Central Queensland Hospital and Health Service

ANNUAL REPORT

2017–2018

Queensland Government

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Letter of compliance

Queensland
Government

Central Queensland
Hospital and Health Service

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

Dear Minister Miles,

I am pleased to submit for presentation to the Parliament the Annual Report 2017-2018 and financial statements for Central Queensland Hospital and Health Service.

I certify that this Annual Report complies with:

- The prescribed requirements of the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2009;* and
- The detailed requirements set out in the *Annual report requirements for Queensland Government Agencies.*

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

Yours sincerely

Cr Paul Bell AM
Chair
Central Queensland Hospital and Health Board

September 2018

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Message from the Chair

Cr Paul Bell AM

2017-18 was our year of vision.

CQ Health completed extensive staff and community consultation to develop and deliver a very clear strategic intent for future health service delivery in *Destination 2030: Great Care for Central Queenslanders*.

This vision provides clarity to our staff and community while guiding our decision-making and investment in a values-based and culturally strong environment. Though still young, Destination 2030 has delivered significant results as our great staff deliver great care.

From the implementation of our 10,000 Lives campaign, aimed at encouraging a healthy lifestyle and addressing the key health risks of our community to reduce the considerable health disparities we face, to delivering more than 11,000 Telehealth appointments saving Central Queenslanders almost $5 million kilometres of travel, our vision is delivering rewards.

The development of our services and facilities continues with the Rockhampton Hospital car park to be completed in early 2018 and construction of the $42 million Emergency Department at Gladstone Hospital to start later this year.

CQ Health delivered great results for Central Queenslanders – as highlighted throughout this annual report – with a $4.4 million budget deficit.

CQ Health and its employees have an exciting future. Our aim in the next two years is for patients and consumers to be at the heart of how we design and deliver our services. By 2020 we will have:

- Achieved one of the best staff experiences in Queensland for regional health services
- Delivered more than $110m capital investment
- Implemented health pathways in partnership with General Practitioners across Central Queensland
- Established the first stage of our sub-specialist hospital services
- Commenced the first element of our 10-year health and wellbeing strategy with the launch of our 10,000 lives program
- Closed the gap in Indigenous life expectancy by two years

In 2018/19 we will prepare for the introduction of electronic medical records across our health services, implement real-time patient experience capability, develop and improve our staff development and recruitment processes, plan for the delivery of expanded research and education facilities across the health service, develop partnerships to close the indigenous health gap by 2030 and invest in expanded capability and capacity across our health service.

I would like to recognise the CQ Health Board for its support and resolute conviction to Central Queensland, and Chief Executive Steve Williamson and his Executive Team who have developed as a supportive and focused leadership group to allow our health service to evolve and our staff to thrive.

All that said, it is our great people, our 3700 staff, who have delivered the results. I thank every staff member for their commitment and determination and pledge that I will continue to support our considerable cultural improvements to deliver a great place to work and great career opportunities.

Together, we will continue to grow our reputation as a health service our community can trust.

Message from the Chief Executive

Steve Williamson

CQ Health's great people delivered truly great care during 2017-18.

Our 3700 staff deliver care in all corners of Central Queensland, improving the lives of hundreds of thousands of Central Queenslanders every year, delivering safer care, more care, timely care, care closer to home and innovative care.

The health service achieved year-on-year reductions in the number of serious clinical incidents and is committed to relentlessly search for safer ways to deliver health services.

CQ Health staff delivered more surgery, more outpatient appointments, treated more people in our emergency departments, delivered more Telehealth appointments, and more breast screens.

The additional services were also delivered on time.

On 30 June 2018, no patient was waiting longer than clinically recommended for surgery, outpatient appointment, scope procedures or an oral health appointment and our emergency departments achieved the 80% benchmark for patients treated and discharged within four hours.

There was significant growth in treatments and service delivery at our Gladstone, Emerald and Biloela hubs and at many of our smaller facilities as CQ Health continues to deliver care closer to home and deliver its vision of reducing the incidents of patient travel by 10,000 a year.

Innovation also delivered care closer to home and more sustainable care, such as the ability for patient to receive their chemotherapy at a rural facility while supervised by a specialised clinician via videoconference without the need to travel to Rockhampton, and the introduction of Rural Generalist training model at Biloela to improve the sustainability of birthing services.

2017-18 was a benchmark year for CQ Health, highlighted by significant service improvements delivered through improved staff, consumer and community engagement. From this benchmark, CQ Health will continue to drive a cultural improvement program and deliver a great place to work.

Supported by research, learning, partnerships, a philosophy of continual improvement, and a desire to deliver saving to be reinvested into service improvement, CQ Health will continue to meet the growing health needs of Central Queenslanders.

I recognise the support and guidance of Chair Paul Bell OAM and the dedicated members of our Board who have steered our direction as community representatives.

The Executive Management Team has provided the stability that our organisation needed and has grown in its ability to lead in a way that removes obstacles for our staff to deliver improvements. From now, it shall be known as the Executive Leadership Team.

As we moved into another exciting year with the ongoing desire to do the best we possibly can for Central Queenslanders, it is the staff of CQ Health to whom I reserve my biggest thanks, my greatest respect and my deep gratitude.

It is the staff who deliver our services and create the experience for our patients and consumers. From those who make our gardens inviting and relaxing, those who keep our ward clean and our facilities safe, those who provide therapy and support and our great allied health, nursing and midwifery and medical clinicians – your commitment to your communities is outstanding.

I have said it before, I am truly proud to be the Chief Executive of this great health service and the outstanding team behind it.

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Chapter 1
Introduction

Aunty Annie Gela and her Torres Strait artwork which adorns part of the new Cancer Services Building at Rockhampton Hospital.

Acknowledgement of Traditional Owners

CQ Health respectfully acknowledges the Traditional Owners and Custodians both past, present and future of the land, air, and waters which we service; and declare CQ Health's commitment to reducing inequalities between Aboriginal and Torres Strait Islander and non-Indigenous health outcomes in line with the Australian Government's Close the Gap initiative within the Central Queensland region.

CQ Health is committed to addressing the health inequities and Close the Gap by 2030.

Organisational snapshots

ZERO waiting too long for specialist outpatient appointment on 30 June 2018
ZERO waiting too long for surgery on 30 June 2018
ZERO waiting too long for a dental appointment
ZERO waiting too long for a scope procedure

3010 FTE

Delivered **2143** babies

Treated **125,400** in our EDs

Performed **12,486** breast screens

Performed **13,440** surgeries

358,309 outpatient appointments

Treated **107,650** inpatients

238,846 oral health treatments

Provided **11,107** Telehealth sessions

Invested **more than a million** dollars a day in wages

Vision: Great Care for Central Queenslanders
Mission: Great people, delivering quality care and improving health
Values: CQ Health is committed to its guiding values:

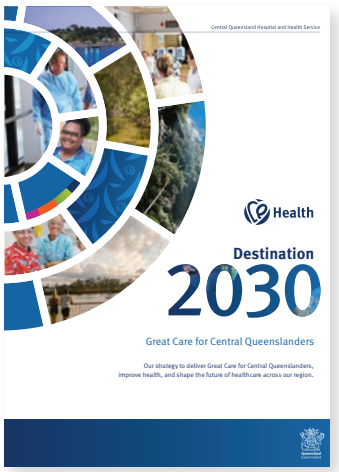
Care – We are attentive to individual needs and circumstances
Integrity – We are consistently true, act diligently and lead by example
Respect – We will behave with courtesy, dignity and fairness in all we do
Commitment – We will always do the best we can all of the time

These values, and the CQ Health strategic objectives as identified in its Strategic Plan 2017-2021, align with the Queensland Public Sector values and support the Queensland Government's objective of:

- Delivering quality frontline services
- Building safe, caring and connected communities
- Creating jobs and a diverse economy

This annual report highlights how CQ Health contributed to the government's objectives.

During 2017, CQ Health consulted extensively with staff, partners, service providers and the community to develop a long-term strategic vision and



Destination 2030: Great Care for Central Queenslanders was approved by the Board and adopted by the health service on 27 October 2017.

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

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

- Great Care Great Patient Experience (Chapter 2)
- Great People Great Place to Work (Chapter 3)
- Great Partnerships (Chapter 4)
- Great Learning and Research (Chapter 5)
- Sustainable Future (Chapter 6)

Destination 2030: Great Care for Central Queenslanders supports the Queensland Government priorities identified in Our Future State: Advancing Queensland priorities:

- Creating jobs in a strong economy;
- Give all our children a great start;
- Keep Queenslanders healthy;
- Keep communities safe;
- Protect the Great Barrier Reef; and
- Be a responsive government.

It also supports the 10 Ministerial transformation priorities:

- Reducing low value interventions
- Effective procurement arrangements
- Scaling innovation, reducing variation in costs and reducing variation in clinical outcomes across HHSs
- Expanded scope of practice for nursing and Allied Health Professional workforce
- Using capital investment to achieve productivity improvements
- Hospital avoidance and hospital substitution models
- Alternative models of care for frail and older people
- Regional, rural and remote telehealth services
- Managing project costs through better development of capital cases
- Reducing obesity-related health costs

CQ Health will develop short-term and medium-term "roadmaps" to ensure it is on track to meet the designated targets.

In 2017-18, CQ Health identified 53 roadmap projects of which 31 were completed and 20 closed for 2017-18. The next stage of these projects will form part of the 2018/19 project plan. Two projects were not completed and will remain active.

A roadmap to 2020, identifying key projects to ensure the 2020 measurables are met, has been developed and endorsed by the CQ Health Board.

The 2018/2019 budget and key funding allocations will also support the vision highlighted in Destination 2020: Great Care for Central Queenslanders.

2018-19 budget
$610 million
almost **$44 million** more than 2017-18 budget

Key actions for the next financial year

- **$4.4 million** for community mental health treatment services
- **$1.3 million** to improve gastrointestinal endoscopy services
- **$200,000** to support the adult Step-Up, Step-Down facility being established under the Mental Health Connecting Care to Recovery initiative
- **$600,000** for additional clinical staff to meet increasing demand for health services in Queensland correctional facilities
- progressing the **$25.5 million** Rockhampton Hospital Carpark
- continuing works on the **$42 million** Gladstone Hospital Emergency Department
- beginning **$5.7 million** worth of major renovations to the North Rockhampton Nursing Centre
- Improved productivity to deliver more services for Central Queenslanders

More beds

- 6 more cardiology beds
- 4 more palliative care beds

More activity

$9.1 million growth funding to meet projected increases in activity including emergency department presentations, elective surgery and outpatients

Improved services

- More telehealth including Telechemo at Theodore
- Day surgery and nursery at Gladstone Hospital
- Expanded obstetric and surgical services in rural Central Queensland
- High Dependency Unit at Gladstone
- Cardiology, paediatrics and rural generalist development
- Community mental health expansion
- Step up Step Down mental health facility in Gladstone

More jobs

- More than 70 new jobs across CQ Health
- 11 more midwives to support our maternity services
- 8 new senior medical officers and rural generalist doctors including:
  - anaesthetists at Gladstone
  - Cardiologist and paediatrician at Rockhampton
  - Rural generalist doctors at Biloela
- Up to 30 new community mental health roles to support mental health services across Central Queensland
- Investment in Indigenous health roles
- More nurses across our health service including 3 Nurse Navigators and 81 graduate nurses

The Central Queensland Hospital and Health Board and Central Queensland Hospital and Health Service were established on 1 July 2012 under the Hospital and Health Boards Act 2011.

CQ Health has 3010 full-time equivalent (FTE) staff focused on patient safety and delivering public hospital and health services in an area of approximately 117,000 square kilometres - from Gladstone in the south, inland to the Southern and Central Highlands and north along the Capricorn Coast - serving an estimated 2018 population of 242,600.

In 2017-18 the organisation treated more than 700,000 patients including 125,000 in our emergency departments and 358,000 through outpatient appointments, plus 239,000 oral health services.

The geographic footprint of the health service is diverse, ranging from regional cities to remote townships in the west and beachside communities along the coast.

The Chief Health Officer's *Health of Queenslanders Report 2016* identifies CQ Health as being home to 5% of the state's population and covering an area equal to 6% of the state. The median age of death is 78 years, two years younger than the state average.

Other risk factors include:

- 17% of adults are daily smokers – 38% higher than the state
- 29% of adults are obese – 20% higher than the state
- 25% of adults are risky drinkers – 15% higher than the state
- Half of all Indigenous deaths occurred in people aged under 58 years – half of all non-Indigenous deaths occurred in people aged under 79 years
- Fewer than 60% of eligible women aged 50-74 years attended Breastscreen

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

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

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

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

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

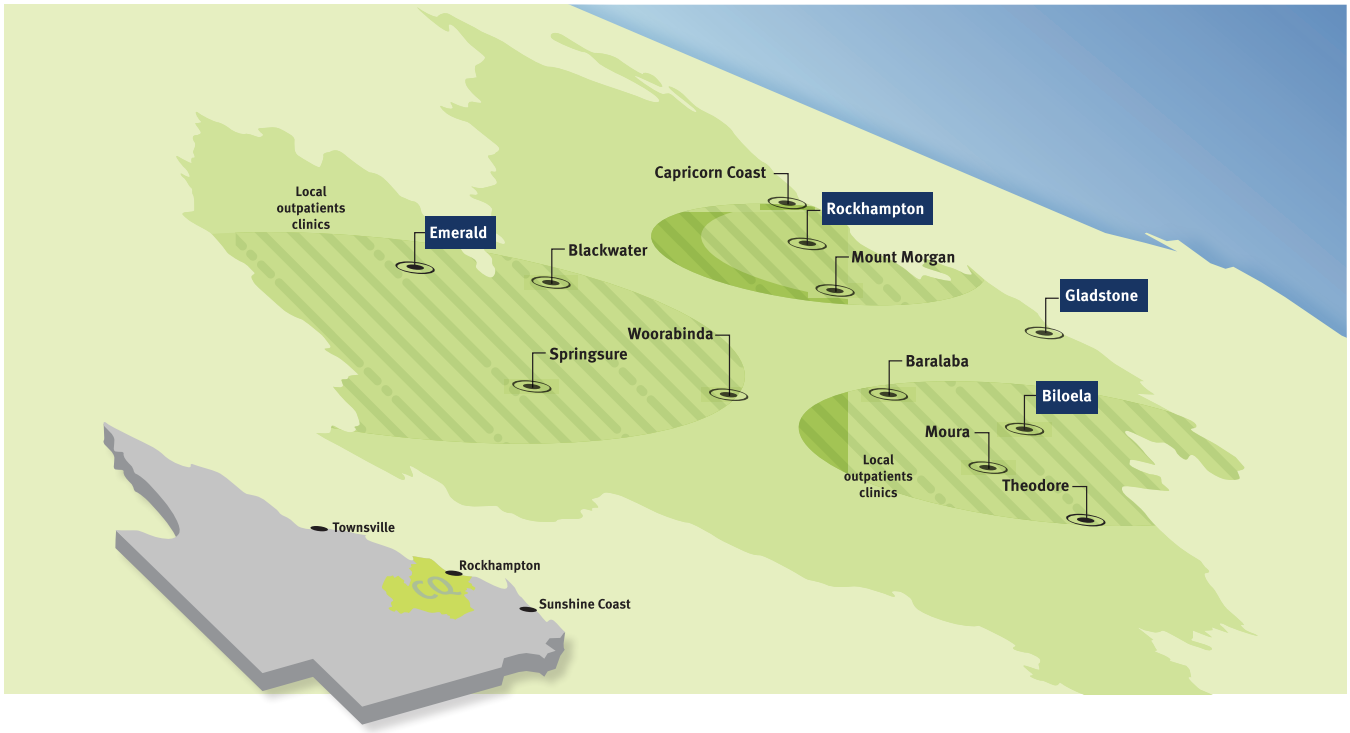
- Baralaba
- Blackwater
- Mount Morgan
- Springsure
- Theodore
- Woorabinda.

Outpatient clinics are located at:

- Boyne Valley
- Capella
- Gemfields
- Tieri.

Aged care facilities:

- North Rockhampton Nursing Centre
- Eventide Nursing Home



Chapter 2

Great care, great patient experience

Louise Cody from Rockhampton is grateful to be receiving care close to home after two years of travelling back and forth to Brisbane. Nurse Navigator Maxine Sebbens linked Louise's specialists in Brisbane with her consultant at Rockhampton Hospital.

Great care - care that is safe and appropriate, delivered in the right place at the right time by the right clinician with the best possible outcome.

Great Care and Great Patient Experience – including care that is easily understood, easy to navigate and delivered by staff who live their values every day – will deliver CQ Health's ultimate aim: Great Care for Central Queenslanders.

To ensure Great Care is delivered as required, CQ Health will develop a Clinical Services Masterplan as the key service planning tool towards 2030.

During 2017-18 CQ Health continued to strengthen the myriad elements that combine to deliver great care including:

- Quality and safety governance
- Consumer, community and clinician involvement in health care planning, improvement and delivery
- Timely care
- Care closer to home
- Close the Gap
- Connected care
- Health system that is easy to navigate
- Health lifestyle improvement
- Great people (See Chapter 3)
- Care delivered by the right service and partnership
- Innovative care

Eradicating illness and disease and a collaborative program, by CQ Health's Capricornia Offender Health Service and Blood Borne Virus and Sexual Health Service, was the subject of a presentation at the Australasian Viral Hepatitis Conference in Adelaide in August 2018. The aim is to eliminate hepatitis C from the offender population at Capricornia Correctional Centre using an antiviral therapy.

2.1. Quality and Safety Governance

CQ Health has a dedicated Quality and Safety unit that works with the health service business units to support safe and quality led care.

The work of the Quality and Safety unit is underpinned by the CQ Health Clinical Governance Framework, which supports the health service strategic plan and outlines the key components of clinical governance based on the National Safety and Quality Health Service standards; the importance of culture to support good clinical governance; the roles and responsibilities of, and essential partnerships between consumers, clinicians and CQ Health's Board in implementing effective clinical governance systems.

In CQ Health, quality and safety led care is everybody's business. The importance of individual and collective roles and responsibilities for safety and quality, dependant on skills and performance, relies on effective governance and management processes. These principles work with the systems that support the health service delivery of safe and high-quality care delivering the best possible outcomes within the complex healthcare environment.

Across the health service there was a 4.8% decline in the number of serious clinical incidents rated as Severity Assessment Code 1. There was also a 3% decline in Severity Assessment Code 2 incidents. The drop, though small, supported a decline in 2016-17 of 21% (Code 1s) and 16% (Code 2s).

CQ Health builds a culture of continual improvement by sharing learnings from reviews and investigations into clinical incidents with the whole health service. The focus on safety includes a focus on patient safety alerts, the Patient on Our Shoulder Newsletter and wider dissemination of Safety and Quality reports from ward to Board.

Other CQ health improvements in the Quality and Safety space include:

- Implementation of RiskMan as a statewide IT system to collect, integrate, manage and report clinical incidents and consumer feedback
- Quality and Safety team building to strengthen communication and work between teams
- Development and implementation of training and resources for key staff to strengthen the quality and timeliness of incident investigation and reporting
- Strengthen partnership with consumers to identify any points or queries that patient or family would like the team to consider during high level analysis
- Strengthening and monitoring a balanced scorecard for safety and quality to ensure transparency and tracking of performance
- Visits to each facility from the Quality Safety and Risk team to provide tailored support and to influence a safety and quality culture

The ethos of continuous improvement and learning is best represented by improvements delivered across the CQ Health maternity services.

