**	(20,000)
Other comprehensive income			
Items that will not be reclassified subsequently to operating result			
Increase in asset revaluation surplus	C8-1	**23,696**	18,082
Total other comprehensive income		**23,696**	18,082
Total comprehensive income for the year		**(8,373)**	(1,918)

The accompanying notes form part of these statements.

STATEMENT OF FINANCIAL POSITION

As at 30 June 2017

	Notes	2017 $'000	2016 $'000
Assets			
Current assets			
Cash and cash equivalents	C1-1	**11,872**	1,382
Receivables	C2-1	**27,838**	34,913
Inventories	C3-1	**3,769**	4,852
Other current assets		**1,090**	327
Total current assets		**44,569**	41,474
Non-current assets			
Property, plant and equipment	C4-1	**712,721**	711,524
Intangible assets	C5-1	**1,509**	649
Total non-current assets		**714,230**	712,173
Total assets		**758,799**	753,647
Current liabilities			
Bank overdraft	C1-1	**-**	7,084
Payables	C6-1	**43,658**	43,153
Accrued employees benefits	C7-1	**3,956**	2,600
Unearned revenue		**165**	293
Total current liabilities		**47,779**	53,130
Total liabilities		**47,779**	53,130
Net assets		**711,020**	700,517
Equity			
Contributed equity		**653,940**	635,064
Accumulated surplus		**(37,977)**	(5,908)
Asset revaluation surplus	C8-1	**95,057**	71,361
Total equity		**711,020**	700,517

The accompanying notes form part of these statements.

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2017

	Contributed equity $'000	Accumulated surplus $'000	Asset revaluation surplus (Note C8-1) $'000	Total equity $'000
Balance 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 at 30 June 2016	**635,064**	**(5,908)**	**71,361**	**700,517**
Balance at 1 July 2016	635,064	(5,908)	71,361	700,517
Operating result for the year	-	(32,069)	-	(32,069)
Other comprehensive income				
Increase in asset revaluation surplus	-	-	23,696	23,696
Total comprehensive income for the year	-	**(32,069)**	**23,696**	**(8,373)**
Transactions with owners as owners				
Non appropriated equity asset transfers	270	-	-	270
Non appropriated equity injections	53,909	-	-	53,909
Non appropriated equity withdrawals (depreciation funding)	(35,303)	-	-	(35,303)
Net transactions with owners as owners	18,876	-	-	18,876
Balance at 30 June 2017	**653,940**	**(37,977)**	**95,057**	**711,020**

The accompanying notes form part of these statements.

STATEMENT OF CASH FLOWS

For the year ended 30 June 2017

	Notes	2017 $'000	2016 $'000
Cash flows from operating activities			
Inflows:			
User charges and fees		**798,624**	756,268
Grants and other contributions		**17,715**	19,879
Interest receipts		**71**	80
GST input tax credits from Australian Tax Office		**15,300**	16,528
GST collected from customers		**633**	575
Other receipts		**7,413**	11,774
Outflows:			
Employee expenses		**(88,820)**	(83,633)
Health service employee expenses		**(536,291)**	(504,097)
Supplies and services		**(210,754)**	(219,338)
Grants and subsidies		**(45)**	(32)
GST paid to suppliers		**(15,088)**	(17,008)
GST remitted to Australian Tax Office		**(636)**	(581)
Other		**(10,858)**	(9,754)
Net cash provided by (used in) operating activities		**(22,736)**	(29,339)
Cash flows from investing activities			
Outflows:			
Payments for property, plant and equipment		**(12,510)**	(23,152)
Payments for intangibles		**(1,089)**	(19)
Net cash provided by (used in) investing activities		**(13,599)**	(23,171)
Cash flows from financing activities			
Inflows:			
Equity injections		**53,909**	22,023
Net cash provided by (used in) financing activities		**53,909**	22,023
Net increase / (decrease) in cash and cash equivalents		**17,574**	(30,487)
Cash and cash equivalents at the beginning of the financial year		**(5,702)**	24,785
Cash and cash equivalents at the end of the financial year	**C1-1**	**11,872**	(5,702)

The accompanying notes form part of these statements.

STATEMENT OF CASH FLOWS

For the year ended 30 June 2017

NOTES TO THE STATEMENT OF CASH FLOWS

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

	2017 $'000	2016 $'000
Operating result for the year	**(32,069)**	(20,000)
Non-cash items included in operating result:		
Depreciation and amortisation expense	**35,303**	37,251
Equity funding for depreciation and amortisation	**(35,303)**	(37,252)
Net loss on disposal of non-current assets	**492**	372
Donated assets received	**(287)**	(538)
Change in assets and liabilities:		
(Increase)/decrease in trade and other receivables	**6,866**	(7,942)
(Increase)/decrease in GST receivables	**209**	(486)
(Increase)/decrease in inventories	**1,083**	(864)
(Increase)/decrease in prepayments	**(763)**	6
Increase/(decrease) in payables	**505**	2,213
Increase/(decrease) in accrued employee benefits	**1,356**	806
Increase/(decrease) in unearned revenue	**(128)**	(2,905)
Net cash from operating activities	**(22,736)**	(29,339)

CF-2 Non-cash investing and financing activities

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

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

GENERAL INFORMATION

These financial statements cover the Hospital and Health Service (the HHS) as an individual entity.

The HHS is a not-for-profit statutory body under the *Hospital and Health Boards Act 2011* and is domiciled in Australia.

The 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 CHHHS_Board@health.qld.gov.au

or visit the website at www.health.qld.gov.au/cairns_hinterland/.

COMPLIANCE WITH PRESCRIBED REQUIREMENTS

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 2017, 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.

PRESENTATION

Currency and rounding

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

There were no material restatements of comparative information required to ensure consistency with current period disclosures.

AUTHORISATION OF FINANCIAL STATEMENTS FOR ISSUE

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

Section A

HOW WE OPERATE – OUR OBJECTIVES AND ACTIVITIES

A1 OBJECTIVES OF HHS

The HHS is responsible for providing primary health, community and public health services in the area assigned under the *Hospital and Health Boards Regulation 2012*.

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

A1-1 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.

A2 CONTROLLED ENTITIES

The Health Service has no wholly-owned controlled entities or indirectly controlled entities.

A3 INVESTMENT IN PRIMARY HEALTH NETWORK

Northern Queensland Primary Health Network Limited (NQPHNL) was established as a public company limited by guarantee on 21 May 2015. CHHHS 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 the north of 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 controls NQPHNL. The HHS currently has 16.6% of the voting power of the NQPHNL – below the 20% 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 16.6 percent voting power, limiting the extent of any influence that the 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 NQPHNL being transferred directly or indirectly to or amongst the members. As NQPNHL is not controlled by the HHS and is not considered a joint operation or an associate of the HHS, financial results of NQPHNL are not required to be disclosed in these statements.

A4 ECONOMIC DEPENDENCY

The HHS's primary source of income is from the DoH for the provision of public hospital, health and other services in accordance with a service agreement with the DoH, (refer to Note B1-1) The current service agreement covers the period 1 July 2016 to 30 June 2019. 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. The HHS has an agreed and approved budget operating deficit with the DoH for 2017-18 of $29.6M, which will ensure availability of cash to pay ongoing day-to-day operational expenditure.

