2011–12

Annual Report

Queensland Health

Queensland Government

Attribution:
Content from this annual report should be attributed as:
The State of Queensland (Queensland Health) annual report 2011–2012.

ISSN: 1838-4110

Public Availability Statement
Copies of this publication can be obtained at www.health.qld.gov.au or phone the Senior Communications Officer, Media and Communications Unit, Office of the Director-General on (07) 3234 0111.

The Queensland Health 2011–2012 Supplement to the Annual Report is available online at www.health.qld.gov.au

Interpreter Service Statement
Queensland Health Annual Report 2011–2012.

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on (07) 3234 0111 and we will arrange an interpreter to effectively communicate the report to you.

Letter of compliance

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

Dear Minister

I am pleased to present the Annual Report 2011–2012 and financial statements for Queensland Health.

I certify that this annual report complies with:

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

A checklist outlining the annual reporting requirements can be found on page 122 of this annual report or accessed at www.health.qld.gov.au/publications/corporate/annual_reports/.

Yours sincerely

Dr Tony O'Connell
Director-General

Contents

Every day in Queensland Health...

Non-admitted patient services in public hospitals

4628 emergency services are provided for non-admitted patients in acute public hospitals.

30 626 non-admitted patient services are provided in acute public hospitals.

Admitted patient services in public hospitals

120 babies are born in acute public hospitals.

1367 people receive same day admitted care in acute public hospitals.

8531 people receive admitted care in acute public hospitals.

Residential services in aged care facilities

1309 people receive residential care in 20 aged care facilities.

13 HEALTH (13 43 25 84)

781 callers receive clinical advice from qualified nurses.

Radiation treatment

348 radiation treatments are provided to patients at Queensland public radiation facilities including Townsville Hospital, Princess Alexandra Hospital, Mater Campus, Cairns Cancer Centre and the Royal Brisbane and Women's Hospital.

Dental

1727 adult dental appointments are provided.

1574 child and adolescent dental appointments are provided.

647 children and adolescents complete dental treatment.

Year in review

From 1 July 2012, Queensland's public health system underwent the most significant organisational change in a generation: Queensland Health was transformed from a large, somewhat unwieldy organisation to a significantly smaller department and 17 Hospital and Health Services (HHSs) providing healthcare. The department continues as a regulator and assumed a new role as System Manager. In addition, 2011–2012 was a significant year on a financial front for Queensland Health. For the first time in six years Queensland Health has not required Queensland Treasury to provide additional appropriation as the department managed to deliver a surplus.

To attain these significant achievements, 2011–2012 has been a year of preparation, ensuring the disparate elements, which comprise the new organisational arrangements, would be developed, aligned and in place by the end of the year. Staff from all over Queensland contributed to this gargantuan effort:

- consulting with consumers, clinicians and the community
- drafting legislation and regulations
- managing the recruitment and induction process for Chairs and members of new Hospital and Health Boards
- developing a common framework from which to assess and compare performance
- reviewing policies, procedures and protocols for their applicability to HHSs
- developing new Service Level Agreements between the department and the HHSs.

These organisational changes and the related changes to our funding models are designed to address the burgeoning costs of healthcare. During 2011–2012, we experienced a growth of 4.5 per cent in activity in our hospitals. An annual increase of this size in future years is not sustainable. Given these trends of increased costs of healthcare and increased numbers of patients it is imperative that we transform the funding model for the Queensland public health system.

Funding will be linked increasingly to the nature and extent of services provided by hospitals. As System Manager, the department will be more prescriptive about the type and quality of services it will purchase from HHSs. The price paid will ultimately be based on the most efficient way to safely provide these services. In 2012–2013, we will start this process by paying the average price for the safe provision of a service.

As a result, new models of care are being developed to ensure the public health system continues to be able to respond to the health needs of our ageing population for the foreseeable future. During 2011–2012, there has been an increased effort to:

- develop initiatives like the *Hospital-in-the-Home Initiative* which provides people with cellulitis, venous thrombosis and respiratory problems with the option of being safely cared for by clinicians in their own home
- develop new models of care for asthma and diabetes which promote early identification and thereby minimise or avoid the impact of chronic disease: both for the individual patient and to the costs for the system
- introduce ways to ensure our outpatient services are more accessible and sensitive to patients' needs for continuity of care. By developing more effective clinic discharge procedures, we can minimise travel for patients and strengthen partnerships with general practitioners and other local primary healthcare providers.

We delivered the first multi-site redesign project funded under the Clinical Services Redesign Program, *Improve and Move (I AM) Chest Pain Project*. This project is designed to consider the care of adult chest pain patients presenting to hospital emergency departments. Patients with chest pain form up to 10 per cent of emergency department attendances and represent a significant group of 'access blocked' patients. Because chest pain is complex to assess, improving the flow of the patient through the continuum of care will have positive outcomes for patient, clinicians and the healthcare system.

These kinds of reforms are essential if we are going to ensure the quality and accessibility of healthcare in future decades.

Innovation will also be generated through new technology. During 2011–2012, the availability of *The Viewer*, particularly in remote and rural locations, helped clinicians focus on improving the early detection and treatment of chronic illnesses. *The Viewer* is an in-house developed solution that is the first of its kind in Australia and allows patient records from different locations to be seen in one place, giving clinicians faster access to information and results. It is key to Queensland Health's commitment to closing the gap in health service access for Indigenous communities. In May 2012, its significance was recognised when *The Viewer* won the National Excellence in eGovernment Awards.

One of the key benefits of the reforms will be the increased opportunities for locally led innovation and improvement. In Australia, the delineation of responsibilities for healthcare is largely an accident of our history; the federated model of healthcare provision has often presented a barrier at the national and state level to providing the continuity of care necessary for patients—especially those with chronic disease. The devolution of decision-making to the local level and the imperatives in the new legislation to ensure clinician and consumer engagement by HHSs combine to present us with the opportunity to achieve real change in continuity of care.

Fortuitously, I was recently appointed as Chair of the Community Care and Population Health Principal Committee. The role of this committee is to advise the Australian Health Ministers Advisory Council (AHMAC) on national community and population-based health service activities, including primary care. I look forward to optimising the opportunities afforded by the new organisational arrangements and the enthusiasm generated by these reforms.

This is a time of significant change, and I am most heartened by the enthusiasm of staff and our stakeholders for these reforms. I also understand this is often accompanied by the challenges of change. Again, I pay tribute to the resilience of our staff, who remain our most valuable asset.

Dr Tony O'Connell
Director-General
Queensland Health

Mandate

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

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

This responsibility was discharged through a network of 17 health service districts, public health services, a range of statewide support services—such as radiology and pathology—and supporting corporate functions.

Our vision

Working together for a healthier Queensland.

Our purpose

Providing safe, sustainable, efficient, quality and responsive health services for all Queenslanders.

Our values

Caring for people

We will show due regard for the contribution and diversity of all staff and treat all patients and consumers, carers and their families with professionalism and respect.

Leadership

We will exercise leadership in the delivery of health services and in the broader health system by communicating vision, aligning strategy with delivering outcomes, taking responsibility, supporting appropriate governance and demonstrating commitment and consideration for people.

Partnership

Working collaboratively and respectfully with other service providers and partners is fundamental to our success.

Accountability, efficiency and effectiveness

We will measure and communicate our performance to the community and governments. We will use this information to inform ways to improve our services and manage public resources effectively, efficiently and economically.

Innovation

We value creativity. We are open to new ideas and different approaches and seek to continually improve our services through our contributions to, and support of, evidence, innovation and research.

Strategic direction

There are five strategic priorities in the *Queensland Health Strategic Plan 2011–2015:*

1. Effective and efficient health promotion, illness prevention and early intervention

Queenslanders want to be better informed on how they can live longer, have healthy lives and how they can prevent ill health. By working together through health promotion, preventative measures and early intervention we can help create a healthier and more resilient Queensland.

2. Access to quality services delivered in the right way, at the right place and the right time

We are committed to providing Queenslanders with access to the best possible health services now and into the future. This includes ensuring our services are appropriately delivered, resourced and are designed to meet the changing needs of our communities.

3. Improve the equity of health outcomes

In Queensland, substantial health inequalities exist for:

- Aboriginal and Torres Strait Islander peoples
- people living in areas of socioeconomic disadvantage, areas of reduced accessibility and greater remoteness
- people from culturally and linguistically diverse backgrounds.

We will work to make sure that all Queenslanders have the best possible and appropriate access to health services and outcomes.

4. Create a sustainable, proactive and continually improving health system

To meet the changing needs and future requirements we are committed to developing, implementing and maintaining safe, high-quality effective and efficient health services. We will continually review and renew our services and systems to ensure that they are up-to-date, sustainable and of the highest quality.

5. A sustainable and high-quality workforce to meet future health needs

We recognise that the productive capacity of our workforce is vital in providing safe, high-quality services and Queensland's future health needs. We are committed to enhancing the skills and competencies of our existing staff to meet the challenges we face and to ensuring the most efficient and effective utilisation of staff to deliver required health services. We will continue to reshape the culture and employment experience in Queensland Health to meet the health service challenges of today and tomorrow.

Queensland Health continues to face a challenging operating environment. These challenges include:

- a growing and ageing population
- economic, fiscal and health technology impacts
- a growing burden of disease, particularly in relation to chronic conditions
- the health impacts of socioeconomic disadvantage and cultural and linguistic diversity
- the burden of disease from all causes among Aboriginal and Torres Strait Islander Queenslanders
- the dispersion of Queensland's population across the state
- workforce challenges.

Highlights for 2011–2012

The road to reform

A major reform program was undertaken in 2011–2012 to ensure the transformation of Queensland's public health system from 1 July 2012. The reform program included:

- the drafting of legislation with the Queensland Parliament passing the *Hospital and Health Boards Act 2011*
- the creation of 17 HHSs as statutory bodies
- the appointment of the Chairs and members of Hospital and Health Boards with the expertise to manage large, complex healthcare organisations
- the devolution of accountability for health service delivery to the Hospital and Health Boards
- a legislative imperative for improved engagement with clinicians, consumers, community and primary healthcare organisations
- development of Service Level Agreements for 2012–2013 between the Director-General and each HHS to reflect the new relationship between the department as the System Manager and each HHS as the provider of services
- enhancement of the Healthcare Purchasing Framework to enable resources to be committed in a manner that improves health; reduces inequalities; and enhances the patient experience. The purchasing intentions and delineation of the corresponding in-year service agreement management rules have been incorporated in each HHS agreement
- inclusion in each HHS agreement of the newly developed Hospital and Health Service Performance Framework which sets out a transparent, rules-based process for monitoring performance against clearly identified targets. It includes a procedure for managing performance issues, including poor performance. The Hospital and Health Service Performance Framework for 2012–2013 also incorporates a mechanism to recognise and reward high performance
- the development of Health Service Directives to be issued on 1 July 2012 and the identification of existing Queensland Health policies and protocols which will apply to HHSs up to 30 June 2013.

Finding efficiencies in the face of rising costs

It is imperative that efficiencies are found in the provision of healthcare while delivering improvements in the safety and quality of healthcare. Healthcare costs have increased at a rate significantly higher than the Consumer Price Index. The following initiatives exemplify the effort to identify more efficient ways of providing high-quality care.

In 2011–2012, the *Health Practitioners Models of Care Project* supported reviewing current work practices and developing work designs that make the best use of available resources. To date, the project has supported more than 50 trial models of care that:

- better utilise support staff
- examine advanced or extended scope of practice
- decrease duplication
- utilise technology
- increase service coordination.

Among the projects underway is the statewide implementation of Orthopaedic-Podiatry Triage clinics; a project to identify and address barriers and enablers to an interdisciplinary post-hospital nutrition care model; a trial of allied health screening and brief intervention to decrease waiting lists in general paediatrics; extending the scope for prescribing botox for adult neurology patients; development of a clinical pathway for musculoskeletal presentations including prescribing anti-inflammatory medication by physiotherapists; and feasibility studies for paediatric podiatry and virtual foot ulcer emergency services.

The *Transfusion Clinical Nurse Consultants Scheme* preserves precious fresh blood resources, delivers cost savings through reduced blood use and reduces unnecessary transfusions, thereby reducing risk to patients. The scheme operates in seven of Queensland's largest hospitals, deploying specialist nurses to lead, coordinate and encourage effective blood use. Demand for blood is increasing rapidly as the population grows, ages and new uses for blood products are found. Managing the growth in demand with a limited supply, which primarily comes from volunteer donors, is key to making sure the system is sustainable.

Reducing the prevalence of pressure injuries generates significant savings. The *2011 Statewide Patient Safety Bedside Audit* collected pressure injury prevalence in Queensland Health facilities (hospitals and residential aged care facilities). The results show:

- the overall pressure injury prevalence as 12.4 per cent
- hospital-acquired pressure injury prevalence as 8.8 per cent
- inpatient hospital-acquired pressure injury prevalence as 7.9 per cent.

These results show the prevalence of inpatient hospital-acquired pressure injuries reduced from 10.2 per cent in 2010–2011 to 7.9 per cent in 2011–2012. This reduction saved:

- approximately 10 000 acute overnight hospital inpatient episodes
- 126 in-patient bed days.

The *Pressure Injury Prevention Program* (PIP) is upgrading an online clinical education package for pressure injury prevention to meet the newly released Australian Wound Management Association Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury.

Forensic and Scientific Services (FSS) reduced turn-around times for urgent DNA profiles from the Queensland Police Service from five working days to three. DNA profile matching, to identify potential suspects, is an essential tool for police in their investigations. The ability to access DNA profiles on potential suspects within 72 hours has been recognised by research as a critical factor in solving alleged offences. This improved turn-around time has been achieved by the introduction of new technology and extensive review and refinement of internal processing steps.

Finalising enterprise bargaining agreements

During 2011–2012, Queensland Health negotiated and finalised a number of agreements, including:

- *Health Practitioners' (Queensland Health) Certified Agreement (No. 2) 2011 (HPEB2)*
- *Queensland Public Health Sector Certified Agreement (No. 8) 2011 (EB8)*
- *Queensland Health Building, Engineering and Maintenance Services Certified Agreement (No. 5)2011 (BEMS5)*
- *Terms and Conditions of Employment, Queensland Government Visiting Medical Officers 2011 (not a certified agreement)*

Negotiations also commenced and in-principle agreements were reached for replacement agreements for the following:

- *Nurses and Midwives (Queensland Health) Certified Agreement 2009 (EB7)*
- *Medical Officers' (Queensland Health) Certified Agreement (No. 2) 2009 (MOCA2).*

Providing healthcare to regional Queensland

Queensland continues to be the only mainland state in which more people live outside the capital city than in it. As a consequence, an ongoing priority and challenge is providing healthcare to Queenslanders living in regional Queensland. The following initiatives exemplify efforts in 2011–2012 in this regard:

- Queensland Health conducted successful trials between April and June 2012 at Hervey Bay and Mackay using a combination of video conferencing and remote control testing audiology equipment to diagnose hearing problems in newborn babies. This innovation will reduce the burden and cost of travel to families at an intrinsically stressful time in their lives.
- Access to pharmaceutical services was improved in rural and remote areas with the installation of additional specially designed electronic dispensing kiosks in Primary Healthcare Centres (PHCs). The kiosks are designed for Indigenous and rural and remote health centres and can be used by nurses and other health workers without the need for extensive training. These kiosks provide simple, easy-to-use touch screens for production of medication labels, electronic medication records as well as providing simple stock control. Twelve kiosks were successfully installed and trialled in Cape York.
- The use of Telehealth increased, thereby improving access to healthcare for Queenslanders across the state. In 2011–2012, there was a 27 per cent increase in Telehealth occasions of service compared with the previous year. There were 13 635 non-admitted occasions of service in 2011–2012, compared with 10 753 for the

equivalent period the previous year. Of these, 2580 were delivered by private practitioners, accessing the newly added Telehealth Medicare Benefits Schedule (MBS) items. Queensland Health information systems were upgraded to record admitted patient Telehealth activity for the first time. In 2011–2012, 2332 admitted patient Telehealth events were recorded.

- The teleradiology network continued to provide clinicians in rural and remote sites with timely access to radiology reporting services. Clinicians can access their patients' images and reports online at all connected sites. In 2011–2012, the number of Queensland Health medical imaging facilities connected to the Picture Arcing and Communication System increased by 12 to 64. The number of facilities using the Enterprise Radiology Information System (QRiS) increased by 13 to 97 with the addition of Biggenden, Boigu Island, Childers, Chinchilla, Eidsvold, Gayndah, Gin Gin, Maryborough, Monto, Mundubbera, Quilpie, Royal Children's Hospital, and Saibai Island.
- A Picture Archiving Communications System was integrated with the BreastScreen Queensland clinical information system. It will enable specialist clinicians to read breast screen images either centrally or at any BreastScreen Queensland service across the state. This will address radiologist workforce shortages in regional areas and ensure that women receive consistent, high-quality reading services irrespective of where they live or which service they attend. Implementation is planned for completion in December 2012.
- In February 2012, Retrieval Services Queensland relocated to the new Queensland Emergency Operations Centre (QEOC) at Kedron. This move will improve coordination of state disaster management activities and the retrieval and transfer of patients across the state through:
  - better integration of aeromedical responses; direct involvement of staff from the Queensland Emergency Medicine System Coordination Centre and Retrieval Services Queensland; and integration with the Department of Community Safety telecommunications technology
  - collocation of all relevant clinicians and senior management; and a dedicated Telehealth room that significantly improves capability for specialist clinical support to rural and remote patients.
- In 2011–2012, the department established 34 pocket simulation centres across Queensland. These centres enable local clinicians to provide simulation-based training specific to local requirements and are often in the clinicians working environment. Without these pocket simulation centres a large number of Queensland Health clinicians would not have access to this training without travelling vast distances. The department is on target to establish 80 pocket simulation centres by 2014. More than 300 simulation providers, including simulation educators, simulation coordinators and faculty members, have now been trained to support or facilitate simulation-based education at pocket simulation centres across Queensland. The financial year 2011–2012 saw the first official graduate from the Vocational Graduate Certificate in Healthcare Simulation, which provides formal recognition of healthcare simulation education as a specialised career pathway.
- Capital funding was allocated to the James Cook University (JCU) Dental School to support the development of training facilities in Cairns and Townsville.
- Three new self-drive mobile dental clinics (Drovers) were delivered for Cherbourg, the Torres Strait and Cape York to improve access to dental services for Indigenous Queenslanders. The Drovers were funded by the Commonwealth Government under the National Partnership Agreement (NPA) on Health Infrastructure.

Responding to growth in the south-east corner

- Princess Alexandra Hospital (PAH) expansion (July 2011): The PAH expansion delivered an expanded emergency department, additional radiation oncology bunkers and a new helipad.
- Mental health community care unit (August 2011): Queensland Health delivered a new 20-bed community care unit (CCU) at Coorparoo.
- Queen Elizabeth II Jubilee (QEII) Hospital expansion (February 2012): The QEII Hospital expansion delivered a new palliative care inpatient unit.
- Royal Brisbane and Women's Hospital [RBWH] (October 2011): A sixth radiation oncology bunker and a sixth linear accelerator were installed at the RBWH.
- Ipswich Hospital Oral Health relocation (December 2011): As part of the Ipswich Hospital expansion, oral health services were relocated to a newly

purpose-built location. The new Ipswich Community Dental Clinic started the provision of services in late 2011.

- Robina Health Precinct (March 2012): The Robina Health Precinct brought together a variety of health services to complement and enable the Robina Hospital expansion and Gold Coast University Hospital (GCUH) projects.
- Sunshine Coast Health Service District (November 2011): Additional bed capacity was created for Nambour and Caloundra hospitals.
- Sunshine Coast Interim Service Enhancements Phase 1—Nambour (February 2012): A series of service developments were undertaken at Nambour General Hospital delivering a new cardiac catheterisation lab, vascular surgery procedural suite, dedicated endoscopy procedural unit and outpatient neurosurgery service.
- Toowoomba Hospital Emergency Department upgrade (July 2011): The Toowoomba Emergency Department upgrade delivered a transit lounge for use by people awaiting discharge or transfer by ambulance—a brand new service for the hospital.
- The Mental Health Toowoomba Child and Youth Unit (October 2011): A new eight-bed child and youth unit and day centre was developed on the Toowoomba Hospital campus.
- Toowoomba Regional Cancer Centre (April 2012): The Toowoomba Regional Cancer Centre expanded the capability of the Toowoomba Hospital to deliver effective cancer care to rural and regional patients.

Research

Queensland Health continued to increase its research capacity and skills development through the creation of networks and partnerships between hospitals, medical research institutes and universities in the conduct of innovative research.

In 2011–2012, the department's FSS Virology Unit, in collaboration with Monash University, demonstrated for the first time that the Wolbachia bacterium inhibits replication of arboviruses, such as dengue fever, yellow fever and chikungunya, in mosquitoes. The ability of Wolbachia to block virus replication in mosquitoes has the potential to halt the spread of infection. Recent field trials in north Queensland, conducted by the JCU, Monash University and the University of Melbourne, demonstrated that Wolbachia has the capacity to invade natural mosquito populations, thereby reducing their susceptibility to these viruses. This discovery has the potential to transform the way arboviruses are controlled and be a life saving solution in developing countries, where many of these viruses cause significant morbidity and mortality. The research forms part of the Grand Challenges in Global Health Initiative of the Bill and Melinda Gates Foundation.

The department's *Health Research Fellowship Program* had a strong focus on supporting frontline clinician researchers to provide real patient outcomes. Forty-two clinician researchers in Queensland Health were supported during 2008–2011 in areas including oncology, infectious diseases, mental health, nutrition, nursing and midwifery, oral health, and Aboriginal and Torres Strait Islander Health.

The $276.1 million Translational Research Institute (TRI), currently being constructed at the PAH, will allow, for the first time in Australia, biopharmaceuticals and treatments to be discovered, manufactured, and clinically tested in one location. TRI will be the only such facility in the southern hemisphere and one of only a few in the world. The TRI building is due for completion in late 2012. The fitout of R-Wing at the PAH and the BioPharmaceuticals Australia building are due for completion in mid-2013.

Payroll and rostering systems

In November 2011, the Auditor-General reported the Queensland Health payroll and rostering system had reached a level of stability. This system stability was achieved through a comprehensive program of payroll system fixes, improvements and enhancements. More system fixes and enhancements are planned throughout 2012 to further improve the accuracy of employee pays.

These include a pay date change, electronic payslips, electronic rostering, and additional system visibility for line managers.

During 2011–2012, the payroll program focussed on providing support for staff to address their payroll concerns. A payroll network was established to provide a forum for information sharing on payroll-related matters statewide. An escalation process was also established whereby an employee who had a payroll issue that was not able to be resolved with Queensland Health could refer the matter to the Queensland Workplace Rights Ombudsman for consideration.

From 30 May 2012, the process commenced to recover overpayments made to staff that arose due to payroll-related issues. Staff were sent a letter providing an updated summary of what their pay history showed regarding overpayments to minimise potential tax impacts. It also provided staff with a starting point for discussions if they had not commenced repayment or been allocated a case manager. Given the large number of staff affected, this is a considerable process that will take time. Staff members with the largest overpayment amounts were contacted first.

Fraud management

With the discovery of a significant fraud in December 2011, the department took immediate action to strengthen financial internal controls including the development and implementation of a new Internal Control Framework (ICF). The controls are part of an overall strategy to improve fraud risk management and include:

- the segregation of duties
- independent signature verification
- improved controls around vendor creation
- vendor management
- system access
- cost centre management.

In addition, there was a review and rationalisation of expenditure delegations and the development of training and awareness programs.

Queensland Health is committed to delivering further initiatives in 2012–2013 ensuring enhanced fraud risk management that reflects its future structure and operating environment and the effective and efficient management of public resources.

Divisions and districts

In 2011–2012, Queensland Health comprised 17 health service districts, nine divisions and the Office of the Director-General. From 1 July 2012, as part of the National Health Reform Agreement, Queensland Health transformed into 17 HHSs, three divisions, two commercialised business units and the Office of the Director-General. As their own statutory bodies with hospital and health boards, the HHSs are accountable to the local community and the Queensland Parliament. The HHSs are:

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

In the 2011–2012 financial year, prior to the 1 July transformation, Queensland Health's health service districts and divisions were:

Centre for Healthcare Improvement

The Centre for Healthcare improvement (CHI) was responsible for leading improvement in the overall quality of healthcare in Queensland Health, targeting major system-wide improvements in:

- patient access to services
- patient experience, safety and high-quality clinical outcomes delivered safely
- design of clinical service delivery
- healthcare culture and leadership
- health and medical research
- clinical skills development.

Clinician leadership in these improvements is a critical ingredient for success, and strong local ownership of the changes is vital to sustain improvements over time.

Division of the Chief Health Officer

The Division of the Chief Health Officer delivered policies, programs, services and regulatory functions to improve the health of the Queensland population by promoting and protecting health and wellbeing, detecting and preventing disease and injury, and supporting high-quality healthcare service delivery.

The division delivered services in communicable disease prevention; environmental health; promotion of healthy living choices (physical activity, nutrition, sun safety, alcohol and tobacco use); health surveillance; emergency management coordination; and public health response to disasters and disease outbreaks, victim support and aeromedical patient retrieval; licensing of private hospitals; organ and tissue donation; and the provision of health services at correctional centres. The division was policy custodian for multicultural health policy; population cancer screening policy and quality assurance, and mental health policy and legislation.

Several of the division's prevention, promotion and protection services are delivered through a network of public health units across Queensland. The public health workforce is a mix of medical, nursing and health practitioner professionals, including specialist clinical and public health physicians and nurses; epidemiologists; data managers; public health nutritionists; health promotion officers; environmental health officers; public health officers; entomologists; and mental health specialists.

Clinical and Statewide Services Division

Clinical and Statewide Services (CaSS) delivered pathology, forensic, scientific, diagnostic, therapeutic and clinical support to assist the health service districts to manage clinical effectiveness and efficiency, enhance patient and community safety, and improve standards of care. The division also provided 13 HEALTH, which gives all Queenslanders access to health advice 24-hours-a-day, seven-days-a-week. CaSS was organised into six branches:

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

The division maintained its commitment to:

- delivering quality support services that add value for our clients
- driving innovation, safety and efficiency in all service delivery
- building a viable and sustainable business through effective structure and robust systems
- creating a high performing and rewarding workplace.

Health Planning and Infrastructure Division

The Health Planning and Infrastructure Division (HPID) was responsible for leading and coordinating statewide health service and infrastructure planning and ensuring that the life of built assets is maximised.

The division was responsible for planning and delivery of the $7 billion hospital and health facility infrastructure and redevelopment program. The program includes developing the GCUH ($1.76 billion), the Queensland Children's Hospital [QCH] ($1.4 billion), the Sunshine Coast University Hospital [SCUH]($2.03 billion) and significant expansions and redevelopments at Cairns Base Hospital, Mackay Base Hospital, Rockhampton Hospital and Townsville Hospital, together with multiple smaller projects across the state. HPID worked in close collaboration with health service districts, other government agencies and key stakeholders on service and infrastructure planning and delivery. The core challenges for planning and asset delivery and management are Queensland's projected population growth and ageing population and the commitment to improve the community's access to safe and sustainable health services.

Human Resource Services Division

The Human Resource Services Division (HRS) provided contemporary human resource (HR) strategy, policy, data and support to deliver sustainable quality healthcare services. A key challenge was addressing the need to grow and improve productivity, capacity and capability and removing the barriers that prevent our workforce from delivering healthcare services in a flexible and efficient way.

The division provided strategic leadership and advice for all human resources matters across Queensland Health. It included leadership and management of industrial relations issues to deliver planned outcomes within appropriate industrial, employment and occupational health and safety frameworks. The division was responsible for ensuring relevant legislation, industrial and employment arrangements and instruments are embedded in strategy and policy and, when mandated, ensuring compliance across the organisation.

The Payroll Portfolio Program Office was established in September 2011 to bring together the various teams working on payroll-related projects, processes and delivery. This enabled single-point accountability for the achievement of portfolio priorities and the appropriate application of Queensland Health resources. An integrated organisational health structure was established within HRS. The organisational health approach recognises a direct link between employee health, safety, wellbeing and organisational performance. Organisational health plays a key role in retaining and building a high-quality workforce to meet the changing demands of delivering health services.

Finance, Procurement and Legal Services Division

Finance, Procurement and Legal Services (FPL) Division provided strategic financial policy and governance frameworks (Finance Branch), legal services (Legal Unit), procurement policy, planning and contract administration (Health Services Purchasing and Logistics Branch) to improve healthcare for all Queenslanders.

In 2011–2012, the major areas of focus included improving financial performance, enhancing Own Source Revenue, continuing development of the Activity Based Funding (ABF) Model and activities associated with implementing National Health Reform. Finance Branch focussed on improving financial performance; facilitating financial reporting requirements for health service districts becoming statutory bodies known as HHSs; enhancing own source revenue; continuing development of the ABF model; and activities associated with implementing national health reform.

The ABF framework allocates funding to hospitals based on the cost of healthcare services (referred to as ‘activities’) delivered. The framework promotes smarter healthcare choices and better care by placing greater focus on the value of the healthcare we deliver for the amount of money expended.

The Legal Unit provided legal advice (including statutory interpretation) to the Minister for Health, Director-General and the department on a wide range of complex organisational legal matters impacting upon the health portfolio. In addition, the Legal Unit drafted and negotiated legal arrangements on behalf of Queensland Health. The Mental Health Court Registry was supported by the Legal Unit. The Mental Health Court considers and determines criminal responsibility and fitness for trial in relation to mentally ill and intellectually disabled offenders.

The Health Services Purchasing and Logistics Branch was responsible for managing a range of commodities and services, covering medical consumables, health technology equipment and specialist health services provided by non-government organisations. The branch also led efforts to minimise Queensland Health’s carbon footprint, energy consumption and demand through a range of eco-efficiency and carbon management strategies.

Information Division

Information Division was responsible for operating information systems and technologies so Queensland Health staff have access to information needed to support healthcare.

Information Division provided:

- reliable access to Queensland Health’s major information systems through a wide variety of desktop computers, laptops, personal computing devices and telephones
- leadership and guidance in identifying and resolving the information and technology implications of changes in healthcare
- leadership in developing and implementing

information management and Information and Communications Technology (ICT) strategies, policies and standards
- ease of governance to ensure the greatest healthcare value from investments that influence information and ICT.

Performance and Accountability Division

The Performance and Accountability Division (PandA) supported Queensland Health in achieving its strategic objectives by strengthening governance and accountability, and by providing trusted information, which supports decision-making and public reporting, contributes to improved openness and transparency and informs improved planning, monitoring and evaluating of health services.

The division was responsible for:

- developing frameworks, policies and standards for governance, accountability and performance across Queensland Health
- providing clear direction for the development and review of Queensland Health policies
- collecting, processing, analysing and disseminating statistics on the health of Queenslanders and their use of health services
- leading the development and implementation of a compliant administrative and functional records management program
- managing applications under the *Right to Information Act 2009* and the *Information Privacy Act 2009* for access/amendment to Queensland Health documents
- leading the production of an annual purchasing plan to purchase health services for the local population through service level agreements with health service districts
- negotiation of annual service agreements with health service districts including activity levels and overall funding.

In recognition of the major contribution made by the Mater and the Sisters of Mercy to delivering public patient health services, the division facilitated a special relationship between Queensland Health and Mater Health Services, South Brisbane. The division comprised the Health Statistics Centre, Information Integrity and Policy Services, Healthcare Purchasing Branch and the Performance Management Branch.

Policy, Strategy and Resourcing Division

The main focus of Policy, Strategy and Resourcing (PSR) Division was integrating health policy, strategic planning and resourcing. The division played a critical role in the national and whole-of-government health agenda, including:

- NPAs
- registration and accreditation
- Aboriginal and Torres Strait Islander health policy
- maternal, child health and safety policy.

In addition, the division supported the development of sustainable service models for rural and remote Queensland. PSR comprised:

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

Office of the Director-General

The Office of the Director-General incorporated the following branches and units:

- Assurance and Risk Advisory Services Branch—including the statutory governance functions of internal audit, risk management and internal witness support
- Departmental Liaison Unit
- Executive Support Unit
- Ethical Standards Unit
- Integrated Communications Branch
- Parliamentary and Ministerial Services Unit.

Cairns and Hinterland Health Service District

The Cairns and Hinterland Health Service District covers 142 900 sq km and serves an estimated resident population of 253 071. At June 2011, 10.4 per cent of the district's population was Indigenous.

Facilities are:

- Cairns Base Hospital—the referral hospital for Far North Queensland
- Atherton Hospital—provides primary and secondary levels of healthcare
- Mareeba Hospital
- Herberton Hospital/Aged Care Unit
- Mossman Multipurpose Health Service (MPHS)—comprises an acute inpatient unit and a residential aged care unit
- Gordonvale Memorial Hospital and Palliative Care and Respite Centre
- Innisfail Hospital—provides primary and secondary levels of healthcare
- Tully Hospital
- Babinda Hospital.

Community Health Centres are at Edmonton, Cairns North, and Smithfield in Cairns, Atherton, Mareeba, Yarrabah, Mossman, Innisfail, Tully, Jumbun and Mission Beach. PHCs are at Malanda, Millaa Millaa, Mount Garnet, Ravenshoe, Georgetown, Dimbulah, Forsayth, Croydon, Chillagoe and Cow Bay.

Cape York Health Service District

The Cape York Health Service District covers a geographical area of 127 900 sq km and represents approximately 17 per cent of the total area of North Queensland. The Cape York Health Service District services the remote communities within Cape York Peninsula with an estimated resident population of 10 076 (June 2011). At June 2011, 61.4 per cent of the district's population was Indigenous.

Cape York delivers comprehensive primary health and sub-acute care services through the operations of two MPHSs at Cooktown and Weipa, and 10 PHCs at Napranum, Mapoon, Coen, Aurukun, Lockhart River, Pormpuraaw, Kowanyama, HopeVale, Laura and Wujal Wujal. Significant partnerships between peak bodies, such as the Apunipima Cape York Health Council, Far North Queensland Rural Division of General Practice, the Royal Flying Doctor Service (Queensland Section), and the Commonwealth and State Governments have realised new opportunities and initiatives.

Central Queensland Health Service District

The Central Queensland Health Service District covers the local government areas of Banana Shire Council and the Central Highlands, Rockhampton and Gladstone regional councils. The district covers a geographical area of 114 009 sq km and had an estimated resident population of 226 418 people at June 2011. At June 2011, 4.6 per cent (9647) of the district's population was Indigenous. The district delivers services across four areas—Rockhampton, Gladstone, Central Highlands (based at Emerald) and Banana (based at Biloela). The major acute referral centre for the district is Rockhampton Hospital. There are also hospitals in Gladstone, Biloela, Moura, Emerald and Capricorn Coast. MPHSs are at Baralaba, Blackwater, Springsure, Theodore, Woorabinda and Mount Morgan. PHCs operate at Gemfields, Capella, Tieri and Boyne Valley.

Central West Health Service District

Central West Health Service District covers a geographical area of 382 800 sq km—22 per cent of Queensland—and had an estimated resident population of 12 455 people at June 2011. At June 2011, 8.3 per cent of the district's population was Indigenous.

The district provides level one to level four healthcare services, including 24-hour emergency services, acute inpatients, aged care, allied health, oral health, outpatients, maternity, and surgery. Visiting specialists provide a range of health services, including child psychiatry; dermatology; ear, nose and throat; gastroenterology; palliative care; oncology; cardiology; general surgery; endocrinology; physician; ophthalmology; orthopaedics; psychiatry; and respiratory services. Community health services include aged care assessments; alcohol, tobacco and other drugs services; child health; child safety; Indigenous health; mental health; and mobile women's health services. The district's major hospital is in Longreach. It is the district's only procedural hospital, providing surgical and birthing services.

Other facilities include Blackall Hospital, an acute care facility; MPHSs are located at Alpha, Barcaldine and Winton. Aramac, Boulia, Isisford, Jundah, Muttaburra, Tambo and Windorah have PHCs, each staffed by

one registered nurse and an operational officer. PHCs provide 24-hour emergency services with hospital-based ambulance services provided by the Queensland Ambulance Service and staffed by Queensland Health.

Children's Health Services

Children's Health Services provides:

- paediatric services to the local community
- tertiary paediatric services at the Royal Children's Hospital
- child and youth mental health services
- child and youth community health services
- outreach children's specialist services across Queensland
- implementation and support for new and enhanced emergency, inpatient and ambulatory children's services in Greater Metropolitan Brisbane as part of the South East Queensland Paediatric Plan
- paediatric education and research
- advocacy of children's health services across the state and nationally.

The Royal Children's Hospital (RCH), situated at Herston, Brisbane, is the major specialist paediatric hospital in Queensland and is a centre for paediatric treatment, care, teaching and research. RCH clinical services focus on two broad categories—children and young people in the greater Brisbane area, in particular north of the Brisbane River, and the provision of tertiary paediatric services to the entire state and northern New South Wales.

Children's Health Services also offers a range of outreach clinics and telemedicine to improve access to services throughout the state. An integrated Child and Youth Family Health Service was established, bringing together staff from community child health services, previously run by Metro South and Metro North Health Services, into a single service under Children's Health Services. This integrated service supports consistency in service delivery, improves opportunities for staff professional development, reduces service gaps and encourages innovation.