A clinical review of the Rockhampton Hospital maternity unit in 2016 delivered a series of observations and recommendations. Those recommendations were implemented at Rockhampton Hospital, and provided an opportunity to deliver improvements across the health service.

Maternity services at Gladstone, Biloela, Emerald and Theodore were also reviewed – and compared against the learnings from an Office of the Health Ombudsman review of Gold Coast maternity services – to identify improvement opportunities.

In consultation with staff and communities, those recommendations were implemented or are being implemented. This includes the recommendation that birthing services not be reintroduced at Theodore Hospital because of the safety risk posed by distance to the nearest emergency service.

This process has delivered further improvements in safety and quality for women, their babies, and CQ Health staff.

CQ Health will also scrutinise quality and safety governance at Gladstone Hospital maternity unit during the transition of maternity services following the announced cessation of maternity services at Gladstone Mater Hospital effective 1 October 2018.

2.2. Timely care

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

At June 30, no CQ Health patient was waiting longer than recommended for surgery, an outpatient appointment, a scope procedure or an oral health appointment and the health service had one of the best National Emergency Access Target (emergency department wait times) in Queensland.

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

2.3. Surgery

CQ Health delivered a significant increase in surgery for Central Queenslanders. In all, 13,441 surgeries were performed.

A total of 3,828 emergency surgeries were performed, with 3066 performed at Rockhampton Hospital.

9,613 elective surgeries were performed.

Facility	Indicator	2018
Rockhampton Hospital	Elective Surgery	7,004
	Emergency Surgery	3,066
	TOTAL	10,070
Gladstone Hospital	Elective Surgery	1,972
	Emergency Surgery	665
	TOTAL	2,637
Emerald Hospital	Elective Surgery	637
	Emergency Surgery	97
	TOTAL	734
CQ Health	Elective Surgery	9,613
	Emergency Surgery	3,828
	TOTAL	13,441

2.4. Emergency Department

Access to treatment in CQ Health emergency departments met benchmark with 80.26% receiving treatment and being discharged within 4 hours.

Across Central Queensland there were 125,393 presentations to emergency departments, including 29,937 presentations at Gladstone Hospital.

At Gladstone Hospital 88.6% of those presentations received treatment and were discharged within 4 hours.

Facility	2018
Baralaba Hospital	538
Biloela Hospital	6,602
Blackwater Hospital	4,216
Capricorn Coast Hospital	14,424
Emerald Hospital	12,490
Gladstone Hospital	29,937
Mount Morgan Hospital	2,755
Moura Hospital	1,735
Rockhampton Hospital	48,181
Springsure Hospital	1,539
Theodore Hospital	613
Woorabinda Hospital	2,363
CQ Health	125,393

2.5. Outpatient

The specialist outpatient departments across CQ Health continued to deliver an additional 10,000 appointments and at 30 June 2018 no patient had waited longer than clinically recommended.

The 358,300 appointments included 56,000 appointments at Gladstone Hospital.

The CQ Health and CQUniversity partnership that delivers a sub-acute and chronic care rehabilitation service and supervised training of allied health students delivered more than 53,400 appointments at the university's Rockhampton campus.

2.6. Endoscopy procedures

CQ Health increased its focus on the timely delivery of endoscopy procedures during 2017-18 to ensure timely diagnosis and early treatment to achieve improved health outcomes for patients.

In all, 3206 gastrointestinal endoscopy procedures were delivered at Rockhampton, Gladstone and Emerald hospitals.

On 30 June 2018 no patient was waiting longer than clinically recommended for an endoscopy procedure.

Facility	Modality	2018
Emerald Hospital	Inpatient	366
Gladstone Hospital	Inpatient	984
Rockhampton Hospital	Inpatient	1,856

2.7. Oral Health

CQ Health Oral Health Services was 4% over target delivering almost 239,000 services during almost 63,000 appointments.

These appointments include more than 25,000 for patients aged 0-15 years, delivered from the fleet of 10 dental vans and 8 fixed school clinics.

The general oral health waitlist was at 19 months, well below the state benchmark of 2 years.

Oral Health Services is also a Queensland leader when it comes to encouraging its patients to quit smoking. The statewide benchmark for checking the smoking status of patients is 75% and in June 2018 the oral health team was at 94% and the lead in the state. Dentists also had discussions with 70% of their smoking patients about taking part in the Smoking Cessation Clinical Pathway Program while the state target is between 30% and 60%.

Oral Health Services also:

- Partnered with University of Queensland and CQUniversity to support student dentists and student oral health therapist placements
- partnered with Rockhampton Correctional Centre to provide dental and denture services to inmates
- supported indigenous clients through regular clinics at Woorabinda Hospital and though allocation of dental vans at Woorabinda State School and Baralaba State High School
- is preparing for the introducing tele-dentistry services for appropriate services.

2.8. Care closer to home

The footprint of CQ Health is almost twice the size of Tasmania stretching from west of Emerald to the Gladstone coastline and from Theodore to the Capricorn Coast.

With limited east-west air travel and considerable road transport times, reducing patient travel – and the impact that travel has on the patient, families, friends and their experience, reducing the need for patient travel is a key target of our strategic vision. We aim to reduce the incidence of patient travel for care by 10,000.

The introduction of new services, innovative delivery models and the expansion of our Telehealth program delivered outstanding results.

Through innovation, CQ Health has developed the ability to deliver Telechemotherapy at Theodore, Biloela and Emerald, and the initiative will be used at other rural and regional communities. Emerald patients are now able to be trained to receive home renal dialysis in a new service for the Central Highlands and the Biloela Hospital has been accredited as a Rural Generalist training facility which will allow more services, particularly maternity services, to be sustained locally.

There are expanded outpatient services at Gladstone Hospital and minor orthopaedic and general surgery procedures are now being delivered at that facility.

Under agreement with major health facilities in Brisbane we can provide urology services in Rockhampton and are able to bring our children with cancer home to Rockhampton sooner so they can be with family and friends.

Plans for 2018/2019 are more exciting:

- More community mental health treatment services
- New Step Up Step Down Mental Health facility in Gladstone
- More endoscopes
- 24-hour nursery and High Dependency Unit at Gladstone Hospital
- Expanded obstetric and surgical services in rural Central Queensland
- More cardiology and paediatric services across Central Queensland.

Perhaps the biggest contributor to the reduction in the need for patients to travel is the great CQ Telehealth team and their significant achievements during 2017-18.

Telehealth is a video link between patients and health professionals, either from smaller rural hospitals to specialists in Rockhampton, or to more specialised teams in Brisbane or tertiary hospitals.

Telehealth delivered extensive benefits to patients, saving an estimated 4.2 million kilometres of travel through more than 11,000 sessions by connecting patients with clinicians by videoconference.

During the year, 15 new Telehealth services were introduced, and the team has exciting plans, such as:

- Inpatient Telehealth within Central Queensland
- Expansion of Maternity and Antenatal Telehealth Service project
- Tele-dentistry
- Tele-ophthalmology
- Tele-rehabilitation services
- Renal Services Strategy - home dialysis
- Regional services
- Enhanced haematology and oncology at Gladstone

2.9. Consumer and community involvement in health care planning, improvement and delivery

A key Destination 2030: Great Care for Central Queenslanders vision is for patient experience to be amongst the best in the country with consumers are at the heart of all we do. CQ Health has completed a Patient Experience Strategy to ensure progress.

By 2020, CQ Health will embed patients and consumers at the heart of how it designs and delivers services.

This will include the capability to monitor patient experience in real time to support continual quality improvement.

Patient and consumer participation is supported by community, CQ Health staff and CQ Health clinical consultation and participation to deliver effective service improvement.

Our patients and consumers are being integrated into all levels of service planning and delivery, key recruitments, the development of strategic vision and continuous safety and quality improvement.

CQ Health engages with consumers at all levels across the organisation– strategically, at service level and one to one whilst delivering care.

The Consumer and Community Advisory Committee is responsible for ensuring the voices of consumers, carers and the community influence and shape strategic decisions about service operations, planning and policy development. Advisory committee membership reflects the diversity of our consumers, carers and the wider community and not health care providers.

Consumer engagement drives:

- Improved culture of patient experience and patient-centred care
- Better health outcomes and quality of care
- Increased consumer, carer and community satisfaction with CQ Health

The advisory committee has the strategic governance over patient experience and satisfaction data including statewide and CQ Health survey results and consumer feedback, including complaints and compliments. It identifies opportunities for a quality improvement initiative from key themes.

There is also consumer representation on other key strategic governance committees, including Patient Safety, Quality and Risk, Communicating for Safety and Workforce committees.

At a business unit and service level, consumer representation and strong partnerships exist. Partnering with consumers occurs through consumer membership/engagement at:

- facility specific meetings, including Emerald Quality and Safety meeting
- regular and ad-hoc forums, including breast screening and maternity services
- online participation, including feedback from social media sites and completion of service specific surveys. During 2017-18, CQ Health hosted 91 online consultations recording 3400 responses including almost 200 responses to the BreastScreen Client Satisfaction Survey, 41 for the Early Parenting Group Evaluation Tool, 98 for the Sun Safety Survey – North Rockhampton High, and 100 to the Rockhampton Hospital Maternity Unit Visiting Hours Survey.

The individual partnerships, between consumers and CQ Health staff caring for them, through the delivery of patient-centred care are on-going.

2.10. Clinician engagement

Engaging clinicians in every aspect of health service planning, delivery and improvement leads to safer health care that meets the needs of the community.

The combined knowledge, supported by the strong desire to provide the best possible care every day, is vital in every aspect of health care.

CQ Health took clinician engagement to a new level during 2017-18 with the introduction of a CQ Clinical Senate and the establishment of a CQ Clinical Council.

The CQ Clinical Senate is a multidisciplinary group that represents clinicians to provide independent and impartial strategic clinical advice on system-wide issues that affect quality and efficient patient care.

It brings together representatives of all clinical streams, geographic locations and experience, to share their opinions, innovations, solutions and opportunities with the CQ Health Board and Executive Management Team in a quarterly event. It provides advice on the effective implementation of key clinical projects and activities to deliver the strategic vision highlighted in Destination 2030.

The CQ Clinical Council is a strategic planning committee for health service integration across CQ Health. It is a consultative and advisory body that evaluates outcomes and recommends actions. Its membership includes the Executive Director of Medical Services (Chair), senior nursing and allied health and representation from dental, mental health, education and research, pharmacy, public health, the Primary Health Network and junior and senior medical officers.

CQ Health also introduced a GP (Great Partners) Newsletter to improve engagement with the primary care sector.

Effective information and patient pathways between General Practitioners and CQ Health are essential to deliver great care, great experiences and great patient outcomes.

The first edition was published in April 2018 and a new newsletter is shared with General Practitioners, and the Primary Health Network, every second month.

2.11. Close the Gap

CQ Health's strategic vision is ambitious – to close the health gap for Aboriginal and Torres Strait Islanders by 2030.

About 6% or 14,000 of our estimated population is Aboriginal and Torres Strait Islander and to Close the Gap would have a significant impact on a major portion of the population.

Low birth weights, high rate of smoking during pregnancy, high incidence of diabetes, failure to seek treatment, failure to attend an appointment, failure to remain at appointments and failure to continue the care regime are just some of the contributors of the 12-year gap in life expectancy for Indigenous Central Queenslanders.

Supported by state and Commonwealth government initiatives, CQ Health has developed a program to increase Indigenous health checks, improve diagnosis and access and provide culturally safe spaces. The physical environments of rural sites have been tested against the requirements within the Cultural Safety Framework 2010 to 2033 and a culturally safe place will be established at Rockhampton Hospital in 2018/2019.

Rockhampton Hospital welcomed the contribution of spectacular Torres Strait artwork which adorns part of the new Cancer Services Building (see picture Chapter 1).

The health service also developed a partnership with the Woorabinda community to develop a strategy that supports increasing the health and wellbeing of that community and supports increased community control over health.

Internal changes were identified to ensure health care, and engagement with the Indigenous community, was appropriate and encouraged participation in healthcare.

Newly developed Director of Indigenous Health and an Indigenous health engagement officer positions will be established following a review of competence, governance and Indigenous health structures in the organisation.

This Indigenous health structure will be further enhanced as CQ Health aims to deliver proportional representation of Aboriginal and Torres Strait Islanders in its workforce.

The 10,000 Lives program, discussed above, will be developed to include targeted support to improve Indigenous health. The smoking cessation project has already delivered a measurable response. While CQ Health has a 6% Indigenous population, almost 12% of people who have registered with Quitline from Central Queensland since 10,000 Lives was launched have identified as Indigenous.

2.12. Connected care

Just as Telehealth is revolutionising health care, the digital revolution will deliver significant improvements in the safety and quality of health care.

During 2017-18, CQ Health took the initial steps towards the introduction of service-wide integrated electronic medical records. This will allow medical records to be available in real time to any treating clinician in a public facility in Central Queensland.

It will provide instant access to diagnostic results as they are completed allowing more accurate and quicker diagnosis.

It will also connect a patient's care to the private sector with records available for viewing by General Practitioners and other private clinicians.

During 2018/2019, CQ Health will complete an information and technology infrastructure review to assess its readiness for the introduction of electronic medical records, with implementation to start in 2019/2020.

CQ Health will continue to seek other opportunities to utilise technology to improve care and experience.

2.13. Health system that is easy to navigate

The CQ Health Nurse and Midwife Navigator service grew during the reporting period, helping more patients and clients with complex health care needs to navigate the health system from their primary care provider, through the acute setting, outpatient and specialist care and to their home with, in some cases, community support.

Nurse and midwife navigators take a holistic approach to care, focusing on the entire healthcare journey and all health needs, rather than just on a specific disease or condition. This ensures patients and clients are directed to, and linked with, the most appropriate service where they are needed.

Partnerships with General Practitioners, pharmacies, allied health services and non-government organisations play an important role in meeting the patient and client needs and integrating care and service delivery. This includes linking a patient or client with existing services, but doesn't duplicate services already in place. The aim is to make the journey through the health system easier for the client and their family, and more efficient for the health service.

Those with multiple chronic illnesses benefit from the service, with more than 287 complex patients and clients experiencing this service.

The navigators educate clients through informed decision making, enabling them to understand and better manage their own health care, which:

- Increased client and clinician satisfaction
- Increased evidence of health management and advanced care planning
- Improved client health literacy
- Reduced unscheduled care presentations, admissions and readmission to a hospital

2.14. Public and Community Health

2.14.1. Offender Health

Offenders in correctional settings have been identified as a treatment and assessment priority in achieving Hepatitis C elimination by 2030.

The aim of the CQ Health collaborative is to assess and treat offenders with Hepatitis more quickly to prevent further transmission.

Key barriers to success included:

- Access to radiology
- Transportation offsite
- Staffing constraints and
- Delivering a Telehealth clinic in correctional health centre environment.

To overcome the barriers, a new referral process was developed, delivering a 61% increase in Hepatitis C treatment.

The collaborative project is close to eliminating chronic Hepatitis C infection at the Capricornia Correctional Centre.

2.14.2. CQ Youth Connect

Targeting Indigenous and high-risk Central Queensland youth aged 14 to 25 years, CQ Youth Connect delivered a range of services and achievements during the reporting period including:

- Establishing a second outreach youth sexual and reproductive health service clinic at Headspace in Gladstone helping more than 500 clinical clients and performing more than 700 health checks
- Co-ordinated the training of 4 nurses to implement a School Based Youth Health Service aimed at promoting the use of condoms and delivering a pregnancy testing program
- Launched culturally appropriate condom kits
- Developing partnerships to address: harm minimisation; smoking; develop life skills; and Indigenous youth health
- Provided professional development for 380 staff
- Delivered health education sessions to 6200 youth, and
- Hosted more than 12,000 visitors to health stalls

2.14.3. Public Health Unit

The Central Queensland Public Health Unit delivered a broad range of health prevention control measures – from controlling a mumps outbreak to surveying displays of kilojoules on menu boards and the trapping and testing of mosquitoes. The activities included:

Communicable Disease Control Unit:

- 55 cases of mumps in a Central Queensland community between 25 October 2017 and 9 January 2018 resulted in a mass vaccination program of 329 people between 21 and 29 November 2017
- 11 cases of mumps at Capricornia Correctional Centre between 17 December 2017 and 30 January 2018. Vaccination was offered to all inmates and staff and more than 400 doses administered
- 15 outbreaks of infective gastroenteritis, including one outbreak infecting 77 people, were managed and controlled
- 18 influenza outbreaks managed and controlled.

Immunisation and services to vaccine service providers:

- 1793 immunisation overdue reminders throughout CQ
- Vaccine preventable disease research
- Completed SMS Pre-Call pilot project in Gladstone, in which parents of Aboriginal and Torres Strait Islander children receive an SMS reminder five days before their babies are due to be immunised, won Public Health Association Australia National Immunisation Award in 2018. The program is now funded across CQ Health
- Ground-breaking research on Q Fever at Beef 2018 to gain insight into the existing knowledge of Q Fever and understand the potential barriers to deliver vaccination in the region. More than 80 participants completed a survey, and several interviews conducted to gain a deep understanding of the Q Fever vaccine uptake. This research was conducted in collaboration with CQ Public Health Unit, University of Sydney and Hunter New England Public Health.

Environmental Health Services:

- contributed to state and national research projects including:
  - Sampling of raw offal and chicken meat for the presence of Campylobacter and Salmonella on the meat and outer packaging to gain a better understanding of the sources of these bacterium in Australia

- Trapping mosquitoes at Emerald and Longreach to determine the viruses they carried, with West Nile Virus detected at Emerald and Ross River virus at Emerald and Longreach.

- Statewide legislation compliance projects including:
  - Kilojoule on the Menu Board survey
  - Smoke free environment enforcement compliance on public transport waiting points, skate parks, under 18 sporting events and building entrances
  - Audit of licensed poisons sellers, community pharmacies, mine sites for compliance with medicine and poisons regulation.
- Investigations, health risk assessment and provision of toxicological advice on environmental health issues including:
  - Mass gathering illness outbreak with over 300 participants including the administration of questionnaires, liaison with local government and community groups to isolate the outbreak and render impacted public premises suitable for use
  - Sampling of public potable water supplies for the presence of PFAS chemicals.

2.15. Health lifestyle improvement

The health lifestyle of Central Queenslanders is having a profound impact:

- Smoking rate a third higher than Queensland average
- Obesity levels 20% higher than Queensland average
- 15% more risky drinkers than state average
- 2-year life expectancy gap compared with the average Queenslander
- 12-year gap in Indigenous life expectancy

As a result of lifestyle-related chronic disease such as type 2 diabetes, cancer, heart disease and stroke, the demand on health services is outstripping the population growth.

Improving population lifestyle is a key element of Destination 2030: Great Care for Central Queenslanders and the 10,000 Lives project that supports it.

The 10,000 Lives smoking cessation project was initiated on November 1 2017, to address the high rate of smoking in Central Queensland where approximately 16.7% or 39,323 individuals reported to be daily smokers, compared to the Queensland average of 12%. One of the major goals of Destination 2030 is to reduce the smoking rate to 9.5% by 2030; in effect, saving 10,000 lives from smoking-related deaths.