Section B

NOTES ABOUT OUR FINANCIAL PERFORMANCE

B1 REVENUE

B1-1 User charges and fees

	Share of Funding			
	State	*Australian Government*	2017	2016
	$'000	$'000	$'000	$'000
Funding for the provision of public health services				
Activity based funding	302,442	224,282	**526,724**	513,199
Block funding	40,757	24,275	**65,032**	62,873
Teacher training funding	16,597	3,172	**19,769**	17,042
General purpose funding	133,551	-	133,551	142,607
Total government funding	**493,347**	**251,729**	**745,076**	**735,721**
Pharmaceutical Benefits Scheme subsidy			**35,575**	32,006
Hospital fees			**41,539**	34,125
Rental income			**18**	8
Other			**6,289**	**5,593**
Total			**828,497**	807,453

Accounting Policy – User charges and fees

Funding is provided predominantly by the DoH for specific public health services purchased by the DoH in accordance with a service agreement. The DoH 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. 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 DoH is received fortnightly in advance with the monthly DoH revenue accrual recognised as per the service agreement and budget phasing methodology. 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 DoH and the HHS specifies that the DoH funds HHS's depreciation and amortisation charges via non-cash revenue. The DoH 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.

Hospital fees mainly consist of private patient hospital fees, interstate patient revenue and Department of Veterans' Affairs revenue.

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

B1-2 Grants and other contributions

	2017 $'000	2016 $'000
Australian Government grants		
Nursing home grants	**2,419**	2,796
Specific purpose - capital grants	**762**	657
Specific purpose payments	**10,727**	11,754
Total Australian Government grants	**13,908**	15,207
Other		
Donations other	**569**	475
Donations non-current physical assets	**287**	539
Other grants	**3,238**	4,197
Total	**18,002**	20,418

Accounting Policy – Grants and other 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.

The HHS receives corporate services support from the DoH at 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.

B1-3 Other revenue

	2017 $'000	2016 $'000
Sale proceeds for assets	**16**	53
Licences and registration charges	**26**	29
Recoveries from other agencies and other hospital and health services	**6,617**	11,154
Other revenue	**467**	(1)
Total	**7,126**	11,235

Accounting Policy – 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.

B2 EXPENSES

B2-1 Employee expenses

	2017 $'000	2016 $'000
Employee benefits		
Wages and salaries	**74,653**	70,263
Annual leave levy	**5,294**	5,198
Employer superannuation contributions	**6,046**	5,144
Long service leave levy	**1,574**	1,464
Employee related expenses		
Workers compensation premium	**228**	7
Total	**87,795**	82,076
Number of employees*	**No.**	No.
	194	208

* 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.

Accounting Policy – Employee expenses

Employee divisional include the health executives and divisional directors. Health executives are directly engaged in the service of the HHS in accordance with section 70 of the *Hospital and Health Boards Act 2011* (HHBA). The basis of employment for health executives is in accordance with section 74 of the HHBA.

Employee expenses also include senior medical officers who entered into individual contracts commencing August 2014.

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

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.

Wages, salaries and sick leave

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

Prior history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised.

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

Annual and long service leave

Under the Queensland Government's Annual Leave Central Scheme and Long Service Leave Central Scheme, levies are payable to cover the cost of employees' annual leave (including leave loading and on-costs) and long service leave. No provisions for annual leave and long service leave is recognised in the HHS's financial statements as a 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*. These levies are expensed in the period in which they are paid or payable. Amounts paid to employees for annual leave and long service leave are claimed from the schemes quarterly in arrears.

Superannuation

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

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

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

Key management personnel and remuneration

Key management personnel and remuneration disclosures are made in accordance with FRR 3C of the Financial Reporting Requirements for Queensland Government Agencies issued by Queensland Treasury. Refer to Note G1 for the disclosures on key executive management personnel and remuneration.

B2-2 Health service employee expenses

	2017	2016
	$'000	$'000
Health service employee expenses	530,563	500,548
Health service employee related expenses*	5,205	5,371
Other health service employee related expenses	2,056	2,023
Total	537,824	507,942

Number of employees**	**No.**	**No.**
	4,656	**4,607**

* The health service employee related expenses include $4.9M of workers' compensation insurance premium partly offset by WorkCover recoveries.

** The number of health service employees reflects full-time employees, part-time health service employees and temporary external agency labour measured on a full-time equivalent basis (reflecting Minimum Obligatory Human Resource Information (MOHRI)) at the end of the year.

Accounting Policy – Health service employee expenses

Health service employee expenses represent the cost of DoH employees and other contracted staff to the HHS, paid via invoice, to provide public health services.

As established under the *Hospital and Health Boards Act 2011*, the DoH 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.

In accordance with the *Hospital and Health Boards Act 2011*, the employees of the DoH are referred to as health service employees. Under this arrangement:

- The department provides employees to perform work for the HHS and acknowledges and accepts its obligations as the employer of these employees
- The HHS is responsible for the day to day management of these departmental employees
- The HHS reimburses the department for the salaries and on-costs of these employees.
- The HHS discloses the reimbursement of these costs as health service employee expenses.

B2-3 Supplies and services

	2017	2016
	$'000	$'000
Agency fees	**2,079**	2,313
Electricity and other energy	**8,419**	8,781
Patient travel	**13,913**	14,162
Other travel	**4,736**	6,927
Building services	**2,082**	1,847
Computer services	**3,718**	8,081
Motor vehicles	**596**	568
Communications	**8,688**	9,111
Consultancies	**111**	9,595
Repairs and maintenance	**14,253**	11,999
Minor works including plant and equipment	**2,945**	1,811
Operating lease rentals	**5,380**	5,314
Drugs	**44,602**	43,376
Clinical supplies and services	**51,725**	49,247
Catering and domestic supplies	**12,255**	13,327
Pathology, blood and parts	**16,091**	17,104
Other	**17,920**	15,980
Total	**209,513**	**219,543**

B2-4 Impairment losses

	2017	2016
Impairment losses on receivables	**2,433**	(1,115)
Bad debts written off	**1,308**	3,086
Total	**3,741**	1,971

B2-5 Other expenses

	2017	2016
External audit fees*	**205**	190
Insurance premiums - QGIF	**7,763**	8,048
Insurance premiums - Other	**61**	57
Net losses from the disposal of non-current assets	**492**	372
Special payments - ex-gratia payments	**13**	12
Legal costs	**352**	324
Advertising	**781**	370
Interpreter fees	**270**	249
Other	**1,607**	749
Total	**11,544**	10,371

**Total audit fees paid to the Queensland Audit Office relating to the 2016-17 financial year are estimated to be $0.2M (2016: $0.19M) including out of pocket expenses. There are no non-audit services included in this amount.*

Accounting Policy – Insurance

The HHS is covered by the DoH insurance policy with Queensland Government Insurance Fund (QGIF) and pays a fee to the DoH as a fee for service arrangement.

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.

Section C

NOTES ABOUT OUR FINANCIAL POSITION

C1 CASH AND CASH EQUIVALENTS

C1-1 Cash and cash equivalents

	2017 $'000	2016 $'000
Cash at bank and on hand	**10,351**	-
24 hour call deposits	**1,521**	1,382
Cash and cash equivalents	**11,872**	1,382
Bank overdraft used for cash management purposes	**-**	(7,084)
Cash and cash equivalents in the Statement of Cash Flows	**11,872**	(5,702)

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 2.43% and 2.93%.

Accounting Policy – 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.

In accordance with section 31(2) of the *Statutory Bodies Financial Arrangements Act 1982*, the HHS obtained approval from 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.

C2 RECEIVABLES

C2-1 Receivables

	2017 $'000	2016 $'000
Current		
*Trade debtors	**31,344**	35,867
Other debtors	**424**	333
Less: Allowance for impairment loss	**(5,513)**	(3,080)
	26,255	33,120
GST input tax credits receivables	**1,644**	1,856
GST payable	**(63)**	(66)
	1,581	1,790
Payroll receivables	**1**	1
Sundry debtors	**1**	2
Total	**27,838**	**34,913**

Accounting Policy – 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 D1-5.

Refer to Note D1-5 Financial instruments (credit risk exposure) for an analysis of movements in the allowance for impairment loss.

*Trade debtor balance includes invoices to DoH ($12.9M) and other inter hospital and health services ($0.5M).