Children's Health Services also delivers complex secondary and tertiary level mental health care through the Child and Youth Mental Health Service. This service offers specialised mental health services for families with children and young people who are experiencing severe and complex mental health problems. The service operates both inpatient and community-based services, including early intervention programs.

Darling Downs Health Service District

The Darling Downs Health Service District provides public health and hospital services across the Local Government areas of the Toowoomba Regional Council, Western Downs Regional Council, Southern Downs Regional Council, South Burnett Regional Council, Goondiwindi Regional Council, Cherbourg Aboriginal Shire Council and part of the Banana Shire Council (community of Taroom).

The district has a major teaching role, providing both undergraduate and postgraduate clinical experience for members of the multidisciplinary healthcare teams. The Darling Downs Health Service District is home to:

- a major regional hospital (Toowoomba)
- 22 rural and remote acute facilities
- seven aged care facilities
- a mental health facility (Baillie Henderson Hospital)
- community and oral health services.

Gold Coast Health Service District

The Gold Coast Health Service District provides care in hospital and community settings across the expanding Gold Coast region. The district services the community from the New South Wales border to the Coomera region in Queensland's lower south-east corner, covering 1334 sq km. It operates the Gold Coast Hospital, Robina Hospital, Carrara Health Centre, Gold Coast Surgery Centre and a range of community-based facilities.

The district had an estimated resident population of 536 480 (June 2011) and has a significant tourist and transient population. By 2021, the Gold Coast is expected to have a population of 681 449. District services include all major adult specialties and paediatrics. Chronic disease management is a key focus in the hospital and community care environments. The Gold Coast Hospital trains more medical students than any other hospital in Australia and continues to work with education providers—such as Griffith University and Bond University on the Gold Coast, and the University of Queensland in Brisbane—to train a future health workforce. The GCUH is due to open in late 2012. The Robina Hospital expansion opened in 2011. The Gold Coast Hospital Foundation, based at the hospital, is dedicated to fundraising to support Gold Coast health research and education activities.

Mackay Health Service District

Mackay Health Service District covers 90 346 sq km and provides services to a population of 179 093 (June 2011) in an area covering the Isaac, Whitsunday and Mackay local government regions. The district includes the hinterland communities of Moranbah, Clermont, Dysart, Glenden, Middlemount, Collinsville and Bowen. Mackay Health Service District services an area bound by Sarina in the south, Clermont in the west, Bowen in the north, and Collinsville in the north-west. The Whitsunday Islands in the east are also covered by the district. Facilities include:

- Mackay Base Hospital
- Whitsunday Health Service—comprising Proserpine Hospital and PHC and Cannonvale PHC
- Bowen Hospital and PHC
- Sarina Health Service—comprising Sarina Hospital and PHC
- Dysart Health Service—comprising Dysart Hospital and PHC and Middlemount Community Health Centre
- Moranbah Health Service—comprising Moranbah Hospital and PHC and Glenden PHC
- Clermont MPHS—comprising Montcler Nursing Home, Monash Lodge and the Clermont Hospital
- Collinsville MPHS.

The Indigenous population represents 4.1 per cent (6849) of the overall district population as at June 2011. There is also a significant South Sea Islander community in the district.

Metro North Health Service District

The Metro North Health Service District encompasses an area from north of the Brisbane River to north of Kilcoy, and includes the councils of Brisbane City, Moreton Bay Region and the eastern portion of Somerset Regional Council. While it covers an area of 4154 sq km, or just 0.2 per cent of the total area of Queensland, the catchment area represents approximately 20 per cent of the state's population. The district includes the RBWH, The Prince Charles Hospital (TPCH), Redcliffe Hospital, Caboolture and Kilcoy Hospitals, Brighton Health Campus and Services, primary and community health services, mental health services (MHS), oral health services and subacute services.

The Metro North Health Service District provides a full range of health services—including rural, regional and tertiary teaching hospitals, and statewide super-speciality services. Residential facilities managed by the district include the Eventide Brighton Nursing Home, Ashworth House, Jacana Acquired Brain Injury Bracken Ridge, Cooinda House and the Halwyn Centre. The service provides a wide variety of primary healthcare services, including oral health; mental health; child health; school health; aged care and rehabilitation; palliative care; chronic disease management; general primary medical care; and alcohol, tobacco and other drug services.

Outreach clinical services are provided in non-Queensland Health facilities—such as the high school and primary school nursing and oral health services; antenatal; child health; alcohol and drug services at Indooroopilly, City Watch House and Courts and QMerit Redcliffe; and sexual health services in Fortitude Valley. The district hosts several statewide/super-specialty services, such as heart and lung transplantation at TPCH, and genetic health, severe burns and bone marrow transplantation at the RBWH. Service expansion includes:

- sub-acute capacity and related rehabilitation services at the Brighton Health Campus
- specialised orthopaedics service at TPCH
- renal dialysis and chronic kidney disease services at North Lakes
- a hyperbaric chamber at RBWH
- paediatric Services at TPCH, Redcliffe and Caboolture Hospitals
- mental health beds at Caboolture
- skin bank at the RBWH
- milk bank at the RBWH.

Metro South Health Service District

The Metro South Health Service District includes all of Brisbane City south of the Brisbane River, Redland City, Logan City, Beaudesert City, the eastern portion of the rural Scenic Rim Shire and Gold Coast suburbs north of Pimpama—an area of 4368 sq km. The district's estimated resident population at June 2011 was 1 043 326.

Clinical services are delivered to 22.8 per cent of the Queensland population and the PAH provides tertiary services for Brisbane, southern Queensland, northern

New South Wales and statewide super speciality services. PAH is one of Australia's leading teaching and research hospitals and recognised for its expertise in trauma management and as a major transplantation centre for livers, kidneys, bone cartilage and corneas. The district has oversight responsibility for statewide services, including the Spinal Injuries Unit, the Acquired Brian Injury Outreach Service, the Queensland Amputee Limb Service, the Spinal Outreach Team, the Transitional Rehabilitation Program and the Trauma Service.

District services are provided through six hospitals—PAH, Beaudesert, Logan, Redland, Wynnum and QEII. There is also a first stage emergency clinic at Dunwich on North Stradbroke Island. Residential facilities managed by the district include the Moreton Bay Nursing Care Unit, Redland Residential Care and Casuarina Lodge. The district delivers a wide range of speciality services, including emergency, acute care, surgical, medical, maternity, mental health, rehabilitation, and aged care services.

Primary health services include oral health, mental health, child health, school health, aged care and rehabilitation, palliative care, chronic disease management, general primary medical care, and alcohol, tobacco and other drug services. Outreach clinical services are provided in non-Queensland Health facilities—for example, high schools and primary schools. The services include nursing, oral health, antenatal, child health and sexual health. The district provides a very significant and fully integrated (acute and community) mental health service to residents, including community and acute hospital care.

Mount Isa Health Service District

The Mount Isa Health Service District covers 239 952 sq km, 13.8 per cent of Queensland, and services remote communities in north-western Queensland and the Gulf of Carpentaria. The district's estimated resident population was 31 583 (June 2011). At June 2011, 23.1 per cent of the district's population was Indigenous. A range of healthcare services is provided to area residents, including acute inpatient care covering medical and surgical procedures, paediatrics and maternity; public dental; primary healthcare; chronic disease management; child health; sexual and reproductive health; mental health; alcohol and other drug services; a homeless health outreach team; and a public health team. Visiting specialist services and general practice with rights of private practice support the rural and remote populations' access to quality healthcare.

Mount Isa Health Service District hospitals are at Cloncurry, Doomadgee, Mornington Island, Normanton, Mount Isa and Julia Creek. Primary health facilities are at Dajarra, Camooweal, Burketown and Karumba. Community health services are at Cloncurry, Doomadgee, Mornington Island, Normanton and Mount Isa. Major works include the Mount Isa Hospital redevelopment, including a new outpatient and mental health block, a refurbished and extended emergency department, and a cancer care centre.

South West Health Service District

The South West Health Service District covers 319 884 sq km—18.4 per cent of Queensland—and provides a range of health services to the communities and surrounding areas of Roma, Wallumbilla, Injune, Surat, St George, Dirranbandi, Mungindi, Mitchell, Morven, Augathella, Charleville, Cunnamulla, Quilpie and Thargomindah. The district had an estimated resident population of 26 567 (June 2011). At June 2011, 11.8 per cent of the district's population was Indigenous.

There are six hospitals at Roma, St George, Surat, Injune, Charleville and Cunnamulla; five MPHSs at Mitchell, Dirranbandi, Quilpie, Augathella and Mungindi; three outpatients clinics at Morven, Thargomindah and Wallumbilla; and two residential aged care facilities at Waroona in Charleville and Westhaven in Roma. Flying specialist services consist of a surgeon, an obstetrician and gynaecologist and an anaesthetist based at Roma, providing services to rural and remote locations in the south-west, the western Darling Downs and central and western Queensland. In addition to medical and nursing services, the larger hospitals in Roma, Charleville and St George provide public health services in maternity, pharmacy, radiography, pathology, physiotherapy, occupational therapy, social work, podiatry, speech therapy, counselling and oral health. Outreach services are provided to the smaller centres regularly through visiting clinics.

The South West Health Service District provides a wide range of community health services, including child and family health; alcohol, tobacco and other drugs; a young people's support program; Aboriginal and Torres Strait Islander healthcare; sexual health; a mobile women's service; mental health; oral health; community aged care; chronic disease management; and allied health. Community healthcare centres are at Roma, St George and Charleville.

Sunshine Coast Health Service District

The Sunshine Coast Health Service District provides a comprehensive range of healthcare services including acute inpatient and community services, mental health (acute inpatient and community), community and allied health, and oral health. It has hospitals at Caloundra, Gympie, Maleny, and Nambour. Acute inpatient services are at the Nambour, Gympie, Caloundra, and Maleny hospitals. The district also has a contract with Ramsay Health Care, the operators of the Noosa Hospital. Under this arrangement, Ramsay provides services to public patients at the Noosa Hospital.The district covers a geographical area of 10 270 sq km. At June 2011, the district's estimated resident population was 385 284. The Sunshine Coast Health Service District is a high growth area with an expected population increase of 23.3 per cent by 2021.

Planning is well advanced for the development of the Sunshine Coast University Hospital (SCUH) at Kawana, which will open in 2016. The SCUH will be Queensland's first Public Private Partnership procured hospital. The collocated private hospital is already under construction and will provide services to public patients commencing in late 2013.

Torres Strait and Northern Peninsula Area Health Service District

The Torres Strait and Northern Peninsula Area Health Service District is Queensland's most northern health service district and covers an area of 2438 sq km. It has two hospitals—Thursday Island and Bamaga—and 21 PHCs, including on the islands of Saibai, Boigu, Dauan, Badu, Mabuiag, Moa, Warrabar (Sue), Yorke (Masig), Yam (Iama), Coconut (Poruma), Murray (Mer), Darnley (Erub) and Stephen (Ugar). The district serves an estimated resident population of 11 176 (June 2011). At June 2011, 80.4 per cent of the district's population was Indigenous. In addition to the resident population, there are about 30 000 recorded visits a year from people in the coastal areas of the Western Province of Papua New Guinea.

A public health unit was created late in 2010. It consists of environmental health, population and public health, and health promotion services. Implementing change has been slowed by the need to manage outbreaks of cholera and malaria in the northern islands of the Torres Strait.

Townsville Health Service District

The Townsville Health Service District operates public health facilities in Townsville, Ingham, Palm Island, Magnetic Island, Charters Towers, Richmond, Hughenden, Home Hill, Cardwell and Ayr. It covers a geographical area of 148 200 sq km, with an estimated resident population within the district of 236 400 (June 2011). At June 2011, 6.1 per cent of the district's population was Indigenous. As a major tertiary referral hospital for North Queensland, Townsville Hospital receives inter-hospital transfers and patient retrievals by the Royal Flying Doctor Service and the Queensland Emergency Services rescue helicopter throughout north and north-west Queensland and offshore coastal areas. As a teaching hospital, Townsville Hospital has close associations with JCU and CQU and provides academic and research support for medical, nursing and allied health staff and students.

Community health services in Townsville provide a complete range of primary healthcare services. Ingham Health Service consists of a newly constructed hospital that provides acute medical, palliative and surgical services, and a full range of community and oral health services. Accessible by air and barge services, the Joyce Palmer Health Service provides the Indigenous settlement of Palm Island with a wide range of culturally specific primary, antenatal and postnatal care, and acute and palliative healthcare services, including 15 inpatient beds and emergency services. A primary healthcare facility is on Magnetic Island, which provides nursing, general practitioner and allied health services. Parklands Residential Aged Care facility provides 24-hour nursing/respite care. Other public health services include Charters Towers Health Service, Charters Towers Rehabilitation Unit, Eventide Residential Aged Care Complex and the Richmond, Hughenden, Ayr and Home Hill health services.

West Moreton Health Service District

The West Moreton Health Service District is comprised of four local government areas—the Scenic Rim Regional Council, the Lockyer Valley Regional Council, the Somerset Regional Council and Ipswich City Council. Ipswich is the major city of the region. Esk, Laidley, Gatton and Boonah are small regional towns spread throughout the network area. The health service district services a population of approximately 249 000 people (June 2011). The region's demographics are diverse and include metropolitan and small rural community settings. West Moreton Health Service District has a major teaching role, providing both undergraduate and postgraduate clinical experience for members of the multidisciplinary healthcare team. The service employs more than 2600 staff.

The district is home to one medium sized hospital, four rural facilities, a youth detention centre, a mental health facility (including Queensland's major forensic mental health centre), community and oral health services and a population that is expected to double in the next 10 years. Primary health services delivered across West Moreton include:

- alcohol, tobacco and other drug services
- aged care and rehabilitation
- bowel screening
- breast screening
- child health
- chronic disease management
- Indigenous health
- mental health
- school health
- sexual health
- women's health.

Wide Bay Health Service District

In November 2010, the Wide Bay Health Service District was established as a district in its own right after separating from the larger Sunshine Coast–Wide Bay Health Service District.

The district provides a comprehensive range of healthcare services to a fast growing regional area of approximately 220 000 residents (five per cent of the state population) in South East Queensland. From the coast to the country, the district provides acute inpatient and specialist services, comprehensive mental health services, oral health services and a wide range of community and outreach services. Services will be provided from major facilities in the three urban areas of Bundaberg, Hervey Bay and Maryborough hospitals as well as the eight rural facilities in Biggenden, Childers, Eidsvold, Gayndah, Gin Gin, Monto, Munduberra and Mount Perry. A large aged care facility is also based in Maryborough.

The Wide Bay Health Service District incorporates the North Burnett, Bundaberg and Fraser Coast local government areas and part of Gladstone Regional Council (Miriam Vale) covering a geographical area of 37 000 sq km. The key demographic features of the population are:

- 20 per cent of the population is older than 65 years (13 per cent for Queensland)
- 24 per cent of households receive rent assistance from Centrelink
- 11 per cent of the population was born overseas (18 per cent for Queensland)
- 3.6 per cent of the population is Indigenous
- 6.5 per cent of the population is in 'need of assistance' due to a profound or severe disability (four per cent for Queensland).

Overview of organisational changes

Director-General

Dr Tony O'Connell was appointed Director-General of Queensland Health in October 2011. Dr O'Connell had been acting in the position since the departure of Michael Reid on 22 June 2011.

Hospital and Health Services

The Chairs for 16 Hospital and Health Boards were appointed by the Minister for Health in May 2012.

- Cairns and Hinterland—Mr Robert Norman
- Cape York—Mr Scott McCahon
- Central Queensland—Emeritus Professor Robert Miles
- Central West—Mr Edward Warren
- Children's Health Queensland—Ms Susan Johnston
- Darling Downs—Mr Michael Horan
- Gold Coast—Mr Ian Langdon
- Mackay—Mr Colin Meng
- Metro North—Dr Paul Alexander AO
- Metro South—Mr Terry White AO
- North West—Mr Paul Woodhouse
- South West—Dr Julia Leeds
- Sunshine Coast—Emeritus Professor Paul Thomas AM
- Townsville—Mr John Bearne
- West Moreton—Dr Mary Corbett
- Wide Bay—Mr Gary Kirk.

Chief Nurse

In December 2011, Dr Frances Hughes was appointed Chief Nurse for Queensland Health. Dr Hughes is the former Chief Advisor (Nursing) for the New Zealand Ministry of Health.

Darling Downs–West Moreton Health Service District split

On 1 July 2011, in anticipation of the introduction of the new HHSs the Darling Downs-West Moreton Health Service District was split into two separate districts. The Darling Downs Health Service District was managed from Toowoomba and was comprised of the local government areas of Toowoomba Regional Council, Western Downs Regional Council, Southern Downs Regional Council, South Burnett Regional Council, Goondiwindi Regional Council, Cherbourg Aboriginal Shire Council and part of the Banana Shire Council (community of Taroom). The West Moreton Health Service District was managed from Ipswich and was comprised of four local government areas—Scenic Rim Regional Council, Lockyer Valley Regional Council, Somerset Regional Council and Ipswich City Council.

Finance, Procurement and Legal Services

On 14 May 2012, Susan Middleditch commenced as Deputy Director-General, FPL to replace Neil Castles who was seconded as Director-General of the Department of Local Government.

Health Planning and Infrastructure

In April 2012, Dr John Glaister, Deputy Director-General, HPID, left Queensland Health to take up a secondment as Director-General of the Department of National Parks, Recreation, Sport and Racing.

Human Resource Services

The Workplace Services and the Safety and Wellbeing units were integrated into an Organisational Health structure within HRS. This structure incorporated key elements of employee health including safety; healthy lifestyles; injury management; workers compensation; workplace grievances; review of disciplinary, suspension and dismissal matters; Queensland Industrial Relations Commission advocacy; and employee assistance services.

In September 2011, the Payroll Portfolio Program Office was established to bring together the various teams working on payroll-related projects, processes and delivery to ensure a single point of accountability. On 30 March 2012, John Cairns, Deputy Director-General, HRS, resigned from Queensland Health to take up a position in New South Wales.

Financial highlights

Queensland Health is committed to creating dependable healthcare and better health for all Queenslanders. To achieve this, six major services are utilised to reflect the department's planning priorities. These services are: prevention, promotion and protection; primary healthcare; ambulatory care; acute care; rehabilitation and extended care; and integrated mental health services.

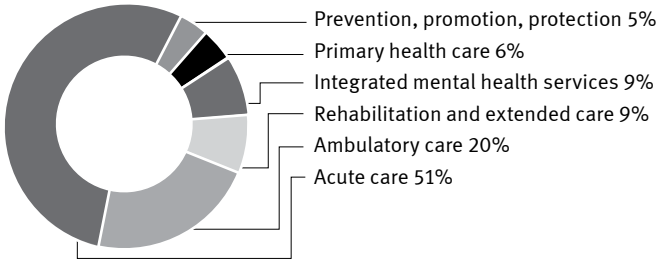
How the money was spent

The department's major services and their relative share are shown in Chart 1.

Queensland Health achieved an operating surplus of $42.336 million while still delivering on agreed major services. The surplus is mainly attributed to the successful implementation of the Queensland Health Performance Management Framework and represents a significant achievement.

Queensland Health, through its risk management framework and financial management policies, is committed to minimise operational expenses and related liabilities. In addition, the department's risk of contingent liabilities, resulting from health litigations, is mitigated by its insurance with the Queensland Government Insurance Fund.

Chart 1: Expense by major services



Income

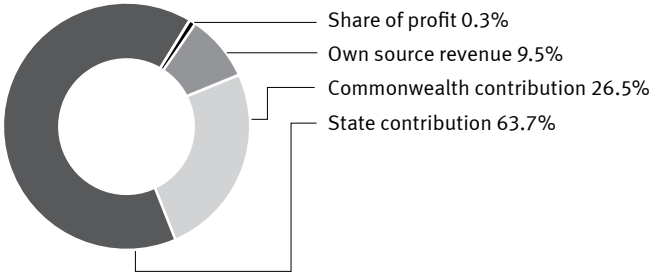
Queensland Health's income includes operating revenue and its share of profit in associates. The operating revenue is sourced from three areas:

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

Chart 2 details the extent of these funding sources for 2011–2012.

Queensland Health's total income from continuing operations and share of profit in associates for 2011–2012 was $11.357 billion. Of this, the state contribution was $7.238 billion (63.7%), Commonwealth contribution was $3.006 billion (26.5%), other revenue was $1.085 billion (9.6%) and share of profit in associates was $0.029 billion (0.3%).

Chart 2: Revenue by funding source



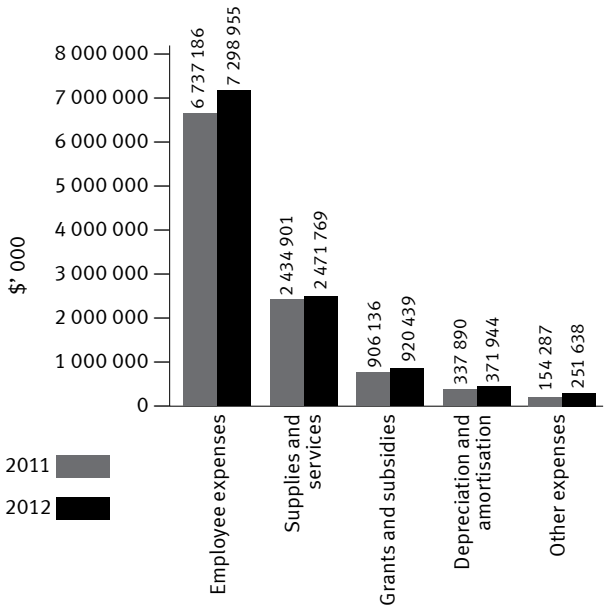
Expenses

Total expenses were $11.315 billion, averaging at $30.91 million per day to provide public health services, an increase of $744.35 million (7.0%) from last year. Graph 1 provides a comparison of expenses in 2010–2011 and 2011–2012.

The increase in expenses incurred includes:

- employee expenses—which reflects the impact of increased staffing and salary increases under the current enterprise bargaining agreement
- depreciation and amortisation—following trends over previous years
- other expenses—reflecting increase in insurance premiums.

Graph 1: Expense two-year comparison



Comparison of actual financial results with budget

Queensland Health actual result in comparison to its budget as published in the State Budget Papers 2011–2012 Service Delivery Statements are presented in the following tables with accompanying notes.

Table 1: Statement of comprehensive income for the year ended 30 June 2012

	Notes	2011–2012 actual $000	2011–2012 budget $000	Variance %
Income				
Departmental services revenue	1	10 053 900	9 935 644	1%
User charges	2	901457	837 466	8%
Grants and contributions	3	329 977	243 447	36%
Other revenue		39 732	29 853	33%
Gains		3419	-	n/a
Total income		**11 328 485**	**11 046 410**	3%
Expenses				
Employee expenses	4	7 298 955	7 121 860	2%
Supplies and services	5	2 471 769	2 537 106	-3%
Grants and subsidies	6	920 439	866 225	6%
Depreciation and amortisation	7	371 944	420 040	-11%
Impairment loss	8	47 718	-	n/a
Appropriation returned		67 559	-	n/a
Other expenses	9	136 361	101 179	35%
Total expenses		**11 314 745**	**11 046 410**	2%
Share of profit of associates	10	28 596	-	n/a
Operating result from continuing operations		**42 336**	**-**	**n/a**

Notes:

1. The increase in service revenue is predominantly due to funding related to the public sector voluntary separation program, funding associated with the transitioning to the hospital and health services, higher than forecast capital expensing, grant indexation and increased essential vaccines funding. These increases are offset by the savings component associated with the public sector voluntary separation program, returned enterprise bargaining and depreciation funding and a reduction in Commonwealth national healthcare specific purpose payments funds.
2. The increase is due to greater than forecast revenue received from the Department of Veteran's Affairs, right of private practice revenues, private patient's fees and other reimbursements.
3. The increase is due to higher than expected revenue from other government departments and various Australian Government funded health services programs.
4. Increase in employee expenses is associated with additional recruitment, increased expenditure for new and existing initiatives and increases due to enterprise bargaining arrangements.
5. The reduction in supplies and services expenses is due to reductions for contractors travel and general supplies and services.
6. Increase is due to indexation arrangements for existing initiatives and new funding arrangements.
7. Decrease is due to lower-than-expected commissioning of buildings, plant and equipment throughout the year.
8. Recognition of bad debts written off and impairment losses on receivables, including an increase in payroll receivables impairment.
9. Increase is due to higher-than-forecast sundry expenditure for existing and new initiatives including insurance.
10. Recognition of share-of-profit in associates including the TRI and the Queensland Children's Medical Research Institute.

Table 2: Statement of financial position as at 30 June 2012

	Notes	2011-12 Actual $000	2011-12 Budget $000	Variance %
Current assets				
Cash and cash equivalents	11	(64 741)	149 050	-143%
Loans and receivables	12	636 886	362 474	76%
Inventories		130 086	123 229	6%
Assets held for sale		75	-	n/a
Other	13	111 618	84 790	32%
Total current assets		813 924	719 543	13%
Non-current assets				
Loans and receivables		20 911	13 829	51%
Property, plant and equipment	14	8 384 794	8 617 514	-3%
Intangibles		149 464	150 948	-1%
Other financial assets	15	20 000	95 312	-79%
Investments in associates	15	69 192	-	n/a
Other		7 629	8 022	-5%
Total non-current assets		8 651 990	8 885 625	-3%
Total assets		9 465 914	9 605 168	-1%
Current liabilities				
Payables	16	496 560	323 621	53%
Accrued employee benefits	17	406 523	357 395	14%
Interest-bearing liabilities	18	-	120 787	-100%
Other liabilities		466	878	-47%
Total current liabilities		903 549	802 681	13%
Non-current liabilities				
Other financial liabilities	19	194 398	110 862	75%
Other liabilities payable		2536	2 367	7%
Total non-current liabilities		196 934	113 229	74%
Total liabilities		1 100 483	915 910	20%
Net assets		8 365 431	8 689 258	-4%
Equity				
Contributed equity	20	4 984 167	4 877 543	2%
Retained surpluses		2 436 803	2 397 181	2%
Asset revaluation surplus	21	944 461	1 414 534	-33%
Total equity		8 365 431	8 689 258	-4%

Notes:

11. Decrease in cash assets is due to net cash used in operating and non-operating activities.
12. Increase predominately relates to the 2010–2011 year end flow through effect and increases in receivables for salary overpayments and interstate patient fees.
13. Increase predominately relates to the prepayment of the 2012–2013 Queensland Government Insurance Fund (QGIF) premium and transfer of non-current prepayments to current prepayments.
14. Reduction is due to capital project deferrals in the Capital Acquisition Plan for projects including, Robina Hospital, Townsville Hospital and SCUH.
15. Movement relates to a revised share of profit under equity accounting for the TRI.
16. Increase reflects 2010–2011 year end balance flow through effect offset by appropriated equity withdrawal payable.
17. Increase due to additional day's accrual for salaries and wages.
18. Decrease due to the re-classification of pre-paid lease payments by the TRI from current to non-current.
19. Increase due to the re-classification of pre-paid lease payments by the TRI from current to non-current.
20. Increase is due to 2010–2011 year end balance flow through effect of higher than expected investment in the capital program in 2010–2011.
21. Decrease is a result of a reduction in asset values due to the outcomes of the revaluation of buildings.

Chief Finance Officer statement

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

For the financial year ended 30 June 2012, a statement assessing Queensland Health's financial internal controls has been provided by the CFO to the Director-General.

The statement was prepared in conformance with Section 57 of the Financial Performance Management Standard 2009. The statement was also provided to the Queensland Health Audit Committee.

Future outlook

In 2012–2013, Queensland Health's overall budget (including Queensland Health and HHSs) will grow to $11.862 billion, representing an increase of 7.4 per cent on the 2011–2012 budget. Whilst the overall budget will increase, there is an underlying requirement for Queensland Health to deliver $326 million of savings to contribute to the state fiscal recovery. Queensland Health will also be investing $1.886 billion in health infrastructure and capital grant projects in 2012–2013. Queensland Health's 2012–2013 budget is inclusive of savings, which will contribute to the state's fiscal repair task.

Funding in 2011–2012 enabled Queensland Health to progress a range of capital projects with completion expected in 2012–2013. These projects will support the delivery of health services and contribute to improved health outcomes for Queenslanders through the delivery of a 750-bed tertiary hospital at the Gold Coast, a range of new mental health units, enhanced and new paediatric and aged care services, new cancer and community healthcare centres and education and research facilities.

Capital facilities intended for completion in 2012–2013 include:

- GCUH
- TRI
- Southern Queensland Indigenous Primary Health Care Centre of Excellence, Inala
- Mental Health stage one Caboolture acute and medium secure units
- Mental Health stage one Mackay acute unit
- Mental Health stage one Logan acute unit
- Mental Health stage one Bayside CCU
- Thursday Island Chronic Disease Centre
- Mental Health stage one Logan CCU
- Mental Health stage one Townsville Child and Youth/Adolescent Unit
- Mount Isa Campus Redevelopment including Regional Cancer Centre.

Hospital and health services

In accordance with the government's commitment at the March 2012 election to revitalise frontline services, on 1 July 2012 hospital and health boards commenced operation and Queensland Health's corporate office transitioned to the role of System Manager. The HHSs have been set up as statutory bodies accountable for the delivery of health services. The focus of the System Manager will be on system-wide policy planning and purchasing. The System Manager has been significantly downsized to deliver a new role. This has also contributed to the delivery of savings.

Purchasing and performance

From 1 July 2012, public health services in Queensland are being delivered using a purchaser-provider model whereby the System Manager purchases health services from HHSs, which is facilitated and monitored through a Service Level Agreement and underpinned by a performance framework.

The *Hospital and Health Services Performance Framework 2012–2013* provides an integrated process for the review, assessment and reporting of performance across the HHSs. The framework forms part of the Service Level Agreement between each HHS and the System manager and is intended to give HHSs a clear understanding of how performance is monitored and assessed.

The framework uses key performance indicators (KPIs) as the basis for monitoring and driving performance. Each KPI includes targets which provide a benchmark for the expected level of performance. Where possible, targets are linked to performance agreed to in national agreements such as the National Healthcare Agreement, NPAs and National Performance and Accountability Framework.

Activity based funding

The National Health Reform Agreement commits the states and territories and the Commonwealth to work in partnership to implement new arrangements for the health system including through the use of ABF. ABF is a system for funding public hospital services provided to individual patients using national classifications and cost weights to determine prices for those services. ABF aims to improve patient access to services and increase public hospital efficiency by funding providers based on the services they provide, rather than on an historical basis. Block funding is provided to support public patient services provided by facilities that are not appropriately funded through ABF.

In 2011–2012, Queensland Health introduced ABF as the dominant mechanism for funding in 28 of the states largest public hospitals. In 2012–2013, Queensland has commenced transitioning to the proposed national ABF model being developed by the Independent Hospital Pricing Authority, and it is proposed to adopt the national model as far as practicable by 2013–2014.

The Commonwealth has also committed to fund 45 per cent of the efficient growth in public hospital activity from 1 July 2014, increasing to 50 per cent from 1 July 2017.

National health funding pool

As a result of the implementation of the National Health Reform Agreement, state and Commonwealth funding arrangements will be more streamlined, and transparent through the creation of a single national health funding pool and an independent administrator.

The National Health Funding Administrator is an independent statutory office holder, whose role (with support from the National Health Funding Body) is to administer the payment of public hospital funding according to the National Health Reform Agreement, and to oversee payments into and out of a national health funding pool.

1 Making Queenslanders healthier

Effective and efficient health promotion, illness prevention and early intervention

Objectives

1.1 Increase action on the promotion of good health, illness prevention and early intervention.

1.2 Encourage healthy behaviours and lifestyle choices to reduce rates of overweight and obesity, smoking, risky drinking, unsafe sun exposure, anxiety and depression and falls by older people.

1.3 Protect the health of Queenslanders by providing access to effective services for the management of preventable environmental health hazards, and the prevention and control of communicable diseases.

1.4 Provide access to effective population screening services for breast, bowel and cervical cancers.

1.5 Work with partners to address factors outside the health system that support health and wellness.

Key strategies

1.1.1 Promote healthy behaviours in pre-school, school, workplace and community settings through collaboration with private, public, non-government sectors, to implement programs addressing risk factors.

1.1.2 Continue to implement A Better Choice strategy by providing a range of targeted promotions. This will empower consumers to make healthier food and drink choices.

1.2.1 Provide a range of targeted promotion prevention and early intervention programs, focussing on:

- improving nutrition and increasing physical activity
- reducing population rates of obesity and overweight, smoking, heavy drinking and unsafe sun exposure
- improving resilience to anxiety and depression
- preventing falls by older people.

1.3.1 Maintain or increase vaccination coverage for Indigenous Queenslanders, areas of low coverage and four-year-old children.

1.3.2 Improve compliance with water quality standards.

1.3.3 Enhance the prevention and control of mosquito-borne diseases.

1.3.4 Improve the coordination of responses to outbreaks, natural disasters and other environmental hazards.

1.4.1 Improve the capacity of the BreastScreen Queensland program to meet participation targets through completion of the digital mammography project and workforce strategies.

1.4.2 Continue to implement the bowel and cervical cancer screening programs.

1.5.1 With our partners, develop and implement an annual target delivery plan to cut by one-third obesity, smoking, heavy drinking and unsafe sun exposure.

Key performance indicators

- Percentage of the Queensland population who:
  - are overweight and obese
  - consume recommended amounts of fruit and vegetables
  - engage in levels of physical activity for health benefit
  - consume alcohol at risky and high risk levels
  - smoke tobacco daily
  - adopt ultraviolet (UV) protective behaviours.
- Percent and number of fall-related hospitalisations for older people in Queensland.
- Vaccination rates at designated milestones for all children aged two years.
- Percent of target population screened for breast cancer, bowel cancer and cervical cancer.

Public Health Report

The Public Health Report is published in accordance with Section 454 of the *Public Health Act 2005*, which requires annual reporting on public health issues for Queensland.

Chronic disease

Chronic disease is the major cause of premature death and illness in Queensland, causing 85 per cent of the total burden of disease and injury in the state. In 2004–2005, chronic disease cost more than 86 per cent of the allocated national healthcare expenditure, or $37 billion. Based on the national proportion of spending on chronic disease, it is estimated that approximately $20 billion was spent in Queensland treating chronic disease in 2009–2010.

Much of chronic disease is preventable.

Recent figures demonstrate the challenges in preventing chronic diseases from occurring. In 2011:

- 57.4 per cent of Queensland adults were overweight or obese
- 14.8 per cent of Queensland adults smoked tobacco daily
- 22.7 per cent of Queensland adults drank alcohol at levels associated with risk of alcohol-related harm over a lifetime
- 50.3 per cent of Queensland adults consumed the recommended two or more serves of fruit on a daily basis with an average intake of 1.6 serves daily
- 9.1 per cent of Queensland adults consumed the recommended five or more serves of vegetables on a daily basis, with the average being 2.4 serves daily.

Diabetes is the fastest growing chronic disease in the world and is the disease with the largest potential for prevention with more than two-thirds due to the joint effect of high body mass and physical inactivity. An estimated 60 new cases of type 2 diabetes are diagnosed each day in Queensland. In 2010, up to 300 000 Queenslanders aged 25 years or over were estimated to have type 2 diabetes, and a similar number are likely to be at risk or undiagnosed. Type 2 diabetes significantly increases the risk of cardiovascular diseases and can lead to serious complications such as blindness, kidney failure, and lower limb amputation.

By 2016, a combination of lifestyle-related conditions such as poor diet, physical inactivity and obesity are predicted to lead to a 17 per cent increase in the burden of type 2 diabetes and, by 2033, the number of Queenslanders with type 2 diabetes is expected to double. Lifestyle changes involving food choices, physical activity and maintaining a healthy weight are essential to the prevention of type 2 diabetes. Queensland Health funded and implemented many initiatives to address these diabetes risk factors.

Injury

Injuries account for 7.1 per cent of the total burden of premature death and disability in Queensland (latest available data is for 2007). An injury is damage occurring to a person's body in a physical sense such as a graze, bruise, sprain, strain or broken bone in a short period of time. Injury is the third largest cause of premature death in Queensland with 1062 premature deaths or 11 per cent of all premature deaths. Falls were the most common fatal injury in Queensland in 2007, causing 485 deaths, where 461 or 95 per cent were of people aged 65 years and older.

Long-term disability, ongoing treatment, rehabilitation and physical impairment can also result from injury. More than one in five Queenslanders (21.5 per cent) reported in 2008 that at some time, they or a member of their immediate family had been injured in a way that permanently affected their lifestyle, work or leisure activities. In 2010–2011, there were 115 238 injury-related hospitalisations in Queensland.

Communicable diseases

Communicable diseases continue to pose a public health risk in Queensland. In 2011–2012, Queensland experienced a number of communicable disease outbreaks requiring a dedicated public health response.