The project was launched with 10,000 Lives tobacco summits held in Rockhampton, Yeppoon, Emerald, Biloela and Gladstone.

Representatives from local government, community organisations, business, education and Queensland Health collaborated to identify innovative ways to collectively achieve the objective of saving 10,000 lives, identifying support gaps and posing possible solutions.

Results indicate the project is creating a positive effect immediately with the number of Central Queenslanders registering on Quitline increasing by 112% in the 10 months since the project was announced – from 1359 registrations to 2885 registrations.

Innovative concepts have been successfully implemented such as the partnership with Triple M promoting a 24-hour challenge for World No Tobacco Day 31 May 2018. The challenge aired over ten days on radio and social media platforms resulting in a 135% increase in Quitline registrations - 154 referrals to Quitline in May 2017 vs. 362 in May 2018.

The 10,000 Lives campaign is being expanded to target lifestyle-related illnesses. In June 2018, 10,000 Lives became a weight loss, girth loss and healthy lifestyle campaign. The 10,000 Steps website was redeveloped to allow participants in a tournament between CQ Health and Mackay Hospital and Health Service to record progress.

There are plans for further expansion to include alcohol consumption.

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

Beef 2018, AgGrow, Romp in the Park for under 8s week, NAIDOC celebrations, sporting and community events are just some of events attended by some or all of the preventive health team that includes:

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

2.16. BreastScreen

BreastScreen promotional funding delivered an outstanding result with the 12,486 screens exceeding the service target.

On average, the team diagnosed 7 breast cancers a month. Of the women screened:

- 552 identified as Aboriginal and Torres Strait Islander
- 487 came from Culturally and Linguistically Diverse background (that is, 4% of women screened speak a language other than English at home)
- 10% had their first screen with us
- 654 were called back for extra testing.

2.17. Continuous improvement

CQ Health has an established Service Transformation team with a focus on continually improving systems and processes across the health service to develop and embed a CQ Way for delivering services to Central Queenslanders.

During the reporting period this small team focused intently on two major projects: Rockhampton Hospital Patient Flow Project; and CQ Health Maternity Project.

These projects were identified as two of the highest risk areas for CQ Health and their aims were:

- Patient Flow – to support an improvement in emergency patient access targets outlined through our Service Level Agreement; and
- Maternity – to support an improvement in Quality and Safety outcomes.

There have been qualitative and quantitative improvements made in both areas. These include improvements in patient access; communication and handover between clinicians; multidisciplinary team work; and discharge processes. This has been achieved through by standardising key activities and improving the way the multidisciplinary leaders of each unit work together.

The successes include:

Patient flow

- Patients transferred to medical ward sooner meaning short wait in emergency department
- Improved patient discharge rate and processes meaning more beds available for patients requiring admission
- Discharge summary completion reduced from two weeks to two days delivering better communication and clinical handover between the hospital and primary care clinician (usually General Practitioner).

Maternity

- Women presenting for antenatal care in first trimester increased to 60% in Rockhampton delivering better health outcomes
- Reduction in haemorrhage incidents and volume of blood loss post birth
- Development of a process to ensure women with a higher risk are transferred to appropriate facilities improving safety for women and baby.

Central Queensland Hospital and Health Service	Notes	2017-18 Target/est.	2017-18 Actual
Service standards Effectiveness measures Percentage of patients attending emergency departments seen within recommended timeframes:			
• Category 1 (within 2 minutes)		100%	95.9%
• Category 2 (within 10 minutes)		80%	84.7%
• Category 3 (within 30 minutes)		75%	82.7%
• Category 4 (within 60 minutes)		70%	89.2%
• Category 5 (within 120 minutes)		70%	97.2%
Percentage of emergency department attendances who depart within 4 hours of their arrival in the department		>80%	83.6%
Percentage of elective surgery patients treated within clinically recommended times:			
• Category 1 (30 days)		>98%	98.8%
• Category 2 (90 days)		>95%	97.9%
• Category 3 (365 days)		>95%	99.9%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	1	<2.0	0.37
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit		>65%	73.0%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	2	<12%	8.9%
Percentage of specialist outpatients waiting within clinically recommended times:			
• Category 1 (30 days)		98%	99.7%
• Category 2 (90 days)		95%	99.9%
• Category 3 (365 days)		95%	100%
Percentage of specialist outpatients seen within clinically recommended times:			
• Category 1 (30 days)		98%	94.9%
• Category 2 (90 days)		95%	95.6%
• Category 3 (365 days)		95%	96.6%
Median wait time for treatment in emergency departments (minutes)		20	11
Median wait time for elective surgery (days)		25	56
Efficiency measure	3	$5,083	$5,150
Average cost per weighted activity unit for Activity Based Funding facilities			
Other measures Number of elective surgery patients treated within clinically recommended times			
• Category 1 (30 days)		1,898	1,766
• Category 2 (90 days)		1,870	1,866
• Category 3 (365 days)		1,974	2,028
Number of Telehealth outpatient occasions of service events		8,555	11,107
Total weighted activity units:	4		
• Acute Inpatient		41,320	40,833
• Outpatients		10,461	9,966
• Sub-acute		4,501	3,690
• Emergency Department		14,294	14,045
• Mental Health		3,700	3,765
• Prevention and Primary Care		2,896	2,826
Ambulatory mental health service contact duration (hours)		>38,352	40,967

Notes:

All data is fiscal year to date 2017/18 unless otherwise specified.

1. Latest SPR data available is March 2018
2. Latest Mental Health data available is May 2018
3. Latest SPR data available is May 2018
4. Latest SPR data available is May 2018

Data Sources:
SPR
2018/19 SDS
Mental Health Key Performance Indicators

Chapter 3
Great people,great place to work

Board Chair Paul Bell presents the Chairman's Award for Outstanding Achievement to Dr Annette Turley at the MedRecruit 2018 CQ Health Staff Recognition Awards.

The Awards recognise the remarkable contribution made by CQ Health staff.

It takes great people to deliver great care and CQ Health is building a great place to work to attract and retain great people.

With our organisational values guiding our actions and interactions every day, we are building a supportive culture based on safety and trust.

Coupled with heightened opportunities of personal and career development, learning and education opportunities and a great quality of life for employees and their families, CQ Health has delivered great outcomes.

This is evidenced in the results of the 2017 Working for Queensland Survey. CQ Health recorded the greatest organisational improvement in Queensland Health and was among the most improved of all government agencies.

Those survey results are supported by CQ Health's own Pulse Survey, which has displayed continuous improvement in workplace pride and culture.

The success and improvements have been the focus of a small working party including the Health Service Chief Executive and Executive Director of Workforce which has developed and begun implementing a multi-platform strategy to deliver sustainable improvements and continued workforce satisfaction.

Those platforms included:

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

The momentum of improvement continues as the health service has set an ambitious but achievable goal of a similar or greater improvement in the September 2018 survey.

Likewise, our staff and the great things they do every day, were recognised at the CQ Health 2018 Staff Recognition Awards. The gala presentation night highlighted just a small part of the fantastic care, integrity, respect and commitment as well as teamwork, innovation and dedication our 3700 people display every day.

It is those great people who have delivered our outstanding results for 2017-18:

- No patient waiting longer than recommended for a specialist outpatient appointment, surgery or dental appointment
- One of the best emergency treatment times in Queensland
- More health services and services closer to home
- Preventive health initiatives such as our 10,000 Lives project
- The first year of our roadmap to Destination 2030.

Across the health service there were 3010 Full Time Equivalent (FTE) positions.

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

CQ Health workforce FTE:

	June FTE
Total	3010

3.1. Staff engagement

During 2017-18 CQ Health lifted staff engagement, and the effective use of their collective knowledge, wisdom and experience, to a new level.

Hundreds of staff were involved in the development, consultation and refinement of CQ Health's strategic vision Destination 2030: Great Care for Central Queenslanders. The vision provides clarity around future service planning and delivery, investment, development and sustainability for staff and the community.

Staff and the community were also consulted on the content of the CQ Health Strategic Plan 2018-2022, Consumer and Community Engagement Strategy, Clinician Engagement Strategy and Roadmap to 2020.

CQ Health hosted 91 electronic public and staff consultations on its internet platform during 2017-18 and received 3400 electronic responses. It also received email and written feedback. The CQ Healthwise Employee Health and Wellbeing Survey 2018 received the highest number of online responses from staff with 364.

As highlighted in Chapter 2, CQ Health increased its clinician engagement with the introduction of the CQ Clinical Senate and the CQ Clinical Council. Both will provide clinicians with direct engagement to the Health Service Chief Executive and the Executive Management Team.

Success is reflected in the 2017 Working for Queensland survey in which CQ Health showed the greatest improvement of all health services and one of the best improvements of all Queensland Government agencies.

3.2. Living our Values – Everyone Every Day

Embedding the organisation's values – Care, Integrity, Respect, and Commitment – continued as a priority as part of the commitment to cultural improvement and development of a great place to work.

Values identification is now normal practice with meeting agendas leading and closing with affirmation of the values. This encourages recognition of participants who have espoused one or more of the values since last meeting.

Recognition of our values in action are clearly visible in the Award categories, the improved culture of the organisation, and the staff satisfaction results in our surveys.

CQ Health staff readily wear their Values Shirts clearly identifying them as employees of CQ Health.

Embedding the CQ Health values – and the behaviours they represent – continued during 2017-18 with 75% of respondents to the June 2018 staff Pulse Survey supporting a renewed push to further acknowledge the accepted and expected behaviours in the workplace.

3.3. Recognition and Rewards

The second MedRecruit CQ Health Staff Recognition Awards and gala presentation night was outstanding and the judges highlighted their difficulty selecting three finalists from the field. Selecting a winner was more difficult.

The winners, announced on 26 July 2018, were:

- MedRecruit Team of the Year: Speech Pathology, Rockhampton Hospital
- CQ Radiology Employee of the Year: Maxine Ballinger
- Chairman's Award for Outstanding Achievement: Dr Annette Turley
- Chief Executive's Behind the Scenes Award: Andrea Dean
- CQ University Improvement and Innovation Award: Acute Care Team, Mental Health Alcohol and Other Drugs Service
- Primary Health Network Compassion Award: Julieanne Martin
- Triple M Central Queensland Community (People's Choice) Award: Maxine Sebbens
- Clinical Excellence Division Clinical Excellence Award: Susan Foyle and Robert Forsythe
- CQ Multicultural Association Inclusion and Diversity Award: Renal Services
- QSuper CQ Health Values Award: Karen Woods and Fiona Feder

3.4. Leadership

3.4.1. Leadership stability

Stability in the CQ Health Executive Management Team has delivered a continuity of direction and decision-making while contributing to the visibility of the team and its individuals.

During 2017-18 there were changes in two of the nine Executive positions

- A full-time incumbent was appointed to the Executive Director Medical Services position in June 2018. The internal appointment took effect I July 2018.
- The Director of Operations and Innovation position, which has had an acting appointment since January 2018, was redeveloped to Executive Director Strategy, Transformation and Allied Health to provide a strong voice for allied health professionals at the Executive level. Recruitment to that position started in July 2018.

3.4.2. Leadership Development

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

A full year of targeted leadership development programs have been implemented as a suite of programs was delivered to a wide cross section of staff. The leadership development activities included:

- Promoting Professional Accountability Clinical Program
- Mastering Safer and Reliable Practice Workshop
- Leading Reliability Improvement for Safer Healthcare
- Mentoring Program
- Executive Leadership Program
- Manage4Improvement Program
- Leader In Action Program
- Coaching Skills for Leaders Workshop
- Quarterly Leadership Summits
- Board and EMT Planning Workshop
- More than 100 staff undertook LEADS 360° Feedback

3.4.3. Leadership summits

CQ Health's leadership summits providing key development and networking opportunities continue to gain strength and produce results. Other health services have attended summits to gain an insight into their operation and success.

There were four leadership summits with more than 100 staff attending each during 2017-18. The key focus areas for these summits were:

- September 2017 – Empower. Engage. Enhance. Enable. The focus was on the Working for Queensland survey results and implementing initiatives to deliver Great people. Great place to work.
- December 2017 – Great people, Great Place to work. The focus was on the year that was and celebrating the achievements and looking at CQ Health's strategic direction
- March 2018 – Great care. Great Experience. The focus was on providing an overview for the Roadmap to 2020, a workshop on the internal pulse survey outcomes, and embedding the organisation's values - everyone everyday
- June 2018 – Sustainable future. The focus was on investing in our future (the next 12 months)

Each summit builds leadership capability and includes break-out sessions with participants involved in exploring innovations, discussing hot topics and identifying team building strategies and opportunities to take back to the workplace.

During the March 2018 leadership summit, attendees were asked why they were proud to be part of the CQ Health team. The answers included:

- Putting patients first
- Team aiming for safest care possible
- The quality of the care we provide...the commitment to each other
- Dedicated nursing staff...heart in right place
- Great talent we have
- How we look after each other
- Culture change...enthusiasm of staff to drive change

- We find a way to get the job done even when it's hard
- A shared commitment
- Proud of my team & very proud of our potential...use us!
- Great facility...team work...happy staff
- Team morale
- Dedication & effort of the team
- Proud of team working together
- Awesome team
- Constantly willing to try and improve
- Commitment to wanting to make a difference
- Being part of the incredible change towards excellence
- People get in and help each other
- Number of services on offer for the public

3.5. Clarity of role, purpose and vision

The development of Destination 2030: Great Care for Central Queenslanders – including the extensive staff consultation for the strategic vision and the supporting roadmaps – provides a clear direction for staff and the community and adds transparency to the decision-making process.

The projects and intent of Destination 2030 will inform staff Performance and Development plans.

3.6. Staff diversity

Diversity and inclusion was identified as a key focus area for our objective of Great People, Great Place to Work.

Using the Queensland Health Workforce Diversity and Inclusion Strategy as a foundation, there are seven identified diversity groups – people with disabilities, non-English-speaking backgrounds, women, mature age, youth, LGBTIQ, and Aboriginal and Torres Strait Islander peoples.

Due to the importance and magnitude of this objective, the Aboriginal and Torres Strait Islander workforce was the first of the priority groups in focus in 2017-18. The strategies and initiatives developed and implemented for that group will be the base to apply to the other priority groups.

During the year the health service introduced strategies to improve the accuracy of base line data and raised awareness of Equal Employment Opportunity data. This will allow the effectiveness of future strategies to be monitored against this baseline.

A Diversity and Inclusion Steering Committee has been established and a Diversity Dashboard will be developed to increase awareness of the data and targets.

During the reporting period, CQ Health achieved the Queensland Health 2022 target of 3% of staff identifying as Aboriginal and Torres Strait Islander peoples, reflecting an ability to improve diversity in our workforce.

CQ Health also supported career development opportunities, staff access to scholarships and course funding, and Diversity Council Australia training for Diversity and Inclusion Steering committee members.

For example, there has been significant investment in the Indigenous traineeship program with six trainees across Central Queensland including:

- Two trainees will complete the traineeship and vocational education qualification by December 2018
- Three trainees will complete traineeship and vocational education qualification by 2018/2019
- One participant in an Indigenous Apprenticeship and expected to complete by 2020.

One trainee has been nominated for the 2018 Queensland School-Based Trainee of the Year Awards as part of the Queensland Training Awards.

3.7. Staff Health, Safety and Wellbeing

The health, safety and wellbeing of our staff is a cornerstone of delivering a great place to work. The achievements during the reporting period highlight significant and ongoing improvements.

An overall indication of workplace safety improvement is a fourth consecutive year of WorkCover premium reduction. Other initiatives and achievements include:

- successful rehabilitation and return to work programs that have delivered better outcomes for staff
- implementation of a statewide, simple-to-use incident management system called RiskMan ensuring accurate reporting and analysis of incidents
- completion of a robust workplace health and safety audit to identify trends or risks and put in place mitigation measures
- delivered well-supported Safety and Wellness Expos during October 2017 to promote health and wellbeing to staff across Central Queensland
- finalisation of a CQ Health Wellbeing Strategy to ensure continued improvements for staff
- expansion of the CQ Health Fitness Passport to include more fitness facilities in the Gladstone and Emerald regions offering discounts to staff. There are more than 350 active staff memberships and 650 total members which includes partners and dependants
- delivery of monthly toolbox talks and a CQ-wide roadshow to provide staff assistance, information, support and updates
- CQ-wide roadshow encouraging staff involvement in the 10,000 Lives health challenge
- A pilot program in Rockhampton and Gladstone hospital's operational services departments aiming to reduce the frequency and severity of musculoskeletal injuries in operational services staff
- ongoing improvements to prevent occupational violence including Aggressive Behaviour Management Instructors meeting with the Metro North Protective Services team in December 2017 to review its Occupational Violence Prevention training against CQ Health's Aggressive Behaviour Management program.

3.8. Public Service Code of Conduct

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

1. Integrity and impartiality

2. Promoting the public good

3. Commitment to the system of government

4. Accountability and transparency

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

Code of Conduct training incorporates the principles of the Public Sector Ethics Act 1994 and was delivered on a regular basis for staff across the health service over the reporting period. It is a mandatory requirement for staff to complete compulsory refresher training every 2 years.

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

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

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

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

3.9. Our Organisation

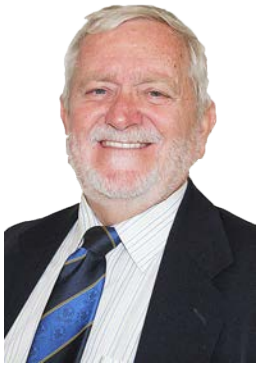
3.9.1. Board

Cr Paul Bell AM

Board Chair, Central Queensland Hospital and Health Board

Date of original appointment: 25 September 2015

Current term of office: 18 May 2017 - 17 May 2020



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

Mr Bell is chair of the Central Highlands Healthcare Ltd Board and a director of the Central Highlands (Qld) Housing Company Ltd. He presently serves as a Councillor on his local council, a position he has held continuously for the past 33 years.

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

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

Mr Graeme Kanofski PSM

Board Member (Deputy Chair), Central Queensland Hospital and Health Board

Date of original appointment: 18 May 2013

Current term of office: 18 May 2017 - 17 May 2019

Mr Graeme Kanofski has 36 years of experience in local government in Queensland, including five years as Chief Executive Officer of the Gladstone Regional Council. He holds a Bachelor of Business degree and has served as President of Local Government Managers Australia.

Mr Kanofski is a well-respected local who has an extensive career history in local government and associated organisations in the Gladstone region. He has studied local government management in El Segundo City in the USA and in the United Kingdom and has a wealth of experience in local government organisations, including: the State Emergency Service, Council Disaster Response Management, Local Government Managers Australia, Gladstone Regional Council, Calliope Shire Council, Director – Gladstone Economic and Industry Development Board, Port Curtis Alliance of Councils and Australian Airport Owners Association.

Mr Kanofski has received a number of awards for his contributions to local government and the public service and has owned and operated small businesses in the Gladstone region. Mr Kanofski retired in 2011 and now resides in Calliope.

Mr Frank Houlihan

Board Member, Central Queensland Hospital and Health Board

Date of original appointment: 9 November 2012

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

Mr Frank Houlihan has 39 years' experience in public accounting practice and is currently the Managing Director of HHH Partners a Chartered Accountancy firm he established in 1986. He holds Bachelor of Commerce and is a Fellow of Chartered Accountants Australia and New Zealand.