Accounting Policy – 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 16 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.

C3 INVENTORIES

C3-1 Inventories

	2017 $'000	2016 $'000
Inventories held for distribution		
Drugs	**3,010**	4,183
Clinical supplies and services	**667**	572
Catering and domestic supplies	**92**	97
Total	**3,769**	**4,852**

Accounting Policy – 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.

C4 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION

C4-1 Property, plant and equipment

	2017 $'000	2016 $'000
Land: at fair value		
Gross	**39,799**	39,908
Buildings: at fair value		
Gross	**1,007,387**	963,913
Less: Accumulated depreciation	**(388,328)**	(357,996)
Total	**619,059**	605,917
Plant and equipment: at cost		
Gross	**112,717**	109,896
Less: Accumulated depreciation	**(60,607)**	(52,383)
Total	**52,110**	57,513
Capital works in progress		
At cost	**1,753**	8,186
Total	**712,721**	711,524

Accounting Policy – Property, plant and equipment

Recognition thresholds

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.

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 F*air 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, market revaluations or indexation. Independent revaluations are performed with sufficient regularity to ensure assets are carried at fair value.

In accordance with Queensland Treasury Non-Current Asset Policy 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.

Construction of major health infrastructure is managed by the DoH. Upon practical completion of a project, assets under construction are assessed at fair value by the DoH through the engagement of an independent valuer prior to the transfer of those assets to the HHS, effected via an equity adjustment.

Fair value measurement

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

Observable inputs are publicly available data that are relevant to the characteristics of the assets/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.

Land

The fair value of land is determined using market based evidence taking into account trends and sales information for each land use category, the land's present use and zoning under the relevant planning scheme, and the physical attributes and constraints on use of the land. As a full comprehensive valuation of land holdings was undertaken within the previous three years, the HHS decided to apply the indexation valuation method for the current year.

In 2015-16 the HHS engaged Knight Frank to value land as at 30 June 2016. In 2016-17 State Valuation Services were engaged to carry out the indexation revaluations on land as at 30 June 2017.

The revaluation program for 2016-17 resulted in a net decrement of $0.2M to the carrying amount of land.

Buildings

In 2015-16 the HHS engaged Davis Langdon Australia Pty Ltd, an AECOM company, to value buildings as at 30 June 2016. In 2016-17 State Valuation Services were engaged to carry out the indexation revaluations on buildings as at 30 June 2017. Independent valuer, GRC Quantity Surveyors carried out the comprehensive revaluations on selected building assets which were subject to District Work in Progress, Capital Work in Progress during the period, or previously not revalued.

For the indexation revaluations, the provided building indices are a series of construction industry index figures that are used to monitor the movement in costs associated with building work within particular segments of the industry.

For the comprehensive revaluations, due to the specialised nature of health service buildings and on hospital-site residential facilities, fair value is determined using current replacement cost methodology, due to there not being an active market for such facilities. The replacement cost estimates are reflective of the anticipated sum that might be expected from an informed transaction between knowing parties at current market conditions as at the measurement date. 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.

The replacement cost estimate of each building was prepared from plans and elevations, together with available schedules and specifications, and information collected from site surveys. The valuer applied a combination of pricing methodologies, all of which were adjusted to reflect the anticipated construction market as at the effective reporting date. Detailed estimates were used to determine the cost of replacing the existing assets with a modern equivalent, taking into account the specific site conditions identified from the site surveys. The replacement cost estimates were benchmarked against a locality index and building price index.

The following key assumptions were made when determining the replacement cost estimate of each building:

- The present use was considered to represent highest and best use;
- The market rates applied were based on tier 1 or tier 2 contractors delivering the replacement equivalent, and have reasonable experience in the design and delivery of hospital and health facilities;
- The documents, including site plans and drawings provided by the HHS to the valuer, were accurate. (Where possible, the valuer verified this information as part of their site inspections);
- Rates for the project on-costs such as professional fees, statutory charges, contingencies etc are reflective of current market rates;
- The rate of physical wear and tear continues at a normal rate and not effected by natural disasters or extreme events;
- A planned maintenance program continues to be implemented, as was evident in the site surveys and inspections; and
- The replacement equivalent incorporates technical or commercial obsolescence in building services. The inclusions have been limited to current building technologies, not cutting edge systems that are new to the market and are not widely incorporated into new building works.

The revaluation program for 2016-17 resulted in a net increment of $23.8M to the carrying amount of buildings, with comprehensive revaluation totalling $12.1M and indexation totalling $11.7M.

Accounting Policy – 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	%
Buildings	**2.5% - 3.33%**
Plant and equipment	**5.0% - 20.0%**

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

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. Existing condition of the building is also taken into account when assessing the remaining useful life of the assets.

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.

Accounting Policy – 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.

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.

C4-2 Property, plant and equipment (current year)

	Land*	Buildings**		Plant and equipment	Work in progress	Total
	Level 2	Level 2	Level 3			
	$'000	$'000	$'000	$'000	$'000	**$'000**
Carrying amount at 1 July 2016	39,908	1,692	604,225	57,513	8,186	**711,524**
Acquisitions	-	-	2,448	5,760	4,302	**12,510**
Transfers in / (out) from other Queensland Government entities***	51	-	433	(214)	-	**270**
Donations received	-	-	-	286	-	**286**
Disposals	-	-	(3)	(488)	-	**(491)**
Transfers between asset classes	-	-	10,735	-	(10,735)	**-**
Net revaluation Increments	(160)	33	23,823	-	-	**23,696**
Depreciation	-	(49)	(24,278)	(10,747)	-	**(35,074)**
Carrying amount at 30 June 2017	**39,799**	**1,676**	**617,383**	**52,110**	**1,753**	**712,721**

C4-2 property, plant and equipment (previous year)

	Land*	Buildings**		Plant and 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 / (out) 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)**
Balance at 30 June 2016	39,908	1,692	604,225	57,513	8,186	**711,524**

* Land Level 2 assets represent land valued using observable inputs.

** 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.

C5 INTANGIBLES

C5-1 Intangible assets

	2017	2016
	$'000	$'000
Software purchased: at cost		
Gross	**2,187**	1,098
Less: Accumulated depreciation	**(678)**	(449)
Total	**1,509**	649

C5-2 Intangibles reconciliation (current year)

	Software purchased	Total
Carrying amount at 1 July 2016	649	**649**
Acquisitions	1,089	**1,089**
Amortisation	(229)	**(229)**
Carrying amount at 30 June 2017	1,509	**1,509**

C5-3 Intangibles reconciliation (previous year)

	Software purchased	Total
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**

Accounting Policy - Intangible assets

Actual cost is used for the initial recording of all 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. 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 amortisation.

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 138 *Intangible Assets*

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, is amortised over its estimated useful life to the HHS.

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.

C6 PAYABLES

	2017	2016
	$'000	$'000
Current		
Trade creditors	**5,922**	5,466
Accrued expenses	**16,970**	17,894
Department of Health payables*	**20,766**	19,793
Total	**43,658**	43,153

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

Accounting Policy – 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.

C7 ACCRUED EMPLOYEE BENEFITS

	2017	2016
	$'000	$'000
Salaries and wages accrued	3,877	2,508
Other employee entitlements payable	79	92
Total	3,956	2,600

C8 EQUITY

C8-1 Asset revaluation surplus by class

	2017	2016
	$'000	$'000
Land		
Balance at the beginning of the financial year	12,715	9,397
Revaluation increment/(decrement)	(160)	3,318
Balance at the end of the financial year	12,555	12,715
Buildings		
Balance at the beginning of the financial year	58,646	43,882
Revaluation increment/(decrement)	23,856	14,764
Balance at the end of the financial year	82,502	58,646
Total	95,057	71,361

Accounting Policy - Asset revaluation surplus

The asset revaluation surplus represents the net effects of revaluation movements in assets

Accounting Policy – 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 DoH.