- There were 13 incidents of Hendra virus infection in horses. These incidents required immediate public health responses to identify and manage nearly 80 human contacts. Fortunately there were no human infections.
- North Queensland has experienced increasing numbers of dengue outbreaks during the past decade. The dengue mosquito, Aedes aegypti, is widespread in Cairns and Townsville. It is also established in many towns across the state, but not in South East Queensland. Another dengue vector, Aedes albopictus, is established in the Torres Strait and poses a real risk of incursion onto mainland Australia. An incursion of either of these vectors into South East Queensland could result in large dengue outbreaks due to high numbers of people

with overseas acquired dengue notified in this area. In the period 1 July 2011 to 30 June 2012, there were 225 dengue cases in Queensland, 209 of which were overseas acquired. Queensland Health is leading a program to decrease the risk of incursion into South East Queensland.

- The rates of notifications of whooping cough (pertussis) increased significantly from 2008 when an outbreak started in Australia. Analysis of data showed the increase in notifications was substantially affected by increased testing and the increased use of a test that is more sensitive in identifying infections. Consequently, milder cases of whooping cough are now being identified. There has been a decreasing trend in the number of notifications since the end of 2011.

Rise in Sexually Transmissible Infections (STI) across Queensland

The numbers of notifications of the majority of STI have continued to rise in recent years in Queensland.

- In 2011, there was a 43 per cent increase in the number of gonorrhoea notifications in Queensland (2879) compared to 2015 in 2010. Brisbane Metro North region had the highest number of notifications (530) followed by Cairns and Hinterland (515).
- Chlamydia is the most commonly notified STI in Australia and Queensland. The number of Queensland notifications reached a plateau in 2011 at 18 320. This was a 53 per cent increase over the 11 973 notifications recorded in 2006, and is consistent with national trends. Young people aged 15 to 24 years make up approximately two-thirds of notifications, and approximately two-thirds of annual notifications are females.
- Indigenous status on notifications for both chlamydia and gonorrhoea is under-reported and consequently actual case numbers are unknown. The data available suggest rates of chlamydia in some Indigenous communities in Queensland may be up to five times higher than for non-Indigenous Queenslanders and up to 11 times higher for gonorrhoea. STIs such as chlamydia and gonorrhoea substantially increase the risk of HIV transmission. Given the high prevalence of STIs in some Indigenous communities, HIV infection would be difficult to control should it become established.
- Syphilis infection remains a serious public health issue, especially for Queensland's Indigenous population. In 2011, there were 340 notifications of infectious syphilis in Queensland, which is higher than the average 220 cases reported in the previous four years. A specific syphilis outbreak has been ongoing throughout 2011 in far west Queensland, requiring a prolonged clinical and public health response.
- The HIV notification rate in Queensland increased from 2.9 per 100 000 in 1998 to a peak of 5.3 per 100 000 in 2010, and was 4.9 per 100 000 in 2011. There were 222 new HIV notifications in 2011, compared with 239 in 2010. Of those who were first diagnosed with HIV in Queensland in 2011, 89 per cent (174) were men. Male-to-male transmission remains the most common risk factor for HIV transmission. HIV notifications in the Indigenous population were similar to the rate in the non-Indigenous population.

Antimicrobial stewardship

Inappropriate prescribing of antibiotics internationally is contributing to the emergence of multi-drug resistant organisms. The development of new more effective antibiotics is declining. To ensure availability of effective drugs in the future, strategies to reduce their inappropriate use are imperative.

An organised antimicrobial management program known as antimicrobial stewardship (AMS) has been shown to improve antimicrobial use in hospitals. The primary goal of AMS programs is to improve patient care by promoting judicious use of antimicrobials, including appropriate antimicrobial drug selection, dosage, route, and duration of treatment. This is achieved by incorporating multiple strategies within the hospital setting including education (both passive and active), clinical guidelines, pre-prescription approval, and post-prescription review.

Fluoridation

The Queensland Water Fluoridation Program (QWFP) implements the *Water Fluoridation Act 2008* which allows public potable water supplies serving over 1000 people to be fluoridated at a prescribed concentration. Before the QWFP commenced in 2008, less than five per cent of Queenslanders had access to fluoridated drinking water. That has now risen to approximately 87 per cent, with South East Queensland and the larger regional centres now completed. Queensland is now in line with water supply fluoridation in other Australian states and territories.

Under proposed amendments to the *Water Fluoridation Act 2008*, those public potable water suppliers that have not yet implemented fluoridation will have the option of proceeding with fluoridation or not. This will not affect the continuation of water fluoridation in those water supplies where it is currently operating.

Queensland Health has worked closely with local governments and the Department of State Development, Infrastructure and Planning to safely and cost effectively conclude the program.

Health promotion, illness prevention and early intervention

Queenslanders want to be better informed on how we can live longer, have healthy lives and how we can prevent ill health. Through health promotion, preventative measures and early intervention, the department can contribute to a healthier and more resilient community.

Health promotion

Social marketing provides communities with the information they require to make healthier choices in their lives. In 2011–2012, social marketing campaigns promoted healthy living messages and information on how to access useful services, including 13 HEALTH (13 43 25 84), 13 QUIT (13 78 48) and BreastScreen Queensland. The department, in partnership with the Commonwealth, delivered the *Swap It Don't Stop It* campaign. This second phase of the *Measure Up* campaign aims to show people how to change their lifestyle to help keep their waistlines in check.

An awards program, organised by Keep Australia Beautiful Queensland, recognised the healthiest community, school and workplace in Queensland, with winners sharing a $1.6 million prize pool. Winners in 2011 were:

- **Healthiest community**—Dalby: The community ran community fun sporting events, weight loss programs, boot camps and fit mind and body programs. The prize money will support the development of the Myall Creek Master Plan and its inclusive strategy focussing on whole of community involvement in fitness and the arts to further build Dalby as a healthy community.
- **Healthiest school**—Eumundi State School: The school ran a healthy food options program which includes edible school gardens, a daily fruit fix for all students, *Smart Choices* in the tuckshop and daily running programs. Plans for the prize money include a new open air classroom in surrounding bushland for intensive learning; garden facilities for growing and harvesting fresh food and cooking meals daily in the class kitchen; and additional sports facilities for participating in daily exercise.
- **Healthiest workplace**—Charters Towers Neighbour Centre Incorporated: The funds will be used for the renovations of Buffalo Hall which will house a staff and community health centre to implement regular sports ability sessions and healthy cooking lessons.

In collaboration with the National Heart Foundation and the Local Government Association of Queensland, the department implemented the *Active Healthy Communities Initiative* across Queensland. This initiative, which aims to enhance local government planning, policy and practice to create environments that facilitate opportunities for physical activity and healthy eating by the community, was awarded the Healthcare Improvement Award 2011 for acute and chronic disease prevention: promoting better community health and wellbeing.

A number of initiatives were implemented in 2011–2012 to reduce unsafe sun exposure. A social marketing campaign aimed to raise awareness of the five sun safety behaviours (wearing protective clothing, hat, sunglasses and sunscreen; and seeking shade). This campaign ran between December 2011 and March 2012 and consisted of television, cinema, radio and online promotions.

The youth sun safety campaign, *Sunburn Fail*, aimed to raise awareness of the risk of everyday and incidental sun exposure, with the key message that you don't have to get sunburnt to get skin cancer in Queensland. The campaign ran from January to June 2012, with the focus predominately being online communication channels.

The positive falls prevention *Stay On Your Feet®* message was successfully promoted to older Queenslanders during April No Falls Month through the release of a specific webpage and the provision of 320 kits to support educational and social activities across Queensland, which has seen a 15-fold increase since 2010.

Tobacco control initiatives in 2011–2012 included the implementation of two social marketing campaigns. The 13 QUIT (13 78 48) campaign was designed to promote the Quitline and encourage smokers with young families to consider their smoking behaviour. The *My Smoking* campaign targeted 18 to 29 year

olds and featured a range of media using young Queenslanders to encourage their peers to think about their smoking and quitting. Environmental health officers across the state continued to monitor and enforce the *Tobacco and Other Smoking Products Act 1998*, including implementing the tobacco display provisions and the sale of smoking products to children.

Health promotion initiatives in 2011–2012 to improve the participation of men in bowel cancer screening included:

- *Pit Stop* men's preventive health program
- workplace-based initiatives
- new educational resources for General Practitioners (GPs), carers and people with a disability.

Healthy Bodies, Healthy Minds is a health promotion resource for early childhood education and care services that includes fact sheets and step-by-step guides for families and educators. In 2011–2012, 866 resources were purchased and distributed through the early childhood sector and community.

Illness prevention

Healthy cooking programs are part of Queensland Health's multi-strategy approach towards the prevention of chronic disease through improved nutrition and physical activity. *Jamie's Ministry of Food* program aims to improve nutrition and health by providing basic cooking skills and food literacy. This can help to limit the risk of overweight and obesity. The program targets adults and children who have limited cooking skills, particularly those in low socioeconomic and at-risk groups. Demonstrations and cooking classes are conducted from a mobile food truck that visits Queensland communities and schools.

The Good Foundation, in partnership with Queensland Health, operated a *Ministry of Food* Centre in Ipswich and a mobile outreach truck to take the program to regional communities. As at 31 March 2011, 615 participants had commenced and/or completed the 10-week cooking program at the Ipswich Centre. From January 2012, the food truck was stationed at Logan for 11 weeks, with 230 participants enrolled and/or completing the 10-week course by March 2012. The *Cook for Life* program provides healthy cooking classes to improve diet quality and overall health outcomes for groups at risk of chronic disease. In 2011–2012 Queensland Health funded Institutes of TAFE across Queensland to deliver 25 programs in 12 locations with 263 participants.

The *Healthy Foods (Store Nutritionist)* program enables stores operating in remote Aboriginal and Torres Strait Islander communities to improve the community's nutrition. Since 2010, a nutritionist has been employed by two remote store groups to assist with food and drink stocking practices, store layout, in-store healthy food promotions and labelling, developing nutrition policy and guidelines, staff training, and engaging with community partners.

A Better Choice strategy aims to increase the supply of healthy food and drink to staff, visitors and the general public in Queensland Health facilities. Communication and resource development has continued to ensure that healthy food and drink are available and promoted in food outlets, catering, vending machines and fundraising. The policy and guidelines for *A Better Choice* are now available on the internet to assist hospital and health services to implement this policy.

The *Know Your Numbers* program provides an opportunity for people to have free checks of their blood pressure at participating pharmacies. People with above normal readings are referred to their GP for a more in-depth assessment and treatment as appropriate. *Know Your Numbers* increases community understanding of the consequences of high blood pressure, including the risk of stroke and cardiovascular disease. In April 2011, *Know Your Numbers* was expanded to include blood glucose testing for type 2 diabetes.

The immunisation coverage of four-year-old children in Queensland continued to be maintained at 89 per cent to 90 per cent. Queensland Health continues to investigate opportunities to Close the Gap in rates between Indigenous and non-Indigenous children. While the rates are comparable for older children there is currently a seven per cent point gap between 12-month old Indigenous and non-Indigenous cohorts.

The Queensland Centre for Mental Health Promotion, Prevention and Early Intervention works in partnership with state and national program leaders to access initiatives that are proven to be effective in the prevention and early intervention of depression and anxiety and associated mental illnesses. This includes oversight of the $3.2 million five-year subscription (2010–2015) to *beyondblue*—the national depression initiative which aims to raise community awareness, enhance protective factors, reduce risk factors, and reduce stigma and discrimination associated with depression, anxiety and related disorders. Funding was also provided to MATES in Construction to maintain and deliver resilience education and

training to building and construction industry apprentices through the Lifeskills Toolbox program and occupationally-specific mental health literacy resources.

The Queensland Centre for Perinatal and Infant Mental Health promotes accessible and responsive services for optimum mental health and, social and emotional wellbeing for women, their infants and families during the perinatal period. The centre leads Queensland's partnership in the National Perinatal Depression Initiative which is working on prevention and early detection of antenatal and postnatal depression and providing better support and treatment for expectant and new mothers experiencing depression.

A breastfeeding promotion initiative, *12+months on the breast*, supported accreditation of maternity and child health services under the UNICEF *Baby Friendly Health Initiative*.

Queensland Health, in partnership with Cancer Council Queensland, provided statewide Sun Smart Grant Scheme funding to more than 350 Queensland not-for-profit organisations, to enable them to enhance sun protection for the children in their care. This was complemented by work undertaken locally with a range of agencies, including local government, child care sector, and community organisations, to support the uptake of policies and programs supportive of skin cancer prevention.

Queensland Health continued its partnership with the Australian Drug Foundation to expand the *Good Sports* program in Queensland. A network of *Good Sports* officers work with community-based amateur sporting clubs to improve responsible management of alcohol practices and change harmful drinking cultures through a structured accreditation program. In 2011–2012, more than 650 clubs were participating or registered in the program.

The *10,000 Steps* program disseminates physical activity information, resources and support via the interactive *10,000 Steps* website (www.10000steps.org.au). Since 2004, organisations and community groups have adopted and implemented *10,000 Steps* to promote physical activity. Individuals use the interactive step log to record and monitor their physical activity. As of April 2012, more than 190 000 individuals and 7300 organisations and community groups were registered with the website. In total, more than 98 billion steps have been recorded.

Healthy Active Ageing Collaboratives delivered a range of strategies to communities across the state to promote health and wellbeing among older Queenslanders, including physical activity initiatives designed to maintain strength and balance and help prevent falls.

Queensland Health Public Health Units worked with a wide range of government and non-government agencies to support the delivery of healthy lifestyle programs, including:

- Get Active Gold Coast Physical Activity Alliance and local government Healthy Communities projects
- Lighten Up to a Healthy Lifestyle Programs
- Living Strong, a healthy lifestyle program developed specifically for Aboriginal and Torres Strait Islander populations and a mentoring program for Aboriginal health workers
- Nutrition in Early Life Health Worker Manual and Growing Strong Training Programs for health staff
- Healthy Jarjums, a healthy food choice resource for primary schools
- Logan Beaudesert Food Security Project, to increase the capacity of emergency food relief agencies to provide healthier food to clients in need.

A Queensland Health collaboration with the Ethnic Communities Council of Queensland resulted in:

- a culturally and linguistically diverse (CALD) *Swap It* program and Living Well Multi-cultural Group Based Healthy Weight Program for new emerging communities (Bhutanese and Afghani)
- 60 Living Well Multi-cultural Lifestyle Modification Programs conducted with approximately 495 participants across targeted CALD communities
- Certificate IV Primary Health and Community Care (Multicultural) Competencies with accreditation granted in November 2011
- CALD diabetes project for the Middle Eastern community and Pacific Islanders living with diabetes type 2 (in partnership with Diabetes Queensland).

Screening

Queensland Health provides breast cancer screening services that aim to reduce deaths from breast cancer and are targeted to women aged 50 to 69 years. The program is delivered through BreastScreen Queensland screening and assessment services, including 22 satellite locations and seven mobile vans covering more than 200 locations. In 2011–2012, digital mammography equipment was implemented in all services, including three new satellite services at Maroochydore, Kirwan and Gladstone and has taken

delivery of six of the eight new digital mobiles. Service capacity increased with the commissioning of the sixth digital mobile in April 2012 and the establishment of an additional 10 new mobile screening sites. Approximately 20 per cent of the program's screening is delivered by mobile vans.

Digital image quality can be checked immediately, improving the capacity to screen more women, particularly in rural and remote areas through substantial reduction in technical repeats. In 2011–2012, 668 000+ digital screenings were performed. Since the introduction of digital imaging in 2008 over 10 600 patient-related technical recalls have been avoided (with 743 avoided in 2011–2012). In addition, the ability to have two radiographers working on each of the seven BreastScreen Queensland (BSQ) digital mobiles can deliver an efficiency gain of 60 per cent with 40 women screened a day instead of 25.

Of the 5811 people who underwent a colonoscopy in a Queensland Health facility between August 2006 and June 2011, a pre-cancerous adenoma was detected in 2296—49 per cent of cases. This demonstrates the significant impact of the program on the prevention and early detection of bowel cancer. New E-Health systems were implemented to automate patient records and support timely clinical decision-making for bowel cancer screening programs in Queensland Health hospitals and facilities. In 2011–2012, over 85 000 procedures were captured, stored and retrieved from a centralised database (Endoscopy Services Information System Solution—ESISS).

The Queensland Cervical Screening Program (QCSP) aims to prevent cervical cancer. The target group for cervical screening is women aged 20–69 years and the recommended screening interval is every two years. In the 2009–2010 biennial period (latest available reporting period), 55.3 per cent of eligible women in Queensland participated in cervical screening. Cervical cancer incidence and mortality rates have halved in Queensland over the last 20 years with screening being a major contributing factor.

The QCSP has implemented a range of strategies to enhance access to cervical screening services for rural and remote women and Aboriginal and Torres Strait Islander women including:

- Healthy Women's Initiative
- Mobile Women's Health Service
- Rural Women's GP Service.

Early intervention

Brief intervention (nutrition and physical activity) training provides health staff working directly with Aboriginal and Torres Strait Islander clients with the necessary skills to provide a brief intervention for nutrition and physical activity. Between August 2011 and April 2012 the training was delivered in eight sites across Queensland, with 107 participants trained. Where possible, Queensland Health has been working collaboratively with the Queensland Aboriginal and Islander Health Council (QAIHC) in the promotion and delivery of this training.

Queensland Health launched an online Alcohol, Tobacco and Other Drug Brief Intervention Training Program to help nurses and allied health professionals develop skills and confidence in providing brief interventions with their clients and patients about alcohol, tobacco and drug use. The program includes a specific module to address pregnant and breastfeeding clients, and one for the general population.

To reduce high tobacco smoking rates among Aboriginal and Torres Strait Islander people, frontline health professionals were trained in techniques in smoking cessation under the Tackle Smoking Program.

In 2011–2012, 27 161 calls were handled by Quitline including 4185 referrals from health professionals. Quitline is a telephone counselling service dedicated to helping smokers quit. The Quitline's new Customer Relationship Management System became operational in December 2011 and supports an environment of ongoing quality assurance with sophisticated data collection, telephony and reporting capability.

Across the state, at least 30 Queensland Health nurses and physiotherapists have been trained to deliver the Safe Recovery Training Program, which is an evidence-based multimedia, falls prevention in-patient education program. Seventy-nine health and exercise professionals from across the state have also been trained to deliver the effective falls prevention program, the Otago Exercise Programme, to Queenslanders aged over 80 years.

Interventions for school-aged children and youth include the *Ed-LinQ* Initiative which works to improve linkages between the education sector, the primary care sector and the mental health sector, with the goal of improving early detection and access to intervention for students with emerging mental illness. The *Ed-LinQ* approach recognises that supporting the mental health and wellbeing of all students is a core focus of the education sector, and works with

primary and secondary schools in the government, independent and Catholic school systems.

People living with and caring for individuals with depression are being supported through the Queensland implementation of the Partners in Depression initiative. The BRiTA Futures Program (Building Resilience in Transcultural Australians groups) was developed to build resilience towards acculturation stress in people with culturally and linguistically diverse backgrounds. It has three components—the primary school version for children aged 9 to 12 years, the adolescent version for young people aged between 12 and 18 years, and the adult and parent version.

Environmental health

Queensland Health provides health risk advice to Queensland's Coordinator-General on mining, major infrastructure and industrial development projects regarding potential environmental health impacts and hazards. This includes issues such as air quality, contaminated soil and water quality.

During 2011–2012, health risk assessments of 23 state significant projects and nine other developments were undertaken.

In 2011–2012, enhanced laboratory capacity enabled better coordination and faster analytical support for environment investigations including:

- the Paddock to Reef Integrated Monitoring, Modelling and Reporting Program
- Gladstone Harbour fish sampling and testing
- establishing any potential community impact of coal seam gas processes
- pesticide levels threatening the Great Barrier Reef and South East Queensland dams.

Draft water quality standards were developed to address public health risks associated with releases of coal seam gas associated water which have a material impact on drinking water supplies. Advice was provided on environmental impact statements, environmental authorities, and transitional environmental programs for proposed coal seam gas water releases.

Recommendations from an independent, external review aimed at enhancing systems around the role, responsibility and accountability of Queensland Health and its partners in managing drinking water-related public health risks were actioned. The standards in the Public Health Regulation 2005 for recycled water were revised to reflect emerging public health issues and new national standards were progressed.

On 1 January 2012, Queensland Health, in collaboration with its interagency partners, established a single point of contact for asbestos-related complaints and enquiries to ensure a consistent and efficient response. This includes a telephone contact 13 QGOV (13 74 68) and web-based services (www.asbestos.qld.gov.au).

Three reports were completed following the summer storm season of 2010–2011:

- Review management of public health risks in drinking water (November 2011)
- Management of food safety risks in Queensland (June 2011)
- Draft health protection—after action report.

In response to these reports, the following actions were undertaken or were nearing completion:

- review of public health information needed in natural disasters. This information included the development of six posters with key public health messages and resources to assist agencies to manage public health risks when planning evacuation centres. Resources that were complete were used successfully during the South West floods in February 2012
- developing the Natural Disaster and Severe Weather Event website
- formalising multi-agency arrangements for the management of food safety incidents, water quality incidents and asbestos incidents
- development of the Public Health Incident Management (internal) website to support health protection staff to manage public health incidents.

Environmental health officers were deployed to protect the public and emergency services personnel involved in the South West Queensland floods by assessing and managing public health risks associated with food preparation and handling at evacuation centres and temporary food businesses, drinking water quality, waste disposal, and the control of mosquitoes and black flies.

National partnership agreements

National Partnership Agreement on Preventative Health

The National Partnership Agreement on Preventative Health (NPAPH) commenced in 2009–2010 and provides funding for Queensland to further augment current initiatives to address preventable chronic diseases. Queensland will receive $68.62 million in funding over the six years of the agreement.

The NPAPH seeks to address the rising prevalence of lifestyle-related chronic disease by promoting healthy behaviours and developing implementation plans for social marketing, healthy children and healthy workers.

1. Healthy children

The *Healthy Children Queensland Implementation Plan* aims to increase healthy eating and physical activity in a range of settings where children live, learn and play through the following programs:

- Good Start—a program for Pacific Islander and Maori children, delivered through community organisations and families to encourage healthy eating and physical activity
- Need for Feed—a healthy cooking program for young people in state high schools, delivered after school, on weekends or during school holiday periods by Diabetes Australia
- working with families and early childhood care settings, including supported playgroups and outside school hours care services to improve nutrition and physical activity
- supporting schools and sporting clubs to improve the supply and promotion of healthy food and drinks
- working with the Department of Transport and Main Roads and Local Governments to increase the number of children being active on the journey to and from school
- providing grants to community groups to improve healthy eating and physical activity levels in local settings.

2. Healthy workers

The *Queensland Healthy Workers Implementation Plan* aims to promote healthy lifestyle programs in workplaces over four years—from July 2011 to June 2015.

The following healthy worker initiatives are being supported:

- ten targeted strategies for identified high-risk or hard-to-reach workplaces
- five centralised support strategies for best practice workplace wellness, including the provision of resources and tools through a web portal; telephone and web-based information, and services to support individual behaviour change; and funding support to help workplaces implement comprehensive workplace wellness programs.

3. Social marketing—MeasureUp

The Queensland Implementation Plan for Social Marketing—MeasureUp raises awareness of the impact of lifestyle risk factors and chronic disease. Four activities are being delivered to extend the reach of the national *Swap It, Don't Stop It* campaign:

- Queensland Health coordinated more than 90 nutrition and physical activity programs, including TAFE Cook for Life; *10,000 Step*s and Heart Foundation Walking; and Cancer Council Queensland Relay for Life.
- The Ethnic Communities Council Queensland delivered *Swap It, Don't Stop It* Programs through trained multicultural health workers.
- The Queensland Aboriginal and Torres Strait Islander Health Council delivered the Hero Rewards, Good Quick Tukka Programs and capacity building initiatives in the community controlled sector.
- Diabetes Australia (Queensland), in partnership with the Heart Foundation, Cancer Council Queensland and Nutrition Australia Queensland collaborated in supporting the national *Swap It, Don't Stop It* campaign with health promotion and public relations activities.

4. Enhanced surveillance

The Queensland Health self report health status surveillance system, established in 2009–2010, continued to provide annual assessment and reporting of the prevalence of preventative health indicators for adults, and assessment for children every two to three years. In 2010–2011, prevalence of these indicators for adults and children was assessed and reported in a suite of seven reports released on the Queensland Health website.

National Partnership Agreement on Essential Vaccines

In August 2009, the Council of Australian Governments established the National Partnership Agreement on Essential Vaccines (NPAEV) to:

- minimise the incidence of major vaccine preventable diseases in Australia
- maintain and, where possible, increase immunisation coverage rates for vulnerable groups with a focus on minimising disparities between Indigenous and non-Indigenous Australians
- enable all eligible Australians to access free, high-quality essential vaccines in a timely manner through the National Immunisation Program
- increase community understanding and support for the public health benefits of immunisation.

The NPAEV allows Commonwealth-funded vaccines to be distributed to vaccine service providers, and contains four performance benchmarks to evaluate the agreement's effectiveness:

1. maintaining or increasing vaccine coverage for Indigenous Australians—Queensland has met this benchmark and coverage is being maintained
2. maintaining or increasing coverage in agreed areas of low immunisation coverage—Queensland has no areas classified as low immunisation coverage
3. maintaining or decreasing wastage and leakage—Queensland has met the benchmark
4. maintaining or increasing vaccination coverage for four-year-olds—Queensland has met the benchmark and coverage is being maintained.

2 Right way, right place, right time

Access to quality services delivered in the right way, at the right place and the right time

Objectives

2.1 Ensure sufficient service capacity in order to respond to and manage growing and changing community needs.

2.2 Increase coordination and continuity between health services and sectors to ensure consumers experience a streamlined and smooth healthcare journey.

2.3 Provide consumers and carers with information to make informed choices about their care and service options.

2.4 Support an expanded range of services available in a primary care setting through working with the Australian Government and our partners.

2.5 Provide mothers and babies with the best start and support the achievement of the best possible early child health and development.

2.6 Improve the safety, quality, effectiveness, efficiency and sustainability of health services with a focus on emergency departments, medical and surgical services, post-acute and sub-acute care and rehabilitation.

2.7 Provide chronic disease management and end-of-life services in an appropriate setting.

2.8 Provide safe, sustainable and appropriate oral health services on a statewide basis.

2.9 Improve access, coordination and continuity of care across mental health services and providers.

Key strategies

2.1.1 Develop a new *Queensland Health Services Plan 2011–2026*.

2.1.2 Implement the Clinical Services Capability Framework (v3) and prepare to evaluate its effectiveness to identify potential improvements and prospective planning opportunities.

2.2.1 Work with Medicare Locals and other healthcare providers to better integrate local health services and drive improvements in health outcomes across the entire health system.

2.3.1 Develop mechanisms to ensure consumers and the community have meaningful opportunities to engage with Hospital and Health Services to achieve better health outcomes.

2.3.2 Empower and assist consumers to manage their own health by providing interactive access to a network of health resources.

2.4.1 Continue to develop and support the provision of telephone and online health services.

2.4.2 Continue to work with General Practice Queensland and other partners to improve health outcomes for patient, consumers and communities.

2.5.1 Provide mothers with access to ante- and post-natal care and increase opportunities for women to give birth closer to home.

2.5.2 Develop smarter ways to deliver health care by implementing midwifery led models of care including continuity of care models.

2.5.3 Work with our partners to establish centres that integrate early years services.

2.6.1 Improve access to services through the use of demand management strategies such as:

- the development and implementation of the Statewide Surgical Services Program with a focus on meeting NPA targets
- the continued development and implementation of the Queensland Health Patient Flow Strategy, including expanding and upgrading emergency departments.

2.6.2 Increase the number of beds consistent with the More Beds for Queensland strategy.

2.6.3 Develop a Strategic Directions Framework for sub-acute care.

2.6.4 Develop and coordinate the implementation of programs for older people that align with national directions.

2.6.5 Continue to implement the *Patient Safety and Quality Plan 2008–2012* and *Queensland Medication Management Directional Plan 2009–2014* within all services to safeguard and improve the quality of services and safety of consumers.

2.6.6 Ensure all healthcare professionals working in Queensland Health facilities are appropriately registered and credentialed.

2.7.1 Review of the *Queensland Strategy for Chronic Disease 2005–2015*.

2.7.2 Implement the Diabetes Action Plan.

2.7.3 Continue the development and implementation of the *End-of-Life Care Strategy for Queensland*.

2.7.4 Develop strategic directions for:

- cancer and renal health services
- palliative care in the context of the Sub-Acute Care Framework.

2.8.1 Continued implementation of *Australia's National Oral Health Plan 2004–2013*.

2.9.1 Commence implementation of Phase 2 of the *Queensland Plan for Mental Health 2007–2017*.

2.9.2 Progress the clinical reform process to ensure healthcare coordination across mental health care providers (government and non-government).

2.9.3 Commence implementation of the *Queensland Mental Health Natural Disaster Recovery Plan 2011–2013*.

Key performance indicators

- Number and age standardised rate of potentially preventable admitted patient episodes of care.
- Percentage of women who during their pregnancy were smoking after 20 weeks.
- Percentage of women who gave birth and had five antenatal visits or more in the antenatal period.
- Percentage of new case referrals categorised within five days of receipt of referral.
- Percentage of emergency department patients seen within recommended timeframes.
- Percentage of admissions via the emergency department who are admitted within eight hours of their arrival in the emergency department.
- Percentage of elective surgery patients waiting more than the clinically recommended time for their category.
- Percentage of elective surgery patients treated within the recommended timeframe for their category.
- Median waiting times for emergency departments.
- Median waiting times for elective surgery.
- Percentage of elective surgery cancellations (hospital initiated).
- Average number of public hospital beds occupied each day by nursing home type patients.
- Rate of healthcare associated staphylococcus aureus bacteraemia in hospital.
- Percentage of patients that acquire a pressure ulcer during their stay in hospital.
- Percentage of patients receiving appropriate venous thromboembolism (VTE) prophylaxis.
- Hospital Standardised Mortality Ratio.
- Percentage of staff vaccinated against seasonal influenza.
- Number of children, adolescents and adults oral health occasions of service.
- Rate of community follow-up within seven days post-discharge from acute mental health inpatient care.

Providing quality service

Patient flow strategy

An audit conducted in January 2012 indicated that in the first six months of 2011–2012 Queensland Health built an additional 185 beds (including medical, surgical, maternity, neonatal, paediatric, short stay, intensive care, mental health and sub-acute) and 37 emergency department treatment spaces.

Meeting the increased demand and changing health needs of the population also requires innovation in the way we deliver services. As Queensland public hospitals provide both elective and emergency services the increased demand for emergency services impacts on the ability of hospitals to provide elective surgery services. To meet these demands innovative ways to balance these competing services need to be explored.

The *Queensland Health Patient Flow Strategy 2010* was developed to define a statewide approach to better manage the entire journey for patients. The strategy aims to challenge the way that staff think and to reshape Queensland Health processes to enable our health system to cope with the additional pressures being placed upon it. The goals of the strategy are to:

- improve the patient journey and experience
- reduce delays and increase access to services
- ensure best clinical practice across the state.

Key initiatives that have been implemented in emergency departments, inpatient wards, outpatient clinics and elective surgery services in 2011–2012 to support service improvement in relation to the Patient Flow Strategy include the following:

All services

- creation of a central repository of over 30 service improvement initiatives and service delivery models that have proven efficacy in relation to patient flow
- commencement or completion of over 20 clinical redesign projects in health service districts across the state to holistically examine performance, diagnose impediments to patient flow and make recommendations to improve the healthcare experience of patients and improve access to services.

Outpatients

- temporary recruitment of 78 business process officers across the state to improve data capture and reporting processes in order to meet national requirements associated with the implementation of ABF
- implementation of the Queue Manager System in the Mackay Health Service District to streamline patient registration and queuing in outpatient clinics
- statewide review of four outpatient clinics where there is consistently high demand for services, namely: gastroenterology, ophthalmology, urology and orthopaedics. The reviews will include analysis of current and future demand for service provision and recommendations for change to improve access to specialist services
- awarding clinical practice improvement payments to TPCH and Ipswich Hospital in recognition of outstanding performance in improving categorisation of outpatient referrals.

Emergency departments

- appointment of business process improvement officers in 27 emergency departments across the state to examine the quality of data used to report emergency department performance (focussing on triage category one and two patients) and identify key issues impacting on patient flow through the emergency department
- development of an Emergency Department Short Stay Unit Policy and Implementation Standard and associated changes to the Emergency Department Information System (EDIS) to address variation in the operation and data capture of patients admitted to emergency department short stay units
- external review of the interface between Queensland Ambulance Service and the Queensland public emergency departments as part of the Metropolitan Emergency Department Access initiative (MEDAI), including the development of strategies to improve patient access and flow through key emergency departments located in the south-east corner of the state
- implementation of the Emergency Capacity Hospital Overview System (ECHO) with links to EDIS, to provide live updates on emergency department activity, and the installation of ambulance arrival boards in 14 hospitals across the state. This provides real-time feed from the Emergency Services Computer Aided Dispatch System to allow emergency department services to monitor the current status of ambulances en-route to each emergency department.

- development of the Admission Facilitation Implementation Standard to facilitate the timely transfer of patients from the emergency department to an inpatient ward when review by the inpatient team is delayed.

Inpatient services

- installation of 49 Electronic Patient Journey Boards in 14 facilities across the state to improve admission practices, bed management, discharge planning and care coordination
- initiated development of statewide guidelines for Hospital-in-the-Home (HITH) Services to assist health service districts to administer HITH services within appropriate governance and funding structures, deliver high-quality services to patients, promote consistency of access and reduce variation in service provision across the state
- commenced the development of the Patient Flow Survey (PFS) to systematically capture and quantify data about the types of clinical and non-clinical delays in a patient's journey across hospital settings (i.e. from the emergency department through to all inpatient ward types) and provide detailed information about bed utilisation across facilities.

Clinical services capability

The Queensland Health Clinical Services Capability Framework (CSCF) for Public and Licensed Private Health Facilities (Version 3.0) outlines the minimum service, workforce and support service requirements to ensure safe and appropriately supported public hospital and licensed private hospital services. In 2011–2012, implementation of Version 3.0 of the CSCF was supported with the development of a resource kit, including standardised self-assessment checklists, reporting templates and education and training packages for use by public hospitals and privately licensed facilities. As at 30 June 2012, all 17 health service districts had received training in the revised framework and completed self-assessment and reporting requirements.

Senior medical officers and dentists are credentialed in accordance with the updated Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists in Queensland Health Policy and Implementation Standards that became effective on 30 January 2012. Daily audits match Queensland Health employment records with the Australian Health Practitioner Regulation Agency (AHPRA) detailing registered and unregistered healthcare professionals.

Patient safety and quality

In 2011–2012, in accordance with the *Patient Safety and Quality Plan 2008–2012*, Queensland Health:

- interviewed 9518 patients across 31 Queensland public hospitals to gain feedback on their experience of care during their visit to the emergency department
- collected extensive information on a range of patient safety and quality areas of the National Safety and Quality Health Service (NSQHS) Standards across 122 hospitals and 24 residential aged care facilities within Queensland Health (2011 Patient Safety Bedside Audit)
- implemented root cause analysis recommendations to develop clinical pathways for meningococcal disease and head injury
- assessed 164 patient safety device concerns and issued two Patient Safety Alerts and two Patient Safety Notices
- developed the Standardised Paediatric Diabetic Ketoacidosis protocol
- developed the transition framework for adolescents with chronic disease
- developed the Statewide Transient Ischaemic Attacks (TIA)/Stroke Pathway
- developed an asthma control pack and DVD
- conducted the statewide VTE Prophylaxis Audit of 1038 eligible acute adult inpatients to assess the extent to which prescribed chemical prophylaxis is documented in the National Inpatient Medication Chart
- revised statewide Mental Health Standardised Suite of Clinical Documentation, including the accompanying tools for assessing substance use and dependence
- launched the Interim Medication Administration Record (IMAR) in September 2011. The IMAR provides a discharge medication list for patients discharged to residential aged care facilities. In January 2012, 188 IMARs were produced by seven early adopter sites, targeting those patients at higher risk of medication mishap
- disseminated 690 Variable Life Adjusted Display (VLAD) charts each month across 74 public hospitals and 330 charts across 37 private hospitals to monitor safety and quality
- reviewed 200 hospital investigation reports in response to VLAD flags
- provided 1600 hours of education on clinical pathways
- launched Clinician Disclosure Online Learning and facilitated simulation training programs

- trained an additional 26 open disclosure consultants and conducted a refresher master class for 11 existing open disclosure consultants
- implemented the new Informed Decision-Making in Healthcare Policy and published a comprehensive accompanying Guide to Informed Decision-Making in Healthcare for staff
- launched nine new eLearning courses in the clinical skills development services and increased eLearning enrolments by 15 per cent
- established 34 pocket simulation centres throughout the state
- launched the Vocational Graduate Certificate in Healthcare Simulation
- immunised 51.75 per cent of Queensland Health staff against influenza
- conducted a staff opinion survey (12 590 staff) in 11 districts, divisions and statewide services, and included three new measures, (communication, stress and work pressure and respectful workplace) and recorded a positive change in comparison to the 2009 data in 13 of the 18 measures.