Mr Houlihan is also a Director of Central Queensland Rural Health (Registered Charity) and its wholly owned subsidiary Rural Health Management Services Pty Ltd. Both organisations are focused on providing health services to rural communities in Queensland.

His current professional memberships are: Chartered Accountants Australia and New Zealand, The Tax Institute, Tax & Super Australia, CPA Australia and the SMSF Association.

Professor Leone Hinton

Board Member, Central Queensland Hospital and Health Board

Date of original appointment: 29 June 2012

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

Professor Leone Hinton was appointed to the position of Director Corporate Strategy, Planning and Risk, Central Queensland University in 2016. Previously she was the Dean of the School of Nursing, Midwifery and Social Sciences. She has worked at CQUniversity for 30 years. Professor Hinton's expertise in management was recognised in 2010 and again in 2017 where she was awarded the Australian Institute of Managers and Leaders Central Queensland Professional Manager of the Year. Her interests are in organisational culture, change, evaluation, strategic planning and risk management and has a passion in improving health outcomes of people who live in regional, rural and remote Australia.

Professor Hinton began her career as a Registered Nurse working at the Rockhampton Hospital and Mater Hospital before changing career paths to nursing training, education and research at the CQUniversity. Leone is a Fellow of the Australian Institute of Leaders and Managers and the Australian Institute of Governance. Professor Hinton has a Doctor of Professional Studies (Transdisciplinary), a Masters of Education (Education Administration) and Graduate Diploma in Tertiary Education and is a Justice of the Peace.

Ms Karen Smith

Board Member, Central Queensland Hospital and Health Board

Date of original appointment: 18 May 2013

Current term of office: 18 May 2017 - 17 May 2019

Ms Karen Smith is the Nurse Unit Manager for the Intensive Care Unit at Rockhampton Hospital and has held that position since 1993. She has an extensive career in intensive care units across Australia and is an active

member of the Rockhampton community.

Ms Smith began her nursing career as a student nurse at Rockhampton Hospital and chose to specialise in Intensive Care nursing soon thereafter. She has worked at Royal Melbourne Hospital, various Brisbane hospitals and at Rockhampton Hospital. She is a member of a number of specialist groups, including: the Australian College of Critical Care Nurses, the Central ICU Clinical Network and the Paediatric Intensive Care Advisory Group.

Ms Smith is a Registered Nurse and has a postgraduate Certificate in Critical Care Nursing from the Royal Melbourne Hospital. She is an active member of the local equestrian community.

Ms Elizabeth Baker

Board Member, Central Queensland Hospital and Health Board

Date of original appointment: 18 May 2013

Current term of office: 18 May 2017 - 17 May 2019

Ms Elizabeth Baker is an experienced commercial/corporate lawyer with experience in Australian and international business conventions.

Ms Baker has a Bachelor of Law, Masters of Law, Graduate Certificate of Employment Relations and has published numerous papers on various topics relevant to employment relations.

She has served on a number of community boards, including the Gladstone District Health Council and Gladstone Airport Corporation. Ms Baker's professional memberships include: Queensland Law Society, Queensland Industrial Relations Society, Australian Corporate Lawyers Association and Resources and Energy Law Association.

Ms Baker is currently employed as general counsel for Queensland Alumina Limited at Gladstone and is an active member of the Gladstone community.

Dr Poya Sobhanian

Board Member, Central Queensland Hospital and Health Board

Date of original appointment: 17 May 2016

Current term of office: 18 May 2017 – 17 May 2021

Affectionately known as "PJ" by his local patients, Dr PJ Sobhanian's passion is a healthier CQ. PJ is a University of Queensland (UQ) trained Dentist, who completed his placement at the local hospitals of Rockhampton, Yeppoon and Emerald. He later served at Gladstone Oral Health Services before establishing Sunvalley Dental P/L in Gladstone, where he remains the Managing Director.

PJ has extensive Board, advisory and oversight committee experience, including the Gladstone Regional Council Business Improvement Committee (Internal Audit), the UQ Academic Board and the UQ Faculty of Health and Sciences Board of Studies.

PJ strongly believes in caring for our community and working together to achieve sustainable and sound outcomes for our community. These

principles led him to be elected as a Councillor on the Gladstone Regional Council.

In his spare time PJ enjoys watching football with family and friends. He currently resides in Boyne Island.

Dr Anna Vanderstaay

Board Member, Central Queensland Hospital and Health Board

Date of original appointment: 17 May 2016

Current term of office: 18 May 2017 – 17 May 2021

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

Ms Lisa Caffery

Board Member, Central Queensland Hospital and Health Board

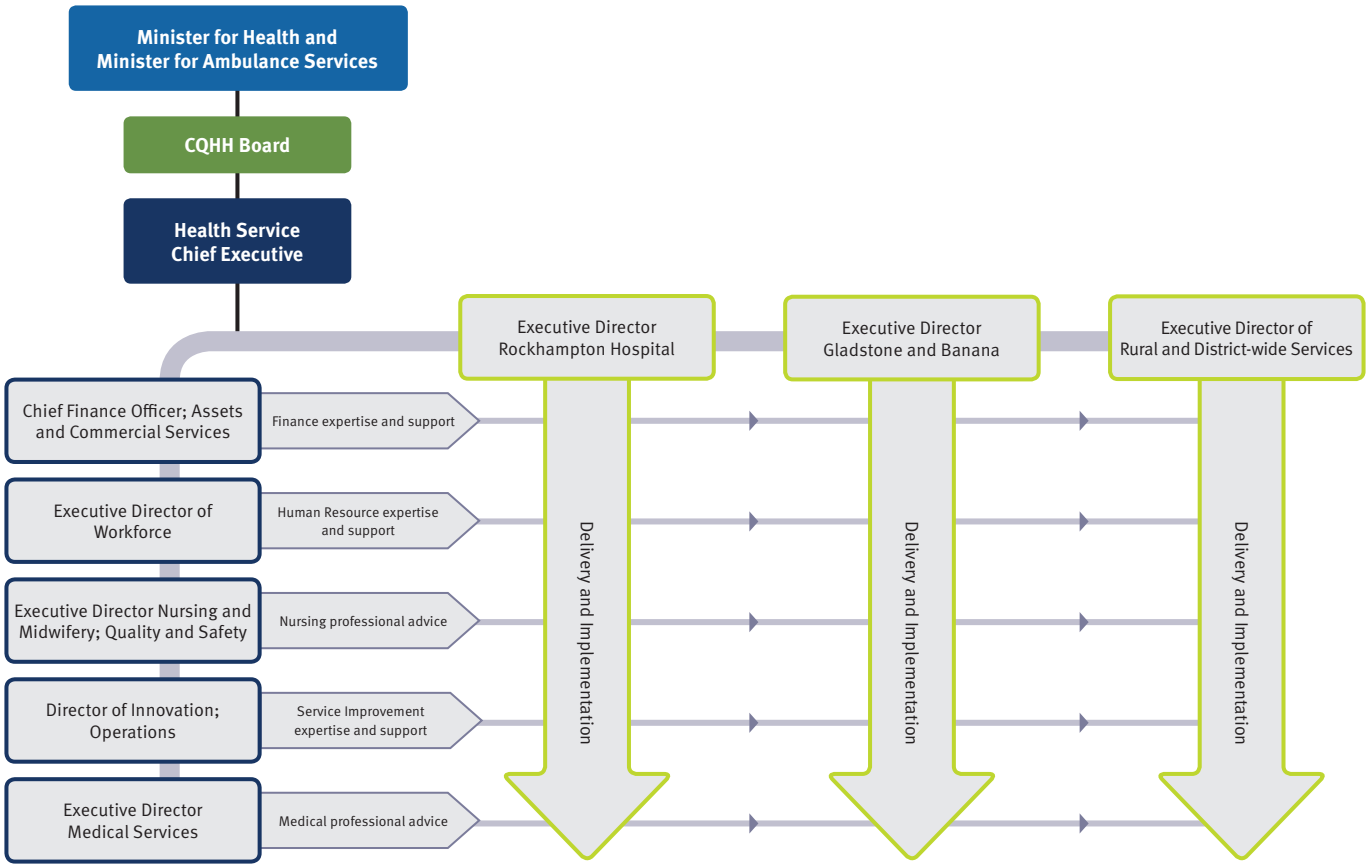
Date of original appointment: 17 May 2016

Current term of office: 18 May 2017 – 17 May 2021

Mrs Lisa Caffery is a highly experienced, analytical and strategic professional in the specialist field of social impact and community engagement. Lisa is a self-employed consultant with leadership and governance experience across the private and public sectors. She has held numerous advisory and strategy development roles in mining, local government, not-for-profit and regional development sectors. In January 2018, Mrs Caffery was awarded a Research Higher Degree Scholarship from Central Queensland University to undertake a Doctor of Philosophy (PhD). Lisa's research focus is in health, rural and regional communities and social impact. Mrs Caffery holds a Bachelor of Arts (Journalism), a Master of Public Relations and is a graduate of the Australian Institute of Company Directors. Lisa resides in Emerald and is committed to enhancing health services and outcomes for people living in rural and regional areas.

3.10. Executive

3.10.1. Executive Structure



3.10.2. Executive Leadership

Chief Executive
Steve Williamson

Steve Williamson was appointed Health Service Chief Executive effective from 9 January 2017.

Mr Williamson moved from the United Kingdom where he had an extensive background at the Executive level in the National Health Service, including roles as Chief Executive, Group Deputy Chief Executive, and Chief Operating Officer.

He also worked for some time in the equivalent of local government, and as an Area Director in the UK's legal court system. Previously, Mr Williamson was an officer in the UK's Royal Navy, and spent much of this time as a Diver and Bomb Disposal Officer, including commanding a counter terrorism bomb disposal service.

Executive Director Medical Services
Dr Annette Turley

Responsible for provision of medical leadership and support throughout CQ Health. Chair of the CQ Clinical Council responsible for developing and maintaining the Clinical Services Master Plan for the health service.

Chief Finance Officer
Muku Ganesh

Responsible for the provision of strategic advice on budget allocations, auditing and performance monitoring against the Service Level Agreement. Responsible for capital development program, asset management and maintenance programs of equipment and buildings, fleet and accommodation management.

Executive Director of Nursing and Midwifery, Quality and Safety
Sandy Munro

Responsible for nursing and midwifery practice, strategic nursing and midwifery workforce, nursing and midwifery standards of practice, workload processes and education. Responsible for the quality and safety systems and clinical governance across the health service.

Executive Director Rural and District Wide Services
Kieran Kinsella

Responsible for health service delivery in rural areas of Central Queensland, and the delivery of health services in the community, Capricornia Correctional Centre, residential aged care facilities, Mental Health Alcohol and Other Drugs Service.

Executive Director Rockhampton Hospital
Wendy Hoey

Responsible for health service delivery at Rockhampton, Capricorn Coast and Mt Morgan hospitals.

Executive Director Gladstone and Banana
Jo Glover

Responsible for health service delivery at Gladstone and Banana region hospitals.

Executive Director Workforce
Peter Patmore

Responsible for human resources, organisational development and workplace health and safety.

Director of Operations and Innovations
Kerrie-Anne Frakes

Responsible for organisational improvement and innovation through the systematic application and development of lean approaches to quality improvements in the health service.

Chapter 4
Great partnerships

CQ Health Chief Executive Steve Williamson and Frenchville Sports Club Capricorn Claws Captain Tia Konui.

Sports teams across the region partnered with CQ Health to promote the 10,000 Lives movement and smoke-free lifestyles.

Delivering safe, sustainable and innovative health care requires effective partnerships that reduce duplication and fragmentation while delivering an easily navigated patient journey.

Education, training, skill development, career opportunities, research, innovation, expertise, economies of scale, service delivery – partnerships have a place in every aspect of health care.

The most important partnerships are those with patients, consumers and staff.

Partnering with our patients and consumers in the delivery of their health care is essential to achieve Great Care and Great Experience. This partnership requires information, communication, consultation and education specifically tailored to the needs of the individual.

CQ Health recognises the face-to-face engagement of our patients and consumers is critical to the success of this partnership and CQ Health staff receive Communication and Patient Safety training.

Delivery of Great Care is a partnership between CQ Health and its employees. The development of a values-based culture that delivers a great place to work and pride in the health service creates an effective team that meets the health needs of the community in a safe and sustainable way.

CQ Health has many effective partnerships such as:

- Tertiary health facilities such as Lady Cilento Children's Hospital, Princess Alexandra Hospital and Royal Brisbane and Women's Hospital, for the partnered delivery of health services in Central Queensland or for the treatment of CQ Health patients in Brisbane
- Primary Health Network for the delivery of co-ordinated care and effective health care pathways between General Practitioner to the public subacute and acute care sector
- Universities and education organisations to deliver effective education, training and upskilling of existing and potential staff
- CQUniversity for the training and development of students and CQ Health staff at the Sub Acute Chronic Care and Rehabilitation clinic at the Rockhampton campus
- University of Queensland and James Cook University for the training of medical students in Central Queensland
- CQ Radiology for the provision of medical imaging across Central Queensland
- GenesisCare for the delivery of radiation oncology and other cancer treatments for Central Queenslanders
- Australian Defence Force for the training of nursing staff in Central Queensland
- Queensland Nursing and Midwifery Union, Together Union and other industrial representatives to ensure the respect of employees working conditions
- Mental health, disability and other community service providers, such as Mind Australia which will provide the service at CQ Health's Step Up Step Down mental health facility in Gladstone when it opens in 2018.

4.1. Medical School

CQ Health is developing new and exciting partnerships as part of its continual improvement philosophy.

It recently announced it was working with CQUniversity and Wide Bay Hospital and Health Service to research the feasibility of establishing a medical school.

As highlighted above, CQ Health actively supports the University of Queensland Rural Clinical School by helping to train fourth year medical students at its Central Queensland facilities.

Success of the proposal to establish a CQUniversity medical school would deliver locally based and locally trained medical students providing a true "bush to beach" experience such as Indigenous health and rural and remote health.

Research indicates doctors who train in regional areas are more likely to stay in regional areas, highlighting the importance of CQ Health support for the training of medical students.

4.2. 10,000 Lives

Delivery of the 10,000 Lives project relies on effective partnerships with existing experts in the field.

The smoking cessation strand is effective because of the partnership with Queensland Health's Quitline, which offers expert advice through to nicotine replacement therapy to help people to kick the habit. Its effectiveness will also rely on partnerships such as:

- Employers, business and industry groups to discourage smoking in the workplace. Business partnerships include Austrak-Parkhurst which launched 10,000 Lives to employees resulting in Quitline referrals, an updated onsite smoking policy and a men's health week where workers had a chance to use the 'smokerlyzer' to test their carbon monoxide level due to smoking.
- Media such as the partnership with Triple M for a 24-hour challenge for World No Tobacco Day May 2018. The challenge aired over ten days on radio and social media resulting in a 235% increase in referrals to Quitline compared to May 2017.
- Sporting groups and organisations to establish venues as smoke-free and for their athletes to promote smoke-free lifestyles. This has delivered the 'CQ Health's Spotlight on a Sports Star' in partnership with the State Cup representative sports teams with weekly social media posts highlighting a local positive role model communicating their healthy smoke-free messages.
- Local, Queensland and Commonwealth governments to promote smoke-free and quitting options and introduce bylaws and legislation that provide smoke-free environments and discourage smoking.
- Many other valuable partners have joined 10,000 Lives to contribute their expertise to influence the smoking rate target including: University of Queensland Public Health Unit, Primary Health Network, Rotary clubs, Central Queensland education departments and schools and regional councils.

CQ Health has identified key partnerships it will develop during 2018/19 including:

- Partnership agreements to deliver the "talent pipeline" process to grow our own staff
- A strategy to significantly expand health education in Central Queensland with our education partners
- Review partner agencies capability to partner CQ Health to deliver Destination 2030 Closing the Gap targets.

Chapter 5
Great learning and research

Nurse Researcher CQ Health and CQUniversity Tracy Flenady, CQ Health Nursing Director Education and Research Julie Kahl, Professor Trudy Dwyer (CQUni), Assoc Professor David Shaker (UQ Rural Clinical School), Professor Grant Stanley (CQUni) and CQ Health Chief Executive Steve Williamson celebrate the launch of the Research Ready program.

CQ Health's vision for learning and research is clear. By 2030, CQ Health:

- Will be a great place to learn for all our staff and trainees across our service, with our people applying knowledge and skills to support safety and quality.
- Will have a great research program and reputation of translating that research quickly into new clinical practices to improve patient and consumer experience and outcomes.
- Will have an inherent culture of embracing and supporting teaching, training and research for all professional disciplines.

To deliver that vision, CQ Health is developing internal programs and external partnerships that will enhance the opportunities for research and to translate the research into practice.

To ensure CQ Health meets the needs of the service into the future, a review of education and research provision across the health service has been sent to tender and will be finalised in late 2018.

CQ Health is part of a team appointed by Queensland Health to lead a statewide research project to validate the Queensland Adult Deterioration Detection System. Nursing Director of CQ Health's Education and Research Unit Julie Kahl joined CQUniversity researchers Associate Professor Trudy Dwyer, CQ Health Nurse Researcher and CQUniversity lecturer Tracy Flenady, Dr Danielle Le Lagadec, Associate Professor Tania Signal and Associate Professor Matthew Browne for the project.

Observation charts used in most Queensland hospital wards use the colour-coded detection tool to track when a patient is deteriorating and to trigger a response.

Patients can deteriorate over several hours or even days while in hospital. Without early warning tools, clinicians might not recognise the signs or might fail to respond appropriately. That system being researched detects deterioration early, and provides clinicians with escalation protocols aimed at improving patient outcomes. For example, the tool highlights when a patient's blood pressure reaches a certain level, along with other factors, that the nursing staff should escalate their concern and gives them a clear path to follow.

The project aims to identify whether the tool is sensitive enough to detect adult clinical deterioration.

5.1. Reskilling, Refresher and Re-Entry program

CQ Health started three programs to support registered nurses, midwives and enrolled nurses to re-enter the workforce in a hospital setting. The project was funded by the Office of the Chief Nursing and Midwifery Officer to establish the processes with a view to implementation across Queensland.

The reskilling program was launched on 29 January 2018 and based on the successful program implemented in Mackay. The reskilling program consists of one week of education using simulation, facilitated workshops and lectures; and two weeks of supervised practice in a clinical area.

The refresher program was designed for Registered or Enrolled Nurses or

Registered Midwives who have had between 3 and 5 years continuous break from the nursing profession, who require a period of upskilling to ensure safe practice. Clinical supervision is provided in the clinical area based on an individualised learning plan.

The program is for Registered and Enrolled nurses or Registered Midwives who have not practised for 5 to 10 years who wish to resume nursing or midwifery practice.

5.2. Joint appointments

Joint appointments are a valuable tool because they work to improve collaboration between institutions, utilising the strengths of each organisation. They are also a strategy to foster excellence in education, clinical practice and to promote clinically relevant translational research.

An example of effective joint appointments was Professor Trudy Dwyer being appointed Visiting Nursing Research Fellow, a joint appointment between CQ Health and CQUniversity. The aim of this position is to progress the nursing research agenda, and to encourage CQ Health clinicians to engage in research that will lead to best practice and safer care. The link between best practice, patient outcomes and patient safety is widely acknowledged.