Section D

NOTES ABOUT RISKS AND OTHER ACCOUNTING UNCERTAINTIES

D1 FINANCIAL RISK MANAGEMENT

The HHS holds the following financial instruments by category:

		2017 $'000	2016 $'000
Financial assets			
Cash and cash equivalents	C1-1	**11,872**	1,382
Receivables	C2-1	**27,838**	34,913
Total		**39,710**	36,295
Financial liabilities			
Payables	C6	**43,658**	43,153
Bank overdraft	C1-1	**-**	7,084
Total		**43,658**	50,237

The HHS is exposed to a variety of financial risks – liquidity risk, market risk and credit risk.

D1-1 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.

Under the whole-of-government banking arrangements, the HHS has an approved working debt facility of $6M to manage any short term-cash shortfalls. This facility has not been drawn down as at 30 June 2017. The debt facility was temporarily raised to $7.5m as of 30 June 2016.

Due to the short-term nature (less than 12 months) of the current payables, their carrying amount is assumed to approximate the total contractual cash flow.

D1-2 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.

The HHS is exposed to interest rate risk on its cash deposited in interest bearing accounts with Queensland Treasury Corporation.

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

D1-3 Credit risk

Credit risk is the potential for financial loss arising from a counterparty defaulting on its obligations. The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any allowance for impairment.

The carrying amount of financial assets represents the maximum exposure to credit risk at the reporting date.

No financial assets have had their terms renegotiated so as to prevent them from being past due or impaired and are stated at the carrying amounts as indicated.

There are no significant concentrations of credit risk. Overall credit risk for the HHS is considered minimal.

Ageing of receivables is disclosed in the following tables:

	Not Past Due	Past Due			
	Less than 30 days	30 - 60 days	61-90 days	More than 90 days	Total
	$'000	$'000	$'000	$'000	$'000
2017					
Receivables	25,593	1,248	850	147	**27,838**
Total	25,593	1,248	850	147	**27,838**
2016					
Receivables	31,614	1,451	1,170	678	**34,913**
Total	31,614	1,451	1,170	678	**34,913**
2017 Individually impaired financial assets					
Receivables (gross)	-	-	-	5,513	**5,513**
Allowance for impairment	-	-	-	(5,513)	**(5,513)**
Carrying amount	-	-	-	-	**-**
2016 Individually impaired financial assets					
Receivables (gross)	-	149	32	2,899	**3,080**
Allowance for impairment	-	(149)	(32)	(2,899)	**(3,080)**
Carrying amount	-	-	-	-	**-**

	2017	2016
	$'000	$'000
Movements in the allowance for impairment loss		
Balance at 1 July	**3,080**	4,195
Amounts written off during the year	**(1,308)**	(3,086)
Increase in allowance recognised in operating result	**3,741**	1,971
Total	**5,513**	3,080

D1-4 Fair value measurements

Cash and cash equivalents are measured at fair value. All other financial assets or liabilities are measured at cost less any allowance for impairment, which given the short term nature of these assets, is assumed to represent fair value.

D2 CONTINGENCIES

D2-1 Litigation in progress

As at 30 June 2017, the following cases were filed in the courts naming the State of Queensland acting through the HHS as defendant:

	2017 Number of cases	2016 Number of cases
Supreme Court	**1**	1
District Court	**2**	1
Tribunals, commissions and boards	**3**	3
Total	**6**	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.

As of 30 June 2017, there were 33 claims (2016: 35 claims) managed by QGIF, some of which may never be litigated or result in payments 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.

D3 COMMITMENTS

D3-1 Non-cancellable operating leases

	2017 $'000	2016 $'000
Commitments under operating leases at reporting date are payable as follows:		
Not later than one year	**2,728**	2,143
Later than one year and not later than five years	**1,223**	1,056
Total	**3,951**	3,199

Accounting Policy – Expenditure commitments

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.

D3-2 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:

	2017 $'000	2016 $'000
Capital works	**2,698**	3,813
Repairs and maintenance	**610**	1,090
Total	**3,308**	**4,903**
No later than one year	3,308	4,903
Total	**3,308**	**4,903**

D4 EVENTS AFTER THE 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 state of affairs of the HHS in future financial years.

Section E

NOTES ON OUR PERFORMANCE COMPARED TO BUDGET

E1 BUDGETARY REPORTING DISCLOSURES

E1-1 Budgetary reporting disclosures

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.

E2 BUDGET TO ACTUAL COMPARISON – STATEMENT OF COMPREHENSIVE INCOME

	Variance Notes	Original Budget 2017 $'000	Actual 2017 $'000	Variance $'000	Variance % of Budget
Income					
User charges and fees	V1	756,542	828,497	71,955	10%
Grants and other contributions		16,640	18,002	1,362	8%
Interest		71	71	-	-%
Other revenue		4,683	7,126	2,443	52%
Total revenue		777,936	853,696	75,760	
Total Income		777,936	853,696	75,760	
Expenses					
Employee expenses	V2	(90,616)	(87,795)	2,821	(3%)
Health service employee expenses	V2	(490,355)	(537,824)	(47,469)	10%
Supplies and services	V3	(151,983)	(209,513)	(57,530)	38%
Grants and subsidies		(550)	(45)	505	(92%)
Depreciation and amortisation		(38,927)	(35,303)	3,624	(9%)
Impairment losses		(1,934)	(3,741)	(1,807)	93%
Other expenses		(3,571)	(11,544)	(7,973)	223%
Total expenses		(777,936)	(885,765)	(107,829)	
Operating result for the year		-	(32,069)	(32,069)	

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 2016/17 Service Agreement with the DoH which provided significant additional funding to provide increased services at Cairns Hospital. Final revenue and expenditure budgets for 2016-2017 were therefore significantly higher than those provided for within the Service Delivery Statements.

EXPLANATION OF MAJOR VARIANCES – STATEMENT OF COMPREHENSIVE INCOME

Major variations between the 2016-2017 budget and 2016-2017 actual include:

V1. User charges and fees

The increase in user charges and fees relates to additional funding provided through amendments to the Service Agreement between the HHS and the DoH. The impact of the additional funding received from the DoH, post setting of the 2016-17 Budget, equates to $45.3M. Of this additional funding, $27.0M relates to increases in service activity in order to achieve Tier 1 Key preformance indicators (KPIs) set out in the Service Agreement, such as National Emergency Access Targets (NEAT), National Elective Surgery Targets (NEST) and Patient Off Stretcher Time (POST); $4.6M due to 2015-16 final Commonwealth Growth Funding to match activity; $4.5M are adjustments to Commonwealth funded programs; $2.6M for adjustments to enterprise bargaining agreements; and $1.4M in reprovision of state deferrals from 2015-16.

The remainder of the favourable variance against budget relates to the re-allocation of own source revenue (OSR) and locally receipted grants (LRG) funding which did not form part of the 2016-17 Service Agreement when the Budget was initially set. This resulted in a further $28.3M in OSR and LRG revenues recognised above initial budget.

These increases from budget were offset slightly by other non-material movements.

V2. Employee expenses and Health service employee expenses

The unfavourable variance in employee expenses and health service employee expenses is due to an increase in the number of staff employed compared to the funding provided for in the initial Service Agreement. The initial Service Agreement only allowed for approximately 4,679 MOHRI for 2016-17, with the final actual MOHRI figure for 2016-17 totalling 4,850, an increase of 171 MOHRI or 3.5%. This increase was required in order to address increased demand for HHS services and 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 2016 for medical staff, 1 April 2017 for nursing staff and 1 September for all other staff totalling $22.7M. An increase in the recruitment of medical officers (6 percent) and nursing staff (2 percent) to support intensification in shift and working patterns due to a surge in demand on services was also a factor.