Medication management

Implemented the department's *Medication Management Directional Plan 2009–2014*:

- provided education and training to trainee and recently registered pharmacists to improve their core knowledge and skills
- developed tools and decision support for safer prescribing and monitoring of high risk medicines such as clozapine and insulin
- improved patient access by adding cost-effective medicines to the Queensland Health List of Approved Medicines (LAM)
- advanced the role of pharmacy assistants as support personnel to free up the pharmacist's time to focus on clinical issues
- worked in partnership with the National E-Health Transition Authority to map the Queensland Health medicines file with the Australian Medicines Terminology to ensure consistent clinical terminology. A paper outlining this work, *Mapping the Queensland Health iPharmacy Medication File to the Australian Medicines Terminology* won the Branko Cesnick Award for Best Scientific Paper at the 2011 Health Informatics Conference.

Haemovigilance report

Queensland Health's Haemovigilance Report details adverse transfusion-related events and uses this information to develop recommendations for improved patient safety. Information and data obtained from the report is forwarded to the National Blood Authority and contributes to both national and state initiatives to improve patient safety in the use of blood and blood products. The inaugural Haemovigilance Report, *The Queensland Blood Management Program: Queensland Incidents in Transfusion (QiiT) Report—A Safer Future for Emily*, was published as an appendix to the *Patient Safety: From Learning to Action Report* in June 2012.

Pathology utilisation medical program

The Pathology Utilisation Medical Program (PUMP) provided health service districts with support material to manage and monitor their pathology activity and decrease the number of unnecessary tests being ordered. Its *Right Time, Right Test, Right Patient* initiative incorporates online resources and tools to ensure appropriate and relevant tests are done.

Emergency departments

Queensland made significant improvements in terms of emergency department waiting times with the median waiting time improving from 29 minutes in 2006–2007 to 23 minutes in 2010–2011.

Queensland also made significant improvements in emergency department median waiting times, improving from sixth place in 2006–2007 to fourth in 2010–2011. The proportion of patients who presented to Queensland emergency departments who were seen within clinically recommended times was 67 per cent, below the national performance of 70 per cent. Queensland improved from sixth place in 2006–2007 to fourth place in 2010–2011 for this measure.

Queensland Health's strategies to improve access included expanding and upgrading emergency departments at a number of facilities throughout the state included:

- The $17.1 million Cairns Hospital Emergency Department (ED) Expansion Project was completed in March 2011 and increased the existing ED capacity to 50 treatment spaces.
- As a component of the $437 million Townsville Hospital Redevelopment, the ED opened in July 2011 with an expanded capacity to 75 treatment spaces. The short stay ward was expanded to 16 treatment spaces and was completed in December 2011.
- The $408 million redevelopment of Mackay Base Hospital includes a significant expansion of the emergency department to 36 treatment spaces.

- Construction of the $65 million Mount Isa Health Campus Redevelopment is underway and includes an expansion and refurbishment of the ED increasing capacity to 27 treatment spaces.
- The $145 million Logan Hospital Emergency Department Upgrade Project will transform Logan Hospital into a new expanded health facility offering a collocated adult and children's ED, increasing the capacity by 18 adult treatment spaces, 12 new paediatric treatment spaces, 8 paediatric short stay beds and the reinstatement of 14 existing inpatient paediatric beds.
- Construction of the $9.7 million Caboolture Hospital Paediatric Services Facility is currently underway with an expected completion date at the end of 2012. The facility will provide five new paediatric short stay beds which will be used to fast track paediatric patients (where appropriate) from the ED.
- Construction of the six paediatric short stay beds component at the $2.8 million Redcliffe Hospital Paediatric Emergency Services facility was completed in March 2012. The facility will be used to fast track paediatric patients, where appropriate, from the ED.
- Construction of a new $45.6 million Paediatric ED at TPCH is scheduled to be completed by the end of 2012. It is providing 20 short stay paediatric ward beds, 12 paediatric ED treatment spaces and eight paediatric outpatient clinics.
- The $134.6 million PAH Expansion officially opened in January 2012. The initiative included a major expansion to the hospital's ED, providing 25 additional adult ED treatment spaces, one additional adult ED short stay bed and a 30-bed Medical Assessment and Planning Unit.
- The $5 million Toowoomba Hospital Emergency Department Expansion Project was completed in January 2012 and delivered four short stay beds and a 12 person transit lounge.
- Construction of the $37 million QEII Hospital Emergency Department enhancement will commence in mid-2012 and is designed to create 11 fast track treatment bays and additional short stay capacity.
- The $128.7 million Ipswich Hospital Expansion Project will deliver an additional 84 beds, 18 adult and 12 paediatric ED treatment spaces, six adult and paediatric ED short stay beds, as well as a dedicated paediatric emergency area.
- The $13.6 million expansion of the Redland Hospital Emergency Department will include a new helipad, four paediatric ED treatment spaces, five adult short stay beds, three inpatient paediatric beds, a new ambulance work station, and four consulting rooms. The expected completion date is the end of 2012.

Elective surgery

Queensland ranked equal first nationally (together with Western Australia) for elective surgery median waiting time performance. Queensland maintained its performance for having the best median waiting time for elective surgery of 29 days compared with the national average of 36 days. Queensland has held this first place position nationally for the past five years.

In 2010–2011, 82 per cent of elective surgery patients in Queensland were seen within clinically recommended timeframes. This result can be attributed to Queensland's focus on treating the longest waiting patients. As a national comparative figure for the median waiting time for elective surgery is no longer available, Queensland is only able to publish a state figure for this indicator.

Queensland Health implemented the following service improvement initiatives to achieve elective surgery performance targets associated with the National Partnership Agreement on Improving Public Hospitals:

- Checklist software was implemented across the state to support health service districts model the impact of process redesign on hospital waiting lists. Checklist software provides local staff with the ability to develop and test scenarios regarding patient queuing. In turn, this allows them to identify process changes required for optimal management of elective surgery waiting lists.
- Progressive implementation of The Productive Theatre Program to improve operating theatre productivity. The program is informed by international best practice.
- Implementation of Operating Room Management Information System (ORMIS) version 7.0 into 24 hospitals across the state. The rollout of ORMIS allows benchmarking of operating room performance through capture and collation of key process metrics for operating theatres.
- Providing additional treatment opportunities through the Surgery Connect Program. The program provides alternative treatment options for long wait elective surgery patients, either in the private sector or by using available capacity in the public sector outside normal operating hours. Since its inception in late 2007, Surgery Connect has undertaken approximately 33 000

procedures, either internally or through outsourcing to the private sector. In 2011–2012, 2123 procedures were undertaken in the private sector through Surgery Connect. The program also provided $23 million to facilitate treatment of long wait elective surgery patients internally in Queensland public hospitals. Investment in minor capital developments and additional surgical equipment to improve surgical throughput in Queensland public hospitals.

- The purchase of additional equipment, including ophthalmology equipment and instruments for the Townsville Hospital Vitreo-Retinal Service in North Queensland and endoscopic equipment for the Metro South Health Service District. This equipment has improved internal capacity with flow on effects in terms of operating room efficiency and waiting times for elective surgery.

Midwifery

Queensland Health continued to increase access to a variety of models of maternity care.

By the end of 2013, it is anticipated that for 10 per cent of all births in Queensland public hospitals, the woman will see the same midwife or small group of midwives during the pregnancy, birth and postnatal period. In 2011–2012, a second edition of the Midwifery Led Model of Care Implementation Guidelines was issued by Queensland Health.

Three projects were funded in 2011–2012 under the Rural Maternity Initiative:

- Darling Downs for the Statewide Collaborative Arrangements Project ($157 000)
- Townsville Indigenous Midwifery Pilot Project ($280 000)
- Beaudesert Midwifery Led Model of Care—Group Practice ($503 000).

In 2011–2012 other initiatives included:

- Credentialing private practice midwives to provide care for private patients and an employment model to ensure continuity of midwifery care if a woman's risk profile changes (Toowoomba Hospital).
- Gold Coast, Ipswich and Caboolture Hospitals local steering committees examining credentialing private practice midwives.
- The Beaudesert Midwifery Led Model of Care is progressing postnatal inpatient services at Beaudesert Hospital. Negotiations are underway with Griffith University to form a partnership aimed at evaluating the model of care and developing strategies to enhance the model. Recruitment of additional continuity of care midwives and a manager position is expected to be fully implemented by late 2012.
- The Townsville Indigenous Midwifery Pilot, assisting Indigenous women to become midwives. The second year (2011) of the pilot had five Indigenous midwifery students enrolled in full time study.
- Updating the Midwifery Drug Therapy Protocol and related Health Management Protocol (HMP) and making it available online. The Workbook Education Tool was updated and is also available online.

End-of-Life Care Strategy

In 2011–2012 Queensland Health:

- continued embedding the Acute Resuscitation Plan (ARP) form and resources into Queensland Health facilities. The ARP, which replaced Not For Resuscitation Orders in 2010, documents decision-making to help reduce unnecessary and unwanted treatments for dying patients
- developed and implemented policies and resources to ensure patients at the end-of-life are appropriately managed in the community, rather than in the hospital
- developed and provided public resources, including a website, that enable Queenslanders to conduct advance care planning to ensure their preferences at the end-of-life are respected
- developed and provided staff resources, including a website, for training around end-of-life decision-making and documentation to enable staff to better meet the legal and ethical frameworks in Queensland.

Outpatient services

Over 290 000 finalised electronic discharge summaries were sent from Queensland Health hospitals to GPs in 2011–2012. A further initiative was introduced to support the creation and delivery of electronic referrals from GPs to Queensland Health specialist outpatient departments. The initiative is improving the quality of communication between the primary and acute care sectors when a patient's condition requires specialist assessment.

In March 2011, a joint General Practice and Queensland Health Outpatient Operational Advisory Committee (OOAC) was convened to assist Queensland Health to:

- identify key priority areas impacting negatively

or positively on delivery of specialist outpatient services
- formulate strategies for each of the key priority areas to minimise their impact on the delivery of specialist outpatient services
- develop an open and supportive environment for all clinicians working within, or referring to, specialist outpatient services in Queensland
- promote education and research in the outpatient setting
- deliver high-quality experiences to patients and carers during their encounter with outpatient services.

The committee met every two months from March 2011 to May 2012, to provide advice in relation to the following:
- the Outpatient Improvement Program—OOAC monitored implementation of the department's statewide program of work designed to better manage the outpatient journey and improve access to outpatient services
- statewide reviews of ophthalmology and gastroenterology outpatient services
- Queensland Health 2011–2012 Purchasing Initiative for Outpatient Services
- management of Category 1 specialist outpatient referrals
- review of acute primary care clinics in Queensland.

Organ and tissue donation service

The Organ and Tissue Donation Service administers and provides organ and tissue donation, retrieval, tissue banking and distribution services for Queensland for transplantation purposes, under the *Transplantation and Anatomy Act 1979*.

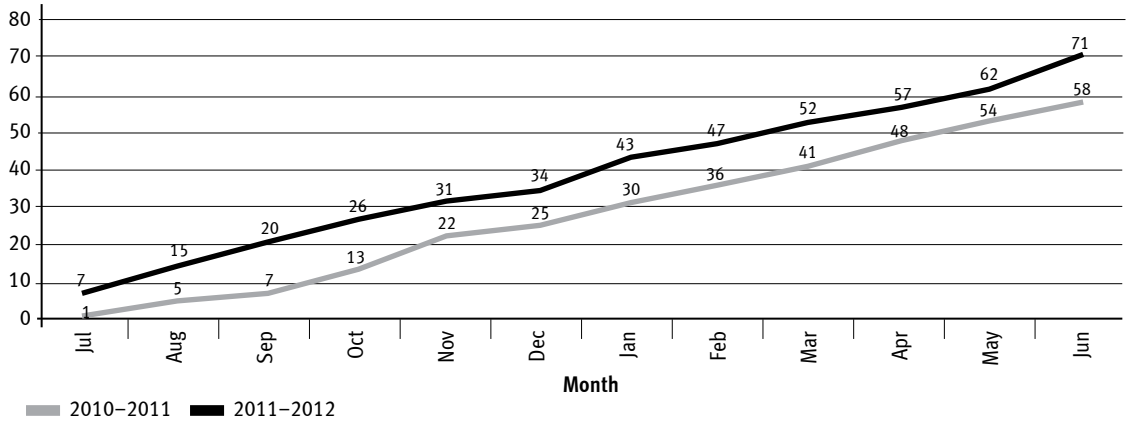
In 2011–2012, the service worked to increase organ and tissue donation outcomes through measures such as:
- further roll-out of the donation after cardiac death program to increase options for donation
- opening of the Queensland Skin Bank in July 2011 to better enable life saving treatment of burns patients in Queensland
- delivering in-service education to 5172 clinicians at 30 hospitals across the state to increase capacity and opportunity for donation to occur
- undertaking community awareness-raising activities particularly during DonateLife Week 2012.

Those measures led to significant improvements in Queensland's donation rates, including:
- improved the organ donor outcome by 18 per cent from July 2011 to June 2012 (71 donors) compared with the same period in 2011 (58 donors)
- improved the tissue donation outcome with 335 donations to the Queensland Eye Bank, 63 to the Queensland Heart Valve Bank, 1351 to the Queensland Bone Bank and 63 to the Queensland Skin Bank.

In 2012–2013, the Organ and Tissue Donation Service will continue to work with the Australian Government's Organ and Tissue Authority and services in other jurisdictions to deliver the National Reform Agenda *A World's Best Practice Approach to Organ and Tissue Donation for Transplantation*.

The 2012–2013 priorities will include:
- further establishment of a clinical governance framework to direct and support the DonateLife network within Queensland and nationally

Graph 2: Organ donation rate 1 July 2010 to 30 June 2012, financial year comparison



- continued delivery of targeted education to those health professionals involved in organ donation to increase effectiveness of conversations with families of potential donors
- improve data collection, evaluation and record capabilities within the DonateLife network to better realise potential
- proactively engage CALD audiences within Queensland to raise awareness of organ and tissue donation for transplantation.

Aged care

A further 127 Transition Care Program places became operational in Queensland bringing the total number of places to 733. This program assists approximately 5000 older people each year with a period of restorative care following hospitalisation.

Aged care assessment teams conducted approximately 30 000 assessments of older Queenslanders this year, assisting them to gain access to community care services and residential aged care services. Queensland Health has maintained improvements in the timeliness of these assessments exceeding the Queensland key performance timeliness benchmark for this activity.

Queensland Health met accreditation standards for its 20 residential aged care facilities and has implemented a quality assurance process to ensure that it continues to meet these standards.

Primary and community healthcare

The current National Health Reform Agreement commits the Commonwealth to developing a National Primary Health Care Framework by December 2012 to set out agreed future policy directions and priority areas for general practice and primary healthcare. Improved service integration is an important focus area for that framework and Queensland Health has been proactively engaging with other states, territories and the Commonwealth to identify and advocate for practical solutions to address the current gaps in primary care service provision.

Oral health services

A number of key strategies were progressed to provide safe, sustainable and appropriate oral health services:

- construction and delivery of three mobile dental clinics to improve dental services to rural and remote Indigenous Queenslanders, funded by the Commonwealth under the NPA on Health Infrastructure
- recruitment of a statewide manager of Indigenous oral health to promote oral health outcomes and service accessibility for Indigenous Queenslanders
- planning for new dental clinics in Hervey Bay and Bundaberg
- continued support for the ongoing roll out of the *Water Fluoridation Implementation Plan*
- completion of the first phase of research into the oral health status of five to 14-year-old children across Queensland to inform future service delivery priorities
- development of oral health resources available to Aboriginal and Torres Strait Islander clients and those from diverse cultural and linguistic backgrounds
- ongoing development of a program to support the future introduction of a full electronic paperless patient dental record
- support for professional development opportunities and the establishment of a culture of continuous learning for dental practitioners in collaboration with Clinical Education and Training Queensland
- support for an increase in the number of Queensland dental graduates by providing support to three Queensland dental schools
- the School Oral Health Service Information Project (SOHSIP) increased the ability for school oral health services to respond to children's needs regardless of location through the implementation of a seamless statewide oral health record for school children. This was delivered to 197 mobile and 158 fixed clinics statewide.

Telephone and online services

In 2011–2012, 13 HEALTH (13 43 25 84) received 305 019 calls, with a majority of calls answered within 20 seconds. More than 84 per cent of calls to 13 HEALTH were referred to health providers other than an emergency department. Following a call to 13 HEALTH, callers are free to use the doctor or service they choose. The most common health issues raised by callers to 13 HEALTH are chest pain, abdominal pain, unwell newborns (age 0-3 months), fever (toddlers) and wound infection.

From 1 July 2011 to 30 June 2012, more than 28 per cent of callers (66 215 calls) that were triaged by 13 HEALTH nurses called from outside South East Queensland.

13 HEALTH is a 24-hour-a-day, seven-days-a-week phone service for Queenslanders, to help take the worry out of health concerns. The community can contact the service for the price of a local call.

Qualified Queensland Health staff operate the service, triaging enquires and providing advice on health issues as well as referral to other health providers, as needed. The advice is confidential, qualified and supportive. The service is designed to help reduce pressure on the state emergency departments.

During natural disasters the Health Contact Centre assists public hospitals emergency department staff by answering all phone-based enquiries. Between 1 July 2011 and 30 June 2012, more than 84 per cent of calls to 13 HEALTH from flood and cyclone-affected areas were referred to health providers other than an emergency department.

Health consumers

By December 2012, HHSs are required to have in place consumer and community engagement strategies that enable participation by health consumers and community members in the delivery and planning of local health services. In 2011–2012, Health Consumers Queensland (HCQ) developed a Consumer and Community Engagement Framework to assist health service districts anticipate this requirement and implement such strategies. The framework provides a consistent and overarching guide to effective engagement strategies. It supports collaborative approaches to engagement that promote seamless and integrated service provision across primary, sub-acute and acute health services.

The framework was released in February 2012, and work is continuing on the development of tools and resources to support this renewed emphasis on effective engagement.

In 2011–2012, HCQ developed *Getting the Healthcare You Need: An Advocacy Toolkit for people using the healthcare system in Queensland* to empower and assist consumers (patients, their families and carers) to more actively participate and make informed decisions around their healthcare and broader health services. The toolkit comprises two documents, a quick reference brochure and a larger document which includes tips, ideas, resources and practical case studies on engaging effectively with health professionals and health services.

Mental health

The Four Year Report on *The Queensland Plan for Mental Health 2007–2017* was published and released in October 2011.

The plan challenges government, private sector, and non-government organisations to work collaboratively to provide recovery-oriented, consumer-focussed mental health services that:

- promote mental health and wellbeing
- where possible, prevent mental health problems and mental illness
- reduce the impact of mental illness on individuals, their families and the community
- promote recovery and build resilience
- enable people who live with a mental illness to participate meaningfully in society.

There are clear targets to measure and evaluate progress over the course of the plan.

Priority 1: Promotion, prevention and early intervention

The Four Year Report noted a downward trend in high or very high levels of psychological distress since 2007, compared with the time of publication. However, the data was gathered prior to the unprecedented natural disasters experienced by Queensland in the summer of 2010–2011.

In this context, the department established a specialist family bereavement service to provide intensive assessment, intervention and support to families who lost loved ones as a result of the 2011 summer disasters. The Mater Statewide Recovery and Resilience Team was established to provide specialist clinical services to children and young people affected by the disasters, and to develop a range of programs and resources for implementation across the state.

There are now recovery and resilience teams (specialised trauma-focussed mental health teams) which can be mobilised to work in disaster affected areas, and which are supported by a referral pathway using 13 HEALTH. In addition, training in Skills for Psychological Recovery was rolled out to appropriately qualified staff across various government and non-government agencies, and training in trauma focussed therapies was provided to specialist mental health clinicians.

The following initiatives undertaken in 2011–2012 were relevant to the plan's first priority:

- *Ed-LinQ* worked at a state and district level to strengthen partnerships between child and youth mental health services, the primary care sector and the education sector to improve prevention, early detection, support and access to referral pathways for school children and young people experiencing mental illness. The *Ed-LinQ* workforce of 13 district coordinators, a statewide coordinator and a transcultural coordinator was enhanced with additional funding to establish an Aboriginal and Torres Strait Islander coordinator and district coordinator for Mount Isa. In collaboration with the New South Wales Department of Health, *Ed-LinQ* modified the New South Wales School-Link statewide training modules for joint delivery to more than 350 child and youth mental health, student support, pastoral care, and primary care service providers. The training covered collaborative management of child and adolescent mental health issues and self harming behaviours.
- Development and implementation of *Change our Minds*, a stigma reduction campaign. This campaign successfully raised awareness and addressed negative perceptions of, and behaviours towards, people with a mental illness. The campaign featured a range of community-based support activities as well as television, radio and print advertising and an interactive website. Evaluation of the *Change our Minds* campaign showed there was a positive impact on community understanding and awareness of the effects of stigma on people with mental illness. Eighty-three per cent of respondents confirmed the importance of reducing negative perceptions of mental illnesses; 28 per cent recalled the billboard/outdoor campaign; 57 per cent recalled the TV campaign; and 42 per cent agreed the campaign increased their level of understanding for people with mental illness.
- *Mental Health First Aid* for youth, and for Aboriginal and Torres Strait Islander Queenslanders: more than 100 Queensland Health and cross-sectoral staff were trained as instructors and three dedicated cluster coordinator positions were funded.
- Development of the *Mental Health Essentials* resource package in collaboration with the Hunter Institute of Mental Health—this is a practical mental health literacy resource for emergency service workers to increase their knowledge and understanding of common mental health disorders, and to improve their detection of symptoms associated with a suspected mental illness. The project provided every Queensland police and ambulance officer with a resource folder containing eight essential fact sheets on mental illness topics including depression and suicide.
- Development of the *Queensland Government Suicide Prevention Action Plan*—a blueprint for a whole-of-government, whole-of-community approach to suicide prevention across the state. Enhances the cross-sectoral response in detecting, responding and managing suicide risk in Queensland. Clinicians worked within 11 acute care teams across the state to strengthen the quality and timeliness of suicide risk assessment and management.
- Five suicide prevention project positions were established to equip frontline staff within the Department of Education Training, and Employment, the Department of Communities, Child Safety and Disability Services, the Department of Community Safety (Queensland Corrective Services) and the Queensland Police Service with the skills and knowledge to detect and manage suicide risk.

Priority 2: Integrating and improving the care system

$380.6 million was invested in the first four years of the plan, to integrate and improve the care system and establish statewide service models that support integrated services and implement a new Consumer Carer and Family Participation Framework.

The plan's 2017 target is to have 40 beds per 100 000 population.

Work progressed on capital works projects to deliver new, upgraded and redeveloped mental health beds, which will result in a net increase of 146 beds. By the end of June 2012, six projects were completed, delivering 70 new and redeveloped beds, including:

- upgrade to eight extended treatment beds in Townsville (completed June 2008)
- five new older persons' extended treatment beds at Nambour (completed December 2009)
- nine new beds in the High Secure Unit at The Park Centre for Mental Health (commenced operation in January 2012)
- a new 20-bed CCU at Coorparoo (completed September 2011)
- an eight-bed adolescent inpatient unit and day program at Toowoomba (construction completed October 2011)

- a new 20-bed forensic extended treatment rehabilitation unit at The Park Centre for Mental Health.

There has been an increase of 569 full-time equivalent (FTE) community mental health positions across Queensland since 2007, including: 366 nurses and allied health professionals; 78 medical officers; 25 technical and operational staff and 100 administration positions to support clinicians. Queensland Health currently has 47 FTE per 100 000 population, resulting in the achievement of 61 per cent progress to the target of 70 FTE per 100 000 population (required by 2016–2017).

A key performance indicator for this priority is the readmission rate within 28 days of inpatient treatment. The Four Year Report found that readmissions had decreased from more than 20 per cent in 2005–2006 to 17 per cent of all separations in 2010–2011. In 2011–2012, preliminary data showed that the readmission rate continued to fall. The Four Year Report noted that decreases in this indicator, demonstrated more sustainable patient care and a reduction in unplanned readmissions.

Priority 3: Participation in the community

The *Supporting Recovery: Mental Health Community Services Plan 2011-17* provided a road map for the future of Queensland's non-government mental health services sector.

Initiatives included:

- **Transitional Recovery Program**: this provides non-clinical personal support (24/7 if required) to help transition; the target group includes people from inpatient services transitioning back into the community through a residential program (flexible stay to 12 months) and outreach. Transitional Recovery Programs are being established at the Gold Coast, Logan, Caboolture and the Sunshine Coast. The four current programs will provide a total of 33 residential places and 16 outreach places.
- **Resident Recovery Program**: this program provides short to medium term non-clinical community based support to assist individuals to break the cycle of moving through acute care, boarding house or hostel accommodation and homelessness in inner north and inner south Brisbane, Ipswich and Toowoomba. 328 people have been supported through the service model during 2011–2012.
- **Transition from Correctional Facilities**: this program provides short to medium term non-clinical support for people transitioning from correctional facilities to improve continuity of care. The program has been expanded and now supports people in South East Queensland, Rockhampton, Maryborough, Townsville and Cairns.
- **Consumer Operated Services**: this program provides a range of services including one-on-one and group peer support programs, telephone support lines and intensive short-term residential support (up to three weeks) to reduce the likelihood of escalation to crisis. Three programs are established—Brisbane, Sunshine Coast and Hervey Bay. The three programs provide a total of 10 residential places providing for throughput of 160 people per year, and non-residential support to 350 people per year. Peer worker training held in 2011–2012 provided 19 days of training with a total attendance of 144 peer workers.
- **Housing and Support Program (HASP)**: this program was delivered collaboratively by the Department of Communities, Queensland Health and non-government service providers to support recovery for individuals with psychiatric disability. It provides social housing linked with non-clinical support services. During 2011–2012, approximately 240 people were supported through HASP.
- **Recovery oriented Certificate IV in Community Mental Health**: provided through the Department of Education and Training, ensured statewide availability of disaster recovery training resulting in 82 workshops to 1600 Queensland Government and non-government staff working in disaster affected communities.
- **Clinical Reform Initiative**: Building the foundations for recovery and participation for people with severe mental illness and psychiatric disability is a focus of the reform agenda in the Queensland Plan for Mental Health. These consumers require dedicated and sustained assistance to access, and remain engaged with the range of health and social support services needed for sustained recovery. Since its commencement in 2010, the clinical reform initiative has supported the progression of needs analysis and strategic planning to achieve better coordinated care and has had a positive impact on a range of mental health services.

Intended system outcomes include:

- increased capacity in community-based mental health services
- processes for performance measurement and service improvement
- strengthened collaboration and coordination across mental health, primary health and social support services at the local level.

Priority 4: Coordinating care

The Four Year Report on the Plan noted the establishment of 20 service integration coordinators to facilitate more seamless care across primary health, housing, employment, disability and mental health services. In 2011–2012, an additional three Aboriginal and Torres Strait Islander Service Integration Coordinators were recruited to implement a Child and Youth Care Coordination project.

Priority 5: Workforce, information, quality and safety

Implementation continued on developing workforce capacity to deliver mental health programs through the *Mental Health Leadership Program* and the Centralised Recruitment Project.

A Statewide Clinical Governance Steering Committee was established to develop and coordinate clinical governance activities in Queensland Mental Health Services. It provides oversight of safe, high-quality and evidence-based care to ensure that patients are the main focus and priority of mental health service delivery.

The Consumer Integrated Mental Health Application (CIMHA) supported mental health clinicians across 120 Queensland locations in providing safer quality mental health services. This integrated system displays a comprehensive picture of a patient's mental health care needs, with a second phase now underway to further support mental health clinicians.

Key achievements for 2011–2012 included:

- continued development of statewide mental health models of service
- targeted implementation of priority models of service in selected areas to improve access, clinical leadership, service responsiveness, consistency of treatment, and quality of care to consumers of public mental health services
- building capacity within mental health services to use data and information to effectively target service improvement initiatives
- a Mental Health and Alcohol and Other Drugs Policy that sets out principles for service integration and associated implementation standard for care coordination.

Queensland Health Victim Support Service

The Queensland Health Victim Support Service (QHVSS) is a service that promotes and supports the recovery of victims of mentally ill offenders. Information, counselling and other supportive activities are provided to clients and their families at any stage after the initial offence and for as long as needed by the client.

There was an increase of 42 per cent in the number of open cases managed by the service in 2011–2012. The service had 172 clients at 30 June 2012 compared with 121 clients at the same time last year. Seventy per cent of these were clients of the service prior to 1 July 2011.

The 172 clients were victims, or family of victims, of a range of offences. These included:

- 58 (34 per cent)—assault causing grievous bodily harm, assault occasioning bodily harm, robbery with violence, serious assault and common assault
- 39 (23 per cent)—murder and dangerous driving causing death
- 34 (20 per cent)—attempted murder
- 16 (9 per cent)—unlawful stalking
- 14 (8 per cent)—rape and sexual assault
- 11 (6 per cent)—miscellaneous offences.

The seriousness and complexity of the offences provide some insight into the traumatic grief experienced by, and the complex psychological needs of, those clients. The QHVSS has managed a total of 428 clients since the establishment of the service in 2008.

Key achievements in 2011–2012 include:

- Negotiation of an arrangement with the Queensland Police Service to identify eligible victims. The police will contact the victim to advise them of the QHVSS and its role. This process of early recognition and intervention with victims is leading to increased referrals to the service and applications for orders and, most importantly, provides victims with access to information and support in a timely and responsive way.
- A representative from the QHVSS participates as a member of a committee which reviews the documentation in relation to a forensic patient when the victim has a Forensic Information Order (FIO) in place. The purpose is to ensure the issues faced by the victim are given due consideration; the proposed risk management plan for the patient minimises risk for both the victim and the patient; and also ensures that information about the offence and the victim is accurately represented.

National partnership agreements

National Partnership Agreement on Improving Public Hospital Services

The National Partnership Agreement on Improving Public Hospital Services (NPAIPHS) has been developed to improve access to public hospital services, including elective surgery, subacute care and emergency department services.

A total of $83.8 million in reward funding is available to Queensland under the NPAIPHS—$42.2 million for National Elective Surgery Target (NEST) and $41.6 million for the National Emergency Access Target (NEAT), subject to achievement of performance targets. Queensland performance against these targets will be assessed at 31 December 2012.

Queensland Health has initiated the following projects to deliver public hospital service improvements:

- QEII Hospital elective surgery enhancement
- Surgical activity (additional)
- Surgical equipment purchase
- Logan Hospital elective surgery and emergency department expansion
- Clinical redesign program
- Caboolture Hospital paediatric emergency department expansion
- Redcliffe Hospital paediatric emergency department enhancement
- Toowoomba Hospital emergency department enhancement
- QEII Hospital emergency department enhancement
- Maryborough Hospital additional rehabilitation beds and space
- QEII Hospital Palliative Care Unit
- Townsville Hospital subacute enhancement
- Cairns Base Hospital enhanced subacute services
- Rockhampton Hospital subacute enhancement
- Logan Hospital subacute expansion
- Provision of new bed based subacute services
- Non-admitted subacute services
- Data improvement project
- Purchase of subacute services from the non-government sector.

National Partnership Agreement on Hospital and Health Workforce Reform

The NPA on Hospital and Health Workforce Reform has been established to improve public hospitals' efficiency and capacity through the following reform components:

- introducing a nationally consistent activity based funding approach
- improving health workforce capability and supply
- enhancing the provision of subacute services
- taking the pressure off public hospitals.

A nationally consistent ABF model has been developed and will be incorporated into the Queensland Health funding process by July 2012. The Queensland Health ABF model was used during 2011–2012 to formulate the HHS contract offers. Queensland Health also exceeded the 20 per cent growth in subacute activity during 2011–2012, as required under the agreement.

Improving international health workforce recruitment efforts is a key platform of workforce reform under this national partnership agreement to address workforce shortages and ensure the workforce can meet increasing demands for services. Through a variety of national health and workforce committees and working groups, Queensland Health has provided comment on the direction and initiatives under the International Health Professionals Work Program.

National Partnership Agreement on the Elective Surgery Waiting List Reduction Plan

The NPA on the Elective Surgery Waiting List Reduction Plan provides funding to reduce the number of Australians waiting longer than clinically recommended times for elective surgery by improving efficiency and capacity in public hospitals.

Queensland Health commenced implementation of the following service improvement initiatives to achieve elective surgery performance targets outlined in the national partnership agreement:

- statewide implementation of checklist software to assist in modelling the impact of process redesign on hospital waiting lists
- progressive implementation of *The Productive Theatre Program* to improve operating theatre productivity
- implementation of ORMIS version 7.0 into 24 hospitals across Queensland
- provision of additional treatment opportunities through the *Surgery Connect Program*, which aims to provide alternative treatment options for 'long wait' elective surgery patients, either in the private sector or by using available capacity in the public sector outside normal operating hours
- purchasing additional equipment to improve capacity and operating room efficiency and waiting times for elective surgery.

National Partnership Agreement on Health Infrastructure

The NPA on Health Infrastructure provides funding to improve the health and wellbeing of Australians through the provision of high-quality physical and technological health infrastructure.

The following projects have been initiated to support the outcomes of the national partnership agreement:

- Central Integrated Regional Cancer Centre—development of cancer centres in Rockhampton, Bundaberg and Hervey Bay, with appropriate networking and linkages to comprehensive cancer services; scheduled for completion in late 2014.
- Sabai Island Primary Health Care Clinic—Indigenous Land Use Agreement registration with the National Native Title Tribunal in June 2012, with award of tender for design and construction in July 2012.
- Digital technology for Breastscreen—BreastScreen Queensland has implemented digital mammography equipment in all services, which has provided additional capacity to screen more women, particularly in rural and remote areas, through the substantial reduction in technical repeats, as digital image quality can be checked immediately.
- Indigenous Mobile Dental Infrastructure—three drover mobile dental clinics have been purchased to improve dental services to Indigenous Queenslanders; and purpose-built facilities have been constructed and delivered to Cherbourg, Cape York, and the Torres Strait and Northern Peninsula.
- Rockhampton Hospital Expansion—scheduled for completion in late 2013 and includes additional operating theatres, refurbishment of central sterile supply department and additional inpatient accommodation.
- Toowoomba and South West Queensland Regional Cancer Centres—completed in April 2012 and expanded the capability of the Toowoomba Hospital to deliver effective cancer care to rural and regional patients through the provision of additional chemotherapy facilities.
- Townsville Hospital Expansion—additional operating theatres, new central energy facility, additional clinical and non-clinical support services and additional inpatient accommodation scheduled for completion in mid 2014.
- Townsville and Mount Isa Regional Cancer Centre—expand the physical infrastructure and existing regional cancer services provided by the Townsville Hospital (scheduled for completion by mid 2014) and the Mount Isa Hospital (scheduled for completion by the end of 2012).

National Partnership Agreement on Health Services

The NPA on Health Services has been developed to improve the health and wellbeing of Australians through the delivery of high-quality health services, including:

- Implementation Plan for Aedes albopictus Prevention and Control in the Torres Strait Program—the objective of this program is the surveillance, control and possible elimination of Aedes albopictus in the Torres Strait. Queensland Health is also working toward decreasing the risk of incursion of the Aedes albopictus mosquito into South East Queensland.
- Implementation Plan for the Aged Care Assessment Program—this program has been developed to assess the care needs of frail older people, and to ensure they are able to gain access to the most appropriate types of care for their needs.

- Implementation Plan for the Extension of the Council of Australian Governments (COAG) Long Stay Older Patients Initiative—this initiative provides funding for minor capital works for services in rural locations to make sure they are more 'age friendly'. It also provides funding to services in metropolitan and regional areas to improve the transition of patients to more appropriate long-term care arrangements.
- Implementation Plan for Healthy Kids Check—the objective of the Healthy Kids Check initiative is to strengthen the linkages between the MBS Healthy Kids Check and state-funded child health services; and to further promote the provision of and uptake of health assessment services to children about to enter the school system. In Queensland, this funding has been used to deliver a child health check program in the remote Cape York communities of Kowanyama, Hopevale, Wujal Wujal, Aurukun, Lockhart River, Coen, Pormpuraaw, Napranum, Laura and Mapoon. This Commonwealth funded initiative ceased on 30 June 2012.
- National Perinatal Depression Initiative—this initiative is focussed on the prevention and early detection of antenatal and postnatal depression and providing better support and treatment for expectant and new mothers experiencing depression. The Queensland Centre for Perinatal and Infant Mental Health promotes accessible and responsive services for optimum mental health and social and emotional wellbeing for women, their infants and families during the perinatal period.
- OzFoodNet—this initiative is a collaborative network of epidemiologists conducting enhanced surveillance, outbreak investigations and applied research into food-borne disease. The OzFoodNet surveillance network actively investigates food-borne disease at the national and local level to improve knowledge of this disease and describe more effectively its epidemiology, and to provide information to assist public health efforts in minimising its incidence in Australia. Surveillance data is collected and reported for the following twelve pathogens/conditions: salmonella, campylobacter, listeria monocytogenes, shiga toxin-producing e. coli (STEC), shigella, yersinia enterocolitica, typhoid fever, paratyphoid fever, ciguatera poisoning, clostridium botulinum, hepatitis A and haemolytic uraemic syndrome (HUS). There were 8204 cases of foodborne illness due to the twelve pathogens or conditions under surveillance notified to Queensland Health during 2011. This compares with 7948 cases and 7277 cases notified in 2010 and 2009 respectively.
- Rheumatic heart fever—the Rheumatic Heart Disease Register and Control Program was established as a coordinated approach to control acute rheumatic fever and the management of the resultant condition, rheumatic heart disease. For the 12-month period between 1 July 2011 and 30 June 2012, 73 new acute rheumatic fever notifications were received, the majority from north Queensland. There are now a total of 1405 registered individuals on the register.