The new partnership will build on strong relationships that already exist with CQUniversity, formalising the processes. Having the role based on campus one day a week delivers the opportunity to target research ideas, provide mentoring to staff interested in research and continue to develop research development initiatives. The first major project the partnership delivered was the Research Ready Grant Program.

5.3. Research Ready

The appetite of CQ Health staff to be part of learning and research is evidenced best by the reaction to the introduction of the Research Ready program.

CQ Health, CQUniversity and the University of Queensland Rural Medical School joined to deliver a Research Ready Grant Program for interested researchers and research groups. The program had the aim of stimulating the development of a strong research and education culture across CQ Health in keeping with the strategic intention of Destination 2030.

The program adopted a collaborative approach by means of a combined mentor program and educational process for aspiring researchers in CQ Health. The program culminated in a round of competitive grant funding for projects emanating from the research ready workshop portion of the program.

Six teams were expected to be part of the initial program, but 24 multidisciplinary teams took part.

It began with an 8-week research skills workshop aimed at developing participant research concepts and ideas into formal grant submissions. Research active staff worked with participants to refine their research questions and methodologies in a series of lectures/seminars. Each participant or team was paired or mentored with a research active staff member who assisted with the development of the grant submission.

A formal grant submission was made to the committee for formal peer review. The benefits of the program included:

- Innovative research capacity building across CQ Health
- Creation of awareness of research possibilities and support
- Clinical practice impact – data and lessons learned will allow for the enhancement and refinement of current clinical care
- Will contribute to clinical training across CQ Health
- Substantial recruitment and retention impact
- Collaborative impact: will encourage extensive collaboration across all the stakeholders involved
- State and national health strategy alignment
- Future research impact
- Downstream revenue generation from research

Nine research teams were successful in receiving grant funding. The first outcomes of their projects will be on show at the Innovation and Research Showcase in November and a new cohort join the program in 2018/2019.

5.4. Human Research Ethics Committee

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

The committee reports annually to the health and medical research council and remains a non-certified committee. The committee continues to meet monthly to review research proposals and convened a special meeting to consider research proposals submitted by participants of the Research Ready Grant Program.

5.5. Education through simulation

Education provided through simulation is an effective teaching and learning strategy where clinical practice is replicated in a safe environment. Simulated learning experiences enable practice of multidisciplinary teamwork, communication and crisis resource management principles in realistic situations. CQ Health will enhance simulation education capability locally with world class resources through expansion of our pocket centre network across Gladstone, Banana and Central Highlands.

The Education and Research Unit delivered more than 295 programs across 15 CQ sites. This was mostly clinical training.

5.6. Beach to Bush

CQ Health began development of a Beach to Bush framework that will support recruitment, development and retention of nurses in rural facilities. The program is in its final stages of development and will target graduate and experienced nurses who may be new to rural nursing.

Experiential and academic incentives are provided to attract nurses to rural practice. Registered Nurses will be rotated through different facilities to grow their experiential knowledge and to ensure equal access to training and learning experiences.

5.7. Postgraduate Programs

To build on the Destination 2030 vision of being an employer of choice, CQ Health introduced the Masters of Clinical Nursing program in partnership with CQUniversity and Mackay and Wide Bay health services.

The program has been specifically designed to build on existing graduate programs and provide an opportunity to achieve an academic award at the end of 12 months. The program was specifically designed for the beginning practitioner and focuses on development of critical thinking and clinically relevant skills.

Simulated assessments have been incorporated into our existing graduate study days so all graduate staff benefit from the course structure, whether they are completing the formal university program or not.

Postgraduate qualifications are linked to significantly improved patient outcomes and are therefore highly desirable in our workforce.

5.8. Books to Bedside

Another joint initiative between CQUniversity and CQ Health is the Books to Bedside course, designed to assist graduate nurse integration into the healthcare workforce. Survey data showed nursing students found integration difficult and stressful due to theory not been translated into clinical skills, lack of confidence with clinical skills, inequity in clinical placement opportunities as a graduate nurse, and perceived lack of support.

This course is simulation based, with some lecture-style learning, covering high-risk nursing procedures as identified by the nurse educator team.

The results have been very positive with participating students expressing increased confidence, increased knowledge, improved workplace readiness, and an easier integration into the workplace as reported by CQ Health staff. This course has become a regular feature.

5.9. Communication and Patient Safety Program

Communication breakdown is a recognised factor in almost all cases of patient harm, internationally. The commitment to improving patient safety across the organisation has been clearly demonstrated through the implementation of the nationally recognised Communication and Patient Safety program as a requirement of all staff.

The key underlying principle of this program is that everyone in CQ Health is trained, regardless of role, because everyone contributes to the ‘communication culture’ of a work area and should be supported to speak up when they have a concern. The interactive program continues to prove popular with staff across the organisation.

Chapter 6
Sustainable future

Construction of the Rockhampton Hospital 597-space $25.5 million car park started in late 2017 and is on target for completion by the end of 2018.

Tender for the $42 million, 26 treatment bay Gladstone Hospital Emergency Department is expected to be released in September 2018 with the main contract to be awarded in December 2018.

Achieving a sustainable future requires success in each of the four previous strategic objectives – and more.

To be sustainable, a service must be:

- Safe
- In sufficient demand from patients/consumers. This delivers economy of scale and ensures clinicians are able to maintain their skills and currency of practice
- Able to recruit new staff and upskill existing staff to maintain the appropriate number of staff with the right skills at the right time
- Committed to continual improvement to deliver contemporary and evolving care
- Cost effective, efficient and affordable
- Supported by the appropriate capital infrastructure and technology
- Able to function, or quickly return to function, during adverse events.

All elements of sustainability must be delivered using a finite funding allocation. CQ Health uses efficiencies and savings to invest in delivering the ambitions of Destination 2030: Great care for Central Queenslanders.

During 2017-18, CQ Health met or exceeded all its KPIs though it overspent its budget by 0.75%. The health service vision is to deliver a 1% surplus each year and to support this vision it has developed a 5-year financial model.

The financial model will be supported by a Clinical Services Master Plan and Infrastructure Master Plan to identify future service and infrastructure needs, ensuring planned and targeted investment.

The health service has also invested in the development of disaster preparedness including the development of rural resilience master plans for key sites in preparation for disaster and severe weather events. Born from the successful management and maintenance of Tropical Cyclones Debbie and Marcia and resulting flooding, the master plans support the continuity of services in rural, regional and potentially isolated areas.

6.1. Infrastructure

6.1.1. Rockhampton Hospital Car Park

Construction of the Rockhampton Hospital 597-space $25.5 million car park started in late 2017 with alternate park-and-ride services established from CQUniversity's TAFE site and an area of land on North Street.

The first suspended concrete floor was poured on 20 June 2018 and the project is on target for completion by the end of 2018.

The project is jointly funded by the Commonwealth and state governments and, when completed, will address parking and access issues for Rockhampton Hospital campus patients, consumers and staff.

6.1.2. Gladstone Hospital Emergency Department

The tender for the $42 million, 26 treatment bay facility is expected to be released in September 2018 with the main contract to be awarded in December 2018. Construction is scheduled to be completed in early 2020.

6.1.3. North Rockhampton Nursing Centre

An $8.4 million upgrade at the North Rockhampton Nursing Centre includes a full refurbishment of the existing 40-bed residential aged care wing, roof repairs and bathroom alterations in the Ivy Baker and Westwood wings. This work is expected to be completed in December 2018.

The kitchen is also being refurbished, with the work to be completed in November 2018.

6.2. Emergency Preparedness and Disaster Resilience

Rockhampton Hospital was the pilot site for Queensland, and possibly Australia, for a World Health initiative which evaluated the hospital and its ability to respond during and after a major incident. Rockhampton Hospital received an "A" rating which is now the benchmark for all Queensland hospital and health services.

The learning from the Hospital Safety Index undertaken with the Health Disaster Management Unit has been incorporated into CQ Health's suite of disaster plans.

The safety index is one of a range of activities and initiatives being implemented across Queensland Health's disaster arrangements, with the goal of 'Building a resilient health system'. It is an internationally applied risk and readiness assessment tool providing a rapid, reliable and low-cost diagnostic tool to measure hospital disaster and emergency incident risk and readiness.

To build the resilience of CQ Health communities, Mass Casualty Incident Plans and Business Continuity Plans have been developed for all multi-purpose health services to ensure they are able to respond to any external disaster until support arrives.

CQ Health also supported a range of events and preparedness exercises including:

- Four days at the State Health Emergency Operations Centre for four days during the Commonwealth Games
- Multi-agency counter terrorism table top exercise in Rockhampton
- Multi-agency table top exercise with an organic phosphate scenario impacting the town of Biloela which required evacuation of hospital patients
- Rockhampton Hospital Emergency Department Mass Casualty Incident Plan tested
- Live exercise at Theodore MPHS to test the multi-agency response to a mass casualty incident.

6.3. Governance

6.3.1. Committees

The Central Queensland Hospital and Health Board has met 11 times since July 2017 and meets monthly.

The Board has four committees – Executive Committee, Finance and Resource Committee, Safety and Quality Committee and Audit and Risk Committee.

Whilst committees are required to meet on a quarterly basis the Finance and Resource Committee has met monthly during 2017-18, the Safety and Quality Committee met five times in preparation of periodic survey and the Executive Committee met 6 times to progress the CQ Health strategic planning process.

The out-of-pocket expenses recorded during this period was $34,711.78.

Executive Committee

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

Finance and Resource Committee

Chaired by Mr Frank Houlihan, the Finance and Resource Committee is responsible for monitoring and assessing the financial management and reporting obligations of the health service. It oversees resource utilisation strategies including monitoring the service's cash flow and its financial and operating performance. The committee is also responsible for bringing the attention of the Board to any unusual financial practices. The Finance and Resource Committee works in close cooperation with the Health Service Chief Executive and Chief Finance Officer.

Safety and Quality Committee

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

Audit and Risk Committee

Members of the Audit and Risk Committee as at July 2017 comprised:

- Chair: Ms Elizabeth Baker
- Dr Poya Sobhanian, Board Member
- Mr Frank Houlihan, Board Member
- Cr Paul Bell AM (ex-offico as Board Chair)
- Steve Williamson (standing rights of attendance as Health Service

Chief Executive)

- Muku Ganesh (standing rights of attendance as Chief Finance Officer)
- Sandy Munro (standing rights of attendance as Executive Director Quality and Safety)
- Lee Peters and Christopher O'Brien (standing rights of attendance as Internal Audit)
- Josh Langdon, Megan Ormes and Steve Stavrou (standing rights of attendance as External Audit)
- Ron Willett (invited as Project Officer – Audit and Monitoring)

As members of the Board Ms Baker, Mr Houlihan and Dr Sobhanian are remunerated for their services to the committee.

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

The Audit and Risk Committee met seven times during the 2017-18 period and followed an approved work plan reflecting the committee's charter.

The role of the committee is to provide independent assurance and assistance to the Board in the areas of:

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

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

Financial statements

- Reviewing the appropriateness of the accounting policies adopted by the health service and ensure they are relevant to the health service and its specific circumstances.
- Reviewing the appropriateness of significant assumptions and critical judgements made by management, particularly around estimations which impact on reported amounts of assets, liabilities, income and expenses in the financial statements.
- Reviewing the financial statements for compliance with prescribed accounting and other requirements.
- Reviewing, with management and the external auditors, the results of the external audit and any significant issues identified.
- Exercising scepticism by questioning and seeking full and adequate explanations for any unusual transactions and their presentation in the financial statements.
- Analysing the financial performance and financial position and seek explanation for significant trends or variations from budget or forecasts.
- Ensuring that assurance with respect to the accuracy and completeness of the financial statements is given by management.

- Integrity oversight and misconduct prevention.
- Providing oversight, direction and guidance on the health service's integrity framework to ensure it is functioning appropriately.
- Overseeing the health service's Lobbyists Contact Register reporting and any significant integrity issues arising.
- Monitoring the effectiveness of the health service's Public Interest Disclosure process.
- Ensuring the health service complies with relevant integrity legislation (e.g. *Crime and Misconduct Act 2001*, *Public Sector Ethics Act 1994*, *Public Interest Disclosure Act 2010*, *Integrity Act 2009*) and whole-of-government policies, principles and guidelines (including the *Code of Conduct for the Queensland Public Service*).
- Providing advice and recommendations on integrity issues to the Board and Executive Management, as necessary.
- Monitoring health service misconduct trends and prevention approaches and address any gaps in dealing with integrity issues in relation to misconduct (including fraud and corruption).
- Ensuring the health service complies with any Crime and Misconduct Commission requirements and recommendations to improve misconduct prevention and response.

Risk management

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

Internal control

- Reviewing, through the internal and external audit functions, the adequacy of the internal control structure and systems, including information technology security and control.
- Reviewing, through the internal and external audit functions, whether relevant policies and procedures are in place and up to date, including those for the management and exercise of delegations, and whether they are complied with.
- Reviewing, through the Chief Finance Officer and the System Manager assurance certifications, whether the financial internal controls are operating efficiently, effectively and economically.

Performance management

- Reviewing the health service's compliance with the performance management and reporting requirements of the *Financial Accountability Act 2009*, the *Financial and Performance Management Standard 2009* and the *Annual Report Requirements for Queensland Government Agencies*.

- Reviewing whether performance management systems in place reflect the health service's role/purpose and objectives (as stated in its strategic plan).
- Identifying that the performance reporting and information uses appropriate benchmarks, targets and trend analysis.

Internal audit

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

External audit

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

Compliance

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

Reporting

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

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

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

6.4. Internal audit

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

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

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

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

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

6.5. External scrutiny

CQ Health's operations are subject to regular scrutiny from external oversight bodies. These include Queensland Audit Office, Crime and Corruption Commission, Office of the Health Ombudsman, Australian Council on Healthcare Standards, Aged Care Standards and Accreditation Agency, National Quality Management Committee of BreastScreen Australia, Postgraduate Medical Education Council of Queensland, Australian College of Accreditation, National Association of Testing Authorities, Queensland Ombudsman, the Coroner and others.

During 2017-2018 the Queensland Audit Office table a number of cross-

service audits in Parliament relevant to CQ Health including:

- The National Disability Insurance Scheme (Report 14: 2017–18)
- Confidentiality and disclosure of government contracts (Report 8: 2017–18)
- Health: 2016–17 results of financial audits (Report 7: 2017–18)
- Fraud risk management (Report 6: 2017–18)

Having considered the findings and recommendations contained in these reports, actions have commenced to implement recommendations or address issues raised.

6.6. Risk management

CQ Health recognises risk management is a key factor to informed decision making and is committed to proactively identifying and managing risks to support the achievement of objectives. The CQ Health Risk Management Framework complies with the Financial and Performance Management Standard 2009, and is aligned with the principles of AS/NZS ISO 31000:2009. It is designed to proactively identify, assess, monitor and report strategic, organisational wide and operational risks. Risks are continuously reviewed and updated by the risk owner, with monitoring of risks achieved through regular reporting to the Board Audit and Risk Committee, which has oversight of all strategic and other risks rated High (20) and above in accordance with the Risk Management Framework.

The health service continues to work towards developing and improving its risk management practices. During the year, risk management practices were further improved with a reviewed of the risk appetite statement, risk management framework and associated risk assessment policy.

Strategic risks were also reviewed to align with Destination 2030: Great Care for Central Queenslanders. RiskMan, the new risk management software, went live which integrates risk reporting of risk with clinical incidents, feedback and case management.

The health service risk assessment policy was established to ensure all staff will have knowledge of their level of accountability and responsibility in risk identification, assessment, reporting, treatment/control of risks as well as participate in management of risks across the organisation. Education on the policy and risk management framework continues to be rolled out; with risk briefing sessions now included in staff orientation.

6.7. Information systems and recordkeeping

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

CQ Health continued its work from 2017 to implement an electronic document and records management system and now has a dedicated system administrator. Training for corporate records management is available for staff at orientation and on demand.

CQ Health is committed to transitioning from paper to digital records.

Paper records required to be kept in accordance with the applicable destruction and retention scheduled are being captured and managed through the records management system. Public records are being retained as long as they are required, in accordance with general or core retention and disposal schedules. Over the course of the financial year, CQ Health followed the General Retention and Disposal Schedule (last reviewed 10 July 2018) for its record disposal program and has transferred 22 boxes of permanent records to the Queensland State Archives. In November 2017, 45 records were reported as lost to the Queensland State Archives, there have been no serious breaches of the public authority's information security.

6.8. Public Interest Disclosure

In accordance with section 160 of the *Hospital and Health Boards Act 2011*, CQ Health is required to include a statement in its Annual Report detailing the disclosure of confidential information in the public interest. There were no disclosures under this provision during 2017-18.

6.9. Summary of financial performance

CQ Health reported an operating deficit of $4.429 million for the 2017-18 financial year.

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

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

The 2017-18 total assets administered by CQ Health reduced by $58.239 million. The variance reflects the outcome of the building and land improvement revaluations resulting in a net decrement of $46.78 million.