V3. Supplies and services

Generally, the cost of supplies and services has amplified in comparison to prior years due to both an increase in the number of patients seen at services delivered by the HHS and acuity in emergency department presentations, which has a flow-on effect through to other parts of the hospital.

The unfavourable variance in supplies and services relates partly to professional service fees ($3.9M), of which the majority is due to the Procurement Optimisation Project conducted by external consultants, Ernst & Young. This project is set to deliver savings from 2017-18.

Pharmaceutical expenses further contribute to the unfavourable variance, which relates to the full year impact of Hep C drugs distributed to patients ($1.9M).

Clinical supplies has also increased, over-and-above the initial budget, due to growth in Weighted Activity Units (WAUs) year on year (6%) and above inflation increases in unit costs for clinical supplies purchased (the Procurement Optimisation Project's goal is to target unit costs of both clinical and non-clinical supplies).

E3 BUDGET TO ACTUAL COMPARISON – STATEMENT OF FINANCIAL POSITION

	Variance Notes	Original Budget 2017 $'000	Actual 2017 $'000	Variance $'000	Variance % of Budget
Assets					
Current assets					
Cash and cash equivalents	V4	4,785	11,872	7,087	148%
Receivables		27,555	27,838	283	1%
Inventories		4,149	3,769	(380)	(9%)
Other current assets		346	1,090	744	215%
Total current assets		36,835	44,569	7,734	
Non-current assets					
Intangible assets	V5	5,104	1,509	(3,595)	(70%)
Property, plant and equipment	V6	705,972	712,721	6,749	1%
Total non-current assets		711,076	714,230	3,154	
Total assets		747,911	758,799	10,888	
Current liabilities					
Payables	V7	48,868	43,658	(5,210)	(11%)
Accrued employees benefits		1,866	3,956	2,090	112%
Unearned revenue		3,327	165	(3,162)	(95%)
Total current liabilities		54,061	47,779	(6,282)	
Total liabilities		54,061	47,779	(6,282)	
Net assets		693,850	711,020	17,170	
Equity					
Contributed equity	V8	646,478	653,940	7,462	1%
Accumulated surplus	V9	(5,907)	(37,977)	(32,070)	543%
Asset revaluation surplus	V10	53,279	95,057	41,778	78%
Total equity		**693,850**	**711,020**	**17,170**	

EXPLANATION OF MAJOR VARIANCES – STATEMENT OF FINANCIAL POSITION

Major variations between the 2016-17 budget and 2016-17 actual include:

V4. Cash and cash equivalents

The favourable variance relates mainly to an injection of equity received from the DoH of $40.0M during 2016-17 to cover the agreed operating deficit position of $39.9M with the DoH. However, the HHS was able to improve the operating deficit position with the implementation of the Organisational Sustainability Plan, which focussed on key saving initiatives across the HHS. This resulted in an improved operating position by $8.0M and has ensured a higher than expected surplus cash position in the operating bank account as at the end of 2016-17.

V5. Intangible assets

The decrease from budget in intangible assets relates to software acquired as part of the Integrated Electronic Medical Record (IEMR)/Digital Hospital Program. This was expected to be capitalised to the HHS balance sheet in 2016-17, however did not eventuate.

V6. Property, plant and equipment

The driver behind the increase in actual property, plant and equipment balances (in comparison to the budget) is due to appreciation in asset revaluations in 2016-17 totalling $23.6M. The budget did not fully anticipate the impact of the asset revaluations undertaken.

V7. Payables

The original budget for payables was based off 2015-16 expenditure (2015-16 resulted in an operating deficit position), which included extra-ordinary costs relating to the Digital Hospital. Though 2016-17 eventuated in an operating deficit, the HHS implemented an Operational Sustainability Plan through-out 2016-17 which resulted in a reduction in operating expenditure and also payables at 30 June.

V8. Contributed equity

The majority of this variance is attributed to an Equity Injection received from the DoH as outlined in Note V4 above, that was offset by the net movement in equity withdrawals of $35.3M, that relates entirely to depreciation.

V9. Accumulated surplus

The original budget for 2016-17 did not anticipate a deficit in 2016-17. The deficit result for the year was due to the expenditure increases outlined in notes V2 and V3 above.

V10. Asset revaluation surplus

The original budget for the asset revaluation surplus for 2016-17 was based on the 2015-16 actuals before the asset revaluations for 2015-16 were finalised. The finalisation of the asset revaluations for 2015-16 resulted in an asset revaluation surplus balance of $71.3M (variance of $19.8M in budget process), adjusting for indexation.

The remainder of the variance is attributable to the increase in the asset revaluation surplus of $23.7M for 2016-17 with asset revaluations undertaken in Cains Hospital D Block - $6.9M, Main Ward Theatre Mareeba - $3.1M, Innisfail Hospital Building 2 - $2.8M, Mareeba Maternity - $2.7M and Tully Maternity - $2.7M.

E4 BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOWS

	Variance Notes	Original Budget 2017 $'000	Actual 2017 $'000	Variance $'000	Variance % of Budget
Cash flows from operating activities					
Inflows:					
User charges and fees	V11	754,255	798,624	44,369	6%
Grants and other contributions		16,640	17,715	1,075	6%
Interest receipts		71	71	-	-%
GST input tax credits from Australian Tax Office		15,770	15,300	(470)	(3%)
GST collected from customers		-	633	633	-%
Other receipts		4,683	7,413	2,730	58%
Outflows:					
Employee expenses	V12	(90,580)	(88,820)	1,760	(2%)
Health service employee expenses	V12	(489,303)	(536,291)	(46,988)	10%
Supplies and services	V13	(152,706)	(210,754)	(58,048)	38%
Grants and subsidies		(550)	(45)	505	(92%)
GST paid to suppliers		(15,782)	(15,088)	694	(4%)
GST remitted to Australian Tax Office		-	(636)	(636)	-%
Other		(3,571)	(10,858)	(7,287)	204%
Net cash provided by (used in) operating activities		38,927	(22,736)	(61,663)	
Cash flows from investing activities					
Outflows:					
Payments for property, plant and equipment	V14	(5,485)	(12,510)	(7,025)	128%
Payments for intangibles		-	(1,089)	(1,089)	-%
Net cash provided by (used in) investing activities		(5,485)	(13,599)	(8,114)	
Cash flows from financing activities					
Inflows:					
Equity injections	V14	5,485	53,909	48,424	883%
Outlaws:					
Equity withdrawals	V15	(38,927)		38,927	(100%)
Net cash provided by (used in) financing activities		(33,442)	53,909	87,351	
Net increase / (decrease) in cash and cash equivalents		-	17,574	17,574	-%
Cash and cash equivalents at the beginning of the financial year		4,785	(5,702)	(10,487)	(219%)
Cash and cash equivalents at the end of the financial year		4,785	11,872	7,087	

EXPLANATION OF MAJOR VARIANCES – 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:

V11. User charges and fees

Refer to Note V1 for additional revenue generated during the year. This is offset by non-cash revenue such as depreciation, funded by equity.

V12. Employee expenses and Health Service employee expenses

Refer to Note V2 above.

V13. Supplies and services

Refer to Note V3 above.

V14. Payments for property, plant and equipment

The variance is an increase in equity injection of $40.0M from the DoH to cover the forecasted deficit operating position of $39.9M – see note V5 above. Further funding provided for the purchase of property, plant and equipment via equity injection contributes to the remainder of the variance between actuals and budget for 2016-17.

V15. Equity withdrawals

Equity withdrawals relate to depreciation funding. This is a non-cash transaction that should not have been included in the original budget cash flows.