National Partnership Agreement on Financial Assistance for Long Stay Older Patients

The NPA for Long Stay Older Patients (LSOP) provides funding to Queensland Health in recognition of the costs incurred in providing care for people in public hospitals who are not able to access nursing home care. Queensland Health has been liaising with the Australian Government's Department of Health and Ageing regarding the national census of LSOP. Census data is used to determine the number of LSOP in each state.

3 Equitable health outcomes for all

Improve the equity of health outcomes

Objectives

3.1 Close the gap in health outcomes for Aboriginal and Torres Strait Islander peoples.

3.2 Improve health outcomes and access to safe and sustainable services for Queenslanders living in rural and remote locations.

3.3 Improve access to services and health outcomes for people from disadvantaged socioeconomic backgrounds.

3.4 Improve access to services and health outcomes for people from culturally and linguistically diverse backgrounds.

3.5 Improve patient transport and accommodation services to enhance continuity of care and ease access to health services.

3.6 Increase the availability of Telehealth and other technologies across Queensland, minimising the need for consumers to travel.

Key strategies

3.1.1 Continue to implement the Making Tracks Policy and Accountability Framework to achieve sustainable health gains through targeted and mainstream health programs focussing on prevention and treatment of chronic disease, and better access to health services across the lifespan and the health continuum.

3.1.2 Implement the Indigenous Alcohol Diversion Program in dedicated communities.

3.1.3 Implement targeted quit smoking interventions for Aboriginal and Torres Strait Islander peoples, including expanding the *SmokeCheck* program, enhancing Quitline and increasing awareness of the risks of smoking.

3.2.1 Drive innovation to improve health service delivery in rural and regional communities, including developing and implementing coordinated medical staffing and business solutions for Queensland rural health services.

3.2.2 Continue to improve the quality, safety and coordination of patient retrieval services.

3.2.3 Continue to implement health components of 'Blueprint for the Bush'.

3.2.4 Provide improved rural maternity and child health services.

3.2.5 Develop a rural and remote infrastructure renewal program.

3.3.1 With our partners, develop a strategic directions framework for people from disadvantaged socio-economic backgrounds program.

3.4.1 Continue to improve the availability and quality of interpreter services and resources for consumers from culturally diverse backgrounds.

3.5.1 Continued provision of the Patient Transport Subsidy Scheme and grants to non-government accommodation providers.

3.6.1 Expand the capacity and increased usage of Telehealth technology to create virtual teams to deliver healthcare remotely.

Key performance indicators

- Percentage of Aboriginal and Torres Strait Islander women who gave birth and had five antenatal visits or more in the antenatal period.
- Percentage of Aboriginal and Torres Strait Islander low birth weights.
- Percentage of admitted Aboriginal and Torres Strait Islander patients discharged against medical advice.
- Aboriginal and Torres Strait Islander identification.
- Number of times an interpreter was requested and provided.
- Telehealth non-admitted occasions of service.

Making Tracks

Making Tracks activity in 2011–2012 focussed on the implementation of initiatives under the Closing the Gap in Indigenous Health Outcomes National Partnership Agreement and the Indigenous Early Childhood NPA.

Tackling smoking

Queensland Health met all deliverables in 2011–2012, including the following:

- Recruitment of six new Aboriginal and Torres Strait Islander counsellor positions at the Queensland Quitline and delivery of an accredited cultural competency training package to 45 Quitline staff.
- 650 Aboriginal and Torres Strait Islander people called the Quitline for counselling and quit smoking advice, representing approximately six per cent of all Quitline callers.
- 315 frontline health professionals trained in the *SmokeCheck* Program at 48 city, regional and remote centres across the state to improve health worker skills and confidence in delivering expert quit smoking advice to Indigenous clients.
- Continued delivery of smoking cessation services in custodial settings including 108 Aboriginal and Torres Strait Islander offenders participating in an intensive quit smoking program with medical support, achieving a 43 per cent quit smoking rate at four weeks and 33 per cent quit rate at 12 weeks.
- Commencement of a new three-year partnership with the Queensland Aboriginal and Islander Health Council to provide practical support and training to tobacco health promotion workers within the community-controlled sector.
- 155 Indigenous sporting and cultural community events and activities across the state received small grants to promote positive smoke-free messages.

Primary healthcare services

All 2011–2012 Queensland Health deliverables under this priority area were met, including:

- multidisciplinary care approaches to improve chronic disease management and treatment—including an Indigenous Cardiac Outreach program which provides specialist cardiology outreach services to 23 communities in the lower Gulf, Central West and Central Queensland; and culturally appropriate care for Indigenous stroke survivors in Cairns and Ipswich
- respiratory specific services—including a lung health outreach program in rural and remote communities and a statewide respiratory training program for Indigenous health workers
- diabetes services—including additional diabetes dedicated nurses, doctors and improved clinical management plans for rural and remote Indigenous communities across Queensland
- supporting the Institute for Urban Indigenous Health to provide a regional model of service planning, delivery and coordination in South East Queensland
- 17 new multi-disciplinary teams in Community Controlled Health Services and General Practice Divisions
- a statewide program to purchase HbA1c machines with internet connectivity and to provide quality assurance training from Flinders University for Community Controlled Health Services
- supporting the establishment of a Centre of Excellence in Indigenous Primary Healthcare at the Inala Indigenous Health Service
- ongoing statewide roll out of the *Audit and Best Practice for Chronic Disease Program* to 60 new sites
- an Indigenous primary healthcare framework to improve models of care across Queensland is also under development.

Fixing the gaps and improving the patient journey

Queensland Health delivered the following outcomes in 2011–2012:

- Strategies to embed the *Queensland Health Cultural Capability Framework 2010–2033* across the organisation are ongoing.
- New and expanded Hospital Liaison Services were finalised, including funding new services to assist Aboriginal and Torres Strait Islander people to navigate through the health system and access appropriate treatment.
- Sites for new or expanded accommodation and transport services have also been identified.

Healthy transition to adulthood

Key deliverables in 2011–2012 included the continuation of the investment over four years from July 2009 for strategies and initiatives aimed at young Aboriginal and Torres Strait Islander people aged 8 to 18 years.

Under this priority area, Queensland Health has been focussing on recruiting Indigenous youth health professionals to deliver programs in areas where evidence suggests services are most needed such as:

- expanded youth sexual health services
- new integrated drug and alcohol health services
- coordinated mental health services including chronic mental health services
- targeted youth offender health programs.

Making Indigenous health everyone's business

During 2011–2012, Queensland Health conducted an open tender process to identify suitably placed non-government organisations that will develop and establish better referral mechanisms between existing social services and existing health services. This work is about improving coordination for service delivery and increasing the responsiveness of all services to the overall needs of vulnerable Aboriginal and Torres Strait Islander families in urban locations.

Palm Island Health Action Plan 2010–2015

The *Palm Island Health Action Plan 2010–2015* (PIHAP) is a community plan developed to improve the level and quality of Queensland Health service delivery to the Palm Island community. The PIHAP is supported by the Palm Island Statement of Intent, which commits the Commonwealth and Queensland governments, the Palm Island Aboriginal Shire Council and the QAIHC to work in partnership to close the gap in health outcomes for Palm Island.

Yarrabah government champion

Under the Queensland Government Champion Program, the most senior officers in the Queensland Public Service work with a particular Aboriginal and Torres Strait Islander community in a whole-of-government context. As Government Champion for Yarrabah, the Director-General of Queensland Health has worked in partnership with the Yarrabah Aboriginal Shire Council and the Yarrabah community to address issues relating to child safety, school attendance, economic development, employment, youth and home ownership. A large component of this work has been visiting Yarrabah, talking with community leaders, and negotiating with other senior government officials to address cross-government barriers and support Yarrabah community leaders in achieving its aspirations.

The Institute for Urban Indigenous Health

Queensland Health has been supporting the development and implementation of innovative models of urban primary healthcare service delivery to target the 41 000 Aboriginal and Torres Strait Islander people living in South East Queensland. This is a dispersed and difficult-to-reach population with a high burden of disease. One example of an effective urban model of service is the Institute for Urban Indigenous Health which integrates regional health planning and culturally effective service delivery for Aboriginal and Torres Strait Islander people. It has developed strong relationships between local Aboriginal and Torres Strait Islander health services, Divisions of General Practice, private practitioners, allied health providers and hospitals to improve access rates and health outcomes for Indigenous people living in South East Queensland.

Rural and remote

E-Health

The Viewer is the latest E-Health solution to assist in the provision of safe quality care to rural and remote Queensland. In 2011–2012, it was introduced in 199 Queensland Health facilities across the state including the Torres Strait and Northern Peninsula regions. *The Viewer* allows patient records from different locations to be seen in one place, giving clinicians faster access to patient information and results, no matter where they are in Queensland.

Telehealth

The rollout of other E-Health services including teleradiology and digital imaging across Queensland provided remote locations with better access to first class healthcare. The QRiS connects rural and remote clients to specialist radiologists in metropolitan areas, and significantly reduced the need for unnecessary patient travel. X-ray images taken in remote facilities are now being viewed by specialists without the patient having to travel vast distances. Queensland Health's teleradiology network ensures medical staff can provide faster assessment and treatment options. QRiS is available in almost 100 Queensland Health facilities and delivered more than 153 000 validated radiology reports in 2011.

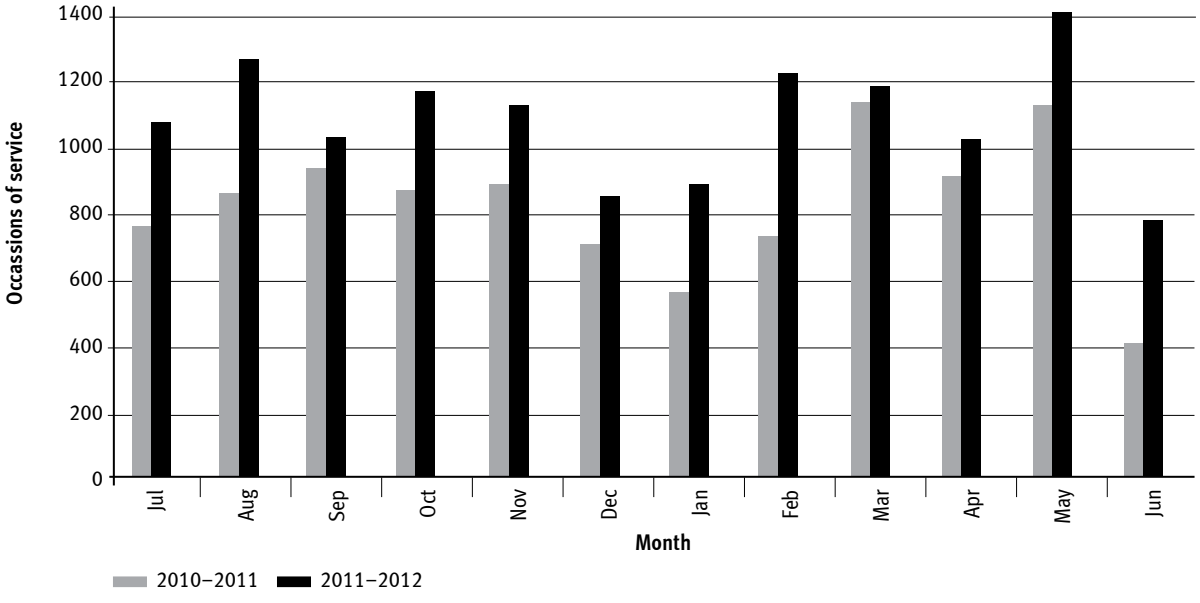
The use of Telehealth—via real time video link to deliver clinical services—increased by 27 per cent in 2011–2012. From July 2011 to June 2012, 13 635 non-admitted public eligible patient Telehealth occasions of services were recorded compared with 10 834

for the same period in 2010–2011. Telehealth is the delivery of health services and information through live and interactive video and audio links, storing and forwarding test results and diagnostic images—such as teleradiology—and using electronic equipment to monitor people in their own home. By using such technology to connect patients, consumers and health service providers across the state, Telehealth has the potential to improve access to specialist care and reduce travel and inconvenience. Telehealth is also able to assist in providing professional support to health service workers in rural and remote areas.

Key achievements during 2011—2012 included:

- a 10 per cent increase in the number of video conferencing systems available. At 30 June 2012, there were 1056 video conferencing units available for use across the state
- a 21 per cent growth in the use of Telehealth to provide mental health services. More than 7500 health consumers were provided with mental health services via video link compared with 6231 in 2010–2011
- a 35 per cent increase in the use of Telehealth to provide interpreting sessions with 468 interpreting sessions completed via videoconference in 2010—2011
- more than 160 000 radiology reports provided via the External Radiology Reporting Interface. The teleradiology network provides access to specialist radiology reporting services to rural and remote communities
- continued growth in the use of Telehealth to optimise the operations of Retrieval Service Queensland with more than 189 patient assessments completed remotely using video conferencing systems prior to patients being transferred from rural and remote sites
- enhanced reporting capability to enable monitoring of admitted patient Telehealth activity. Since the reporting commenced on 1 July 2011, 2332 admitted patient Telehealth events have been recorded
- the introduction of new Telehealth Medicare Benefits Scheme items, enabling reimbursement for services, has seen a strong growth in the use of Telehealth for the delivery of specialist services to private patients. Since the release of financial incentives on 1 July 2011, 2580 non-admitted private patient Telehealth occasions of services have been claimed and paid.

Graph 3: Non-admitted Patient Occassions of Service for Telehealth/Telemedicine by month, Public Acute Hospitals, Queensland, 2010–2011 and 2011–2012 Preliminary data, subject to change



Source: Monthly Activity Collection

Rural and remote workforce

The Radiographer Relief Service (RRS) was established in 2010 and provides radiographer coverage to BreastScreen Queensland Services and Mobile Services across the state. The relief pool supports free BreastScreen Queensland services in rural, remote and regional Queensland. In 2011–2012, the RRS supplied 299 weeks of radiographer cover using 22 radiographers to nine of the 11 BreastScreen Queensland Services.

A rural development pathway for allied health professionals was developed and will commence in 2012. This will facilitate early career allied health professionals' entry into rural or remote practice through providing enhanced professional supervision, training and support resources. The aims of the initiative are to incentivise rural and remote practice for new and recent graduate allied health professionals to support workforce sustainability and to ensure high-quality allied health services are available to rural and remote communities.

The last cohort of Griffith University Medical School's 235 training places, for which the Queensland Government provided additional funding, commenced training in 2010 and are scheduled to graduate in 2013. These graduates are bonded to work in areas of need.

In 2011–2012, there were 177 rural generalist trainees. The trainees are well placed to serve in rural and remote communities, practicing in both primary care and advanced speciality areas such as obstetrics, anaesthetics and emergency medicine. A number of other jurisdictions have indicated an interest in adopting this model and Queensland is working with Health Workforce Australia to develop a national approach to rural generalist medicine.

Improving clinical services to rural and remote areas

Approximately 40 per cent of all births in Queensland occur in rural and regional public hospitals. Queensland is investing in a range of maternity service reforms to support the delivery of sustainable pregnancy, birth and post-birth services closer to where women live. These include workforce initiatives to increase the number of doctors and midwives providing rural obstetric care; changes to the midwifery scope of practice to enhance primary maternity services in rural areas; establishment of more drop-in clinics to increase access for families to community-based antenatal and postnatal care; and funding for new midwifery-led models of care for rural women.

The *Strategic Direction for Rural Surgery 2012–2022* was developed in 2011–2012 and will strive to improve the delivery of surgical services to residents in rural Queensland through focussing on the five national rural health priorities defined in the *National Strategic Framework for Rural and Remote Health* released by Health Ministers in April 2012.

During 2011–2012, the following grant payments were made to non-government organisations to build or enhance accommodation for patients travelling to receive treatment for cancer, heart disease and other illnesses:

- $340 000 to the Cancer Council Queensland to purchase and refurbish a facility for patient accommodation in Cairns, which opened in September 2011
- $500 000 to Cancer Council Queensland to purchase and refurbish a facility for patient accommodation in Toowoomba, which opened in December 2011
- $500 000 to the Leukaemia Foundation of Queensland to extend existing patient accommodation facilities in Townsville with an anticipated completion date later in 2012
- $50 000 to Australian Red Cross towards the cost of demolishing and rebuilding its existing patient accommodation facility to significantly increase patient accommodation in Cairns with an anticipated completion date in 2013
- $3.5 million to Cancer Council Queensland in February 2012, for the purchase and refurbishment of a patient accommodation facility in South Brisbane, due for completion in 2013.

Table 3

Accommodation grant payments

Capital funding grant payments for patient accommodation facilities constructed or refurbished resulting in additional appropriate accommodation for patients travelling to access specialist health services. Payments in 2011–2012 are part of allocations made under a 2009–2010 commitment.	
Australian Red Cross—Cairns (total grant $5m 2011–2013)	$50 000
Cancer Council Queensland—Cairns (total grant $2.5m 2010–2012)	$340 000
Cancer Council Queensland—Toowoomba (total grant $3m 2010–2012)	$500 000
Cancer Council Queensland—South Brisbane (total grant $4.97m 2012–2013)	$3 500 000
Leukaemia Foundation Queensland—Townsville (total grant $2.93m 2010–2012)	$500 000
Total	**$4 890 000**

Aeromedical Retrieval Services—Rotary wing

Funding provided to external providers under funding deed and contract arrangement for the provision of rotary wing aeromedical retrieval assets, with activity clinically coordinated by Retrieval Services Queensland.	
CareFlight—Gold Coast	$2 761 045
CareFlight—Toowoomba	$2 498 723
Sunshine Coast HRS—Marcoola	$4 360 296
Sunshine Coast HRS—Bundaberg	$1 976 689
CQ Rescue	$3 103 491
Capricorn HRS	$2 360 249
Australian Helicopters Pty Ltd	$6 216 677
Total	**$23 277 171**

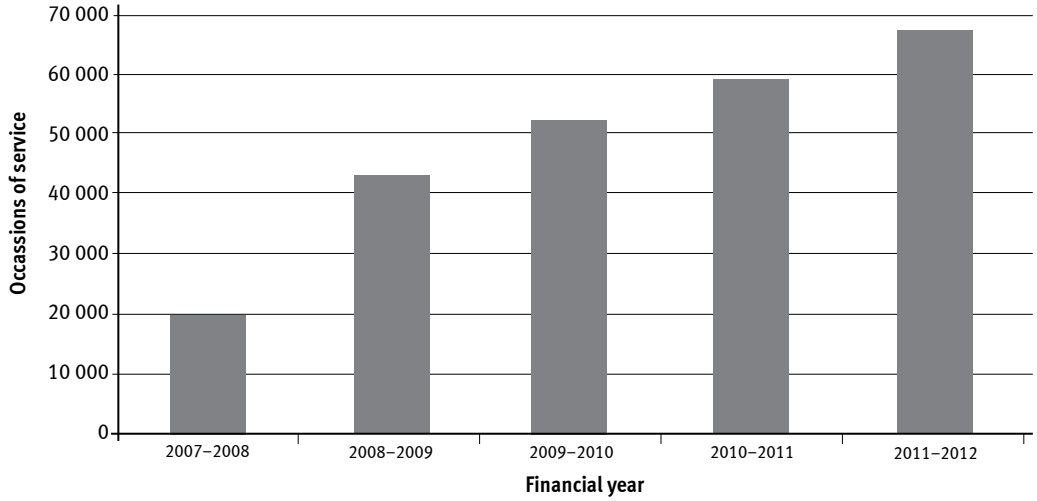
Aeromedical Retrieval Services—Fixed wing

Funding provided for fixed wing aeromedical retrieval assets, with activity clinically coordinated by Retrieval Services Queensland.	
Royal Flying Doctor Service	$41 616 366
Careflight Queensland Jet	$1 505 040
Total	**$43 121 406**

Consumers from culturally diverse backgrounds

In 2011–2012, Queensland Health developed 43 health information resources for consumers from CALD backgrounds. Topics included mental health, oral health, physiotherapy, and child and family health. The resources were each translated in up to 32 languages. The Queensland Health website now features translated health information in more than 60 languages.

Graph 4: Increase in interpreter service provision since the establishment of the Queensland Health Interpreter Service



There was an 80 per cent increase in the use of Telehealth to provide interpreting sessions with 412 interpreting sessions completed via videoconference, compared with 229 in 2010–2011.

National partnership agreements

National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

The NPA on Closing the Gap in Indigenous Health Outcomes has been developed to close the life expectancy gap between Aboriginal and Torres Strait Islanders and non-Indigenous Australians within a generation.

The Queensland implementation plan under this national partnership agreement includes initiatives across five nationally agreed priority areas:

1. Tackling smoking—because smoking is a leading cause of chronic disease.
2. Primary healthcare services that deliver—because getting early intervention and treatment can help extend the life of Aboriginal and Torres Strait Islander people with chronic disease.
3. Fixing the gaps and improving the patient journey—providing new services to support the treatment and the journey of patients within our healthcare system.
4. Healthy transition to adulthood—to address young people's behaviours during high-risk periods in their life.
5. Making Indigenous health everyone's business—supporting vulnerable families accessing social services including health services.

National Partnership Agreement on Indigenous Early Childhood Development

The NPA on Indigenous Early Childhood Development has been implemented as part of the Closing the Gap initiative and is committed to:

- improving development outcomes for Indigenous children
- achieving sustained improvements in pregnancy and birth outcomes for Indigenous women and infants
- improving Indigenous families' use of early childhood development services.

Antenatal care, pre-pregnancy and teenage sexual and reproductive health

The following programs have been developed to increase the accessibility and appropriateness of maternal health services delivered to Aboriginal and Torres Strait Islander women and their families in Queensland:

- Aboriginal and Torres Strait Islander Maternal and Infant Care teams at Toowoomba, Ipswich, Caboolture, Rockhampton, Townsville, Mount Isa and Cape York
- Aboriginal and Torres Strait Islander Maternal and Infant Care Health workers in major maternity units at Toowoomba, Ipswich, the Royal Brisbane and Women's Hospital, Redcliffe, Logan, Mount Isa, Townsville, and in the near future, Mackay.

Sites report improved connectedness with Aboriginal and Torres Strait Islander women, increases in the number of antenatal contacts and the timeliness of these contacts, and improved gestational outcomes, and reduction in risky behaviours (for example smoking).

In recognition of the high levels of early pregnancy in the Aboriginal and Torres Strait Islander population, programs have been funded to improve the health and wellbeing of Aboriginal and Torres Strait Islander young people. These include the:

- employment of Aboriginal and Torres Strait Islander Young Parent Support Workers on Palm Island and Cherbourg
- employment of Aboriginal and Torres Strait Islander Youth Health Workers in Toowoomba, Ipswich, Townsville, Cape York, Mount Isa, Torres Strait, and in the near future, Mackay
- employment of Aboriginal and Torres Strait Islander Sexual and Reproductive Health Workers to provide services to Aboriginal and Torres Strait Islander young people at risk of entering or in detention centres
- employment of Aboriginal and Torres Strait Islander Healthy Women's Workers in Longreach and Cape York
- development and delivery of a wide range of sexual and reproductive health educational resources and health promotion activities and events across Queensland.

Programs have indicated high levels of engagement with the target populations and increased participation in sexual health testing and treatment.

In order to ensure that the maternal, child and youth health workforce of Queensland is able to appropriately and effectively respond to Aboriginal and Torres Strait Islander people a workforce development program is also being implemented with the Commonwealth funding. This supports:

- the employment of two nurse educators to identify and deliver a training and education program to both Queensland Health and non-government healthcare providers of maternal, child and youth health services to Aboriginal and Torres Strait Islander people
- development of the For Me and Bub, Smoking and Alcohol Prevention Program which trains maternal and child health staff in the delivery of brief intervention counselling to pregnant Aboriginal and Torres Strait Islander who report smoking or alcohol use.

Maternal and child health services

Queensland Health is supporting the:

- expansion of maternal and child health services in Cape York
- delivery of *Deadly Ears*, Queensland Health's Aboriginal and Torres Strait Islander Ear Health Program for children to manage and reduce the high rates of ear disease in Aboriginal and Torres Strait Islander communities
- enhancement of maternity services to increase access to culturally appropriate and timely care for Aboriginal and Torres Strait Islander women and their families.

The most significant issue to impact on the implementation of this national partnership agreement has been the recruitment of appropriately skilled and qualified Aboriginal and Torres Strait Islander Health Workers. There have also been delays associated with programs that required outsourcing to external service providers.

4 Sustainability and innovation in the health system

Create a sustainable, proactive and continually improving health system

Objectives

4.1 Improve health system sustainability by implementing health reforms that drive innovation, efficiency and improvements for consumers.

4.2 Actively encourage innovation and evidence-based improvement in service models to deliver the best possible service outcomes with available resources.

4.3 Engage partners in health service planning and delivery.

4.4 Develop and manage infrastructure and assets to ensure safe, efficient and effective service delivery.

4.5 Increase capacity for education, learning and research.

4.6 Develop and maintain systems to assess and monitor quality outcomes and provide feedback to health professionals, service providers, the community and governments to support continuous improvement and innovation.

4.7 Provide leadership for and foster collaboration across the broader Queensland health and medical research sector to improve the translation of research into practice and promote the transfer of knowledge into improved health outcomes.

4.8 Increase the availability and use of technological advances to improve the efficiency, effectiveness and quality of health services.

4.9 Implement an integrated electronic medical record across Queensland Health to increase availability of information for providers and enhance their ability to deliver safe and effective healthcare.

4.10 Contribute to the development and implementation of a nationally consistent approach to activity based funding to improve the efficiency and effectiveness of service provision and provide mechanisms to reward good practice and support quality initiatives.

4.11 Support ‘green’ initiatives that protect our lifestyle and environment.

Key strategies

4.1.1 Implement national health reforms so that HHSs have the flexibility to be more innovative and responsive to local health priorities.

4.2.1 Continued implementation of the Clinical Redesign Program.

4.2.2 Continue to support the development of the transition of primary health service provision to community controlled Aboriginal and Torres Strait Islander health services where there is appropriate community support and capacity.

4.2.3 Create a culture that invites participation in research, problem-solving and innovation.

4.2.4 Recognise and promote achievements in innovation and continuous improvement.

4.3.1 Develop mechanisms to ensure local clinicians have a voice in the planning, implementation and review of services at the local health and hospital network level.

4.3.2 Engage clinicians in development and management activities.

4.3.3 Building collaboration through networks, communities of practice and consumer engagement.

4.4.1 Maintain infrastructure and assets through developing and implementing effective maintenance and life cycle replacement strategic planning, management and funding models.

4.4.2 Deliver long-term health service and capital planning for future health services.

4.5.1 Ensure health service planning recognises the need for education, learning and research facilities to be integrated or collocated with service delivery.

4.6.1 Implement the Queensland Health Performance Management Framework to increase the monitoring and evaluation of service delivery to continually improve the quality, safety and efficiency of health service delivery and inform resource allocation decisions.

4.6.2 Effective mechanisms are established to hold HHSs accountable for their performance.

4.6.3 More effectively integrate risk management into the work of Queensland Health executive committees and the department's strategic planning.

4.7.1 Establish the Knowledge Transfer Initiative to drive the translation of research conducted in Queensland Health into real world outcomes (commercial products and clinical care).

4.7.2 Promote Queensland's research and development expertise and capability to potential researchers, funders, partners and to the community through community engagement activities.

4.8.1 Continued implementation of the Queensland Health Technology Assessment Process including the New Technology Funding Evaluation Program mechanism.

4.9.1 Progress implementation of the eHealth strategy and continue the roll out and expansion of the Telehealth network.

4.9.2 Increase the information available to healthcare providers by implementing an integrated electronic medical record in alignment with the national Personally Controlled Electronic Health Record.

4.9.3 Develop and implement a transparent and effective governance framework to enable the efficient and effective use of ICT in support of health outcomes.

4.10.1 Implement funding models that drive transparency and efficiency in the funding of public health services.

4.11.1 Minimise energy consumption, its carbon footprint and demand.

4.11.2 Achieve enduring cultural change in carbon reduction management across the entire organisation.

Key performance indicators

- Expenditure on maintenance.
- Cost per weighted activity unit.
- Weighted activity units.
- Cost per weighted activity unit for sub-and non-acute patients.
- Sub- and non-acute weighted activity units.
- Own source revenue.
- Achieving a balanced operating position.
- Electricity consumption reduced across all Queensland Health facilities.

Clinical services redesign, innovation and excellence

Queensland Health's Clinical Services Redesign Program (CSRP) supports local clinicians and other frontline workers to diagnose and solve local barriers to efficient patient care. During 2011–2012, the CSRP commenced or completed 16 projects, as well as the *Improve and Move Chest Pain* statewide initiative.

These projects improved access to emergency departments and outpatient care; reduced delays during hospital stays; and improved the patient experience through enhanced communication and engagement with patients and their carers.

In 2011–2012, priorities for clinical services redesign included:

- the establishment of a formalised 'redesign school' to further support the education and training of the Queensland Health workforce in improvement methodologies
- commencement of a further ten major redesign projects
- the extension of successful solutions across Queensland by bringing clinicians and hospital staff together in regional and statewide forums.

The Gold Coast's *Patient Journey Project* undertaken at the Southport and Robina hospitals is an exemplar of clinical services redesign. Prior to the project, less than 50 per cent of category 2 emergency department patients were seen within the recommended 10 minutes and over 40 per cent of all patients requiring a hospital admission waited more than eight hours for a hospital bed.

In 2011–2012, the *Patient Journey Project* transformed performance opening a Medical Assessment and Planning Unit; and establishing a new Patient Access and Flow Unit. As of April 2012, more than 80 per cent of the category 2 emergency department patients are seen within 10 minutes and less than 20 per cent of patients requiring admission spend over eight hours in the emergency department. Although improvements are still required, these results represent significantly improved access for the people of the Gold Coast. From 1 July 2012, the Gold Coast HHS will be responsible for making further access improvements to support the needs of the growing Gold Coast community.

An online discussion forum was established in 2011 to facilitate communication between Queensland Health staff about issues that affect patient flow. Staff from across the state can post queries about topics that affect patient flow and share best practice learnings. A central repository was established of 30 service improvement initiatives and service delivery models that have proven efficacy in relation to patient flow. This central repository is hosted on the patient flow website.

In 2011, three Queensland Health projects were recognised for their outstanding contribution to health service provision in the Healthy Category of the Premier's Awards for Excellence in Public Service Delivery:

- The *Electronic Patient Journey Boards Project* was recognised as an innovative and cost-effective solution to managing information vital to patient care and duly awarded winner of the Healthy Category.
- The Queensland Health *Emergency Medical System Coordination Centre* and Cairns and Hinterland Health Service were named joint winners of the Disaster Management Category in recognition of their preparation and response to severe Tropical Cyclone Yasi.
- The *End of Life Project* was awarded Highly Commended status in recognition of efforts to improve communication and planning in relation to end-of-life care.

Introduced in 2010–2011, clinical practice improvement payments recognised and financially rewarded health service districts for improving performance in relation to outpatient service delivery. In 2011–2012, four health service districts received reward funding. The Sunshine Coast and Rockhampton Health Service Districts received $100 000 each for meeting outpatient delivery indicators.

Clinicians leading reform

Queensland Health continued to engage and support clinicians to share their collective knowledge on how to deliver the best care to Queenslanders through strategic oversight and secretariat support of:

- state and geographic-area clinical network meetings—there were 18 formal clinical networks that met regularly across the state to consider a variety of strategic and operational issues that impact on service provision
- the Queensland Clinical Senate—this network of 65 clinicians met to provide strategic advice to

the Director-General on key issues and matters relating to health service delivery. The Senate was the primary stakeholder group consulted in relation to the design of the Queensland Health Clinician Engagement Framework

- clinical workshops and forums targeting specific issues—these are dependent on whether the topic has statewide or local relevance
- the Outpatient Operational Advisory Committee—provided a forum for primary care and specialist clinicians from government, general practice and non-government organisations to collectively consider ambulatory care service integration issues that have a negative impact on continuity of care of Queenslanders.

Funding models

The Queensland Health (Phase 14) ABF Model was reviewed to ensure the transparency and efficiency of the current state ABF model. The review was used to inform the 2012–2013 purchasing model. This process was used to determine hospital and health service contract offers (budget allocation and activity targets). A nationally consistent ABF model was developed by the Independent Hospital Pricing Authority (IHPA) and will be included in the Queensland Health Decision Support System (DSS). It is currently planned to use the nationally consistent ABF model to inform the 2013–2014 State Purchasing Model.

Research and health technology assessments

The Office of Health and Medical Research implemented a strategy to change culture and build capacity in research, problem-solving and innovation through:

- the Health Research Fellowship Program and the Near Miss Funding
- establishment of the Knowledge Transfer Initiative to drive the translation of research conducted in Queensland Health into commercial products and clinical care
- the promotion of Queensland's clinical research and development expertise and capability to potential researchers, funders, partners and the community through community engagement activities, streamlining of administrative and regulatory processes impacting health and medical research, including human ethics approval and governance processes.

The Database of Research Activity (DoRA):

- puts patients in touch with research in which they want to participate
- puts researchers in touch with potential collaborators
- allows potential funders and partners to find expertise and assess capability in clinical research.

Six hundred research activities have been published and maintained on DoRA since its establishment in May 2011.

The Office of Health and Medical Research also implemented a strategy to identify, protect and commercialise intellectual property emerging from the department's research and development. This includes:

- engaging *Uniquest* to provide commercialisation services to Metro North Health Service District: a number of commercialisation prospects were identified, including several inventions that have been identified as suitable for patent protection
- engaging the *Australian Institute of Commercialisation* to provide intellectual property, commercialisation, and research collaboration services to the Gold Coast Health Service
- continuing the agreement with the *Medical Research Commercialisation Fund*, to support investment in medical research.

Under the Queensland Health Technology Assessment Program in 2011–2012, 14 new health technologies were reviewed under the New Technology Funding Evaluation Program. Eight of these were funded for implementation and evaluation. These technologies are new to Queensland's public health sector and include:

- BioNESS L300 foot drop system to support functional gait in acute and sub-acute stroke patients who demonstrate foot drop as a result of first time stroke (pilot at the RBWH, Gold Coast Hospital, Ipswich Hospital and the Townsville Hospital)
- EX-VIVO lung perfusion system to recondition non-viable or marginal donor lungs to enhance overall numbers of lung transplant operations in Queensland each year (TPCH)
- laser lead extraction to aid in the removal of chronically implanted pacemaker and defibrillator leads (TPCH)

- GeneXpert MTB/RIF for simultaneous detection of M. tuberculosis complex and resistance to rifampicin from sputum samples (Queensland Mycobacterium Reference Laboratory, RBWH)
- Fibroscan for the detection of liver fibrosis and management of chronic viral hepatitis patients (RBWH and PAH)
- NxStage home haemodialysis machines for patients with end stage renal failure requiring haemodialysis (PAH and Cairns Base Hospital)
- renal denervation to treat patients with resistant hypertension (PAH)
- monoplace recompression chamber to administer hyperbaric oxygen therapy (RBWH).

Comprehensive Health Technology Assessments (HTAs) were commissioned on:

- a Comprehensive Epilepsy Service for patients with refractory epilepsy
- obesity management service for the delivery of bariatric surgery within a framework of multidisciplinary model of care for adults and children.

These assessments include a systematic review of the clinical literature and an economic evaluation.

As part of the broader HTA program, 14 research reports were prepared on new health technologies in order to provide advice to clinical executives and health service districts.

Infrastructure, assets and planning

The streamlining of policies to guide health infrastructure and project management was a key priority in 2011–2012. The development of an Asset Management Policy and Implementation Standard provides a strategic policy framework that brings together existing asset management related policies. Implementation standards specifying requirements for maintenance planning, funding, delivery and information management were implemented to support the Building and Infrastructure Maintenance Policy. The capital infrastructure planning process was enhanced to improve the consistency, rigour and quality of capital planning.

Other key achievements for 2011–2012 in regard to health infrastructure and asset maintenance included:

- implementation of annual maintenance planning providing detailed programs of works
- development and improvement of the Computerised Maintenance Management System
- review and rationalisation of approximately 200 maintenance task specifications
- delivery of emergency maintenance and infrastructure failure rectification projects being progressed within the Maintenance Enhancement Program and Critical Maintenance and Infrastructure Works Program
- infrastructure plans for Redland, Dalby and Gladstone hospitals.

The Building Performance Evaluation Methodology and Guidelines were prepared as a performance monitoring tool, which contributes to a continuous improvement cycle to drive innovation and efficiency within hospitals. It also serves to better support service quality, improve patient outcomes and support links between facility design and performance to the long-term strategies of Queensland Health.