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

Measures	2017-18 Actuals	2016-17 Actuals	2015-16 Actuals
	$'000s	$'000s	$'000s
Income	580,279	571,007	518,068
Expenses	584,708	564,790	526,948
Operating Surplus/(deficit)	(4,429)	6,287	(8,880)
Net land revaluation movement on land and buildings	(46,760)	(46,567)	30,213
Cash and cash equivalents	14,933	14,107	15,246
Total Assets	432,141	490,380	554,763
Total Liabilities	30,208	27,820	29,262
Total Equity	401,933	462,560	525,501

Chapter 7
Financial Statements

7.1. Statement of comprehensive income for the year ended 30 June 2018

OPERATING RESULT	Notes	2018 $'000	2017 $'000
Income from Continuing Operations			
User charges and fees	B1-1	**42,466**	45,027
Funding public health services	B1-2	**512,049**	504,457
Grants and other contributions	B1-3	**21,894**	17,741
Other revenue	B1-4	**3,870**	3,852
		580,279	571,077
Total Income from Continuing Operations		**580,279**	571,077
Expenses from Continuing Operations			
Employee expenses	B2-1	**54,684**	46,169
Health service employee expenses	B2-2	**306,726**	290,861
Supplies and services	B2-3	**184,073**	189,504
Other expenses	B2-4	**12,060**	6,992
Depreciation	C4-1	**27,165**	31,264
Total Expenses from Continuing Operations		**584,708**	564,790
Operating Results from Continuing Operations		**(4,429)**	6,287
Other Comprehensive Income			
Items that will not be reclassified to Operating Result			
Increase/(decrease) in asset revaluation surplus	C6-2	**(46,760)**	(46,567)
Total other comprehensive income for the year		**(46,760)**	(46,567)
Total comprehensive income for the year		**(51,189)**	(40,280)

7.2. Statement of financial position as at 30 June 2018

	Notes	2018 $'000	2017 $'000
Current Assets			
Cash and cash equivalents	C1	**14,933**	14,107
Receivables	C2-1	**13,909**	18,503
Inventories	C3	**4,015**	3,804
Other		**513**	2,126
Total Current Assets		**33,370**	38,540
Non-Current Assets			
Property, plant and equipment	C4-1	**398,771**	451,840
Total Non-Current Assets		**398,771**	451,840
Total Assets		**432,141**	490,380
Current Liabilities			
Payables	C5	**30,208**	27,820
Total Current Liabilities		**30,208**	27,820
Total Liabilities		**30,208**	27,820
Net Assets		**401,933**	462,560
Equity			
Contributed equity		**360,548**	369,986
Accumulated surplus/(deficit)		**5,221**	9,650
Asset revaluation surplus	C6-2	**36,164**	82,924
Total Equity		**401,933**	462,560

7.3. Statement of changes in equity for the year ended 30 June 2018

	Accumulated surplus $'000	Asset revaluation surplus $'000	Contributed equity $'000	Total equity $'000
Balance as at 1 July 2016	**3,363**	**129,491**	**392,647**	**525,501**
Operating Result				
Operating result from continuing operations	6,287	-	-	6,287
Other Comprehensive Income				
Increase/(decrease) in asset revaluation surplus	-	(46,567)	-	(46,567)
Total Comprehensive Income for the Year	6,287	(46,567)	-	(40,280)
Transactions with Owners as Owners:				
Equity injections - minor capital works	-	-	8,603	8,603
Equity withdrawals - Depreciation funding	-	-	(31,264)	(31,264)
Net Transactions with Owners as Owners	-	-	(22,661)	(22,661)
Balance at 30 June 2017	**9,650**	**82,924**	**369,986**	**462,560**
Balance as at 1 July 2017	9,650	82,924	369,986	462,560
Operating Result				
Operating result from continuing operations	(4,429)	-	-	(4,429)
Other Comprehensive Income				
Increase/(decrease) in asset revaluation surplus		(46,760)		(46,760)
Total Comprehensive Income for the Year	(4,429)	(46,760)	-	(51,189)
Transactions with Owners as Owners:				
Net assets received (transferred during year via machinery-of-Government change) (Note C6-1)	-	-	988	988
Equity injections - minor capital works	-	-	16,741	16,741
Equity withdrawals - Depreciation funding	-	-	(27,167)	(27,167)
Net Transactions with Owners as Owners	-	-	(9,438)	(9,438)
Balance at 30 June 2018	**5,221**	**36,164**	**360,548**	**401,933**

7.4. Statement of cash flows for the year ended 30 June 2018

	Notes	2018 $'000	2017 $'000
Cash flows from operating activities			
Inflows			
User charges and fees		**42,052**	46,094
Funding public health services		**489,045**	467,304
Grants and other contributions		**17,146**	17,749
GST input tax credits from ATO		**13,523**	12,339
GST collected from customers		**498**	463
Other receipts		**3,837**	3,805
Outflows			
Employee expenses		**(54,403)**	(45,760)
Health service employee expenses		**(305,783)**	(289,260)
Supplies and services		**(181,972)**	(193,394)
GST paid to suppliers		**(13,169)**	(12,701)
GST remitted to ATO		**(455)**	(488)
Other		**(6,374)**	(6,259)
Net cash used in operating activities	CF-1	**3,945**	(108)
Cash flows from investing activities			
Inflows			
Sales of property, plant and equipment		**143**	93
Outflows			
Payments for property, plant and equipment		**(20,003)**	(9,728)
Net cash used in investing activities		**(19,860)**	(9,635)
Cash flows from financing activities			
Inflows			
Equity injections		**16,741**	8,604
Net cash provided by financing activities		**16,741**	8,604
Net increase / (decrease) in cash and cash equivalents		**828**	(1,139)
Cash and cash equivalents at the beginning of the financial year		**14,107**	15,246
Cash and cash equivalents at the end of the financial year	C1	**14,933**	14,107

7.5. Notes to the statement of cash flows

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

	2018 $'000	2017 $'000
Operating surplus/(deficit)	**(4,429)**	6,287
Non-cash items included in operating result:		
Depreciation	**27,165**	31,264
Funding for depreciation	**(27,165)**	(31,264)
Net gain on disposal of non-current assets	**(38)**	(53)
Loss on disposal - (netted off account)	**29**	175
Changes in assets and liabilities:		
(Increase)/decrease in receivables	**(34)**	1,487
(Increase)/decrease in funding receivables	**4,231**	(5,959)
(Increase)/decrease in GST receivables	**354**	(362)
(Increase)/decrease in inventories	**(211)**	40
(Increase)/decrease in prepayments	**1,613**	(256)
Increase/(decrease) in accounts payable	**628**	(3,539)
Increase/(decrease) in accrued contract labour	**943**	1,602
Increase/(decrease) in revenue received in advance	**539**	79
Increase/(decrease) in accrued employee benefits	**277**	416
Increase/(decrease) in GST payable	**43**	(25)
Net cash used in operating activities	**3,945**	**(108)**

CF-2 Non-Cash Investing and Financing Activities

Assets and liabilities received or donated/transferred by the Hospital and Health Service to agencies outside of the Wholly-Owned Public Sector Entities are recognised as revenues (refer Note B1-3) or expenses (refer to Note B2-4) as applicable.

7.6. Notes to the financial statements

SECTION A

GENERAL INFORMATION

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

The Hospital and Health Service is controlled by the State of Queensland which is the ultimate parent.

The head office and principal place of business of CQHHS is:

Rockhampton Hospital Campus
Canning Street
Rockhampton QLD 4700

STATEMENT OF COMPLIANCE

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

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

In addition, the financial statements comply with Queensland Treasury's Minimum Reporting Requirements for the year ending 30 June 2018, and other authoritative pronouncements.

New accounting standards applied for the first time in these financial statements are outlined in Note D5.

THE REPORTING ENTITY

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

MEASUREMENT

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

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

Historical Cost

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

Fair Value

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

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

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

Present Value

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

Net Realisable Value

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

PRESENTATION MATTERS

Currency and Rounding

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

Comparatives

Comparative information reflects the audited FY17 financial statements.

Current/Non-Current Classification

Assets and liabilities are classified as either 'current' or 'non-current' in the Statement of Financial Position and associated notes.

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

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

AUTHORISATION OF FINANCIAL STATEMENTS FOR ISSUE

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

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SECTION B NOTES ABOUT OUR FINANCIAL PERFORMANCE

B1 REVENUE

Note B1-1: User charges and fees

	2018 $'000	2017 $'000
Pharmaceutical Benefits Scheme	**15,426**	18,738
Sales of services	**4,198**	3,580
Hospital fees	**22,842**	22,709
Total	**42,466**	45,027

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

Note B1-2: Funding public health services

	2018 $'000	2017 $'000
National Health Reform		
Activity based funding	**323,120**	311,303
Block funding	**78,584**	66,098
Teacher training funding	**10,235**	9,656
General purpose funding	**100,110**	117,400
Total	**512,049**	504,457

Accounting Policy – Funding public health services
Funding revenue is received in accordance with service agreements with the Department of Health Queensland (the Department). Larger hospitals are funded on an activity unit basis whereas funding for smaller hospitals is based on block funding and other funding models. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by the CQHHS. At the end of the financial year, a financial adjustment may be required where the level of services provided is above or below the agreed level. Activity based funding may include an accrual estimate to recognise revenue for admitted patients who have not yet been discharged; based on the number of bed days multiplied by 45% of the funding unit price.

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

Note B1-3: Grants and other contributions

	2018 $'000	2017 $'000
Australian Government grants		
Nursing home grants	**9,992**	10,868
Specific purpose grants	**3,387**	3,686
Total Australian Government grants	**13,379**	14,554
Other grants		
Other grants	**3,265**	3,187
Services received below fair value		
Services received below fair value	**5,250**	-
Total	**21,894**	17,741

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

Contributed physical assets are recognised at their fair value.

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

The Department provides services free of charge to CQHSS which include payroll, accounts payable, finance, taxation, procurement and information technology infrastructure services. The fair value of these services is estimated at $5.250M for the 2017-2018 financial year and is recognised in the Statement of Comprehensive Income.

Note B1-4: Other revenue

	2018 $'000	2017 $'000
Proceeds	**(1)**	(9)
Regulatory fees	**26**	27
Other recoveries	**3,664**	3,318
Insurance recoveries	**9**	69
Other revenue	**172**	447
Total	**3,870**	3,852

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

B2 EXPENSES

Note B2-1: Employee expenses

	2018 $'000	2017 $'000
Employee benefits		
Wages and salaries	**46,421**	39,231
Annual leave levy	**2,832**	2,486
Employer superannuation contributions	**3,440**	2,917
Long service leave levy	**964**	817
Termination benefits	**706**	359
Employee related expenses		
Workers compensation premium	**84**	92
Other employee related expenses	**237**	267
Total	**54,684**	46,169

	2018 No.	2017 No.
Full-Time Equivalent (FTE) Employees at 30 June	**121**	104

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

Note B2-2: Health service employee expenses

	2018 $'000	2017 $'000
Department of Health Queensland - health service employees	**306,726**	290,861
Total	**306,726**	290,861

	2018 No.	2017 No.
Full-Time Equivalent Health Service employees at 30 June	**2,795**	2,681

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

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

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

Accounting Policy – Employee benefits
Salaries and wages, rostered days-off, sick leave, annual leave and long service leave levies and employer superannuation contributions are regarded as employee benefits.

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

Workers' compensation insurance is a consequence of employing employees, but it is not counted in an employee's total remuneration package. It is not an employee benefit and recognised separately as an employee related expense.

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

Accounting Policy – Sick leave
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**.**

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

Accounting Policy - Superannuation
Employer superannuation contributions are paid to QSuper, the superannuation scheme for Queensland Government employees, at rates determined by the Treasurer on the advice of the State Actuary.

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

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

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

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

B2 Expenses (continued)

Note B2-3: Supplies and services

	2018 $'000	2017 $'000
Consultants and contractors	**37,925**	43,612
Electricity and other energy	**7,270**	6,613
Patient travel	**29,258**	26,841
Other travel	**1,529**	1,116
Building services	**3,401**	2,621
Computer services	**2,230**	2,029
Motor vehicles	**408**	367
Communications	**5,291**	4,492
Repairs and maintenance	**5,731**	7,671
Minor works including plant and equipment	**656**	1,081
Operating lease rentals	**3,714**	3,656
Inventories consumed - held for distribution		
Drugs	**20,380**	22,923
Clinical supplies and services	**18,229**	18,493
Catering and domestic supplies	**6,357**	6,280
Outsourced service delivery		
Medical imaging	**15,000**	13,893
Medical	**3,916**	5,947
Other services	**2,116**	2,274
Pathology, blood and parts	**14,013**	13,195
Other	**6,649**	6,400
Total	**184,073**	189,504

Note B2-4: Other expenses

	2018 $'000	2017 $'000
External audit fees	**229**	165
Other audit fees	**23**	24
Insurance	**4,856**	5,000
Insurance premiums - other	**135**	221
Losses from disposal of non-current assets	**29**	176
Special payments - ex gratia payments	**182**	6
Other legal costs	**206**	274
Advertising	**152**	178
Grants distributed	**413**	408
Interpreter fees	**38**	33
Impairment losses on trade receivables	**381**	434
Services Received Free of Charge	**5,250**	-
Other expenses	**166**	73
Total	**12,060**	6,992

Accounting Policy – Distinction between grants and procurement

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

Accounting Policy - Operating lease rentals

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

Disclosure – Operating Leases

Operating leases are entered into as a means of acquiring access to office accommodation and storage facilities. Lease terms extend over a period of 5 to 10 years. The department has no option to purchase the leased item at the conclusion of the lease although the lease provides for a right of renewal at which time the lease terms are renegotiated.

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

Accounting Policy - Revaluations

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

Audit fees

The external audit fee for 2018 is $174,000; $219,940 for 2017.

Insurance

The Insurance Arrangements for Public Health Entities enables Hospital and Health Services to be named 'insured parties' under the Department of Health's policy. For the 2017-2018 policy year, the premium was allocated to CQHHS according to the underlying risk of an individual insured party.

Special Payments

Special payments represent ex gratia expenditure and other expenditure that CQHHS is not contractually or legally obligated to make to other parties. Special payments during 2017-18 include the following payments over $5,000:

- Three compensation payments from court settlements representing the $20,000 insurance excess for each case.
- Two ex gratia payments awaiting the outcome of a health litigation case
- One settlement agreement with a Senior Medical Officer for general damages

Grant distributed

Distribution of funding as per Service Level Agreement for the provision of aged care residential services, community care, and respite care at Theodore Multi-Purpose Health Service. The services are outsourced to the Theodore Council of the Ageing.

SECTION C NOTES ABOUT OUR FINANCIAL POSITION

C1 CASH AND CASH EQUIVALENTS

	2018 $'000	2017 $'000
Imprest accounts	**4**	6
Cash at bank	**12,438**	11,481
QTC cash funds	**2,491**	2,620
Total	**14,933**	14,107

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

CQHHS cash contributions primarily originate from Private Practice clinicians and external entities to provide for education, study and research in clinical areas. As at June 30, 2018 amounts of $ 2.49 million ($2.67 million in 2016-17) in general trust including $0.551 million ($0.539 million in 2016-17) for earnings in excess of what is agreed under the Granted Practice retention arrangement. A further $0.006 million ($0.006 million in 2016-17) for clinical drug trials were set aside for the specified purposes underlying the contribution. Contributions are also received from benefactors in the form of gifts, donations and bequests for stipulated purposes.

C2 RECEIVABLES

Note C2-1: Receivables

	2018 $'000	2017 $'000
Trade debtors	**7,893**	7,785
Less: Allowance for impairment	**(508)**	(434)
	7,385	7,351
GST receivable	**1,131**	1,485
GST payable	**(53)**	(10)
	1,078	1,475
Funding public health services	**5,446**	9,677
Total	**13,909**	18,503

Accounting Policy – Receivables
Trade debtors are recognised at amortised cost which approximates their fair value at reporting date. Trade receivables are generally settled within 30 days, while other receivables may take longer than twelve months. A large proportion of trade receivables arises on the date of discharge of patients, however, fees are submitted to the Health Funds to be recovered once claim processing has been finalised. This could delay the receivable with up to 60 days.

Disclosure – Credit risk exposure of receivables
The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any allowance for impairment.

No collateral is held as security and no credit enhancements relate to receivables held by CQHHS. In terms of collectability, receivables will fall into one of the following categories:

- within terms and expected to be fully collectible
- within terms but impaired
- past due but not impaired
- past due and impaired

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

Note C2-2: Impairment of Receivables

Disclosure - Ageing of trade receivables

	2018 Gross Receivables $'000	2018 Allowance for Impairment $'000	2018 Carrying Amount $'000	2017 Gross Receivables $'000	2017 Allowance for Impairment $'000	2017 Carrying Amount $'000
Less than 30 days	**11,374**	**(21)**	**11,353**	16,118	(34)	16,084
30 to 60 days	**1,112**	**(47)**	**1,065**	1,110	(15)	1,095
60 to 90 days	**604**	**(13)**	**591**	486	(16)	470
Greater than 90 days	**1,327**	**(427)**	**900**	1,223	(369)	854
Total outstanding	**14,417**	**(508)**	**13,909**	18,937	(434)	18,503

C2 RECEIVABLES (continued)

Disclosure - Movement in allowance for impairment for impaired receivables

	2018 $'000	2017 $'000
Balance at 1 July	**434**	397
Amounts written off during the year	**(302)**	(398)
Amounts recovered during the year	**5**	2
Increase/(decrease) in allowance recognised in operating result	**371**	433
Balance at 30 June	**508**	434

Accounting Policy - Impairment of receivables

CQHHS assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes financial difficulties of the debtor, changes in debtor credit ratings and current outstanding accounts over 120 days. The allowance for impairment reflects CQHHS's assessment of the credit risk associated with receivables balances and is determined based on historical rates of bad debts (by category) over the past three years and management judgement.

If CQHHS determines that an amount owing by such a debtor does become uncollectible (after appropriate range of debt recovery actions), that amount is recognised as a bad debt expense and written off against receivables. The amount written off in the current year regarding receivables is $302 thousand (2017: $398 thousand).

C3 INVENTORIES

Note C3: Inventories

	2018 $'000	2017 $'000
Inventories held for distribution - at cost		
Clinical supplies	**2,675**	2,450
Catering and domestic	**59**	70
Pharmacy drugs	**1,270**	1,266
Other	**11**	18
Total	**4,015**	3,804

Accounting Policy - Inventories

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

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

Net realisable value is determined based on the department's normal selling pattern. Expenses associated with marketing, selling and distribution are deducted to determine net realisable value.

C4 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION

Note C4-1: Property, Plant and Equipment - Balances and Reconciliations of Carrying Amount

30 June 2018	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Gross	**17,523**	**741,008**	**57,463**	**17,259**	**833,253**
Less: Accumulated depreciation	**-**	**(402,226)**	**(32,256)**	**-**	**(434,482)**
Carrying amount at 30 June 2018	**17,523**	**338,782**	**25,207**	**17,259**	**398,771**
Represented by movements in carrying amount:					
Carrying amount at 1 July 2017	**17,523**	**403,347**	**22,946**	**8,024**	**451,840**
Transfers in from other Queensland Government entities	**-**	**962**	**25**	**-**	**987**
Acquisitions	**-**	**434**	**7,049**	**12,520**	**20,003**
Disposals	**-**	**(2)**	**(132)**	**-**	**(134)**
Transfers out to other Queensland Government entities	**-**	**-**	**-**	**-**	**-**
Transfers between classes	**-**	**3,250**	**35**	**(3,285)**	**-**
Net revaluation increments/(decrements)	**-**	**(46,760)**	**-**	**-**	**(46,760)**
Depreciation expense	**-**	**(22,449)**	**(4,716)**	**-**	**(27,165)**
Carrying amount at 30 June 2018	**17,523**	**338,782**	**25,207**	**17,259**	**398,771**

30 June 2017	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Gross	17,523	768,899	53,328	8,024	847,774
Less: Accumulated depreciation	-	(365,552)	(30,382)	-	(395,934)
Carrying amount at 30 June 2017	17,523	403,347	22,946	8,024	451,840
Represented by movements in carrying amount:					
Carrying amount at 1 July 2016	17,141	474,977	25,564	2,477	520,159
Transfers in from other Queensland Government entities	-	-	-	-	-
Acquisitions	-	961	2,386	6,382	9,729
Disposals	-	(31)	(186)	-	(217)
Transfers out to other Queensland Government entities	-	-	-	-	-
Transfers between classes	-	835	-	(835)	-
Net revaluation increments/(decrements)	382	(46,949)	-	-	(46,567)
Depreciation expense	-	(26,446)	(4,818)	-	(31,264)
Carrying amount at 30 June 2017	17,523	403,347	22,946	8,024	451,840

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

Note C4-2: Accounting Policies

Recognition thresholds

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

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

Acquisition of assets

Historical cost is used for the initial recording of all property, plant and equipment. Historical 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. Items or components that form an integral part of an asset are recognised as a single (functional) asset.

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

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

Subsequent expenditure

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

Initial measurement

Upon recognition, property, plant and equipment is measured at historical cost, net of accumulated depreciation and accumulated impairment.

Impairment of non-current assets

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

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

Depreciation

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

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

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

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

Class	Depreciation Rates (%)
Land Improvements	1-5%
Building - Shell	2-3%
Building - Fit out	2-5%
Building - Services	3-5%
Other building	2-10%
Plant and equipment	5-20%

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

Componentisation of complex assets

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

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

Subsequent measurement at fair value

Fair value is the price that would be received or paid for an asset at arm's length between willing market participants under current market conditions (i.e. an exit price) regardless of whether that price is directly derived from observable inputs or estimated using another valuation technique.