Section F

WHAT WE LOOK AFTER ON BEHALF OF THIRD PARTIES

F1 TRUST TRANSACTIONS AND BALANCES

F1-1 Patient trust receipts and payments

	2017 $'000	2016 $'000
Trust receipts and payments		
Receipts	357	653
Payments	(338)	(693)
Increase/(decrease) in patient funds	19	(40)
Trust assets and liabilities		
Current assets		
Cash held and bank deposits*	83	64
Total current assets	**83**	**64**

* Represents patient trust funds and refundable deposits

Accounting Policy – 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.

F1-2 Granted right to private practice receipts and payments

	2017 $'000	2016 $'000
Receipts		
Private practice receipts*	**18,039**	**15,840**
Total receipts	**18,039**	**15,840**
Payments		
Payments to doctors	**1,565**	**158**
Payments to HHS for recoverable costs	**15,826**	**15,311**
Total payments	**17,391**	**15,469**
Increase/(decrease) in net right of private practice assets	**648**	**371**
Right of private practice assets		
Current assets		
Cash	2,283	1,636
Total current assets	2,283	1,636

Accounting Policy – Granted Right of Private Practice arrangement

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

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 arrangements include options for revenue assignment or revenue retention. Revenue assignment allows 100 percent of private patient billings be assigned to the HHS and the clinician has full access to Attraction and Retention allowances. Revenue retention allows the clinician to access professional services revenue after the payment of service fees, GST and any service retention amount to the HHS. For senior medical officers, this retention arrangement provides partial access to the Attraction and Retention allowance.

There are no amounts payable for right of private practice.

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 (service 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 but the activities are included in the annual audit performed by the Auditor-General of Queensland. As at 30 June 2017 the balance was $2.3M.

Section G

OTHER INFORMATION

G1 KEY MANAGEMENT PERSONNEL AND REMUNERATION EXPENSES

G1-1 KEY MANAGEMENT PERSONNEL

From 2016-17 the HHS's responsible Minister is identified as part of its key management personnel. This is consistent with additional guidance included in AASB 124 *Related Party Disclosures*. The Minister for Health and Minister for Ambulance Services is the Honourable Cameron Dick.

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 2016-2017. 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)
Hospital and Health Board			
Administrator* Michael Walsh	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 Boards Act 2011*).	Appointments are under the provisions of the *Hospital and Health Boards Act 2011* by Governor in Council. Notice is published in the Queensland Government Gazette.	19/09/2016 (07/11/2016)
Administrator* Terry Mehan			14/11/2016 (15/05/2017)
Chair Carolyn Eagle			01/10/2015 (19/09/2016)
Chair Clive Skarott			15/05/2017
Deputy Chair Leeanne Bou-Samra			01/07/2012 (19/09/2016)
Deputy Chair Luckbir Singh			15/05/2017
Dr Felicity Croker			23/08/2013 (19/09/2016)
Dr Peter Smith			17/05/2013 (19/09/2016)
Joann Schmider			18/05/2016 (19/09/2016)
Anita Veivers			18/05/2016 (19/09/2016)
Gillian Shaw			18/05/2016 (19/09/2016)
Christopher Boland			15/05/2017
Dr Sean McManus			15/05/2017
Professor Lee Stewart			15/05/2017
Tracey Wilson			15/05/2017
Jodi Peters			15/05/2017
Nancy Long			15/05/2017

Position	Responsibilities	Contract classification and appointment authority	Date appointed to position (Date resigned from position, if applicable)
Cairns and Hinterland Hospital and Health Service - Executive			
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
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.	MEDC3Servue, Appointed by Chief Executive under *Hospital and Health Board Act 2011*.	01/07/2012 (03/01/2017)
A/Executive Director Medical Services*** Dr Donald Martin	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.	Appointed Hardy Group International to engage Dr Donald Martin as interim EDOM on a contractual based arrangement.	12/12/2016
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.	HES2-3, 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.	HES2-3, Appointed by Chief Executive under *Hospital and Health Board Act 2011*.	30/01/2017 (14/02/2017)

Position	Responsibilities	Contract classification and appointment authority	Date appointed to position (Date resigned from position, if applicable)
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
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 (21/11/2016)
Executive Director People and Culture*** Rebecca Wells	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.	Appointed Dixie Solutions Pty Ltd to engage Rebecca Wells as interim EDPC on a contractual based arrangement.	17/01/2017
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 (28/11/2016)
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 (15/01/2017)

Position	Responsibilities	Contract classification and appointment authority	Date appointed to position (Date resigned from position, if applicable)
A/Executive Director Nursing & Midwifery** Mary Streatfield	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.	NRG13, Appointed by Chief Executive under *Hospital and Health Board Act 2011*.	08/08/2016 (11/09/2016)
A/Executive Director Nursing & Midwifery** Andrea O'Shea	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	NRG13, Appointed by Chief Executive under *Hospital and Health Board Act 2011*.	18/07/2016
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 appointed and employed by DoH
**Denotes directly employed by HHS.
***Denotes an external contract arrangement

G1-2 Remuneration expenses

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

- *Hospital and Health Boards Act 2011* and
- 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 and;
  - » 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.

Key management personnel – Minister

The Legislative Assembly of Queensland's Members' Remuneration Handbook outlines the ministerial remuneration entitlements. The HHS does not incur any remuneration costs for the Minister of Health and Ambulance, but rather ministerial entitlements are paid primarily by the Legislative Assembly with some remaining entitlements provided by the Ministerial Services Branch with the Department of Premier and Cabinet.

From 1 July 2016, all ministers are reported as key management personnel of the Queensland Government. As such, the aggregate remuneration expenses for all Ministers are disclosed in the Queensland Government and Whole of Government consolidated financial statements from 2016-17, which are published as part of the Queensland Treasury Report on State finances.

Key management personnel – Board

The HHS appoints and controls the Board. Remuneration arrangements of the Board are approved by the Governor in Council and the Board members are paid annual fees consistent with the government titled "Remuneration procedures for part-time chairs and members of Queensland Government bodies".

G1-3 KEY MANAGEMENT PERSONNEL REMUNERATION AND EXPENSES

1 July 2016 - 30 June 2017

	Short Term Benefits					
	Monetary Expenses	Non-Monetary Benefits	Long Term Employee Benefits	Post Employment Benefits	Termination Benefits	Total Remuneration
	'000	'000	'000	'000	'000	'000
Current						
Chair Clive Skarott AM	9	-	-	1	-	**10**
Deputy Chair Luckbir Singh	5	-	-	-	-	**5**
Board Member Christopher Boland	5	-	-	-	-	**5**
Board Member Dr Sean McManus	5	-	-	-	-	**5**
Board Member Professor Lee Stewart	-	-	-	-	-	**-**
Board Member Tracey Wilson	5	-	-	-	-	**5**
Board Member Jodi Peters	5	-	-	-	-	**5**
Board Member Nancy Long	5	-	-	-	-	**5**
Chief Executive Clare Douglas	425	25	8	37	-	**495**
Chief Operating Officer Tina Chinery	247	-	4	25	-	**276**
Chief Finance Officer Stephen Thacker	211	-	3	20	-	**234**
Executive Director Allied Health Donna Goodman	144	9	-	17	-	**170**
A/Executive Director Nursing & Midwifery Andrea O'Shea	220	9	-	19	-	**248**
A/Executive Director Medical Services Dr Donald Martin	229	-	-	-	-	**229**
A/Executive Director People and Culture Rebecca Wells	240	-	-	-	-	**240**
Former						
Chair Carolyn Eagle	17	-	-	1	-	**18**
Deputy Chair Leeanne Bou-Samra	12	-	-	1	-	**13**
Board Member Dr Felicity Croker	10	-	-	9	-	**19**
Board Member Dr Peter Smith	13	-	-	1	-	**14**
Board Member Joann Schmider	10	-	-	1	-	**11**
Board Member Anita Veivers	10	-	-	1	-	**11**
Board Member Gillian Shaw	12	-	-	1	-	**13**