To support HHSs to align with changing patterns of need while ensuring effective use of resources, district-wide health service plans have been informed by service planning benchmarks and data in partnership with the following districts:

- Townsville Health Service District
- Cairns and Hinterland Health Service District
- Mount Isa Health Service District
- Central Queensland Health Service District.

Three new tertiary hospital builds are to be delivered by 2016, including the GCUH ($1.76 billion), QCH ($1.4 billion) and the SCUH ($2.03 billion).

The capital infrastructure program comprised over 200 projects across a broad range of health infrastructure—including community health centres, hospitals, health technology, pathology, research and scientific services, mental health services, residential care, staff accommodation, and information and communication technologies.

The infrastructure program is generating approximately 40 000 construction jobs over the life of the program.

The GCUH is the largest public health infrastructure project currently underway in Australia. It will feature leading edge technology and one of the state's largest clinical teaching and research facilities, providing specialised health services that meet the needs of patients and the learning requirements of students. It

is estimated that the 750-bed GCUH will have capacity to manage the demand for health services on the Gold Coast until 2020. The hospital design incorporates future-proofing initiatives that provide the ability for the facility to expand by around 60 per cent and caters for changing models of care and technology. The major initiative in model of care, patient safety and management flexibility is the inclusion of 70 per cent single rooms (as opposed to the traditional 25 per cent ratio). It is estimated that over 9800 construction-related jobs will be created over the life of the project, and once fully operational the facility will employ approximately 5000 staff.

The QCH will be a purpose-built facility and, once completed, will be the major specialist children's hospital for the state providing clinical, educational and support services to the statewide network of children's health services.

The SCUH is the centrepiece of a network of health services offering a comprehensive range of community and primary healthcare for the Sunshine Coast community. The hospital is Queensland's first PPP project and the largest hospital PPP in Australia. Key features of the hospital include a cancer care centre, neurosurgery, cardiothoracic surgery, maxillofacial surgery and a trauma service. The Kawana Health Precinct will also include a private hospital, a skills, academic and research centre and health-related commercial developments in the Kawana Health Innovation Park.

Future capital infrastructure plans are proposed to be undertaken during 2012–2013 in Cape York, Mackay, Darling Downs, South West, Metro South, Gold Coast, West Moreton and the Sunshine Coast. Statewide clinical stream plans to be undertaken in 2012–2013 include intensive care services, diabetes services and respiratory medicine services. Capital infrastructure planning studies are proposed to be undertaken during 2012–2013 in Townsville and other areas that are yet to be determined.

Energy efficiency

All capital infrastructure planning terms of reference for capital infrastructure planning studies include building principles which ensure environmentally sustainable designs and energy conservation obligations are considered.

Queensland Health carbon management projects have generated utility savings of 35 498 tonnes CO2, 38 107 387 kilowatt hours of electricity, 92 655 gigajoules of gas, and 334 170 kilolitres of water.

ICT and E-Health

The E-Health Program aims to increase the amount of information available electronically to healthcare providers at the time they need it, and wherever they need it. The latest solution, *The Viewer*, allows patient records from different locations to be seen in one place, giving clinicians faster access to patient information and results. *The Viewer* is available to authorised users and provides a single point of access where clinicians can view a range of important summary patient information. The solution is available to any Queensland Health facility connected to the department's network.

Queensland Health is in the initial stages of introducing an integrated electronic medical record (ieMR) solution which will progressively replace paper-based records. ieMR will provide key sites with integrated advanced decision support.

The Queensland Health E-Health Program is working closely with other jurisdictions and the National E-Health Transition Authority (NeHTA) to support the development of the Personally Controlled Electronic Health Record. Queensland Health is participating in a Wave 1 pilot in the north of Brisbane.

Queensland Health established an ICT Enterprise Governance Framework in 2010 outlining mechanisms to manage investment and mitigate risks to the ICT portfolio. The framework supports senior executives in understanding and fulfilling the legal, regulatory and ethical obligations in relation to the organisation's investment and use of ICT. In 2011–2012, this ICT governance framework was reviewed and updated to reflect the organisational health reform scheduled to commence on 1 July 2012.

A draft HHSs ICT Governance model was also developed and distributed to guide the new HHSs in the establishment of appropriate local governance mechanisms.

Community engagement and service planning

All health service plans undertaken in 2011–2012 included significant key stakeholder and community engagement. From August through to December 2011, Cairns and Hinterland, Townsville, Central Queensland and Mount Isa health service districts undertook targeted consultation on the future service directions with General Practice Queensland, Medicare Locals (or their equivalent), non-government and private organisations, resource sector companies, universities and other local interest groups. In addition, districts hosted community forums to actively inform communities of the future directions for Queensland Health services.

Gold Coast University Hospital project

Community engagement has continued to be a high priority throughout the construction stage of the GCUH. The Stakeholder Advisory Group (comprising members representing the local community, universities, health service providers and local business) have met bi-monthly with executive team members of the GCUH project team. The district's community advisory group has been engaged to provide input to a number of aspects for the project (including art, wayfinding and prototype patient rooms). A number of community open days have been held, including opportunities to tour buildings as they achieve practical completion, in addition to presentations to local community groups. Static displays in shopping centres and libraries provide further project information to members of the public. The GCUH project website continues to experience high volumes of traffic and includes functionality to direct general enquiries to members of the project team.

Queensland Children's Hospital project

The QCH project team regularly engages with the community to ensure they are kept informed about the project including its benefits, future services and amenities, key construction milestones and activities, and planning for the move into the new hospital in late 2014.

During October and November 2011, the QCH project team and builders Abigroup ran a colouring-in competition giving Queensland children the opportunity to name the six cranes on the construction site.

The Name the Cranes competition invited children aged three-to-14 years of age to colour in one of two crane illustrations, give it a name, and say why they chose that name.

Six winners were chosen from more than 300 entries received all over the state. Winners attended an official crane naming ceremony at the hospital construction site in South Brisbane, and received a prize pack including a QCH construction hat, certificate and $100 movie pass donated by Abigroup. The six cranes now proudly bear banners with their new names.

Sunshine Coast University Hospital project

The SCUH has enjoyed the input and advice of its community reference group which is made up of 15 representatives of the local community and community interest groups. The community reference group has provided input on the design plans for the SCUH and will continue to be a source of advice to the project team as the design takes shape and construction gets underway. The group also plays an important role in sharing information provided on SCUH with other community members.

Hospital redevelopments

Each of the large hospital redevelopments in Cairns, Townsville, Mackay, Rockhampton and Mount Isa have undertaken regular community engagement and consultation activities. The Regional Enhancement Program (REP) which led and managed the design and construction of four new multipurpose health services at Winton, Mount Morgan, Baralaba and Biggenden have undertaken community advisory group processes during the planning and design.

National partnership agreements

National Partnership Agreement on E-Health

The NPA on E-Health establishes a Healthcare Identifiers (HI) Service and national E-Health standards, infrastructure and legislation to enable the development of a national E-Health system for Australia.

The adoption of the HI Service and national E-Health standards, infrastructure and legislation are critical to the success of the Personally Controlled Electronic Health Record (PCEHR) System, which will be launched on 1 July 2012.

Queensland Health has developed the HI Service Strategy and Implementation Plan which identifies the mechanisms required to link the Queensland Health patient identifiers with an Individual Healthcare Identifier (IHI) and provides strategic direction for HI Service integration. The aim is to ensure Queensland Health will have the ability to support current processes, while supporting future linkage to the HI Service.

A 'seed' Healthcare Provider Identifier–Organisation (HPI-O) was obtained by Queensland Health in May 2011. This is a key requirement for Queensland Health to interact with the HI Service. An options analysis is being undertaken to identify the preferred HPI-O hierarchy structure to represent Queensland Health when interacting with the HI Service.

Queensland Health is participating as part of the 'Wave 1' E-Health Implementation Site Project with Metro North Brisbane Medicare Local (MNBML). Queensland Health received funding from the NeHTA to implement a long-term solution to connect to the HI Service using existing Queensland Health infrastructure. As part of this project, the consumer's IHI will be included on the new Clinical Document Architecture (CDA) formatted discharge summary.

Queensland Health is collaborating with the NeHTA to complete a data profiling exercise to identify the likely percentage of Queensland Health patient records that can be successfully matched to an IHI.

Queensland Health is also participating in a steering committee that has been formed to guide development of the Intergovernmental Agreement (IGA) on E-Health, which will replace the NPA on E-Health when it initially expires.

The NPA on E-Health requires that a review of the operation of the HI Service, as well as operation of the legislation, commences on 1 July 2012. Queensland Health is providing input into this review through representation on the National Health Information Regulatory Framework (NHIRF) Working Group.

Significant financial investment is required for Queensland to progress full implementation of national eHealth foundations such as the HI Service and establish the infrastructure and systems needed to be PCEHR ready.

National Partnership Agreement on the Digital Regions Initiative

The NPA on the Digital Regions Initiative was signed on 9 May 2009 and ends on 30 June 2013. The agreement is to deliver innovative digital enablement projects supporting improved health, education and emergency services in regional, rural and remote communities throughout Australia.

In November 2011, two implementation plans were signed under this NPA:

- Townsville National Broadband Network Telehealth Diabetes Trial
- PAH Online Outreach Services.

The Townsville trial is providing Telehealth home monitors for patients with type 2 diabetes living in the National Broadband Network rollout areas in Townsville. Patients who require assistance to control their diabetes are being recruited through general practices and are randomly assigned to an intervention or control group.

In 2011–2012, the PAH Online Outreach Services project established a Telehealth facility at the PAH in Brisbane and equipped rural hospitals with a videoconferencing capability. Videoconferencing will enable the delivery of specialist services from Brisbane to regional and rural Queensland, commencing with specialist geriatric services to Kingaroy, Dalby and Warwick, and specialist diabetes and endocrinology services to Mount Isa, Cloncurry and Cunnamulla. In addition, a solution will be implemented for the review of echo-cardiac and dermatological images.

5 Developing our staff

A sustainable and high-quality workforce to meet future health needs

Objectives

5.1 Identify and develop leadership at all levels with the personal qualities and professional capabilities to deliver high-quality and safe services, and to inform the long-term direction for the delivery of those services.

5.2 Build and maintain a positive and safe workplace culture where staff can perform at their best, are acknowledged and is supportive of professional development.

5.3 Increase the workforce participation of Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds across all occupational streams and across all areas within Queensland Health.

5.4 Grow a competent and culturally-capable workforce.

5.5 Build positive and productive relationships with stakeholders and partners, such as unions and education and training providers, to develop a flexible workforce that ensures a productive and sustainable workplace.

5.6 Recruit, develop and retain a skilled research workforce through improved institutional support for research in Queensland's health service settings.

5.7 Grow and develop the future clinical workforce in line with our 15-year strategic goals.

5.8 Support 'fair' initiatives for safe and caring communities.

Key strategies

5.1.1. Provide a comprehensive suite of development options for Queensland Health leaders, as outlined in the Healthcare Culture and Leadership Service Framework.

5.2.1 Promote a 'safety for all' culture by promoting both physical and psychological wellbeing, assessing and managing safety issues quickly and effectively, and actively supporting preventative and safe return to work programs.

5.2.2 Continue to advise and support the implementation of a Fatigue Risk Management System (FRMS) as per HR Policy—Medical Fatigue Risk Management.

5.2.3 Foster a culture of growing performance through:

- a review of the performance management system to make it easier and useful
- building the capability and capacity of Queensland Health staff to reward high performance and address poor performance.

5.2.4 Continued implementation of the Payroll Improvement and Payroll Foundations Programs.

5.3.1 Continue to implement the Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework.

5.3.2 Develop an employer brand and employee value proposition that positions Queensland Health as an employer of choice, which attracts and retains staff from diverse backgrounds to more closely reflect and serve our diverse community.

5.4.1 Continue to implement the Aboriginal and Torres Strait Islander Cultural Capability Framework to improve access to and delivery of mainstream health services and programs to Indigenous people.

5.4.2 Implement strategies to develop staff cultural capabilities in order for them to interact more effectively with people from culturally diverse backgrounds.

5.5.1 Recruit additional medical, nursing and allied health staff consistent with workforce planning processes.

5.5.2 Continue to increase access to evidence-based training for clinical staff to improve efficacy, efficiency and quality of patient care.

5.5.3 Promote cross-professional education and training to increase the ability of the workforce to deliver multi-professional care.

5.5.4 Work with partners to build capacity to provide clinical supervision and training positions to meet future workforce need and health service priorities.

5.5.5 Support and empower all staff to undertake professional development to increase the ability of the workforce to provide the highest level of care and services.

5.5.6 Manage change effectively by engaging stakeholders early, communicating the reasons for change and ensuring the benefits of change are realised.

5.6.1 Continue to support health researchers through the Health Research Fellowship Program and the Near Miss Funding Program.

5.7.1 Publish and commence implementation of a *Queensland Health Clinical Workforce Plan 2011–2026*.

5.7.2 Develop and implement a Queensland Health Statewide Clinical Workforce Policy.

5.8.1 Continue and enhance the volunteer programs in Queensland hospitals.

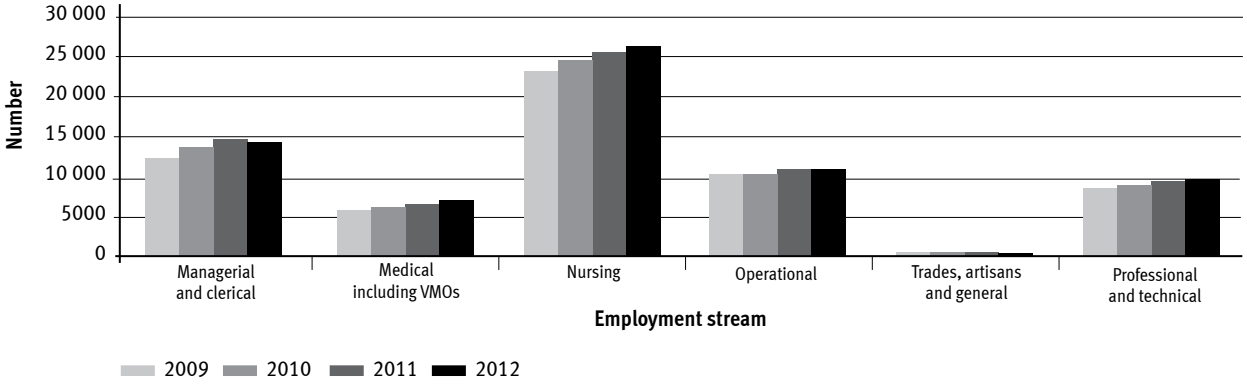
Key performance indicators

- Sick Leave (paid and unpaid) hours vs Occupied FTE.
- Workcover hours lost (Workcover) vs Occupied FTE.
- Aboriginal and Torres Strait Islander workforce.
- Staff/Union relationship.
- Increase in number of people wishing to be volunteers in hospitals.

Our people

Queensland Health employed more than 68 864 FTE staff during 2011–2012. Graph 5 shows the number of Queensland Health FTE employees by employment stream. Approximately 63 per cent of Queensland Health staff are health practitioners, professionals and technicians, medical (including visiting medical officers [VMOs]) or nursing employees.

Graph 5: MOHRI occupied FTE by employment stream



In 2011–2012, average fortnightly earnings for Queensland Health employees were $2853 for females and $4291 for males.

Queensland Health's retention rate for permanent employees was 92.4 per cent in 2011–2012. The retention rate is the number of permanent staff employed by Queensland Health at the start of the financial year and who remain employed at the end of the financial year, expressed as a percentage of total staff employed.

Queensland Health's separation rate for 2011–2012 was 7.4 per cent and describes the number of permanent employees who separated during the year as a percentage of permanent employees in Queensland Health.

Early retirement, redundancy and retrenchment

There were four voluntary early retirements from Queensland Health during 2011–2012 at a value of $447 737.99 including incentive payments, accrued recreation leave and long service leave entitlements.

Voluntary Separation Program

A Voluntary Separation Program was introduced as part of the Mid-Year Fiscal and Economic Review in January 2011. This program was one of a number of measures designed to deliver additional savings and reprioritise spending. The program was targeted primarily at non-frontline areas, as a service reprioritisation strategy to ensure continued growth in frontline areas. Queensland Health sought expressions of interest from certain surplus/unattached employees and certain non-frontline officers. Offers were made to eligible employees based on the criteria as outlined in the Public Service Commission guidelines. In 2011–2012, 852 employees accepted offers of voluntary separation packages at a cost of $97.8 million.

Safety for all

In accordance with the Safer and Healthier Workplaces Framework, the department continued to implement the *Occupational Health and Safety Strategic Plan 2007–2012* and the Occupational Health and Safety Management System. There was increased attention on preventative strategies, including risk assessment, safe work procedures and targeted training.

Whilst the system audit achieved positive results, the cost and duration of injuries increased compared to the previous financial year. Queensland Health continues to review the performance and implement preventative strategies and management of workplace injuries and return to work programs.

Table 4: Workplace incidents and injuries

	2009–2010	2010–2011	2011–2012
Number of incidents/near-misses reported	21 530	23 174	23 459
Number of injury workers' compensation claims *	3000	3260	3644
Total days lost	42 065	45 250	58 381
Average days lost	14.0	13.9	16.0
Total claims cost	$10 602 164	$11 507 578	$15 331 864
Average claims cost	$3534	$3530	$4207

** All workers' compensation claims lodged regardless of acceptance by WorkCover Queensland.*

Source: Incident Management System and WorkCover Queensland.

Health service district data on fatigue was collected and analysed. Occupational health and safety steering and advisory committees routinely consider fatigue risks and strategies on how best to support the implementation of a fatigue risk management system. The Medical Fatigue Risk Management Training Modules were refined into a single interactive online training package, facilitating ease of access to training resources. Similarly the Medical Fatigue Risk Management Resource Pack was revised and will be delivered to hospital and health services in late 2012.

Payroll Portfolio Program Office

During 2011–2012, Queensland Health transitioned all payroll-related programs and activities into a single portfolio consistent with recommendations from the Queensland Audit Office in June 2011 (QAO Report No. 7 of 2011). This brings together all payroll initiatives under a single governance committee known as the Payroll Portfolio Steering Committee. This committee provided oversight for payroll priority initiatives under the payroll reform strategy.

Leadership development, talent management and succession planning

In 2011–2012:

- Over 2500 Queensland Health staff participated in more than 109 leadership development programs and workshops, including the highly successful Medical Leadership in Action Program and the Emerging Clinical Leaders Program. 360 degree feedback summary reports for Queensland Health clinical and non-clinical executives continue to show improvement in key leadership qualities.
- Queensland Health launched the *Step Up* Medical Registrars Leadership Program. The program focusses on developing and strengthening the skills Medical Registrars need to supervise and motivate other medical staff and provide effective leadership in a healthcare team.
- *Teaching on the Run* is a multi-professional program aimed at practising clinicians responsible for teaching, supporting and supervising learners in a clinical setting. The program has four modules, each of three hours duration—Clinical Skills Teaching; Feedback and Assessment; Supporting the Learner; and Planning Learning.
- The *Multidisciplinary Introduction to Clinical Education* (MICE) program is a generic, entry level introduction to clinical education/supervision which emphasises a focus on teaching consistent with inter-professional clinical practice. *Clinical Educator Preparation and Support* (CEPS) online modules were developed specifically for the MICE program by the Department and the University of Queensland School of Medicine, Health and Rehabilitative Sciences.
- A Centre of Excellence for Leadership was established in February 2012. In establishing the centre, principles and mechanisms were established to align leadership development initiatives and ensure a focus on talent management and succession planning. An implementation plan outlining tasks and milestones for establishment of the centre is being developed and aims to ensure:
  - a strategy for leadership development that incorporates Queensland Health leaders' views on the roles and responsibilities of leaders
  - governance and funding mechanisms for a collectively owned centre of excellence in leadership development that aligns with business needs
  - specifically targeted programs for those with potential to succeed in identified critical roles.
- A workshop was developed for clinical educators and student supervisors to support students from CALD backgrounds. The aim of the workshop is to recognise the influence of culture in the context of student supervision and to establish clear placement expectations to maximise cultural understanding. The proposed new Queensland Health Multicultural Health Policy and Implementation Standards refer to the need to "build the cultural competence of the future workforce" and the increasing cultural diversity of students completing placements within Queensland Health, necessitates that training is provided to staff working with students from CALD backgrounds.
- Resources to support staff included:
  - the Health Care Providers' Guide to Engaging Multicultural Communities and Consumers
  - a series of health data reports profiling the health status of the Indian-born, Italian-born and Vietnamese-born communities of Queensland
  - the results of the Pacific Islander and Maori Health Needs Assessment
  - an analysis of hospital separation data on the health of Australian South Sea Islander people in Queensland
  - a report on strategies to increase the engagement of Queenslanders from culturally and linguistically diverse backgrounds in physical activity.
- Orientation sessions to 8364 new staff included presentations on the importance of provision of culturally competent care. In addition, more than 4088 staff attended training sessions to build their cross-cultural knowledge and skills.
- Developing Business Excellence (DBE) Program is designed to foster leadership capability of current and future corporate services and clinical support leaders, focussing mainly on district staff. There are two streams:
  - Future Leaders: targeting leaders AO8 and above
  - Talent Development: targeting talent at AO4-AO7 levels.

  In 2011–2012, the program had a total of 35 participants, 17 in Future Leaders and four in Talent Development.

- Nine Public Sector Management Program (PSMP) scholarships were offered to Queensland Health employees in the 18-month leadership and management education program targeting senior-to-middle managers and emerging leaders (AO5-AO8)—seven in Brisbane, and two in Townsville. A joint venture between Federal, State, Territory and Local Governments, the program combines tertiary study with experiential learning and focusses on the strategic direction of the contemporary public sector. On successful completion, students are awarded a Graduate Certificate in Public Sector Management by Flinders University.
- Two Queensland Health employees were offered a scholarship in Australia and New Zealand School of Government (ANZSOG) programs, one in each of the Executive Fellow (EFP), and Executive Master of Public Administration (EMPA) programs. ANZSOG is a world-leading educational institution that teaches strategic management and high-level public policy to public sector leaders. The Queensland Government offers scholarships each year for both the EFP (up to eight places) and the EMPA (up to ten places) for Queensland public sector leaders. Nominations for these scholarships are endorsed by the agency's chief executive officer and coordinated by the Public Service Commission (PSC).

Aboriginal and Torres Strait Islander cultural capability framework

The availability of health services and programs that are culturally and clinically equipped to provide healthcare for and with Aboriginal and Torres Strait Islander people is one of the key factors that will contribute to closing the life expectancy gap within a generation (by 2033).

In 2011–2012, a new mandatory full day program to strengthen the cultural capability of Queensland Health staff, was completed and implemented. One hundred and thirty trained facilitators are now delivering training across the state in every district.

Health service districts developed local cultural and health service information to ensure local relevance of the Aboriginal and Torres Strait Islander Cultural Practice Program. This information included demographic and burden of disease data, and cultural information relevant to Aboriginal and Torres Strait Islander people within the district's catchment area.

Districts progressively increased the display of Aboriginal and Torres Strait Islander artwork, artefacts and flags to increase the cultural safety of facilities.

Resources to assist clinical staff with the delivery of culturally capable healthcare were developed and published on the Queensland Health intranet. Additional resources, including posters and brochures, were developed to improve the identification of Aboriginal and Torres Strait Islander people in health services.

An example of the framework in action was demonstrated in the Torres Strait and Northern Peninsula Area Health Service District where for cultural reasons two Aboriginal and Torres Strait Islander Cultural Practice Program coordinators/facilitators (male and female; from Eastern and Western islands) were appointed. The coordinators act as cultural advisors as well as training facilitators and also work in partnership with Commonwealth and other Queensland Government departments to achieve a unified cultural education program. With strong support from community leaders they contributed to improved relationships between the health service, local communities and their elected bodies.

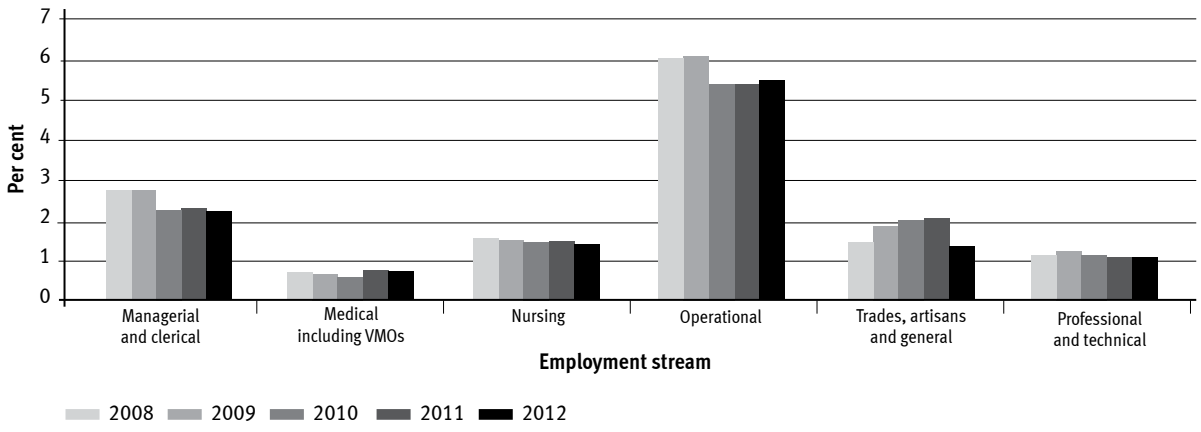
Aboriginal and Torres Strait Islander staff network

Queensland Health established an Aboriginal and Torres Strait Islander Staff Network as a positive and effective way to retain its current staff and to position Queensland Health as a responsive future employer of Aboriginal and Torres Strait Islander people.

Queensland Health has an obligation to meet employment targets and to deliver better health service outcomes for Aboriginal and Torres Strait Islander people. Queensland Health's stated priority outcome is to close the life expectancy gap between Indigenous and non-Indigenous Australians within a generation.

As of 30 June 2012, the staff network's membership stood at 239 out of an overall total of 1726 staff who identified as Aboriginal or Torres Strait Islander currently employed within Queensland Health, which is an overall increase of 64 per cent from the same time last year. This means that 13.85 per cent of currently employed Aboriginal and Torres Strait Islander staff are members of the staff network. Currently, Aboriginal and Torres Strait Islander staff make up 2.10 per cent of the total staff employed within Queensland Health.

Graph 6: Percentage Aboriginal and Islander workforce



Recruitment

The *Queensland Health Clinical Workforce Strategy 2011–2026* establishes a clear vision for the future clinical workforce to support the delivery of required public health services in Queensland. The strategy provides the overarching framework for developing and reviewing profession, service and/or specialty-specific workforce plans. Future action will focus on:

- growing a knowledgeable, skilled, competent, and culturally-capable clinical workforce
- building a sustainable clinical workforce that meets service needs and financial constraints
- optimising distribution of the clinical workforce to achieve equitable access to healthcare, recognising the specific requirements of target and priority groups.

Clinical workforce planning has been undertaken for the new major hospitals under construction as well as the refurbishment of other facilities around the state. Over 750 additional clinical staff were recruited in 2011–2012 to critical and hard-to-fill vacancies in health service districts across Queensland. Experienced health professionals are sourced through targeted sourcing initiatives in domestic and relevant international markets to supplement local supply in disciplines and specialties of identified shortage.

In 2011–2012, Queensland Health:

- advertised through a wide range of print and online recruitment portals both nationally and internationally
- advertised through a range of clinical and non-clinical journals and associations
- engaged the services of an executive recruitment firm for key positions (for example, 17 chief executive positions for the new HHSs).

Forty-two leading international and national clinician-researchers were attracted to work for Queensland Health from 2008 to 2011. This includes six well recognised, high achieving clinician-researchers awarded a Senior Clinical Research Fellowship (SCRF). These Fellows come from Queensland, Western Australia, South Australia and Ireland. A further 23 Health Research Fellowships (HRF), and 13 Clinical Academic Fellowships (CAF) were awarded. These Fellowships are aimed at early, mid and late career researchers wishing to base themselves in Queensland.

The Fellowship recipients have:

- generated evidence to inform health policy, practice and service delivery, research best models-of-care and develop cost saving methods for treatment
- secured $49 million of additional competitive research funding leveraged from interstate and international funding sources
- generated 340 publications including press, peer-reviewed journals and book chapters
- created 44 new positions in research teams of successful Fellows
- 94 additional Masters and PhD students.

The key benefits of this recruitment strategy include improved capacity in Queensland to undertake clinical duties in allied health, nursing and medicine professions; strengthened collaborative partnerships between hospitals, medical research institutes, health service organisations and universities; and it enabled Queensland to retain the best and brightest to generate evidence to inform health policy, practice and service delivery, research best models of care and develop cost saving methods for treatment improved patient care, outcomes, safety, experience and treatments as well as delivering health more effectively and efficiently and informing the redesign of health services.

In 2011–2012, a new statewide approach to basic physician training was developed and commenced. *Queensland Basic Physician Training Pathway* comprises a centralised approach to recruitment and selection of basic physician trainees, with a local networked approach to trainee placement. The first cohort of Pathway Medical Registrars commenced in February 2012. The pathway aims to increase the overall number of physician trainees; provide equal access to tertiary hospital time to all physician trainees; and ensure a constant and reliable cohort of trainees each year to regional and outer-metropolitan facilities. From an educational perspective, the pathway will improve access to educational resources for all trainees statewide by distributing existing educational resources/activities and developing and disseminating additional educational initiatives. Physician trainees preparing to sit the clinical exam were able to attend the inaugural Clinical Examination Preparation Program (individual evening sessions and a weekend course) that provided broad exposure to all sub-specialties and practical advice from topic experts.

HHS chief executives

In December 2011, a global executive search commenced for the 17 HHS chief executive roles targeting senior health and government professionals nationally and internationally. In accordance with the *Hospital and Health Boards Act 2011*, selection and appointment of each HHS chief executive is made by the relevant Hospital and Health Board.

Queensland Health also recently introduced a new governance and reward framework in relation to the new positions of HHS chief executives. This contemporary and competitive framework has been developed after reviewing remuneration and reward arrangements in public sector health services in other jurisdictions and the private sector, and is in line with the new direction of the PSC. The establishment of an executive remuneration committee will provide governance of the framework and responsiveness to market and industry trends.

Volunteers

During 2011–2012, three meetings of the Queensland Health Volunteer Managers Network were held—on 28 July 2011, 17 October 2011 and 15 February 2012. An annual survey was conducted in July 2011 to determine the number of Queensland Health volunteers, their location, and gender breakdown. Of the 2882 Queenslanders who volunteer their time in hospitals, 76 per cent are women. The Darling Downs Health Service District (31 per cent—891); the Cairns and Hinterland Health Service District (13 per cent—366); and the Sunshine Coast Health Service District (10 per cent—302) have the largest number of volunteers. Queensland Health is also represented on the whole-of-government Volunteering Governance Group and the Volunteering Senior Managers Group.

Workplace harassment

Queensland Health remains committed to a culture free from all forms of harassment and continues to support and develop strategies to address workplace harassment when it occurs and to educate staff about appropriate workplace conduct. Strategies include the Workplace Equity and Harassment Officer network and awareness campaigns.

When instances of workplace harassment occur, employees have access to a number of sources of information and advice, including:

- Workplace Equity and Harassment Officers
- a workplace harassment hotline
- the Staff Complaints Liaison Office
- people and culture (human resource) units
- the Employee Assistance Service.

Workplace Equity and Harassment Officer Network

Workplace Equity and Harassment Officers (WEHOs) play an important role in Queensland Health's response to resolving equity and harassment issues in the workplace.

WEHOs are Queensland Health employees who have been trained to provide confidential advice and support to other Queensland Health employees on a number of subjects, including:

- bullying/workplace harassment
- sexual harassment
- discrimination
- other equity issues.

Queensland Health has conducted extensive WEHO training over 2011–2012. There was a reduction in the number of WEHOs from 381 to 351 (approximately eight per cent).

Professional development for HR practitioners

- HR Practitioner Network—a department-wide virtual community with over 1300 members designed for staff currently working or interested in human resources. The network facilitates the sharing of best-practice research, as well as

promoting professional development including internal job opportunities. The network also administers the Learning Special Interest Group, a self-perpetuating online group with approximately 600 members focussed on building and sharing education, training and development information across the organisation.

- **HR Graduate Program**—six graduates completed the 2011 program, graduating in February 2012. The 12-month program, designed to attract and retain recent university graduates, includes a range of formal training and development activities, networking, and hands-on experience gained through three four-month placements. This year graduates were placed in districts and facilities across the state including Cairns, Townsville, Mackay, Darling Downs, West Moreton, Gold Coast, Logan and Brisbane. Since 2007 the program has recruited over 30 HR graduates into Queensland Health and involved over 150 HR managers, supervisors and mentors.
- **Certificate IV in Human Resources**—36 HR practitioners across Queensland Health participated in the 2011–2012 cohort, all completing and receiving the nationally accredited qualification in partnership with the Metropolitan South Institute of TAFE. The certificate provided participants with foundation HR knowledge in the Queensland Health context, and built on current relevant work experience—strengthening the qualified HR talent pool within the organisation.
- **HR Forum**—in August 2011, 200 HR executives and leaders attended the annual HR Forum. This year's forum focussed on the role of HR in the National Health Reform environment. The forum provided an opportunity for HR practitioners across the state to come together for the purposes of information sharing, participating in learning opportunities, building professional networks, strengthening the skills of HR practitioners and improving HR service delivery across Queensland Health. As a collaborative cross-government initiative (holding the forum at the Metropolitan South Institute of TAFE in Brisbane), Queensland Health supported students in achieving their qualifications by participating in the forum.

Shared services

The Shared Service Initiative is a whole-of-government approach to the delivery of corporate services. The aim is to provide high-quality, cost-effective corporate support services across the Queensland Government. Shared Services are underpinned by standardising business processes, consolidating technology, and pooling resources and expertise. The Queensland Health Shared Service Partner (QHSSP) aims to provide efficient, high-quality and innovative corporate transactional services that support the delivery of health services and promote organisational effectiveness for Queensland Health.

The QHSSP delivers the following services:

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

Achievements include:

- implementation of new payroll hubs at Mackay and the Gold Coast
- ongoing implementation of the Supply Chain Management Integration Strategy to design, develop and implement a model of service delivery that supports a lean, high-performance supply chain capable of achieving best practice
- completion of a business continuity management plan for each QHSSP service area and completion of business continuity plans for each QHSSP facility.

In consultation with health service districts, QHSSP has developed a range of key performance indicators for each service area.

Executive Management Team (EMT) and Chief Executive Officer (CEO) profiles

Dr Tony O'Connell
Director-General

Dr Tony O'Connell entered the Australian health system as a medical student more than 40 years ago. He has specialist qualifications in intensive care and anaesthesia, and has been an examiner for the National Intensive Care College. Before coming to Queensland he acted as Deputy Director-General—Health System Performance in the New South Wales Department of Health. He directed the New South Wales Government's major redesign program for the department.

Tony has been involved in statewide system change for two decades and his major achievements have been facilitating significantly improved access performance for emergency and elective patients in New South Wales in the face of rising demand for services, and best-ever elective surgery performance in Queensland. He has led teams receiving premier's awards for public service excellence in both states.

Jan Phillips
Acting CEO, CHI

Jan Phillips has led system-wide improvements in clinical safety and quality, access, and patient experience. Since 2006, she has led the Healthcare Culture and Leadership Service.

Jan has performed executive director roles in HR management, strategic planning, information management, innovation and organisational development. She also has national and international experience as an invited speaker and facilitator, and has published articles on leadership, organisational improvement and workplace culture reform. Her qualifications are in social work, leadership and company directorship. She is a Fellow of the Australian Institute of Company Directors.

Dr Jeannette Young
Chief Health Officer

Dr Jeannette Young is the Chief Health Officer for Queensland, a role she has filled since August 2005. Before that, she was Executive Director of Medical Services at the PAH, Executive Director of Medical Services at Rockhampton Hospital, and held a range of positions in Sydney. Jeanette's original clinical background is in emergency medicine. She has specialist qualifications as a Fellow of the Royal Australasian College of Medical Administrators and a Fellow by Distinction of the Faculty of Public Health of the Royal College of Physicians of the United Kingdom. She is an Adjunct Professor at Queensland University of Technology and Griffith University.

Jeannette sits on the Queensland Board of the Medical Board of Australia and is a member of numerous Queensland and national committees and boards, including the Queensland Institute of Medical Research Council, the National Health and Medical Research Council (NHMRC), the Australian Health Protection Committee, and the Australian National Preventive Health Agency.

Ray Brown
Chief Information Officer

Ray Brown has worked in the ICT industry for over 30 years, mostly within the public sector. He has held senior ICT management and Chief Information Officer (CIO) roles that have supported frontline service delivery organisations for over 20 years including the former Departments of Family Services, Corrective Services and the Queensland Police Service.

Ray joined Queensland Health in June 2008 as an executive director and was appointed to the role of CIO in August 2009. During this period the Information Division has successfully deployed several new enterprise-wide clinical systems and initiatives to improve ICT governance, planning, architecture and service delivery.