Key estimate and judgement:

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

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

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

All CQHHS assets 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:

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

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

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

Revaluation of property at fair value

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

Comprehensive revaluations are undertaken at least once every five years. However, if a particular asset class experiences significant and volatile changes in fair value, then that class is subject to specific appraisal in the reporting period, where practical, regardless of the timing of the last specific appraisal. Where assets have not been specifically appraised in the reporting period, their previous valuations are materially kept up-to-date via the application of relevant indices. CQHHS uses indices to provide a valid estimation of the assets' fair values at reporting date. Materiality is considered in determining whether the differences between the carrying amount and the fair value of an asset is material (in which case revaluation is warranted).

Land

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

In 2017-18, CQHHS's land was valued by SVS using independent market valuation or market indices. The effective date of valuation was 30 June 2018. Management has assessed the valuation provided by SVS as appropriate for CQHHS and accepted the result of the independent valuation.

The fair value of land was based on physical inspection and publicly available data on sales of similar land in nearby localities. SVS indicated that they used observable inputs from market transactions data and therefore these inputs fall into level 2 within the fair value hierarchy. The revaluation of land for 2017-18 resulted in a net decrement of $0.902 million ($0.382m increment in 2017). Management has elected to not recognise the decrement to the carrying amount of land.

Buildings

In 2017-18 CQHHS engaged AECOM as the independent valuers to undertake building revaluation in accordance with the fair value methodology. AECOM performed an independent valuation of 75% of the value of CQHHS's buildings portfolio (93) buildings and land improvement assets) and indexation of the residual building portfolio previously valued in prior financial years. The effective date of the valuation was 30 June 2018.

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

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

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

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

While an index of 3% (0% 2016-17) was recommended by AECOM to be applied to buildings not comprehensively revalued during 2017-18, the index was below the cumulative CQHHS materiality threshold of 5% required for application to the portfolio.

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

Note C4-3: Categorisation of Assets and Liabilities Measured at Fair Value

	Level 2		Level 3		Total Carrying Amount	
	2018 $'000	2017 $'000	2018 $'000	2017 $'000	2018 $'000	2017 $'000
Land	**17,523**	16,957	**-**	566	**17,523**	17,523
Buildings	**-**	-	**338,782**	403,347	**338,782**	403,347
Total	**17,523**	16,957	**338,782**	403,913	**356,305**	420,870

C5 PAYABLES

	2018 $'000	2017 $'000
Trade creditors		
Department of Health Queensland	**2,081**	1,334
Other trade creditors	**15,317**	15,436
Accrued health service labour - Department of Health Queensland	**10,271**	9,327
Accrued employee benefits	**1,898**	1,621
Revenue received in advance	**641**	102
Total	**30,208**	27,820

Accounting Policy – Payables
Payables are recognised for amounts to be paid in the future for goods and services received. Trade creditors are measured at the agreed purchase/contract price, gross of applicable trade and other discounts. The amounts owing are unsecured.

C6 EQUITY

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

- Cash equity contributions fund purchases of equipment, furniture and fittings associated with capital work projects managed by CQHHS. CQHHS received 987K funding from the State as equity injections in 2018 (2017: nil). These outlays are paid by the Department of Health Queensland on behalf of the State.
- CQHHS received $27,167 million funding in 2018 (2017 $31.264 million) from the Department to account for the cost of depreciation. Funding for depreciation charges is via non-cash revenue. The Department retains the cash to fund future major capital replacements. As depreciation is a non-cash expenditure item, the Health Minister has approved a withdrawal of equity by the State for the same amount, resulting in a non-cash revenue amount and a corresponding non-cash equity withdrawal.

Note C6-1: Contributed Equity - Asset transfers

	2018 $'000	2017 $'000
Transfer in - practical completion of projects from the Department	**962**	-
Net transfers equipment between Hospital and Health Services	**25**	-
	987	-

The variance reflects the outcome of the building and land improvement revaluations. This has resulted in a net decrement of $46.78 million due to assumptions underlying the valuations (including the current replacement cost for the buildings and the residual useful lives) and gross floor areas of the buildings. Non-reciprocal transfers of assets are recognised through equity when the Chief Finance Officers of both entities agree in writing to the transfer. Construction of major health infrastructure is managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department to CQHHS. During this year a number of assets have been transferred under this arrangement.

Note C6-2: Asset revaluation surplus by class

	Land $'000	Buildings $'000	2018 Total $'000	2017 Total $'000
Balance 1 July	**382**	**82,542**	**82,924**	129,491
Revaluation increments/(decrements)		**(46,760)**	**(46,760)**	(46,567)
Balance 30 June	**382**	**35,782**	**36,164**	82,924

SECTION D NOTES ABOUT RISKS AND OTHER ACCOUNTING UNCERTAINTIES

D1 FINANCIAL RISK DISCLOSURES

Note D1-1: Financial instrument categories

Central Queensland Hospital and Health Service (CQHHS) has the following categories of financial assets and financial liabilities:

Category	Notes	2018 $'000	2017 $'000
Financial assets			
Cash and cash equivalents	C1	**14,933**	14,107
Receivables	C2-1	**13,909**	18,503
Total		**28,842**	32,610
Financial liabilities			
Payables	C5	**30,208**	27,820
Total		**30,208**	27,820

Note D1-2: Financial risk management

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

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

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

Credit Risk

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

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

Liquidity Risk

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

CQHHS is exposed to liquidity risk in respect of its accounts payable (Note C5) and liquidity management strategies aim to reduce the exposure to liquidity risk by analysing accounts payable accounts and managing cash flows ensuring that sufficient funds are available to meet employee and supplier obligations at all times. An approved debt facility of $4.5 million under Whole-of-Government banking arrangements to manage any short-term cash shortfalls has been established. No funds had been withdrawn against this debt facility as at 30 June 2018 (2017: Nil).

Market Risk

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

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

CQHHS does not recognise any financial assets or liabilities at fair value. The fair value of trade receivables and payables is assumed to approximate the value of the original transaction, less any allowance for impairment.

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

Interest rate sensitivity analysis shows, that the impact of interest rate fluctuations QTC cash funds have a minimal effect on the operating result of CQHHS.

D2 CONTINGENCIES

(a) Litigation in Progress

As at 30 June 2018, the following cases were filed in the courts naming the State of Queensland acting through the CQHHS as defendant:

	2018 Number of cases	2017 Number of cases
Supreme Court	**2**	7
District Court	**7**	4
Magistrates Court	**-**	-
Tribunals, commissions and boards	**-**	-
	9	11

Insurance cover for CQHHS's exposure to litigation is underwritten by the Queensland Government Insurance Fund (QGIF) and WorkCover Queensland. For matters managed by QGIF the CQHHS's liability is limited to an excess per insurance event of $20,000. As at 30 June 2018, CQHHS has 43 claims currently managed by QGIF (some of which may never be litigated or result in payments to claimants). At year end, the maximum exposure associated with these claims is $860K.

During the financial year, 9 of the medical indemnity claims managed by QGIF were lodged with either the Supreme Court, District Court, or Magistrates Court. CQHHS legal advisers and management believe it would be misleading to estimate the final amounts payable (if any) in respect of the litigation before the courts at this time. As of 30 June 2018, there were no open claims before tribunals, commissions or boards that have been referred to QGIF for management or being managed by CQHHS.

D3 COMMITMENTS

(a) Non-cancellable operating lease commitments

Commitments under operating leases at reporting date are as follows:

	2018 $'000	2017 $'000
Operating Leases		
No later than 1 year	**927**	1,504
Later than 1 year but no later than 5 years	**324**	708
Later than 5 years	**-**	-
Total	**1,251**	2,212

CQHHS has 87 non-cancellable operating leases relating predominantly to office and residential accommodation (2017: 80). 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.

(b) Capital expenditure commitments

	2018 $'000	2017 $'000
Property, Plant and Equipment		
No later than 1 year	**325**	466
Later than 1 year but no later than 5 years	**-**	116
Later than 5 years	**-**	-
Total	**325**	582

Material classes of capital expenditure commitments contracted for at reporting date but not recognised in the accounts are disclosed; mostly relating to medical equipment purchases under $200K.

D4 CRITICAL ACCOUNTING JUDGEMENTS AND KEY SOURCES OF ESTIMATION UNCERTAINTY

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

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

- Activity based funding revenue – Note B1-2.
- Property, plant and equipment – Note C3
- Service received below fair value, free of charge – Note B1-3 and Note B2-4

D5 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE

First year application of new standards or changes in policies

No Australian Accounting Standards have been early adopted for the 2017-2018 financial year by the CQHHS.

Changes in accounting policies

CQHHS did not voluntarily change any of its accounting policies during 2017-2018.

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

Accounting Standards applied for the first time in 2017-2018

AASB 2016-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 107 This standard has become effective from 1st July 2017. AASB 2016-2 will require additional disclosures to enable the reader to evaluate changes in liabilities arising from financing activities. These disclosures will include both cash flows and non-cash changes between the opening and closing balance of the relevant liabilities and be disclosed by way of reconciliation in the notes to the Statement of Cash Flows. As CQHHS does not have any borrowings / finance leases no changes to the financial statements are required.

Accounting Standards issued but with future commencement dates

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

AASB 9 Financial Instruments, AASB 7 Financial Instruments Disclosures (for first time application), ***and AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)***

These standards will first apply to CQHHS 2018-2019 financial statements. The main impacts of these standards on CQHHS are that they will change the requirements for the classification, measurement, impairment and disclosures associated with financial assets. AASB 9 will introduce different criteria for whether financial assets can be measured at amortised cost or fair value.

There will be no change to either the classification or valuation of the cash and cash equivalent items.

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

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

Lease receivables

The loss allowance for lease receivables should reflect the '12-month expected credit losses'. Twelve-month expected credit losses are the expected credit losses that result from default events that are possible within 12 months after the reporting date. This means the lifetime cash shortfalls that will result if a default occurs in the 12 months after the reporting date, weighted by the probability of a default occurring in that period. The probability of default within 12 months may be lower than the probability of default over the life of the financial asset, therefore resulting in a lower loss allowance. If there is a significant increase in credit risk, the impairment allowance will need to reflect lifetime expected losses.

Further, the amount of impairment for trade receivables owing from other government agencies of $7.4 mill is not material due to low credit risk (high quality credit rating) for the State of Queensland and a provision will continue not to be raised for this category of trade receivables.

All financial liabilities listed in Note C5 will continue to be measured at amortised cost. CQHHS does not expect a material change in the reported value of financial liabilities.

These changed amounts will form the opening balance of those items on the date AASB 9 is adopted. However, CQHHS will not restate comparative figures for financial instruments on adopting AASB 9 as from 1st July 2018. Aside from a number of one-off disclosures in the 2018-19 financial statements to explain the impact of adopting AASB 9, a number of new or changed disclosure requirements will apply from that time. Assuming no change in the types of financial instruments that CQHHS enters into, the most likely ongoing disclosure impacts are expected to relate to the credit risk of financial assets subject to impairment.

AASB 16 Leases

AASB 16 Leases will first apply to the CQHHS 2019-2020 Financial Statements. When applied, the standard supersedes AASB 117 *Leases*, AASB Interpretation 4 *Determining whether an Arrangement contains a Lease*, AASB Interpretation 115 *Operating Leases – Incentives* and AASB Interpretation 127 *Evaluating the Substance of Transactions Involving the Legal Form of a Lease.*

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 agencies that lease assets. The impact on the reported assets and liabilities would be largely in proportion to the scale of the agency's leasing activities.

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

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

The CQHHS's leases with internal-to-Government lessors are primarily for office accommodation through the Queensland Government Accommodation Office and employee housing under the Government Employee Housing program.

At 30 June 2018, the CQHHS has operating lease commitments of $793K and annual lease payments of $306K per year for office accommodation and operating lease commitments of $706K and annual lease payments of $702K per year for employee housing.

For Government Employee Housing, operating lease commitments at reporting date total $2.38mil with annual lease payments of $476K per year.

Considering their operation and impact across the whole-of-Government, the CQHHS is currently awaiting formal guidance from Queensland Treasury as to whether these two arrangements should be accounted for on-balance sheet under AASB 16.

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

In the event these arrangements are to be accounted for on-balance sheet, the CQHHS estimates a right-of-use asset and lease liability on transition of approximately $793K for office accommodation leases and $3.08mil for employee housing based on current operating lease commitments. There will be no material financial statement impact if these arrangements are not accounted for on-balance sheet.

The Department also has a number of cancellable motor vehicle leases with QFleet that are not presently included as part of the operating lease commitments note as they do not constitute a lease under AASB 117 and Accounting Interpretation 4. The department is also awaiting confirmation from Queensland Treasury that QFleet arrangements will continue to fall outside the requirements of AASB 16 for on-balance sheet accounting.

The CQHHS does not currently have right-of-use arrangements in rural and remote regions that would be recognised in the balance sheet.

AASB 1058 Income of Not-for-Profit-Entities* and AASB 15 *Revenue from Contracts with Customers

These standards will first apply to the CQHHS from its financial statements from 2019-2020.

Under the new standards, other grants presently recognised as revenue upfront may be eligible to be recognised as revenue progressively as the associated performance obligations are satisfied, but only if the associated performance obligations are enforceable and sufficiently specific.

Depending on the specific contractual terms, the new requirements may potentially result in a change to the timing of revenue from sales of CQHHS's goods and services, such that some revenue may need to be deferred to a later reporting period to the extent that CQHHS has received cash but has not met its associated obligations (such amounts would be reported as a liability - unearned revenue in the meantime).

CQHHS has commenced a staged process to prepare for the substantial impact of AASB 15 and AASB 1058 by analysing current arrangements for sale of its goods and services, including the extent of additional disclosure. The amount by which each financial statement line item is affected in the 2019/2020 financial year, when comparing AASB 15 with AASB 111 Construction of Assets, AASB 118 Revenue and related interpretations, that were in effect before the change.

Even though the amounts in revenue contracts are material the expected impact is low as CQHHS already includes performance obligations such as the transfer of promised goods or services at an amount that reflects the transaction price. These revenue amounts are recognised when performance obligations are met.

Preparing for and implementing the new accounting standards may have additional resourcing implications.as to ensure transactions from contracts and agreements are recognised in accordance with the new standards and Queensland Treasury Financial Reporting Requirements.

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

D6 SUBSEQUENT EVENTS

There are no matters or circumstances that have arisen since 30 June 2018 that have significantly, or may significantly affect CQHHS's operations, the result of those operations, or the HHS's in future financial years.

SECTION E NOTES ON OUR PERFORMANCE COMPARED TO BUDGET

E1 BUDGETARY REPORTING DISCLOSURES

This section discloses CQHHS's original published budgeted figures for 2017-18 compared to actual results, with explanations of major variances, in respect of CQHHS's Statement of Comprehensive Income, Statement of Financial Position and Statement of Cash Flows.

E1.1 Budget to actual comparison – Statement of Comprehensive Income

	Variance Notes	Original SDS Budget 2018 $'000	Actual 2018 $'000	Original SDS Budget V Actual Variance $'000	Variance % of original budget
OPERATING RESULT					
Income from Continuing Operations					
User charges and fees		41,830	**42,466**	636	2%
Funding public health services		506,828	**512,409**	5,581	1%
Grants and other contributions	1	14,425	**21,894**	7,469	52%
Other revenue		3,258	**3,870**	612	19%
Total Revenue		566,341	**580,279**	13,938	
Total Income from Continuing Operations		566,341	**580,279**	13,938	
Expenses from Continuing Operations					
Employee expenses		53,475	**54,684**	1,209	2%
Health service employee expenses		314,938	**306,726**	(8,212)	(3%)
Supplies and services	2	163,317	**184,073**	20,756	13%
Depreciation	3	32,535	**27,165**	(5,370)	(17%)
Other expenses	4	2,076	**12,060**	9,984	481%
Total Expenses from Continuing Operations		566,341	**584,708**	18,367	
Operating Results from Continuing Operations		-	**(4,429)**	(4,429)	
Other Comprehensive Income *Items that will not be reclassified subsequently to profit or loss*					
Increase/(decrease) in asset revaluation surplus	5	-	**(46,760)**	(46,760)	100%
Other comprehensive income for the year		-	**(46,760)**	(46,760)	
Total comprehensive income for the year		-	**(51,189)**	(51,189)	

Note:

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

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

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

E1.1 Budget to actual comparison – Statement of Comprehensive Income (continued)

Explanation of Major Variances - Statement of Comprehensive Income

1. Grants and contributions - The variance is mostly due to the inclusion of services below fair value ($5+mil). Refer to note B1-3.

2. Supplies and services – The difference is due to the increase in usage of outsourced medical staff (Medical $13.4mil and Nursing $6.1mil. and increased cost of drugs.

3. Depreciation - The decrease in depreciation against budget relates to the downward revaluation of assets of $46mil. Refer to Note C4.

4. Other expenses – The increase in other expenses is due to the recognition of services below fair value ($5mil) and the allocation of QGIF Insurance ($4mil) to other expenses.

5. Increase / (decrease in asset revaluation reserve – The variance reflects the outcome of the building and land improvement revaluations. This has resulted in a net decrement of $46.78 million due to assumptions underlying the valuations (including the current replacement cost for the buildings and the residual useful lives) and gross floor areas of the buildings.

E1.2 Budget to actual comparison – Statement of Financial Position

	Variance Notes	Original SDS Budget 2018 $'000	Actual 2018 $'000	Original SDS Budget V Actual Variance $'000	Variance % of original budget
Current Assets					
Cash and cash equivalents	6	25,705	**14,933**	(10,772)	(42%)
Receivables	7	13,734	**13,909**	175	1%
Inventories		3,899	**4,015**	116	3%
Other		1,979	**513**	(1,466)	(74%)
Total Current Assets		45,317	**33,370**	(11,947)	
Non-Current Assets					
Property, plant and equipment	8	538,281	**398,771**	(139,510)	(26%)
Total Non-Current Assets		538,281	**398,771**	(139,510)	
Total Assets		583,598	**432,141**	(151,457)	
Current Liabilities					
Payables		31,664	**30,208**	(1,456)	(5%)
Total Current Liabilities		31,664	**30,208**	(1,456)	
Total Liabilities		31,664	**30,208**	(1,456)	
Net Assets		551,934	**401,933**	(150,001)	
Equity					
Contributed equity		551,934	**360,548**	(191,386)	(35%)
Accumulated surplus/(deficit)		-	**5,221**	5,221	100%
Asset revaluation surplus		-	**36,164**	36,164	100%
Total Equity	9	551,934	**401,933**	(150,001)	

Note:

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

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

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

Explanation of Major Variances - Statement of Financial Position

6. Cash and cash equivalents - Due to increased activity and resulting costs relating to employees, drugs and patient travel as is shown in the Cash Flow Statement. Budget also included the receipt of minor capital funding.

7. Receivables - The variance is because of activity achieved above target.

8. Property, plant and equipment – Due to the reduction in fair values of land and building as well as the expectation that the construction of the Rockhampton Hospital carpark would be completed and capitalised within FY18.

9. Equity – The budget included the increase in property, plant and equipment (carpark) and did not consider the downward valuation of assets.