1 July 2016 - 30 June 2017

	Short Term Benefits					
	Monetary Expenses '000	Non-Monetary Benefits '000	Long Term Employee Benefits '000	Post Employment Benefits '000	Termination Benefits '000	Total Remuneration '000
Executive Director Medical Services Dr Neil Beaton	232	9	-	14	-	**255**
A/Chief Operating Officer Mary Streatfield	15	9	-	1	-	**25**
Executive Director People and Culture Caroline Wagner	152	5	1	6	-	**164**
Executive Director Information Strategy & Planning Bradley McCulloch	121	9	1	7	-	**138**
Executive Director Nursing & Midwifery Glynda Summers	140	4	-	11	-	**155**
A/Executive Director Nursing & Midwifery Mary Streatfiled	25	-	-	2	-	**27**

1 July 2015 - 30 June 2016

	Short Term Benefits					
	Monetary Expenses '000	Non-Monetary Benefits '000	Long Term Employee Benefits '000	Post Employment Benefits '000	Termination Benefits '000	Total Remuneration '000
Current						
A/Chief Executive Clare Douglas	-	-	-	-	-	-
Chief Finance Officer Stephen Thacker	120	-	2	12	-	134
Chief Operating Officer Tina Chinery	23	-	-	2	-	25
Executive Director Allied Health Donna Goodman	172	9	-	19	-	200
Former						
Chair **Deputy Chair** from 01/07/2015 -30/09/2015 Carolyn Eagle	80	-	-	9	-	89
Chair from 29/6/2012 - 1/10/2015 Robert Norman	24	-	-	1	-	25
Board Member Leeanne Bou-Samra	50	-	-	5	-	55
Board Member from 17/05/2013 - 17/05/2016 Mario Calanna	45	-	-	5	-	50
Board Member Dr Felicity Croker	49	-	-	-	-	49

1 July 2015 - 30 June 2016	Short Term Benefits		Long Term Employee Benefits	Post Employment Benefits	Termination Benefits	Total Remuneration
	Monetary Expenses	Non-Monetary Benefits				
	'000	'000	'000	'000	'000	'000
Board Member from 17/05/2013 - 17/05/2016 Bruce Peden	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
Chief Executive from 01/07/2012 - 10/06/2016 Julie Hartley-Jones	276	13	5	25	159	478
Executive Director Medical Services Dr Neil Beaton	416	9	9	25	-	459
A/Chief Operating Officer from 12/02/2015 - 30/05/2016 Mary Streatfield	175	9	3	16	-	203
Chief Operating Officer from 01/07/2012 - 04/12/2015 Robin Moore**	(29)	10	(1)	(4)	2	(22)
Executive Director People and Culture Caroline Wagner	180	9	3	17	-	209
Executive Director Information Strategy & Planning Bradley McCulloch	183	9	3	18	-	213
Executive Director Nursing & Midwifery Glynda Summers	222	4	4	21	-	251

Refer to Notes G1-1 and G1-3 for appointment and resignation dates of Key Management Personnel.

Note:

- Robin Moore's remuneration is in credit due to salary recoveries relating to over-payments during 2014-15.
- 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.

G2 RELATED PARTY TRANSACTIONS

The HHS does not have any subsidiaries, associates or joint ventures with other parties and, therefore, no related parties of this kind to declare. The HHS does not make loans loans to, nor receive loans from, related parties.

G2-1 Parent entity and other HHSs

The HHS is controlled by the State of Queensland, which is the ultimate parent entity. All State of Queensland controlled entities meet the definition of a related party under AASB 124 *Related Party Disclosures*.

Department of Health

The HHS receives funding from the DoH in return for specific public health services, purchased by the DoH in accordance with a service agreement between the

DoH and the HHS. The service agreement is periodically reviewed and updated for changes in activities and prices of services delivered by the HHS.

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

Refer to note B1-1 user charges and fees for DoH funding.

Refer to note C2-1 receivables for DoH debtor balance as at 30 June 2017.

Refer to note C6 payables for DoH creditor balance as at 30 June 2017.

Other Hospital and Health Services

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

Refer to note C2-1 receivables for other inter hospital and health services debtor balance as at 30 June 2017.

G2-2 Key management personnel

Disclosures relating to key management personnel are set out in G1.

Dixie Solutions Pty Ltd

The HHS had transactions with Dixie Solutions Pty Ltd to the value of $240,000 for 2016-17. These transactions have been investigated and were found to be in accordance to the current contract with the HHS.

Identified close family members

The HHS employs and contracts 6,134 (MOHRI head count) staff through an arm's length process. Two are close family members of key management personnel.

G2-3 Other government entities

CHHHS transactions with other government entities are on normal terms and conditions and were immaterial in nature.

The other government entities include:

Department of Housing and Public Works

CHHHS pays rent to Department of Housing and Public Works for government employee housing and property leases. Vehicle leasing and strategic fleet management services are provided by the Department of Housing and Public Works via Qfleet.

Queensland Treasury Corporation

CHHHS has an investment bank account with the Queensland Treasury Corporation for general trust monies.

G3 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 2017, amounts of $1.5M (2016: $1.4M) in General Trust and $0.9M (2016: $1.7M) for research projects are set aside for the specified purpose underlying the contribution.

G4 FIRST YEAR APPLICATION OF NEW ACCOUNTING STANDARDS OR CHANGE IN POLICY

Changes in accounting policy

The HHS did not voluntarily change any of its accounting policies during 2016-17.

Accounting Standards applied for the first time in 2016-17

Australian Accounting Standard AASB 124 *Related Party Disclosures* came into effect for the first time in 2016-17. This standard requires note disclosures about relationships between a parent entity and its controlled entities, key management personnel (KMP) remuneration expenses and other related party transactions, and does not impact on financial statement line items.

G5 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 9 *Financial Instruments* and AASB 2014-7 *Amendments to Australian Accounting Standards* arising from AASB 9 (December 2014).

These standards will become effective for reporting periods beginning on or after 1 January 2018. The main impacts of these standards on the HHS are that they will change the requirements for the classification, measurement, 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 15 *Revenue from Contracts with Customers* and AASB 1058 *Income of Not-for-Profit Entities*

These standards will become effective for reporting periods beginning on or after 1 July 2019. AASB 15 will replace AASB 118 *Revenue*, AASB 111 *Construction Contracts* and a number of interpretations. AASB 1058 will replace AASB 1004 *Contributions*. Together they contain a comprehensive and robust framework for the recognition, measurement and disclosure of income including revenue from contracts with customers.

The HHS is yet to fully assess the way that income is measured and recognised to identify whether there will be any material impact arising from these standards.

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 on 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.