Kathy Byrne
Chief Executive, CaSS

Kathy Byrne has a significant track record in strategic and operational leadership and achievement in five states and territories in Australia.

After many years as a health service chief executive, Kathy joined the leadership team of Queensland Health in 2009 as the Chief Executive of CaSS and took on responsibility for a wide range of clinical support services with a statewide scope throughout Queensland that directly support frontline patient care.

Her executive role in Queensland Health includes membership of the Queensland Health EMT and executive lead for the development of the statewide services response in the National Health Reform. Kathy is also a board member of the Australian Healthcare and Hospitals Association.

Susan Middleditch
Deputy Director-General, FPL

Susan Middleditch was appointed to Queensland Health on 14 May 2012.

Susan is a motivated leader with a proven track record in delivering results in high performing organisations. As a Certified Practicing Accountant, Susan brings with her extensive financial and business experience and joined Queensland Health from the former Department of Employment, Economic Development and Innovation, where she was Group Executive, Business Operations and CFO.

Susan also possesses high-level experience in strategic planning, risk management, human resource policy development and commercial finance, stemming from previous executive-level roles she has held with the South East Queensland Water Grid Manager, Commerce Queensland and the Australian National Training Authority.

Glenn Rashleigh
Acting Deputy Director-General, HPID

Glenn Rashleigh joined Queensland Health on 6 June 2011. Prior to this, Glenn held a range of general management positions with Laing O'Rourke Construction Ltd (formerly Barclay Mowlem Construction and Barclay Bros) in Queensland and the Northern Territory for over 30 years. He was also a member of the Board for the Queensland Master Builders Association for 12 years and represented the construction and development industry on numerous boards and committees over the past 20 years.

Lyn Rowland
Acting Deputy Director-General, HRS

Lyn Rowland's career, spanning over 30 years, has been in both the public and private sectors with a major focus on reform of human resources practices and change management.

Lyn commenced her career in HR in Local Government in 1981 working with three Melbourne city councils where she held roles as HR Manager and HR/Industrial Relations (IR) Manager. Post Victorian Local Government she held executive HR positions with Melbourne Water, City of Adelaide, Normandy Mining and the Australian Magnesium Corporation.

In 2003, Lyn joined Queensland Rail as the Executive General Manager HR/IR and worked with the board, CEO and senior executive to transform the corporation from a state-based monopoly to a commercially competitive transport solutions business.

In 2009, Lyn accepted a position with Limitless Holdings (the international development division of the Dubai Government) as the Head HR Far East, based in Singapore.

Lyn joined Queensland Health in February 2012 and provides strategic leadership and advice for all human resources matters across Queensland Health. This includes the Payroll Portfolio Program, shared services, workplace relations, occupational health, safety and wellbeing, and strategic remuneration, organisational development and leadership advice.

Terry Mehan
Deputy Director-General, PandA

Terry Mehan is the Deputy-Director General, PandA. He was previously General Manager of Central Area Health Service and Southern Area Health Service, and Zonal Manager (Northern Zone) in Queensland Health. He has more than 30 years experience in senior executive positions in health and aged care with a strong focus on service integration and promoting population health. His current role focusses on strengthening governance and accountability across Queensland Health. Terry has specialist expertise in health service management, delivery and planning. He is an experienced chief executive of small rural hospitals, major regional hospitals and large metropolitan teaching hospitals.

Dr Michael Cleary
Deputy Director-General, PSR

Dr Michael Cleary is an emergency physician who has been with Queensland Health for 27 years. He has held a range of executive roles in Queensland Health and is a Queensland Health pre-eminent staff specialist. He is also Professor at the School of Public Health at the Queensland University of Technology.

Michael was previously Executive Director and Director of Medical Services for Logan and Beaudesert Hospitals, the Metro South Health Service District and the TPCH. He was appointed to lead PSR in April 2010.

Julie Hartley-Jones, CBE
CEO
Cairns and Hinterland Health Service District

Julie Hartley-Jones came to Queensland in January 2009 as CEO of the Cairns and Hinterland Health Service District and has a background in renal nursing. She has held senior nursing and management positions in England, including Chief Nurse of the Oxford Radcliffe Hospitals National Health Service Trust where she was responsible for more than 5500 nurses and midwives. Julie was then a Director of Nursing and moved to Australia in 2006 as Area Director of Nursing (DON) for Northern Sydney Central Coast Area Health Service in New South Wales, where she was responsible for more than 6000 nurses and midwives. She moved to Director of Clinical Operations in 2007.

Julie has been a guest speaker at many national and international conferences on renal care. She was President of the European Dialysis and Transplant Nurses Association in 1997–1998 and is an International Adviser to the National Kidney Federation of Singapore. She was made a Commander of the Most Excellent Order of the British Empire (CBE) for services to renal nursing in the 2000 British New Year Honours List. She has a Bachelor of Science in biology from the University of London, and a Master of Business Administration from Oxford Brookes University at Oxford.

Susan Turner
CEO
Cape York Health Service District

Susan Turner has been CEO since January 2010. Before joining Queensland Health she worked in chief executive officer roles in primary care in New Zealand and was extensively involved in significant healthcare reforms. She has worked in the health system for more than 20 years, including Capital Coast Health, the Waitemata District Health Board, acute mental health services, non-government health service provision, and primary healthcare organisations. Susan has a wide range of experience with communities and across sectors with a particular emphasis on Indigenous development. Her interests include transformational change in health systems, and innovation in Indigenous services, high needs and remote design and delivery.

Maree Geraghty
Acting CEO
Central Queensland Health Service District

Maree Geraghty has been Acting CEO of the Central Queensland Health Service District since January 2011. She was previously CEO of the South West Health Service District from November 2008, after being District Manager from 25 March 2008. Maree began work with Queensland Health in 1993 and has held a range of positions in corporate and health service delivery environments, including Principal Policy Officer to the Deputy Director-General; Manager, Child and Youth Health Policy; and Executive Director,

Community, Allied Health and Aged Care, Redcliffe-Caboolture Health Service District. She has a Bachelor of Arts degree, a Graduate Diploma in Education, and a Masters in Business Administration. Maree has a keen interest in developing evidence-based integrated models of care, clinical and corporate governance, communication, forming strategic partnerships, and building a culture of innovation and organisational improvement.

Jill Magee
CEO
Central West Health Service District

Jill Magee was raised in Charleville and completed her secondary school education there before moving to Brisbane to complete her nursing studies, including general, midwifery and child health. In 1996 she completed a Post Graduate Degree in Nursing and a Graduate Certificate in Management. Jill's 30-plus years experience in health include work in the government, non-government and private sectors. She has worked in Brisbane South, Logan-Beaudesert, West Moreton, South Burnett and Fraser Coast health service districts before taking the opportunity, in the 2006 Queensland Health restructure, to return to the bush. Jill has a particular interest in quality and safety.

Dr Peter Steer
CEO
Children's Health Services

Dr Peter Steer was appointed CEO of the Children's Health Service District in January 2009. His appointment followed a long and distinguished career as a neonatologist, senior medical administrator and academic in Australia and overseas. Peter was previously President of the McMaster Children's Hospital in Canada and Chief of Paediatrics at McMaster and St Joseph's Healthcare at Hamilton. He was also a Professor and Chair of the Department of Paediatrics at McMaster University. Peter has previously held senior leadership roles at the Mater Children's Hospital, the University of Queensland's School of Public Health and the Centre of Clinical Studies for Women's and Children's Health. He is a University of Queensland graduate.

Dr Peter Bristow
CEO
Darling Downs Health Service District

Dr Peter Bristow was appointed as Acting CEO of the Darling Downs Health Service District in June 2011. Peter came to Toowoomba in the year 2000 to take up the role of Toowoomba Hospital Intensive Care Services Director after spending four years as a Staff Specialist (Intensive Care) at the Alfred Hospital in Melbourne.

Peter is a member of the Australia and New Zealand Intensive Care Society and in 2000 was elected their Data Management Committee Chairman. His work resulted in the creation of a national benchmarking scheme which compares the performance of intensive care units around the nation.

Peter was appointed as the Executive Director of Medical Services in November 2004. He has a strong background in hospital medicine and is an intensive care specialist, previously working as the Intensive Care Unit (ICU) Director in Toowoomba. He has been a doctor for 25 years and worked in New South Wales and Victoria prior to coming to Toowoomba in 2000.

Peter has presented and published in ICU literature with his main research interests being severity of illness scoring systems and predictive algorithms.

Dr Adrian Nowitzke
CEO
Gold Coast Health Service District

Dr Adrian Nowitzke was born in Rockhampton and raised in Bundaberg before moving to Brisbane to undertake medical training and study for a Bachelor of Medical Science through the University of Newcastle. He then undertook specialist training in neurosurgery. Adrian is currently enrolled in the Brisbane Graduate School of Business executive MBA program. He has a strong vision for an integrated health service for the people of the Gold Coast that builds on the strengths of its staff and community relationships. He is the responsible officer for the district's operations and the project owner for the expansion of Robina Hospital and the building of the GCUH.

Kerry McGovern
CEO
Mackay Health Service District

Kerry McGovern joined the Queensland Government in 1968 and is now in his 43rd year of service. Initially completing studies in environmental health, he chose a career in health administration and was appointed a Hospital Board Manager in 1983. Kerry has served in senior executive roles in Cairns, Townsville, the Torres Strait, Innisfail, the Tablelands and Mount Isa. He has been CEO of the Mackay Health Service District since 2006. He was also appointed a Hospital Inspector and was Assistant Northern Zone Manager for three years. Kerry holds a tertiary qualification in financial accounting and is a board member of the Mackay Regional Development Corporation.

Professor Keith McNeil
District CEO
Metro North Health Service District

Prof Keith McNeil became CEO of the Metro North Health Service District in 2008. He is internationally recognised as an expert in lung transplantation and pulmonary vascular disease. He received postgraduate training in respiratory medicine in Queensland and underwent sub-specialty training in cardio-pulmonary transplantation and pulmonary hypertension in the United Kingdom.

In 1996, he was recruited to Cambridge as a transplant physician and Director of Pulmonary Vascular Diseases. During that time, he was an adviser to the United Kingdom's Department of Health on pulmonary hypertension, and established the United Kingdom National Centre for Pulmonary Endarterectomy at Papworth Hospital. Returning to Australia in 2001, Keith became Head of Transplant Services at TPCH in Brisbane, and Associate Professor of Medicine at the University of Queensland. Keith was appointed Professor of Medicine at the University of Queensland in 2007 and maintains his clinical and research interests.

Dr David Theile senior
CEO
Metro South Health Service District

Dr David Theile graduated Bachelor of Medicine/ Bachelor of Surgery with honours from the University of Queensland in 1962. Postgraduate training as a Resident and Surgical Registrar at Royal Brisbane Hospital resulted in him becoming a Fellow of the Royal Australasian College of Surgeons in 1967. After three years in the United Kingdom, he returned to Brisbane, gained the degree Master of Surgery and in 1974 was appointed to the Visiting Staff of PAH as a General Surgeon, a position he held until 2006.

In 2000, David was appointed Chairman of the Division of Surgery at PAH and he occupied that post until he was appointed Clinical CEO of PAH in May 2006. In October 2008, he was appointed District CEO of Metro South.

David has served as National President of the Royal Australasian College of Surgeons and was awarded the college's highest award (the Sir Hugh Devine Medal). In 1997, David was made an Officer of the Order of Australia for services to surgery. His previous roles include Clinical Professor of Surgery; VMO Surgeon, PAH; VMO Surgeon, Redcliffe Hospital; Senior Surgical Registrar, the Whittington Hospital, London; Lecturer in Surgery, the Royal London Hospital; and Resident Medical Officer then Surgical Registrar, Brisbane General Hospital.

Suzanne Sandral
CEO
Mount Isa Health Service District

Suzanne Sandral is a registered nurse and midwife. She has had a varied professional career covering medical, surgical and oncology/haematology nursing; and has worked in operating theatres and radiotherapy. She has been a remote area nurse and an occupational health and safety nurse at the Granites Goldmine in the Tanami Desert, Northern Territory.

In her years as a health administrator, Suzanne has worked in Sydney, London, the Northern Territory, India, Vietnam and now Queensland. In India and Vietnam she was an executive member of the project and commissioning teams that built hospitals in Kolkata (Calcutta), India, and Ho Chi Minh City, Vietnam.

Suzanne left Sydney and the Wollongong area in 1997, where she had been the DON of several private hospitals, and headed to the Alice Springs Hospital. She later gained experience as the occupational health and safety nurse in a gold mine and then an Indigenous owned and run community. In 2000, she became the DON of a hospital under construction in Kolkata, in West Bengal, India.

Chris Small

Acting CEO
South West Health Service District

Chris Small holds the substantive position of the South West Health Service District DON, and has been in this role since August 2009. Prior to this, he was the DON/Facility Manager of Mitchell Hospital.

Chris completed his training at the PAH in 1992. Since this time he has completed a number of tertiary studies in clinical and management. Chris has a passion for delivering innovative rural healthcare that focusses on advanced clinical skill development to ensure evidenced-based acute and emergency care is given, but also on creative health promotion and chronic disease programs to address the broadening burden of disease in rural communities.

Chris also has a strong interest in quality, patient safety and clinical governance. Chris has worked in a range of positions both in the public and private sectors, including roles as Quality Manager across a group of hospitals, Clinical Nurse in Anaesthetics and Recovery and Nurse Unit Manager of a Medical/High Dependency Unit ward.

Kevin Hegarty

CEO
Sunshine Coast Health Service District

Kevin Hegarty has served in senior positions in Queensland Health since joining the department in 1995. He was first appointed as a District Manager in 2001 at the then Rockhampton Health Service District. Kevin began as District Manager of the Sunshine Coast in December 2003 and was appointed District CEO of the Sunshine Coast-Wide Bay Health Service District in late 2008. From 1 November 2010, the Sunshine Coast Health Service District became an entity in its own right with Kevin remaining District CEO. He has interests in mental health, Indigenous health, developing partnerships with universities, divisions of General Practice, and other significant community organisations.

Paul Stephenson

CEO
Torres Strait-Northern Peninsula Health Service District

Paul Stephenson has been a District Manager/CEO since July 2005, initially in the Cape York Health Service District. He then moved to Mount Isa in November 2009 and to the Torres Strait in 2011. He was previously Acting District Manager of the Torres Strait and Northern Peninsula Area Health Service and Cape York. Paul joined Queensland Health in 1990 as a Clinical Nurse Consultant/Program Manager in specialised health and was then a DON/Service Manager for the Cooktown and Mossman health services in north Queensland. His interests include integrated rural health service development; Indigenous health; and community development.

Dr Andrew Johnson

CEO
Townsville Health Service District

Dr Andrew Johnson was appointed District Executive Director Medical Services in July 2000 and has been Acting CEO since March 2011. He has been an Eminent Staff Specialist since January 2006. Andrew's qualifications include MBBS UNSW 1989; MHA UNSW 1995; and Fellow Royal Australasian College of Medical Administrators 1996. He has a background as an Adjunct Associate Professor of Medicine, James Cook University, and served in the Royal Australian Air Force. Andrew worked for three years in New South Wales public hospital management and for three years in the private sector in Cairns. His main interests are patient safety, medical workforce, emergency preparedness and disaster management, and medical education.

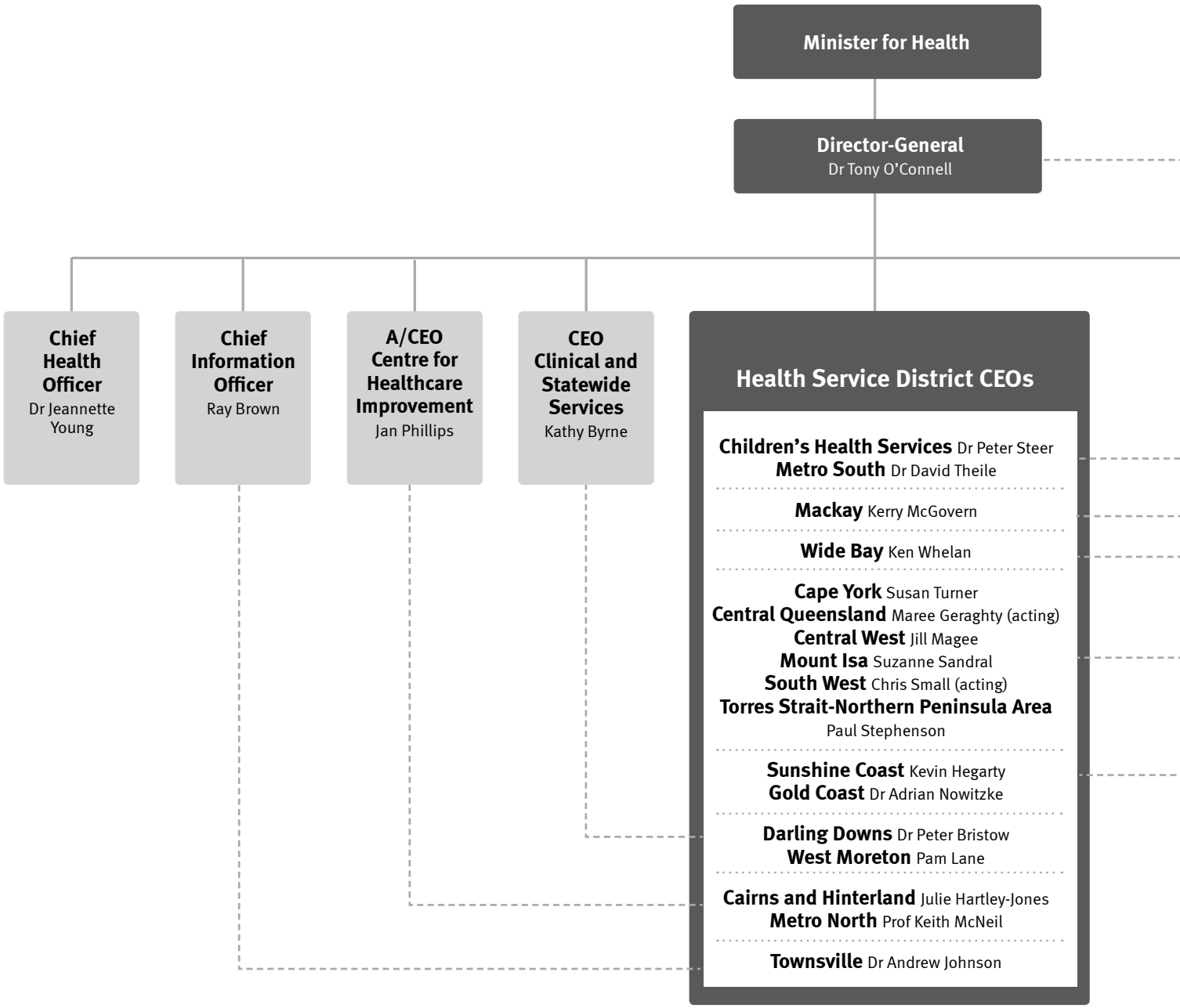
Pam Lane
District CEO
West Moreton Health Service District

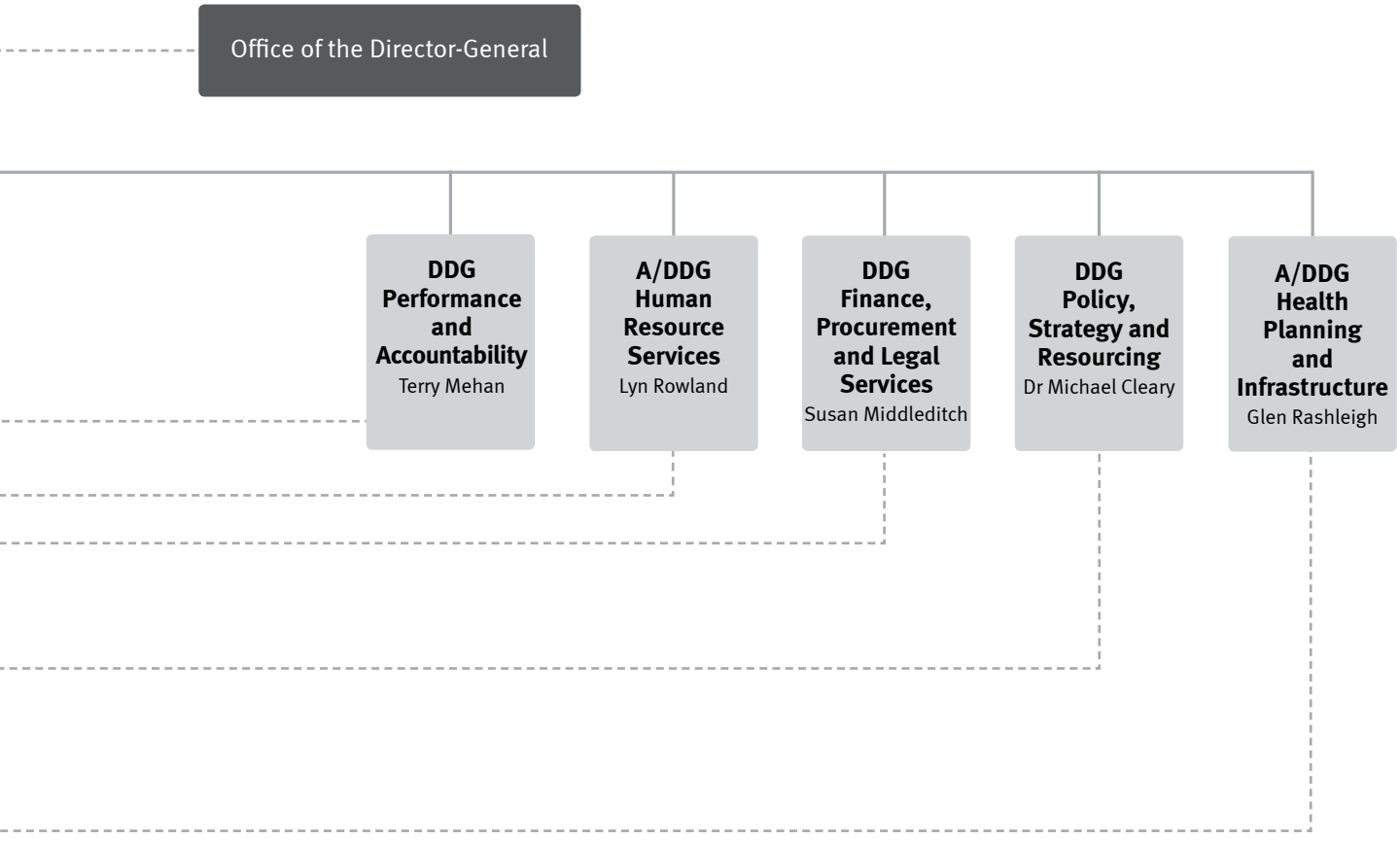
Pam Lane has more than 20 years experience in leading and managing a diverse range of health services focussing on improving patient services and developing staff. Pam began her nursing training in 1966 at Toowoomba Base Hospital and worked as a midwife for 20 years. In 1993, she started at Ipswich Hospital as DON and after six years became District Manager of the West Moreton Health Service District. The amalgamation of the West Moreton and South Burnett Health Service Districts saw Pam become District Manager of the new district in February 2007. In November 2008, she was successful in gaining the position of CEO for the newly formed Darling Downs-West Moreton Health Service District. Following the de-amalgamation of these districts on 30 June 2011, Pam continues in the role of District CEO for the West Moreton Health Service District. Pam is a member of many community organisations, including the Ipswich Hospital Foundation, Ipswich Hospice, Zonta and the University of Queensland Advisory Board.

Ken Whelan
CEO
Wide Bay Health Service District

Ken Whelan became CEO for the newly formed Wide Bay Health Service District in November 2010. Before entering management, he was a registered nurse. Ken has been in health management for almost 23 years and in CEO roles for the last 13 years. He has led two district health boards in New Zealand and was District Manager at Townsville Health Service District for nearly six years.

Queensland Health organisational chart





Direct report

Portfolio relationship

DDG Deputy Director-General

CEO Chief Executive Officer

Governance and accountability

Executive committees

Executive Management Team

The EMT purpose is to:

- support the Director-General to meet responsibilities outlined in the *Health Services Act 1991* and other relevant legislation
- make recommendations on the department's strategic direction, priorities and objectives and endorse plans and actions to achieve the objectives
- set an example for the corporate culture throughout the organisation.

The EMT's functions are to:

- set the department's strategic direction and priorities
- ensure available resources for delivering public sector health services are used effectively and efficiently
- monitor the organisation's performance against its strategic objectives and key performance indicators
- set a culture of risk-based decision-making throughout the organisation
- ensure effective governance systems are in place.

EMT membership:

- Director-General
- CHO
- CHI
- Chief Executive, CaSS
- CEO, CHI
- Deputy Director-General, PandA
- Deputy Director-General, FPL
- Deputy Director-General, HRS
- Deputy Director-General, PSR
- Deputy Director-General, HPID
- Chair, CEO and Deputy Director-General Forum.

Key achievements for 2011–2012 included:

- recommendations to the Director-General on approving the annual budget that aligned to the strategic plan
- providing leadership for the introduction of National Health Reform
- endorsing Queensland Health's ABF model.

EMT met 40 times in 2011–2012.

CEO and Deputy Director-General Forum

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

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

CEO-Deputy Director-General Forum membership:

- Director-General
- All district chief executive officers
- All deputy directors-general of corporate divisions
- All chief executive officers of corporate divisions
- CHO
- CIO.

The CEO and Deputy Director-General Forum was held 11 times in 2011–2012.

Close the Gap Executive Committee

The Close the Gap Executive Committee was established in August 2009. Its purpose is to:

- provide strategic advice and recommendations to EMT on Queensland Health's contribution towards Closing the Gap in Indigenous health outcomes by 2033

- monitor the development and implementation of the Making Tracks and Close the Gap policies and associated implementation plans—including Queensland Health's commitments under the COAG Indigenous Health Outcomes and Indigenous Early Childhood NPA
- monitor progress in the performance accountabilities of district chief executive officers, deputy directors-general and other corporate heads in contributing to the Close the Gap agenda and provide advice to the performance and accountability directorate on successes and underperformance, as appropriate.

The Close the Gap Executive Committee contributes to managing and delivering health services by:

- overseeing development, approval and publication of the Making Tracks Indigenous health policy and associated plans, including initiatives funded under the COAG Indigenous Health Outcomes and Indigenous early childhood NPA
- overseeing development, approval and publication of the COAG Indigenous Health Outcomes NPA implementation plan and securing funding to support its implementation
- monitoring progress in implementing Close the Gap initiatives and achieving Close the Gap accountabilities articulated in Making Tracks
- implementing initiatives developed under the COAG Indigenous Health Outcomes and Indigenous Early Childhood NPAs and the performance agreements of district chief executive officers, deputy directors-general and other corporate heads
- considering and assessing financial, patient safety and quality, people, information and infrastructure impacts of its decision-making and collaborating with other executive committees and functional areas, where relevant
- identifying risks and mitigation strategies associated with all decisions made
- implementing processes to enable the Close the Gap Executive Committee to identify, monitor and manage critical risks as they relate to the committee's functions.

The committee met six times in 2011–2012. There are no external members.

Health Infrastructure and Projects Executive Committee

The Health Infrastructure and Projects Executive Committee (HIPEC) aims to:

- ensure capital works and infrastructure align with Queensland Health's strategic and endorsed service planning directions
- provide strategic advice and recommendations to ensure investments in physical infrastructure and assets are optimised for achieving Queensland Health's health service delivery outcomes and that the asset base is sustainable in the long-term
- ensure all strategies and planning (including enabling planning) are coordinated, integrated and aligned, and lead to the achievement of Queensland Health's strategic objectives
- oversee and support development of appropriate policies and procedures to support the effective delivery of infrastructure projects, planning activities and physical infrastructure and assets, including non-hospital accommodation (owned and leased)
- consider and assess the financial, patient safety and quality, people, information and infrastructure impacts of its decision-making and collaborate with other executive committees and functional areas, where relevant.

To contribute to the management and delivery of health services, HIPEC:

- obtains approval for the Capital Acquisition Plan
- reviews, monitors, prioritises and manages Capital Acquisition Plan performance, including reviewing specific project delivery methodologies, reviewing project and program risk assessments and related mitigation strategies, and financial performance
- oversees development and implementation of Queensland Health's Capital and Asset Planning Framework and recommends approval
- obtains approval for the annual Asset Strategic Plan
- has executive overview of asset management strategy and policy, and recommends policy approvals
- reviews and monitors asset performance and infrastructure risks
- engages with departmental planning units (including other enabling planning units), health service districts and external stakeholders on infrastructure planning, capital works and assets

- oversees development of the department's Capital Investment Plan and recommends which proposed capital projects proceed to further planning and/or future budget submissions
- oversees outcomes of infrastructure planning activities and recommends further activities
- oversees development of design guidelines and recommends approval.

HIPEC met 10 times in 2011–2012. There are no external members.

Health Reform Program Executive

The Health Reform Program Executive was established in January 2011 and replaced the National Health Reform Program Executive as the formal Health Reform Program Board from 2 March 2012. It is a time-limited committee that meets fortnightly.

The purpose of the Health Reform Program Executive is to:

- function as the health reform portfolio/program board
- oversee work priorities and performance of the Queensland Health Reform Transition Office and the Senior Director, Queensland Health Reform Transition Office
- support the timely escalation of program risks and issues for consideration by the Senior Responsible Owner (Director-General Queensland Health)
- manage the relationship between the Queensland Health Reform Program and the Health and Disability Reform CEOs Committee as the program's sponsoring group to ensure that, as far as possible, Queensland Health's priorities are addressed in the committee's deliberations.

The Health Reform Program Executive met 11 times in 2011–2012.

Table 5: Health Reform Program Executive membership in 2011–2012

Name	Membership	Dates
Dr Tony O'Connell	Director-General	January 2012–June 2012
Dr Michael Cleary	Deputy Director-General, PSR	January 2012–June 2012
Dr Peter Steer	Chair, District CEO and Deputy Director-General Forum	January 2012–June 2012
Susanne LeBoutillier	Senior Director, Queensland Health Reform Transition Office	January 2012–June 2012
Kathy Byrne	Chief Executive, CaSS	February 2012–June 2012
John Cairns	Deputy Director-General, HRS	February 2012–March 2012
Helen Gluer	Acting Director-General, Health Corporate Services Authority	February 2012–March 2012
Neil Castles	Deputy Director-General, FPL	February 2012–April 2012
Susan Middleditch	Deputy Director-General, FPL	May 2012–June 2012
Dan Harradine	Executive Director, Office of Director-General	January 2012–June 2012

Human Resources Executive Committee (HREC)

The HREC aims to:

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

To contribute to the management and delivery of health services, the HREC:

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

HREC considered and established a risk register for high level human resources risks for the organisation. HREC met five times in 2011–2012. There are no external members.

Information and Communication Technology Executive Committee

The Information and Communication Technology Executive Committee (ICTEC) aims to:

- ensure the effective use of ICT to assist Queensland Health to achieve its strategic objectives
- set the direction for ICT to ensure alignment between ICT investment and Queensland Health strategies
- determine ICT investment priorities
- endorse ICT strategies and plans developed to deliver on Queensland Health objectives and priorities
- assess and recommend funding for ICT investments
- review the progress of ICT programs and projects to ensure value is delivered
- realign investments, as appropriate.

To contribute to the management and delivery of health services and achieve Queensland Health's strategic objectives, the ICTEC:

- endorses the departmental ICT strategy as specified by the Financial and Performance Management Standard 2009 and portfolio plans for each ICT portfolio within Queensland Health
- monitors and reviews the ICT Capital Acquisition Plan
- prioritises a program of work to address key ICT asset replacement priorities detailed in the annual asset strategic plans for each division and district
- endorses and oversees the information management program of work across Queensland Health
- monitors the performance of the portfolio of ICT programs and projects across Queensland Health
- realigns investments where performance expectations are not being met
- monitors the realisation of benefits from the suite of investments
- reviews and monitors ICT portfolio risks
- reviews and monitors ICT service performance across Queensland Health
- monitors implementation of audit recommendations for ICT
- ensures whole-of-government issues are considered and reporting requirements satisfied
- considers and assesses the financial, patient safety and quality, people, information, and infrastructure impacts of its decision-making and collaborates with other executive committees/functional areas where appropriate/relevant.

ICTEC met nine times during 2011–2012.

Integrated Policy and Planning Executive Committee

The IPPEC aims to integrate, coordinate and endorse statewide policy development and implementation, and health service planning within Queensland Health to:

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

To contribute to the management and delivery of statewide and district health services, IPPEC:

- gives executive overview of strategic and statewide policy and health service planning
- develops, coordinates and integrates within Queensland Health, in collaboration with relevant stakeholders, including health service districts
- gives direction on developing and establishing planning systems to improve integration of policy development, health service planning and other key planning activities across health service districts, the department and government
- considers contributions of policy development and planning activities to achieving Queensland Health's strategic objectives
- considers identified issues, risks and opportunities from strategic policy development, health service planning and other planning processes, including budget and performance management processes
- considers strategic and statewide policy and planning implications at statewide and district levels in Queensland Health
- gives direction on priority Queensland Health planning and policy projects and how they will be progressed
- engages effectively with internal and external Queensland Health policy and planning stakeholders to seek input for policy and planning decisions, including relevant consultation with health service districts and other key stakeholders before discussion of agenda items and/or finalisation of decisions
- where appropriate promotes organisation-wide integration when undertaking policy and planning activities, including:
  - communicating and advocating for integration of processes and systems
  - leading integration practices within their areas of responsibility
- endorses statewide policy development and planning activities at key project stages ensuring they:
  - are consistent with Queensland Health endorsed processes
  - promote effective implementation planning as a key element
- monitors consistency between statewide and health service district (where there may be statewide or cross-district implications) policy development and planning
- endorses development of systems that support integrated policy and planning development
- leads development, implementation and review of the Statewide Health Services Plan, a legislative requirement (*Health Services Act 1991*, s3, s7)
- is supported by the IPPEC Standing Sub-Committee.

IPPEC met eight times in 2011–2012. IPPEC membership includes a representative from the Queensland Clinical Senate. In the first half of the financial year a clinical senate member external to Queensland Health filled the role, whilst in the second half of the financial year the position was filled by an internal Queensland Health member of the clinical senate.

National Health Reform Executive Committee

To contribute to the management and delivery of health services, the National Health Reform Executive Committee (NHREC) was a time-limited committee established to oversight and make recommendations to the Chair on critical policy and strategic decisions for implementing the COAG health reform agenda in Queensland.

The committee functioned under the authority of the Director-General for Queensland Health and provided advice to:

- the Minister for Health
- the National Health Reform Inter-Departmental Chief Executive Officer Committee.

The NHREC met eight times in 2011–2012. It was disbanded in February 2012 and replaced by the Health Reform Program Executive.

Table 6: National Health Reform Executive Committee membership in 2011–2012

Name	Title	Dates
Dr Tony O'Connell	Director-General	October 2011–February 2012
	Acting Director-General	July 2011–September 2011
Jacqueline Ball	Executive Director, Strategic Policy, Funding and Intergovernmental Relations Branch	July 2011– February 2012
Brigid Bourke	CFO	July 2011–November 2011
Ray Brown	CIO	July 2011–February 2012
Kathy Byrne	Chief Executive, CaSS	July 2011–February 2012
John Cairns	Deputy Director-General, HRS	July 2011–February 2012
Neil Castles	Deputy Director-General, FPL	July 2011–February 2012
Tina Davey	Executive Director, Intergovernmental Relations, Department of the Premier and Cabinet	July 2011–February 2012
Dr Michael Cleary	Deputy Director-General, PSR	July 2011–February 2012
Dr John Glaister	Deputy Director-General, HPID	July 2011–February 2012
Julie Hartley-Jones	CEO, Cairns and Hinterland Health Service District	July 2011–February 2012
Walter Ivessa	Assistant Under Treasurer, Queensland Treasury	July 2011–February 2012
Susanne Le Boutillier	Senior Director, Queensland Health Reform Transition Office	July 2011–February 2012
Terry Mehan	Deputy Director-General, PandA	July 2011–February 2012
Dr Keith McNeil	CEO, Metro North Health Service District	June 2011–February 2012
Catherine O'Malley	Acting Executive Director, Social Policy, Department of the Premier and Cabinet	July 2011–July 2011
Dr Peter Steer	CEO, Children's Health Service District	July 2011–February 2012
Paul Stephenson	CEO, Mount Isa Health Service District	July 2011–August 2011
	CEO, Torres Strait – Northern Peninsula Health Service District	September 2011–February 2012
Dr Jeannette Young	CHO	July 2011–February 2012
Dr Elizabeth Whiting	Queensland Clinical Senate	July 2011–February 2012

Note: No members are remunerated for their participation

Patient Safety and Quality Executive Committee

The Patient Safety and Quality Executive Committee (PSQEC) sets policy direction in patient safety and quality of service delivery, in accordance with the *Health Services Act 1991* and the *Queensland Health Strategic Plan 2011–2015*.