E1.3 Budget to actual comparison – Statement of Cash Flows

	Variance Notes	Original SDS Budget 2018 $'000	Actual 2018 $'000	Original SDS Budget V Actual Variance $'000	Variance % of original budget
Cash flows from operating activities					
Inflows					
User charges and fees		41,830	**42,052**	222	1%
Funding public health services		506,828	**489,045**	(17,783)	(4%)
Grants and other contributions	10	14,425	**17,146**	2,721	19%
GST input tax credits from ATO		-	**13,523**	13,523	100%
GST collected from customers		-	**498**	498	100%
Other receipts	11	16,780	**3,837**	(12,943)	(77%)
Outflows					
Employee expenses		(53,445)	**(54,403)**	(958)	2%
Health service employee expenses		(307,533)	**(305,783)**	1,751	(1%)
Supplies and services		(183,013)	**(181,972)**	1,041	(1%)
Grants and subsidies					
GST paid to suppliers		-	**(13,169)**	(13,169)	100%
GST remitted to ATO		-	**(455)**	(455)	100%
Other payments	12	(2,196)	**(6,374)**	(4,178)	190%
Net cash from/(used by) operating activities		33,676	**3,945**	(29,730)	
Cash flows from investing activities					
Inflows					
Sales of property, plant and equipment		37	**143**	106	286%
Outflows					
Payments for property, plant and equipment	13	(6,572)	**(20,003)**	(13,431)	204%
Net cash from/(used by) investing activities		(6,535)	**(19,860)**	(13,325)	
Cash flows from financing activities					
Inflows					
Equity injections	14	6,572	**16,741**	10,169	155%
Outflows					
Equity withdrawals	15	(32,535)	**-**	32,535	
Net cash from/(used by) financing activities		(25,963)	**16,741**	42,704	
Net increase/(decrease) in cash and cash equivalents		1,178	**828**	(351)	
Cash and cash equivalents at the beginning of the financial year		24,527	**14,107**	(10,420)	(42%)
Cash and cash equivalents at the end of the financial year		25,705	**14,933**	(10,771)	

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

- User charges in original SDS have been dissected into User charges and Funding public health services. User charges in original SDS included funding for depreciation of $31.264 mil which is a non-cash transaction and excluded from the Statement of Cash Flows in audited financial statements. The other side to this transaction is an equity withdrawal of $31.264 mil which has also been removed from SDS Cash flows from financing activities.
- Other receipts in the original SDS has been further dissected into GST input tax credits from ATO, GST collected from customers and other receipts. Interest receipts have been rolled into other receipts as immaterial for actual reporting.
- Other payments in the original SDS has been further dissected into GST paid to suppliers, GST remitted to ATO and Other payments.
- Grants and subsidies in original SDS have been rolled into Other expenses as immaterial by size for individual reporting.
- Bank charges included in Other expenses in original SDS has been reclassified as Supplies and services.

E1.3 Budget to actual comparison – Statement of Cash Flows (continued)

Materiality for notes commentary is based on the calculation of the line item's actual value percentage of the group total. A note is provided for where the line item variance percentage is 5% or greater for employee expenses, supplies and services, and property, plant and equipment and 10% or greater for other line items.

Explanation of Major Variances - Statement of Cash Flows

10. Grants and other contributions - CQHHS undertook the refurbishment of nursing homes which resulted in the temporary closure of beds. The budget was prepared on an overly conservative basis using worst case scenario outcomes.

11. Other receipts – The budget line item for other receipts included GST receipts (estimated at $13mil) and was not split out at the time of the first budget submission.

12. Other payments – Relates to insurance payments (QGIF: $4.8mil) that was not classified to this budget line item.

13. Payments for property, plant and equipment – The variance between the actual payments and budget for Property, plant and equipment payments is $13.431 mil. The reason is that the budget for capital acquisitions ($18.7 mill) is held by the Department.

14. Equity injections – Equity injections increased by $10.169 mill because the capital budget is held by the Department who reimburse CQHHS for payments made in relation to capital works that are funded by the Department by way of equity injections.

SECTION F WHAT WE LOOK AFTER ON BEHALF OF THIRD PARTIES

F1 TRUST TRANSACTIONS AND BALANCES

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

	2018 $'000	2017 $'000
Patient trust receipts and payments		
Receipts		
Patient trust receipts	**4,575**	4,969
Total receipts	**4,575**	4,969
Payments		
Patient trust payments	**4,668**	4,951
Total payments	**4,668**	4,951
Increase/decrease in net patient trust assets	**(93)**	18
Patient trust assets opening balance	**1,044**	1,026
Patient trust assets closing balance	**951**	1,044
Patient trust assets		
Current assets		
Cash at bank and on hand	**578**	661
Patient trust and refundable deposits	**373**	383
Total	**951**	1,044

F2 GRANTED PRIVATE PRACTICE

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

	2018 $'000	2017 $'000
Receipts		
Billings - (Doctors and Visiting Medical Officers)	**4,205**	3,716
Total receipts	**4,205**	3,716
Payments		
Payments to Senior Medical Officers and Visiting Medical Officers	**3,769**	9,619
Hospital and Health Service recoverable administrative costs	**359**	119
Hospital and Health Service education/travel fund	**75**	4
Total payments	**4,203**	9,742

	2018 $'000	2017 $'000
Closing balance of bank account under a trust fund arrangement not yet disbursed and not restricted cash	**56**	70

SECTION G OTHER INFORMATION

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES

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

Ministerial remuneration entitlements are outlined in the Legislative Assembly of Queensland's Members' Remuneration Handbook. CQHHS does not bear any cost of remuneration of Ministers. Most of the Ministerial entitlements are paid by the Legislative Assembly, with the remaining entitlements being provided by Ministerial Services Branch within the Department of the Premier and Cabinet. As all Ministers are reported as KMP of the Queensland Government, aggregate remuneration expenses for all Ministers is disclosed in the Queensland General Government and Whole of Government Consolidated Financial Statements from 2017-18, which are published as part of Queensland Treasury's Report on State Finances.

The following details for non-Ministerial KMP reflect key management personnel who have authority and responsibility for planning, directing and controlling the activities of the CQHHS as a whole.

The following persons were considered key management personnel of the CQHHS during the current financial year.

Position	Incumbent	Contract Classification and Appointment Authority	Date of Initial Appointment	Date of Resignation or Cessation
Non-executive Board Chair Provide strategic leadership, guidance and effective oversight of management, operations and financial performance	Cr Paul Bell AM	Hospital and Health Boards Act 2011 Section 25 (1)(a)	25 September 2015	-
Non-executive Deputy Board Chair Provide strategic leadership, guidance and effective oversight of management, operations and financial performance	Graeme Kanofski PSM	Hospital and Health Boards Act 2011 Section 25 (1)(b)	18 May 2013	-
Non-executive Board Members Provide strategic leadership, guidance and effective oversight of management, operations and financial performance	Professor Leone Hinton	Hospital and Health Boards Act 2011 Section 23 (1)	29 June 2012	-
	Francis Houlihan	Hospital and Health Boards Act 2011 Section 23 (1)	9 November 2012	-
	Karen Smith	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2013	-
	Elizabeth Baker	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2013	-
	Dr Poya Sobhanian	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2016	-
	Dr Anna Vanderstaay	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2016	-
	Lisa Caffery	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2016	-
Health Service Chief Executive Responsible for the overall leadership and management of the CQHHS to ensure that CQHHS meets its strategic and operational objectives	Steve Williamson	S24/s70 Appointed by Board under Hospital and Health Board Act 2011 (Section 7 (3)).	9 January 2017	-
Chief Finance Officer, Assets, and Commercial Services Responsible for the management and oversight of the CQHHS finance framework including financial accounting, budget and performance management frameworks, assets and commercial services, information and technology, and corporate governance systems.	Muku Ganesh	HES 2 Appointed by CE under HHB Act 2011	16 August 2016	-

Position	Incumbent	Contract Classification and Appointment Authority	Date of Initial Appointment	Date of Resignation or Cessation
Executive Director, Rockhampton Hospital Responsible for the leadership, management and coordination of the Rockhampton Hospital Business Unit	Wendy Hoey	HES 2 Appointed by CE under HHB Act 2011	20 June 2016	-
Executive Director Medical Services Central Queensland Responsible for the strategic and professional functions for CQHHS medical workforce, and clinical governance.	Dr Tim Smart	MMOI2 Appointed by CE under HHB Act 2011	27 June (acting from 9 March 2016)	27 October 2017
Executive Director Medical Services Central Queensland Responsible for the strategic and professional functions for CQHHS medical workforce, and clinical governance.	Dr Anette Turley	MMOI2 Appointed by CE under HHB Act 2011	Acting from 16 November 2017	-
Executive Director, Gladstone and Banana Responsible for the leadership, management and coordination of Gladstone and Banana Business Unit	Joanne Glover	HES 2 Appointed by CE under HHB Act 2011	29 August 2016	-
Executive Director of Nursing Midwifery Quality and Safety Responsible for strategic and professional leadership of nursing workforce.	Sandralee Munro	NRG12 Appointed by CE under HHB Act 2011	20 July 2015	-
Executive Director, Rural District Wide Services Responsible for the leadership, management and coordination of the Rural and District Wide Business Unit	Kieran Kinsella	HES 2 Appointed by CE under HHB Act 2011	25 November 2016	-
Executive Director, Workforce Responsible for provision of leadership and oversight of human resource, occupational health and safety functions, and Indigenous training and development for the Health Service.	Peter Patmore (seconded)	HES 2 Appointed by CE under HHB Act 2011	5 September 2016	-
Director, Operations and Innovation Responsible for leading development and implementation of a continuous service improvement approach across CQHHS	Steven Parnell	DSO1 Appointed by CE under HHB Act 2011	9 June 2015	1 January 2018
Director, Operations and Innovation Responsible for leading development and implementation of a continuous service improvement approach across CQHHS	Kerrie-Anne Frakes	HP7 Appointed by CE under HHB Act 2011	Acting from 22 January 2018	

Remuneration policy

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

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

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

- Short-term employee benefits which include: **Monetary benefits** – consisting of base salary, allowances and leave entitlements paid and provided for the entire year or for that part of the year during which the employee occupied the specified position. Amounts disclosed equal the amount expensed in the statement of comprehensive income. **Non-monetary benefits** – consisting of provision of reportable as well as exempt benefits together with fringe benefits tax applicable to the benefit. Benefits provided to individual employees working for a public and non-profit hospital under a salary package arrangement where the grossed-up value is equal or lower than $17,667 are not reported in this Note.
- Long-term employee benefits include long service leave earned.
- Post-employment benefits include superannuation contributions.
- Redundancy payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu on termination, regardless of the reason for termination.
- No performance bonuses were paid in the 2017-18 financial year (2017: $nil).

Board remuneration

Remuneration paid or owing to Board members during 2017-2018 was as follows:

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

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

Remuneration paid or owing to Board members during 2016-17 was as follows:

Board Member	Short Term Employee Expenses		Post employee expenses	Total Expenses
	Base	Non-monetary expenses		
	$'000	$'000	$'000	$'000
Paul Bell (AM)	92	-	8	**100**
Graeme Kanofski (Deputy Chair)	52	-	4	**56**
Professor Leone Hinton	44	-	4	**48**
Francis Houlihan	47	-	4	**51**
Elizabeth Baker	49	-	5	**54**
Bronwyn Christensen	43	-	3	**46**
Dr Poya Sobhanian	48	-	5	**53**
Dr Anna Vanderstaay	45	-	5	**50**
Lisa Caffery	50	-	4	**54**
Karen Smith*	-	-	-	**-**

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

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Other key management personnel remuneration

2017-18

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

2016-17

Position	Short Term Employee Expenses		Long term employee expenses	Post-employment expenses	Termination benefits	Total expenses
	Monetary expenses	Non-monetary expenses				
	$'000	$'000	$'000	$'000	$'000	$'000
Health Service Chief Executive	289	35	5	27	-	**356**
Deputy Health Service Chief Executive	36	-	1	4	-	**41**
Chief Finance Officer, Assets and Commercial Services	290	47	-	1	-	**338**
Executive Director, Medical Services Central Queensland	460	38	9	34	-	**541**
Executive Director, Medical Services Rockhampton and Rural	338	-	7	23	-	**368**
Executive Director, Rockhampton Hospital	204	-	4	16	-	**224**
Executive Director, Gladstone and Banana	174	25	3	17	-	**219**
Executive Director, Nursing, Midwifery, Quality and Safety	223	-	4	17	-	**244**
Executive Director, Rural District Wide Services	188	-	4	16	-	**208**
Executive Director Workforce	158	21	3	17	-	**199**
Director Operations and Innovation	153	-	3	17	-	**173**

G2 RELATED PARTY TRANSACTIONS

Transactions with people/entities related to Key Management Personnel

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

Transactions with Queensland Government controlled entities

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

Department of Health Queensland

Procurement of public hospital services

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

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

The signed service agreements are published on the Queensland Government website and publicly available. The 2017-18 service agreement was for $578 million.

In addition, the Department provides services free of charge to CQHSS which include payroll, accounts payable, finance, taxation, procurement and information technology infrastructure services. The fair value of these services is estimated at $5.25mil for the 2017-2018 financial year and is recognised in the Statement of Comprehensive Income. The associated business expenses paid by Department on behalf of CQHHS for providing these services are recouped by the Department.

Health Service employees

CQHHS is not a prescribed employer and 2,795 health service employees (average MOHRI FTE) are employed by the Department and contracted to work for CQHHS.

Queensland Treasury Corporation

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

Department of Housing and Public Works

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

Transactions between Hospital and Health Services

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

Other

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

G3 FEDERAL TAXATION CHARGES

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

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

7.7. Management Certificate

Certificate of Central Queensland Hospital and Health Service

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

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

b) the statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Central Queensland Hospital and Health Services for the financial year ended 30 June 2018 and of the financial position of the Central Queensland Hospital and Health Service at the end of that year.

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.

Cr Paul Bell, AM
Chairperson
31 August 2018

Steve Williamson
Health Service Chief Executive
31 August 2018

Mukunthan Ganeshalingam
Chief Finance Officer
31 August 2018

7.8. Independent Auditors report

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INDEPENDENT AUDITOR'S REPORT

To the Board of Central Queensland Hospital and Health Service

Report on the audit of the financial report

Opinion

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

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2018, and its financial performance and cash flows for the year then ended

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

The financial report comprises the statement of financial position as at 30 June 2018, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

Basis for opinion

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

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

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

Key audit matters

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

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Specialised buildings valuation ($338.8 million)

Refer to Note C4 in the financial report.

Key audit matter	How my audit addressed the key audit matter
Buildings were material to Central Queensland Hospital and Health Service at balance date, and were measured at fair value using the current replacement cost method. Central Queensland Hospital and Health Service performed a comprehensive revaluation of 75% of the written down value of buildings this year, with remaining assets being revalued using indexation. The current replacement cost method comprises: • Gross replacement cost, less • Accumulated depreciation. Central Queensland Hospital and Health Service derived the gross replacement cost of its buildings at balance date using unit prices that required significant judgements for: • identifying the components of buildings with separately identifiable replacement costs; and • 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. The measurement of accumulated depreciation involved significant judgements for forecasting the remaining useful lives of building components. The values used for indexation purposes are based on estimates of labour and material cost inflation adjusted for specific market conditions and as such also require judgement to appropriately determine. 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. • Assessing the competence, capabilities and objectivity of the experts used to develop the models. • 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. • For unit rates associated with buildings that were comprehensively revalued this year: 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 specialised buildings: o Evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices; and 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 At an aggregated level, reviewing asset management plans for consistency between renewal budgets and the gross replacement cost of assets o Testing that no asset still in use has reached or exceeded its useful life o Enquiring of management about their plans for assets that are nearing the end of their useful life; and o Reviewing assets with an inconsistent relationship between condition and remaining useful life. • Where changes in useful lives were identified, evaluating whether they were supported by appropriate evidence.

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Responsibilities of the Board 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.

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- 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 2018:

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.

31 August 2018

C G Strickland
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

Chapter 8
Appendices

8.1. 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	iii
Accessibility	• Table of contents • Glossary	ARRs – section 9.1	vi 99
	• Public availability	ARRs – section 9.2	Inside front cover
	• Interpreter service statement	Queensland Government Language Services Policy ARRs – section 9.3	Inside front cover
	• Copyright notice	Copyright Act 1968 ARRs – section 9.4	Inside front cover
	• Information Licensing	QGEA – Information Licensing ARRs – section 9.5	Inside front cover
General information	• Introductory Information	ARRs – section 10.1	pg 1-5
	• Agency role and main functions	ARRs – section 10.2	pg 1-5
	• Machinery of Government changes	ARRs – section 31 and 32	n/a
	• Operating environment	ARRs – section 10.3	pg 1-5
Non-financial performance	• Government's objectives for the community	ARRs – section 11.1	pg 3
	• Other whole-of-government plans / specific initiatives	ARRs – section 11.2	pg 3
	• Agency objectives and performance indicators	ARRs – section 11.3	pg 23
	• Agency service areas and service standards	ARRs – section 11.4	pg 23
Financial performance	• Summary of financial performance	ARRs – section 12.1	pg 57
Governance – management and structure	• Organisational structure	ARRs – section 13.1	pg 36
	• Executive management	ARRs – section 13.2	pg 37-38
	• 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	pg 31
	• Queensland public service values	ARRs – section 13.5	pg 3, 31
Governance – risk management and accountability	• Risk management	ARRs – section 14.1	pg 56
	• Audit committee	ARRs – section 14.2	pg 51-55
	• Internal audit	ARRs – section 14.3	pg 55
	• External scrutiny	ARRs – section 14.4	pg 55-56
	• Information systems and recordkeeping	ARRs – section 14.5	pg 56-57
Governance – human resources	• Strategic workforce planning and performance	ARRs – section 15.1	pg 23-30
	• Early retirement, redundancy and retrenchment	Directive No.11/12 Early Retirement, Redundancy and Retrenchment Directive No.16/16 Early Retirement, Redundancy and Retrenchment (from 20 May 2016) ARRs – section 15.2	pg 25
Open Data	• Statement advising publication of information	ARRs – section 16	inside front cover
	• Consultancies	ARRs – section 33.1	https://data.qld.gov.au
	• Overseas travel	ARRs – section 33.2	https://data.qld.gov.au
	• Queensland Language Services Policy	ARRs – section 33.3	https://data.qld.gov.au
Financial statements	• Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 17.1	pg 91
	• Independent Auditor's Report	FAA – section 62 FPMS – section 50 ARRs – section 17.2	pg 92-95

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

8.2. Abbreviations

Abbreviation	Full Name
AASB	Australian Accounting Standards Board
CE	Chief Executive
CMC	Crime and Misconduct Commission
CQ Health	Central Queensland Hospital and Health Service
CT	computed tomography
DHPW	Department of Housing and Public Works
EQuIP	edition of the ACHS Evaluation and Quality Improvement Program
FBT	Fringe Benefit Tax
FTE	Full time equivalent
GP	General Practice
GST	Goods and Services Tax
HARP	Hospital Avoidance Risk Program
HES	health executive service
HHS	Hospital and Health Service
HR	Human Resources
ICU	Intensive Care Unit
IS	Information Standards
IT	Information Technology
MPHS	Multi-Purpose Health Service
MRI	Magnetic resonance imaging
PPE	Property, Plant and Equipment
QAO	Queensland Audit Office
QGIF	Queensland Government Insurance Fund
RCA	Root Cause Analyses
ROPP	Right of Private Practice
SAC1	Severity Assessment Code 1
SVS	State Valuation Service

8.3. Glossary

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

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