MANAGEMENT CERTIFICATE

Queensland Government

Ref:
Telephone: (07) 4226 3226
Email: CHHHS_Finance_&_Performance@health.qld.gov.au

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 2017 and of the financial position of the Hospital and Health Service at the end of that year; and

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

Mr Clive Skarott AM Diploma of Financial Services Justice of the Peace (Qual) FAICD	Ms Clare Douglas B App Sci(Nursing) Grad Dip Health Admin M Management GAICD	Mr Stephen Thacker BA, PGDip, MA, ACCA CIPFA, MAPM, IoD
Chair **Cairns and Hinterland Hospital and Health Service Board**	**Chief Executive** **Cairns and Hinterland Hospital and Health Service**	**Chief Finance Officer** **Cairns and Hinterland Hospital and Health Service**
28 August 2017	28 August 2017	28 August 2017

Level 2, GHD Building
85 Spence Street
PO Box 902
CAIRNS QLD 4870

INDEPENDENT AUDITOR'S REPORT

INDEPENDENT AUDITOR'S REPORT

To the Board of Cairns and Hinterland Hospital and Health Service

Report on the audit of the financial report

Opinion

I have audited the accompanying financial report of Cairns and Hinterland Hospital and Health Service. The financial report comprises the statement of financial position as at 30 June 2017, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2017, and its financial performance and cash flows for the year then ended

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

Basis for opinion

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

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

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

Key audit matters

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

Specialised buildings valuation ($619m)

Key audit matter	How my audit addressed the key audit matter
Buildings were material to Cairns and Hinterland Hospital and Health Service at balance date, and were measured at fair value using the current replacement cost method. Cairns and Hinterland Hospital and Health Service performed a comprehensive revaluation of approximately 7% of its buildings' written down value this year with remaining assets being revalued using indexation. The current replacement cost method comprises: • Gross replacement cost, less • Accumulated depreciation. Cairns and Hinterland Hospital and Health Service derived the gross replacement cost of its buildings at balance date using unit prices that required significant judgements for: • identifying the components of buildings with separately identifiable replacement costs. • developing a unit rate for each of these components, including: o estimating the current cost for a modern substitute (including locality factors and oncosts), expressed as a rate per unit (e.g. $/square metre). o identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference. • indexing unit rates for subsequent increases in input costs The measurement of accumulated depreciation involved significant judgements for forecasting the remaining useful lives of building components. The significant judgements required for gross replacement cost and useful lives are also significant for calculating annual depreciation expense.	My procedures included, but were not limited to: • Assessing the adequacy of management's review of the valuation process. • Assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices. • For unit rates associated with buildings that were comprehensively revalued this year: o Assessing the competence, capabilities and objectivity of the experts used to develop the models. o Reviewing the scope and instructions provided to the valuer, and obtaining an understanding of the methodology used and assessing its appropriateness with reference to common industry practices. o On a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the: ▪ modern substitute (including locality factors and oncosts) ▪ adjustment for excess quality or obsolescence. • For unit rates associated with the remaining buildings: o Evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices. o Recalculating the application of the indices to asset balances. • Evaluating useful life estimates for reasonableness by: o Reviewing management's annual assessment of useful lives. o Testing that no asset still in use has reached or exceeded its useful life. o Enquiring of management about their plans for assets that are nearing the end of their useful life. o Reviewing assets with an inconsistent relationship between condition and remaining useful life. • Where changes in useful lives were identified, evaluating whether they were supported by appropriate evidence.

Refer to Note C4 in the financial report.

Responsibilities of the entity for the financial report

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

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

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

Report on other legal and regulatory requirements

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2017:

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

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

QUEENSLAND
29 AUG 2017
AUDIT OFFICE

D J OLIVE
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

GLOSSARY 9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GLOSSARY OF TERMS

Accessible	Accessible healthcare is characterised by the ability of people to obtain appropriate healthcare at the right place and right time, irrespective of income, cultural background or geography.
Activity based funding (ABF)	A management tool with the potential to enhance public accountability and drive technical efficiency in the delivery of health services by: • capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery • creating an explicit relationship between funds allocated and services provided • strengthening management's focus on outputs, outcomes and quality • encouraging clinicians and managers to identify variations in costs and practices so they can be managed at a local level in the context of improving efficiency and effectiveness • providing mechanisms to reward good practice and support quality initiatives.
Acute	Having a short and relatively severe course of 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; orthotics; 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.
CCC	Community Consultation Committee
CHHHS	Cairns and Hinterland Hospital and Health Service
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	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.
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.
ieMR	Integrated Electronic Medical Record
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.
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.
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% 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.
NQPHN	North Queensland Primary Health Network
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.
Private hospital	A private hospital or free-standing day hospital, and either a hospital owned by a for profit company or a non-profit organisation and privately funded through payment for medical services by patients or insurers. Patients admitted to private hospitals are treated by a doctor of their choice.
Public patient	A public patient is one who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.
Public hospital	Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.
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 percent to greater than 80 percent.
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.
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 • tele-radiology 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

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister/s	ARRs – section 7	3
Accessibility	Table of contents Glossary	ARRs – section 9.1	7 , 136
	Public availability	ARRs – section 9.2	Inside Cover
	Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 9.3	Inside Cover
	Copyright notice	*Copyright Act 1968* ARRs – section 9.4	Inside Cover
	Information Licensing	*QGEA – Information Licensing* ARRs – section 9.5	Inside Cover
General information	Introductory Information	ARRs – section 10.1	8-13
	Agency role and main functions	ARRs – section 10.2	16-17
	Operating environment	ARRs – section 10.3	22
Non-financial performance	Government's objectives for the community	ARRs – section 11.1	50-52
	Other whole-of-government plans / specific initiatives	ARRs – section 11.2	49-52
	Agency objectives and performance indicators	ARRs – section 11.3	53-55
	Agency service areas, and service standards	ARRs – section 11.4	82, 83
Financial performance	Summary of financial performance	ARRs – section 12.1	84, 85
Governance – management and structure	Organisational structure	ARRs – section 13.1	63
	Executive management	ARRs – section 13.2	64, 65
	Government bodies (statutory bodies and other entities)	ARRs – section 13.3	N/A
	Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* ARRs – section 13.4	75
	Qld Public Service Values	ARRs – section 13.5	
Governance – risk management and accountability	Risk management	ARRs – section 14.1	68
	External scrutiny	ARRs – section 14.4	69
	Audit committee	ARRs – section 14.2	62
	Internal audit	ARRs – section 15.3	68
	Information systems and recordkeeping	ARRs – section 15.5	69-70
Governance – human resources	Workforce planning and performance	ARRs – section 15.1	74
	Early retirement, redundancy and retrenchment	*Directive No.11/12 Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	75
Open data	Statment advertising publication of information	ARR – section 16	
	Consultancies	ARR – section 33.1	142
	Overseas travel	ARR – section 33.2	142
	Queensland Language Services Policy	ARR – section 33.3	142
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 17.1	131
	Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 17.2	132, 133

FAA Financial 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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ABN 25 285 907 786

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07 4091 0211

Babinda Multi-Purpose Health Centre

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PO Box 160, Babinda Qld
07 4067 8200

Cairns Hospital

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PO Box 902, Cairns Qld 4870
07 4226 0000

Chillagoe Primary Health Centre

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PO Box 4, Chillagoe Qld 4871
07 4094 7500

Croydon Primary Health Centre

Sircom Street, Croydon Qld 4871
PO Box 10, Croydon Qld 4871
07 4748 7000

Dimbulah Primary Health Centre

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PO Box 148, Dimbulah Qld 4872
07 4093 5333

Forsayth Primary Health Centre

Fourth Street, Forsayth Qld 4871
07 4062 5372

Georgetown Primary Health Centre

High Street, Georgetown Qld 4871
PO Box 33, Georgetown Qld 4871
07 4062 1266

Gordonvale Hospital

1-11 Highleigh Road, Gordonvale Qld 4865
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07 4043 3100

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07 4096 1000

Herberton Hospital
23 Grace Street, Herberton Qld 4887
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Innisfail Hospital
87 Rankin Street, Innisfail Qld 4860
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07 4061 5411

Malanda Primary Health Centre
3/15 Catherine Street, Malanda Qld 4885
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Mareeba Hospital
2 Lloyd Street, Mareeba Qld 4880
PO Box 145, Mareeba Qld 4880
07 4092 9333

Millaa Millaa Primary Health Centre
45 Palm Avenue, Millaa Millaa QLD 4886
07 4097 2223

Mossman Multi-Purpose Health Service
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07 4084 1200

Mount Garnet Primary Health Centre
Gelena Street, Mount Garnet Qld 4872
07 4097 9101

Ravenshoe Primary Health Centre
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PO Box 61, Ravenshoe Qld 4888
07 4097 6223

Tully Hospital
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07 4068 4144

Cairns and Hinterland Hospital and Health Service

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