To contribute to managing and delivering Queensland Health services and achieving Queensland Health's strategic objectives, the PSQEC:

- oversees the Queensland Health Clinical Governance Framework
- endorses clinical guidelines, policies, implementation standards, alerts and advisories and other documents relating to patient safety and quality
- advises the EMT on all matters relating to patient safety and quality
- scans the system, reviewing and monitoring patient safety and quality risks, performance indicators and reports
- directs action to promote improvements in patient safety and quality of healthcare and considers relevant information
- advises on the cost effectiveness of patient safety and quality initiatives
- monitors Queensland Health responses to safety and quality issues
- develops and monitors implementation of the Patient Safety and Quality Plan for Queensland Health.

During the reporting period, the PSQEC endorsed the:

- Queensland Health Guide for Echo-cardiography
- Queensland Maternity and Neonatal Operational Framework: Maternity Shared Care
- Implementation Standard for the professional relationship between dentists and dental therapists
- Rural and Remote Emergency Services Standardisation Project
- Queensland Maternity and Neonatal Clinical Guidelines, Supplements and Operational Framework
- Amendments to Attachment D Standard Process for Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists in Queensland Health—Implementation Standard
- Final Draft Schedule of Interim Changes for the better management of Credentialing risk in the 'Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists in Queensland Health Policy 2011'
- Queensland Maternity and Neonatal Clinical Guidelines and Supplements
- Variable Life Adjusted Display Information Standard 6.2
- Nutrition screening, assessment and support Policy, Standard and Procedure
- Informed Decision-making in Healthcare Policy, Implementation Standard and Guide
- VLAD Annual Report
- Queensland Health Safe Infant Sleeping Policy
- Management of the Deceased Patient Practice Manual 2012
- Nurse Practitioner Credentialing and Defining the Scope of Clinical Practice
- Queensland Maternity and Neonatal Clinical Guideline and Supplement: Normal Birth and Supplement and Perineal Care and Supplement.

PSQEC met 10 times in 2011–2012.

Table 7: Patient Safety and Quality Executive Committee

Name	Membership	Dates
Jason Curry	Chair	July 2011
Dr Michael Daly	Chair	August 2011–October 2011
Dr John Wakefield	Chair	December 2011–June 2012
Terry Mehan	Ex-officio member	July 2011– June 2012
Dr Jeannette Young	Ex-officio member	July 2011– June 2012
Dr Alun Richards	Delegated for CHO	July 2011–March 2012
Prof Jagmohan Gilhotra	Delegated for CHO	April 2012–June 2012
Cheryl Burns/ Frances Hughes	Ex-officio member	July 2011–January 2012 February 2012–June 2012
Dr Grant Howard/ Ruth Hay	Ex-officio member	July 2011–December 2011 January 2012–June 2012
Kathy Byrne	Ex-officio member	July 2011–June 2012
Prof David Thiele	Ex-officio member	July 2011–June 2012
Ken Whelan	Ex-officio member	July 2011–June 2012
Jill Magee	Ex-officio member	July 2011–June 2012
Dr John Wakefield/ Dr Jillann Farmer	Ex-officio member	July 2011–June 2012 February 2012–June 2012
Dr Don Martin	Ex-officio member	July 2011–June 2012
Dr Jill Newland	Ex-officio member	July 2011–June 2012
Barbara Kent	DG appointed member (consumer representative)	July 2011–June 2012
Gary Rebgetz	DG appointed member (consumer representative)	July 2011–June 2012
Marie Pietsch	DG appointed member (consumer representative)	July 2011–June 2012
Dr Judy Graves/ Dr Stephen Ayre	DG appointed member	July 2011–September 2011 February 2012–June 2012
Ian Scott	DG appointed member	July 2011–June 2012
Lynn Jamieson	DG appointed member (external)	July 2011–June 2012
Tony Hall	DG appointed member (external)	July 2011–June 2012

Note: The committee's external members are remunerated for their time and related expenses. The amount paid in 2011–2012 was $13 238.96.

Risk Management Advisory Committee

The Risk Management Advisory Committee (RMAC) continues to direct the development and integration of a strategic approach to managing risks and embedding the process into routine governance and management practice. RMAC functions in accordance with the requirements of the *Financial Accountability Act 2009* and the Financial and Performance Management Standard 2009.

RMAC membership comprises:

- CEO, CHI
- CIO, Information Division
- Deputy Director-General, PandA (Chair)
- Deputy Director-General, PSR
- Deputy Director-General, FPL
- Deputy Director-General, HRS
- Deputy Director-General, HPID
- Three district CEOs
- External risk management professional/adviser.

RMAC met six times in 2011–2012. External RMAC members are remunerated for their time. The amount paid in 2011–2012 was $5600. At this point risk management will have been embedded into core governance and management practices; the committee will dissolve and the monitoring/oversight functions will be transferred to an appropriate committee.

Resource Executive Committee

The Resource Executive Committee (REC) aims to:

- review the financial position and performance of Queensland Health in the current and future years
- give strategic advice and recommendations to the EMT on developing, implementing and managing Queensland Health's financial management strategy
- ensure all financial and organisational performance improvement processes are coordinated and effective, and lead to the achievement of Queensland Health's strategic objectives
- oversee progress against critical objectives and ensure appropriate action to support improvements, where necessary
- promote development of effective teamwork across Queensland Health, and the most effective division of responsibilities for financial strategy and organisational performance improvement
- monitor development of the procurement policy and procedures for Queensland Health as determined by the EMT
- actively manage implementation of the Budget Management Action Plan and monitor and report on outcomes under the plan.

To contribute to managing and delivering health services, REC:

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

Members of the REC

Chair: Deputy Director-General, FPL

Members:

- Director-General
- Deputy Director-General, PSR
- Deputy Director-General, PandA
- Deputy Director-General, HPID
- Deputy Director-General, HRS
- CEO, CaSS
- CEO, CHI
- CHO
- CIO
- General Manager Finance, Queensland Health
- Senior Director, Strategic Policy, Funding and Intergovernmental Relations
- One (1) District CEO from a metropolitan Health Service District
- One (1) District CEO from a regional Health Service District

- One (1) District CEO from a rural Health Service District.

REC met 12 times in 2011–2012. There are no external members on this committee.

Other committees and boards

Activity Based Funding Project Board

The ABF Project Board's purpose is to:

- support the project sponsor in meeting their responsibilities
- provide strategic advice and recommendations to the EMT on developing, implementing and managing activity based funding in Queensland Health
- oversee completion of the development and implementation of an activity based funding model for Queensland Health.

To contribute to management and delivery of health services and achieve Queensland Health's strategic objectives, the ABF Project Board:

- provides business assurance of the ABF project and project products
- monitors and manages the ABF project's progress against the approved business case
- implements robust risk management processes
- ensures stakeholders are appropriately engaged
- ensures the organisational change required is appropriately managed
- approves the transition plan for transferring responsibility of ABF to the business
- oversees the transition of ABF from a project to business as usual
- ensures available resources for the delivery of healthcare purchasing and activity based funding.

ABF Project Board membership comprises:

- Deputy Director-General, PandA
- Deputy Director-General, FPL
- Deputy Director-General, PSR
- CEO, CHI
- CEO, Gold Coast Health Service District
- CEO, Cairns and Hinterland Health Service District
- Chief Financial Officer, Metro North Health Service District
- Clinical Senate Executive
- Clinical Senate Member.

Key achievements for 2011–2012 included:

- completion of 2011–2012 ABF Funding Model
- development and completion of pilot for 2012–2013 Healthcare Purchasing Framework.

The ABF Project Board met 12 times in 2011–2012. No members were remunerated for their participation.

Audit Committee

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

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

To contribute to managing and delivering health services, the Audit Committee's responsibilities cover:

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

Financial statements—the committee:

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

Internal control—the committee:

- reviews, through audit planning and reporting of internal and external audit, the adequacy of the internal control structure and systems, including information technology security and control

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

Internal audit—the committee:

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

External audit—the committee:

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

Compliance—the committee:

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

Reporting—the committee:

- submits reports as required to the Director-General, outlining relevant matters it considers need to be highlighted
- prepares an annual report to the Director-General summarising the performance for the previous year. An interim program of the planned activities for the coming year is also provided.

The Audit Committee met six times in 2011–2012.

Table 8: Audit Committee membership

Name	Membership	Dates
Len Scanlan	Chair (external member)	July 2011–June 2012
Dr Jeannette Young	Member	July 2011–August 2011
Dr Judy Graves	Member	April 2012–June 2012
Terry Mehan	Member	July 2011–June 2012
Julie Hartley-Jones	Member	July 2011–June 2012
Ken Brown	External Member	July 2011–June 2012

Note: External members on the Audit Committee are remunerated for their time. The amount paid during 2011–2012 was $19 715.

Mechanisms to strengthen governance

Ethics and code of conduct

Queensland Health is committed to upholding the values and standards of conduct outlined in the *Code of Conduct for the Queensland Public Service* which came into effect on 1 January 2011. The *Code of Conduct for the Queensland Public Service* applies to all Queensland Health employees and replaced the previous Queensland Health Code of Conduct.

The new Code of Conduct for the Queensland Public Service was developed under the *Public Sector Ethics Act 1994* and consists of four core principles:

- integrity and impartiality
- promoting the public good
- commitment to the system of government
- accountability and transparency.

Each principle is strengthened by a set of values and standards of conduct describing the behaviour that will demonstrate that principle.

All Queensland Health employees are required to undertake training in the *Code of Conduct for the Queensland Public Service* during their induction and thereafter re-familiarise themselves with the code of conduct annually. Queensland Health continues to develop a standard of practice, in consultation with employee unions, to underpin the *Code of Conduct for the Queensland Public Service*. A campaign to ensure employees are aware of the code of conduct was implemented and included in resources, training and face-to-face awareness activities.

Performance management

The Queensland Health Performance Management Framework (QHPMF) 2011–2012 provided a process for cascading the key performance metrics of the department throughout the organisation and formally embedding accountability mechanisms, performance measurement and performance management. The QHPMF provided a transparent, rules-based approach to defining expectations and managing performance. It is also a guide when developing local performance monitoring and management processes.

Monthly performance reviews were undertaken throughout 2011–2012 in accordance with the escalation and de-escalation protocols defined within the QHPMF. Where performance issues were identified, intervention responses were applied and progress monitored monthly until resolved.

In accordance with the requirements of the health reform program in Queensland, a Hospital and Health Services Performance Framework (HHSPF) was developed for 2012–2013 to identify the means by which the System Manager (Queensland Health) will monitor and assess the performance of HHSs. The HHSPF was developed in accordance with the requirements of both the Queensland Government Performance Management Framework and the National Performance and Accountability Framework as defined by the National Health Performance Authority. Its scope is limited to HHSs and public health services provided by Mater Health Services.

The HHSPF is not designed to measure all aspects of HHS performance. Rather, it sets out how a cross section of performance across key priority areas is measured, including the strategic objectives for the public health system and standards and targets set by the Commonwealth and State Governments.

The HHSPF recognises the changing relationship between HHSs and Queensland Health and the devolution of accountability for service delivery. Under these new governance arrangements the service agreement between Queensland Health and each HHS will become the primary means through which the overall health system is managed and through which individual HHSs are held accountable for the delivery of services. With the removal of direct line management responsibility for service delivery, Queensland Health will become focussed on the management of the health system.

Queensland Health will produce a monthly performance dashboard for each HHS; allocate a performance category to each HHS based on their performance against the key performance Indicators defined in their service agreement; identify performance issues and determine appropriate responses; monitor progress against any interventions applied; and recognise high sustained performance across HHSs, where attained.

Performance agreements

Performance agreements between the Director-General and the Deputy Director-General/CEO of each of the Queensland Health corporate divisions or commercialised business units are executed annually. The agreements are primarily focussed on the achievement of the first three elements of the Chief Executive Officer Performance and Development Framework, namely whole-of-government objectives; department priorities; and department governance and management. Monitoring and performance management of the Queensland Health corporate division senior executives against their respective performance agreement is undertaken in accordance with the 2011–2012 QHPMF, which at a minimum requires participation in a mid-year and end-of-year performance review process, and contribution to quarterly reporting requirements against the key accountabilities contained within the performance agreements.

Risk management

The Queensland Health Integrated Risk Management Policy Framework (IRMPF) is based upon the Australian/New Zealand ISO Standard 31000:2009 (formally known as AS/NZS 4360:2004) for risk management. The IRMPF outlines Queensland Health intent, roles and responsibilities and implementation requirements. All accountability areas are responsible for implementing the Integrated Risk Management Policy and developing a risk register. The IRMPF was last updated in January 2012.

Risk management is an integral part of the department's corporate governance framework. Risks are controlled within the financial and management accountabilities of each position. The Director-General, as accountable officer, is supported by the executive management of each corporate division and health service district. The Director-General, and individual executives, manage risks with support from management structures within their areas of responsibility and from local and departmental executive/governance committees.

The Risk Management Unit is responsible for:

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

Mechanisms to strengthen accountability

Assurance and Risk Advisory Services

The RMAC work plan for 2011–2012 includes a number of strategies which are intended to strengthen risk management at the strategic level of the organisation, and in particular to integrate effective risk management into the work of Queensland Health executive committees. These strategies included:

- integrating risk management into executive committee business and processes
- development of a departmental risk profile/register

Table 9: Risk management training achievements during 2011–2012

Activity	Number of sessions	Training hours	Number of staff completed
Risk management online learning module: Introduction and overview of the Queensland Health Integrated Risk Management Policy Framework for managers and staff	Online	455	910
Risk-in-focus session: Advanced risk management training, focussing on key aspects of advanced risk management and its application to management decision-making	3	9	29
QHRisk training: System training in use of the QHRisk risk information system	5	15	20

- rolling out a three stage process across executive committees with the support of the Risk Management Unit. The process was designed to enable executive committees to identify and document key risks, and to map an organisational risk profile for the department.

The process was designed to support the following principles:

- The process should be simple and easy to apply.
- The process should be adaptable to the needs and circumstances of individual executive committees.
- The process should support effective decision-making and resource allocation.
- The process should support the sharing of information across committees and the organisation, and maximise understanding and consistency in risk assessment at the strategic level.
- The process should be consistent with the Queensland Health Integrated Risk Management Framework and recognise good practice in risk management.

The project will deliver the following primary outcomes:

- Each executive committee will identify its high level (strategic) risks. Each risk will be assessed, an owner will be identified and mitigating/control strategies will be agreed and documented. The resulting risk registers will be recorded in a standardised risk register template based on a template which has been developed by the Resource Executive Committee and will be submitted to the RMAC.
- The executive committee risk registers will then be centrally analysed and consolidated. Those risks which require organisation-wide oversight will be identified and translated into an organisational strategic risk register for EMT oversight. The resulting strategic risk register will be submitted to the EMT.

Ethical Standards Unit

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

This key role enables the Director-General to fulfil his statutory obligation to report allegations of suspected official misconduct to the Crime and Misconduct Commission, and to deal with allegations referred back to the department by the commission.

In 2011–2012, the Ethical Standards Unit function expanded with a dedicated misconduct prevention function to raise ethical awareness and promote integrity in the workplace.

The Ethical Standards Unit advises the Director-General, senior management and health service districts about misconduct prevention, managing new allegations of suspected official misconduct and other ethical behaviour issues.

Assessment and investigations

A multi-disciplinary committee assesses new allegations of suspected official misconduct. The committee comprises:

- Ethical Standards Unit Director, Assessment Manager and officers
- a senior Corporate Office Workplace Services Unit representative
- Queensland Health Police Liaison Unit Queensland Police Service (QPS) Inspector
- other specialist stakeholders relevant to the allegations, as required.

The Queensland Health Police Liaison Unit includes a seconded Queensland Police Service Acting Inspector. He gives specialist advice on criminal matters and acts as a liaison point between the department and local police. The Queensland Health Police Liaison Unit also assists in raising awareness amongst Queensland Police Service and Queensland Health staff about the Memorandum of Understanding (MOU) between the Queensland Police Service and Queensland Health. The MOU aims to facilitate reporting of suspected criminal offences by Queensland Health staff and information sharing between the agencies.

During 2011–2012, the Ethical Standards Unit managed 898 complaints involving over 2000 allegations about suspected official misconduct, and assessed and advised Queensland Health work units on another 368 ethical issues that did not involve suspected official misconduct. This compared with 929 complaints involving 1813 allegations about suspected official misconduct in 2010–2011, 577 complaints in 2009–2010 and 411 cases in 2008–2009.

While the number of 'complaints' received has slightly decreased, there has been an increase in the number of allegations received and assessed by the Ethical Standards Unit. The increase is in part due to a change

in how some matters have been reported, received and recorded, but is largely attributed to increased ethical awareness, as a result of a series of state-wide ethical awareness sessions conducted by the unit.

An increase in reporting suspected official misconduct is a positive trend in terms of public confidence in the department's transparency and accountability. It also indicates increased staff awareness of the need to report suspected official misconduct, and how reports can be made.

Prevention

During 2011–2012, Ethical Standards Unit officers delivered 55 ethical awareness sessions to 1102 staff across the state. These sessions were delivered to all levels and professional streams and were customised according to the audience.

Other notable activities include:

- participation in the Appropriate Use Committee for *The Viewer* information system. The Ethical Standards Unit provides input on the appropriate use of confidential patient records accessed through *The Viewer* system
- assessment of 281 employee emails for inappropriate content or conduct to ensure appropriate reporting and management
- review of the Guidelines for Reporting Suspected Stolen Drugs in order to bring them in line with organisational changes from 1 July 2012. Adoption of the Guidelines by Directors of Pharmacy across the state has resulted in greater awareness of reporting obligations, and consistent processes for receiving and investigating reports of lost or alleged stolen medication.

Internal audit

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

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

In 2011–2012, the unit continued data analytics in the move towards continuous auditing and issued 28 audit reports to the Director-General.

The unit's purpose, authority and responsibility are formally defined in its charter which is reviewed by the Audit Committee and approved by the Director-General. The charter is consistent with the International Professional Practices Framework of the Institute of Internal Auditors. All members of the unit are bound by the principles of integrity, objectivity, confidentiality and competency under the institute's code of ethics.

The strategic and annual audit plans direct the unit's activities and provide a framework for it to operate effectively. The annual audit plan—approved by the Director-General—is developed in consultation with key stakeholders and takes into account the strategic risks identified by management. The implementation of audit recommendations that address risk mitigation are followed up regularly and progress reported to the audit committee.

Public interest disclosure of confidential information

In accordance with section 62F of the *Health Services Act 1991*, Queensland Health is required to include a statement in the annual report detailing the disclosure of confidential information in the public interest. During 2011–2012, five requests for public interest disclosure were approved by the Director-General:

- The CHO of New South Wales requested the disclosure of information about a person being managed under the *Protocol for the Management of People with HIV who Place Others at Risk*. The information was required to assist efforts in locating the person and addressing any public health risks.
- The Queensland Police Service requested disclosure of the identity of a patient and a copy of a staff statement. Disclosure was requested to determine whether the information was relevant to an ongoing criminal investigation.
- The CHO of the Northern Territory requested the disclosure of information about a person being managed under the *Protocol for the Management of People with HIV who Place Others at Risk*. The information was requested to assist efforts in locating the person and addressing any public health risks.

- The Department of Community Safety requested access to Townsville Hospital closed circuit television (CCTV) footage. Disclosure of the footage was requested to assist in relation to possible disciplinary action against a Queensland Ambulance Service staff member.
- The disclosure of patient demographic information to a contracted service provider engaged to complete data profiling activities linked to the development of the Healthcare Identifier System.

Service delivery statements

Table 10: 2011–2012 Performance statement

	Notes	2011–12 target/est.	2011–12 actual
Service area: Prevention, Promotion and Protection			
Service standards			
Percentage of the Queensland population who consume recommended amounts of fruits and vegetables	1	7.5%	7.4%
Percentage of the Queensland population who engaged in levels of physical activity for health benefit:			
• persons	1, 2	61.1%	56.3%
• male		66.0%	59.7%
• female		56.3%	52.9%
Percentage of the Queensland population who are overweight or obese:			
• persons	1	58.1%	57.5%
• male		65.9%	64.6%
• female		50.1%	50.4%
Percentage of the Queensland population who consume alcohol at risky and high risk levels:			
• persons	1	12.2%	11.4%
• male		13.0%	12.8%
• female		11.4%	9.9%
Percentage of the Queensland population who smoke daily:			
• persons	1, 3	13.6%	14.4%
• male		15.4%	15.3%
• female		12.0%	13.5%
Percentage of the Queensland population who were sunburnt on the previous weekend:			
• persons	1, 4	6.0%	9.3%
• male		–	11.9%
• female		–	6.7%
Percentage of invasive cancers detected through BreastScreen Queensland that are small (<15mm) in diameter		62%	63.9%
Annual notification rate of HIV infection	5	New measure	5.0
Vaccination rates at designated milestones for:			
• all children 12–15 months		–	91.6%
• all children 24–27 months		–	92.7%
• all children 60–63 months	6	New measure	90.3%
Fall related hospitalisations for older people (aged over 65 years):			
• percentage		2.5%	2.6%
• number		14 306	15 915
Other measures			
Percentage of target population screened for:			
• breast cancer	7	57.5%	57.6%
• cervical cancer	8	57.6%	55.3%
• bowel cancer	9	37.0%	36.6%
Percentage of Queensland population with access to fluoridated drinking water	10	87%	87%
Number of high risk complaints investigated and the risk controlled	11	–	102
State contribution ($000)		**259 043**	**299 138**
Other revenue ($000)		**241 672**	**251 265**
Total cost ($000)	12	**500 715**	**550 403**

	Notes	2011–12 target/est.	2011–12 actual
Service area: Primary Healthcare			
Service standards			
Number and age standardised rate of potentially preventable admitted patient episodes of care:			
• non-Aboriginal and Torres Strait Islander patients		113 059	125 453
		25	27.4
• Aboriginal and Torres Strait Islander patients		7795	8595
	13	69.7	77.1
Percentage of women who, during their pregnancy were smoking after 20 weeks:			
• non-Aboriginal and Torres Strait Islander patients		11%	11.1%
• Aboriginal and Torres Strait Islander patients	14	43%	45.3%
Other measures			
Number of adult oral health weighted occasions of service (ages 16+)	15	1 800 000–2 000 000	1 725 337
Number of children and adolescent oral health weighted occasions of service (0–15 years)	16	1 200 000	1 273 531
State contribution ($000)		**538 005**	**568 574**
Other revenue ($000)		**89 098**	**94 814**
Total cost ($000)	**12**	**627 103**	**663 388**

Service area: Ambulatory Care			
Service standards			
Percentage of emergency department attendances who depart within four hours of their arrival in the department		New measure	63%
Median wait time for treatment in emergency departments (minutes)		–	23
Percentage of emergency department patients seen within recommended timeframes:			
• category 1 (within 2 minutes)		100%	100%
• category 2 (within 10 minutes)		80%	82%
• category 3 (within 30 minutes)		75%	62%
• category 4 (within 60 minutes)		70%	67%
• category 5 (within 120 minutes)		70%	88%
• all categories	17, 18	–	68%
Percentage of live born, low birth weight babies born to:			
• non-Aboriginal and Torres Strait Islander patients		5.8%	6.30%
• Aboriginal and Torres Strait Islander patients	14	9.4%	11.80%
Other measures			
Total weighted activity units:			
• emergency department	19, 20, 21	418 127–459 940	203 228
• outpatients			263 913
Percentage of women who gave birth and had five antenatal visits or more in the antenatal period:			
• non-Aboriginal and Torres Strait Islander women		92.5%	96.3%
• Aboriginal and Torres Strait Islander women	14	89.3%	86.6%
State contribution ($000)		**1 507 617**	**1 564 656**
Other revenue ($000)		**710 531**	**724 113**
Total cost ($000)	**12**	**2 218 148**	**2 288 770**

	Notes	2011–12 target/est.	2011–12 actual
Service area: Acute Care			
Service standards			
Median wait time for elective surgery (days):			
• category 1 (30 days)		—	13
• category 2 (90 days)		—	50
• category 3 (365 days)		—	114
• all categories	22	—	29
Percentage of elective surgery patients treated within clinically recommended timeframes:			
• category 1 (30 days)	23	—	88%
• category 2 (90 days)		—	78%
• category 3 (365 days)		—	90%
Number of days waited at the 90th percentile for elective surgery:			
• category 1 (30 days)		30	35
• category 2 (90 days)		90	133
• category 3 (365 days)		365	365
Percentage of admitted patients discharged against medical advice:			
• non-Aboriginal and Torres Strait Islander patients		0.8%	0.8%
• Aboriginal and Torres Strait Islander patients		2.2%	2.23%
Average cost per weighted activity unit for ABF facilities	24	$4140–$4390	$4422
Other measures			
Total weighted activity units—Inpatients (including critical care)	19, 20, 25	910 380–963 900	925 513
State contribution ($000)		**3 725 780**	**3 699 434**
Other revenue ($000)		**2 064 854**	**2 206 365**
Total cost ($000)	**12**	**5 790 634**	**5 905 798**

Service area: Rehabilitation and Extended Care			
Service standards			
Average number of public hospital beds occupied each day by nursing home type patients		375	372
Other measures			
Total weighted activity units–sub acute	19, 20	91 187–109 425	106 519
Number of State Government Residential Aged Care Facilities and Services meeting National Accreditation Standards		20	20
State contribution ($000)		**490 221**	**474 481**
Other revenue ($000)		**468 860**	**517 187**
Total cost ($000)	**12**	**959 081**	**991 668**

	Notes	2011–12 target/est.	2011–12 actual

Service area: Integrated Mental Health Services

Service standards			
Proportion of re-admissions to acute psychiatric care within 28 days of discharge	26, 27, 28	15%–20%	11.3%
Other measures			
Extended treatment facility and psychiatric hospital patient days	29	New measure	132 044
Mental health acute admitted psychiatric care days		190 000–200 000	207 904
Rate of community follow up within one to seven days following discharge from an acute mental health inpatient unit	27, 28, 30, 31	55%–60%	51.2%
Total weighted activity units–mental health	19, 32	72 274–86 728	87 736
Number of ambulatory service contacts (mental health)	31	New measure	1 213 844
Number of support hours provided by transitional recovery programs	33, 34, 35	165 000	246 429
Number of places provided by transitional recovery programs	33, 34, 35, 36	530	561
Number of places provided by housing and support programs	33, 37	240	245
Number of hours of support through community mental health early intervention programs	33	72 500	77 893
Number of unique service users with psychiatric disability	33, 38	2300–2500	2360
State contribution ($000)		**611 784**	**631 404**
Other revenue ($000)		**338 945**	**325 649**
Total cost ($000)	**12**	**950 729**	**957 053**

Notes:

1. 2011–2012 estimated actual is derived from an interim data set.
2. While the 2011–2012 estimated actual was below the target, rates have increased by 3.6 per cent per year since 2004.
3. While the 2011–2012 target/estimate was not achieved, rates have decreased by four per cent per year since 2001.
4. No target was included for 2011–2012 (males and females) as the baseline survey did not provide information from which a target could be derived.
5. The previous measure (New notifications of HIV infection) has been amended to 'Annual notification rate of HIV infection'. Measurement by notification rate is a new measure, and is a reflection of the number of notifications per 100 000 population. Measures to address HIV notifications during 2012–2013 will be under the direction of the new HIV Ministerial Advisory Committee. Queensland Health anticipates increased testing will result in a short-term increase in the notification rate, but is committed to meeting the United Nations' and Commonwealth declarations to reduce transmission rates by 50 per cent by 2015.
6. The 2011–2012 measure has been amended to be consistent with reporting milestones under the NPA on Essential Vaccines and is represented as a new measure. Queensland, along with other states and territories, is unable to publish vaccination rates for Indigenous children subject to the agreement of data release protocols with the Commonwealth Department of Health and Ageing. These issues are expected to be resolved to enable reporting in the 2013–2014 Service Delivery Statements. Prior to this, Queensland data on vaccination rates for Indigenous children will be publically available in the next performance report for the NPA, which is scheduled to be released later in 2012.
7. The 2011–2012 estimated actual is the most recent period for which data is available (Jan 2009 to Dec 2010). There has been a slight decrease in the participation rate from 58.3 per cent (Jan 2008 to Dec 2009) to 57.6 per cent (Jan 2009 to Dec 2010). Queensland's participation was higher than the national average of 54.8 per cent.
8. The 2011–2012 estimated actual figure relates to the most recent period for which data is available and reported (Jan 2009 to Dec 2010). The Queensland decrease in participation from 57.0 per cent (Jan 2008 to Dec 2009) to 55.3 per cent (Jan 2009 to Dec 2010) mirrored a decrease in the national screening participation rate, from 58.6 per cent to 57.4 per cent over the same period.

9. The 2011–2012 estimated actual figure relates to the participation rate for the 2010 calendar year. The actual rate of 36.6 per cent was lower than the 2011–2012 target/estimate (37.0 per cent) which can be attributed to a suspension of the program nationally due to a fault with the screening kit.
10. The wording of the fluoridation measure has been amended to improve clarity. There has been no change to the scope of the measure.
11. The 2011–2012 estimated actual is based on preliminary/available data. No target is set for this measure as Queensland Health does not have the ability to control the number of high risk complaints received. High risk issues managed may include significant communicable disease outbreaks; suspected intentional food contamination of public health importance and significant environmental health, food and foodborne illness complaints.
12. The QHSSP was incorporated into Queensland Health and is allocated across the services to which it relates. Commonwealth funds received via Queensland Treasury are included in 'other revenue' in the performance statement. It also includes the share of profit in associates. Therefore, these figures are not directly comparable with the statement of Comprehensive Income by Major Departmental Services and Shared Service Provider in the financial statements.
13. Age-standardised rates are calculated per 1000 population.
14. The target/estimate was set to align with the NPA on Closing the Gap in Indigenous Health Outcomes by 2033–2034.
15. The 2011–2012 target/estimate was set based on a preliminary data set.
16. Weighted occasions of service for children and adolescent oral health were introduced as a new measure in the 2011–2012 SDS. The 2011–2012 estimated actuals are based on data sets that continue to be refined.
17. The wording of the service standard has been amended to align with the NEAT. The scope of this measure has not changed. A target is not included for 'all categories' as there is no national benchmark, however the service standard has been included (without a target) as it is a nationally recognised standard measure for emergency department performance.
18. The triage category 3 results have been consistently under target in previous years however performance has improved from the 2010–2011 estimated actual (57 per cent) to the 2011–2012 estimated actual (62 per cent). Category 3 patients represent the largest cohort of patients among the categories (41 per cent).
19. The 2011–2012 target/estimate has been amended to reflect Phase 14 ABF Model Weighted Activity Unit (WAU) to enable comparison with 2011–2012 estimated actuals.
20. The statewide totals (2011–2012 estimated actuals) also include activity provided through agreements with Mater Health Services, St Vincent's Brisbane and services delivered under Surgery Connect.
21. Previous measure was reported across three categories (emergency services, speciality clinics and diagnostics and outreach services) has been amended to 'total weighted activity units: emergency services and outpatients'. The costs for the diagnostics and outreach services are now included in the WAUs as reported.
22. A target is not included for categories 1–3 as there is no national benchmark at the 50th percentile. A target has been included for 'all categories' to be consistent with the HHS Service Level Agreements.
23. Previous measure amended to include reporting by category which is consistent with the HHS Service Level Agreements.
24. The previous service standard 'average cost per WAU for acute admitted patients' has been amended to the average cost per WAU for ABF facilities, which is consistent with the HHS Service Level Agreements. The scope of the measure has not changed. The 2011–2012 target/estimate has been amended to reflect Phase 14 ABF Model WAU to enable comparison with 2011–2012 estimated actuals.
25. Service standard amended from 'Acute admitted patient weighted activity unit to 'Total weighted activity units—inpatients' to be consistent with HHS Service Level Agreements.
26. The methodology for this indicator has been revised. Prior to 2011–2012, this indicator reflected readmission to the same facility, and related only to adults. For 2011–2012 onwards, this now includes readmission to any facility in Queensland, and includes all age groups.
27. Data for 2011–2012 is preliminary. 2011–2012 estimated actual has been calculated on a pro rata basis from the July 2011 to March 2012 figures.
28. The service standard wording has been amended to be consistent with HHS Service Level Agreements.
29. This measure is similar to the discontinued measure 'mental health extended treatment accrued mental health care days', however relates only to standalone facilities not funded through ABF.
30. The methodology has been revised. Prior to 2011–2012 this indicator related only to adults. For 2011–2012 onwards, the indicator reflects performance for all age groups. This has led to a reduction in performance as rates of follow-up are lower among the child/youth and older persons populations.
31. The statewide total also includes service contacts to be delivered by the Mater Health Services.
32. This indicator refers to the number of separations from a mental health service organisation's acute mental health inpatient unit(s) for which a public sector community mental health service contact was recorded in the seven days immediately following that separation.

33. This service standard was transferred from the 'Disability and Community Care Services' service area of the Department of Communities, Child Safety and Disability Services following Machinery-of-Government (MoG) changes.

34. This performance measure relates to the transition from Correction Facilities, Residential Recovery and Transitional Recovery Services.

35. The previous methodology, on which the 2011–2012 estimated actuals were based, counted hours of service received by individual clients (e.g. one hour of service to a group of six clients would count as six hours). The new methodology requires service providers to report the hours of service actually delivered, whether to an individual or to a group of clients. The change is most significant for service types that are delivered in shared residential settings.

36. This measure relates to the total number of clients supported by this service. As it is a short/medium term facility the 'places' are filled by more than one client in a year.

37. The Housing and Support Program coordinates the long-term provision of social housing and support services, so 'places' are typically filled by one client for several years or longer. Figures refer to the number of clients that can be assisted at any one time.

38. The 2011–2012 estimated actual refers to service users whose primary disability is psychiatric and excludes those whose primary disability is not psychiatric, but who also have a significant psychiatric disability.

Major audits and reviews

Auditor-General of Queensland's Report to Parliament No. 11 for 2011—results of audits at 31 October 2011

The most significant part of the report for Queensland Health was in relation to the Auditor-General's qualified opinion for the financial statements. The Auditor-General was not able to express an opinion on the amount recognised as payroll receivable for salary overpayments and the associated allowance for impairment. Queensland Health is working with staff to inform them of overpayments and make arrangements for repayment to be made to the department.

Comment was provided in relation to the internal controls and improvements that were identified during the course of the previous year. Queensland Health remains committed to improving the current system and providing a stable payroll platform and is continuing to work through system improvement processes.

The Auditor-General noted the National Health Reform Agreement and his concern with the limitations of the current financial management system to enable the 17 HHSs to budget, monitor and manage their cash position. Significant work has been undertaken in the finance area of the department working closely with the current district finance officers to identify the needs for reporting and to make the necessary changes to achieve those needs. Substantial work has been undertaken to provide a financial management framework, including commentary on internal audit and audit committee requirements and in providing a draft Financial Management Practices Manual to assist the areas to meet their obligations.

Follow-up on the Patient Information Management and Security Audit

The Auditor-General of Queensland's Report to Parliament No. 12 for 2010 assessed Queensland Health's progress in implementing recommendations listed in previous audit reports (No.2 of 2009: Health service planning and No.5 for 2009: Management of patient flow through Queensland Hospitals). The Auditor-General conducted a further follow-up audit in late 2011 and of the nine outstanding recommendations: four have been resolved; four of the five unresolved recommendations are subject to allocation of funding; and one new finding has been identified around risks to the Queensland Health network.

Workplace Health and Safety Undertaking

Queensland Health completed the third and final Safety Management System Audit in 2011–2012. This concludes the requirement of the Workplace Health and Safety Undertaking signed by Queensland Health and the Department of Justice and Attorney-General in November 2008. The audits identified that the system is sound and maturing through continual improvement.

Aeromedical Helicopter Services Review

Queensland Health is leading a comprehensive review of aeromedical helicopter services that takes into consideration recommendations (5.36 and 5.37) of the *Queensland Floods Commission of Inquiry Interim Report*. The recommendations relate to establishing single point coordination of tasking of the emergency helicopter network. An independent service delivery assessment, led by community helicopter providers, is being conducted to inform the review process and is expected to be available in July 2012. This assessment will inform the Aeromedical Helicopter Services Review report, which is expected to be completed by October 2012.

PricewaterhouseCoopers Audit of Capital Infrastructure Delivery

In 2011, the Director-General approved an operational audit be conducted on the governance arrangements for the delivery of capital infrastructure. The objective of the audit was to examine the effectiveness of governance arrangements, practices and procedures for the delivery of capital infrastructure from the point of public announcement and project approval to practical completion. The scope of the audit focussed on four projects from the infrastructure building program.

The audit found that there was scope for improvement in the guidelines and assurance processes for capital delivery projects. In response, Queensland Health has developed the *Capital Infrastructure Project Delivery Policy* and Implementation Standards as well as a Capital Infrastructure Minimum Requirements Manual (CIMR) and implementation plan. These documents provide mandatory processes and requirements for the reporting and documentation of capital infrastructure projects.

KPMG Audit of Queensland Health payroll system

In late May 2012, KPMG conducted an audit of the Queensland Health payroll system. The key outcomes of the audit included commencing overpayments recovery and implementing a change in pay date for employees. The report also recommends assurance activities to ensure ongoing viability and benefits realisation. Overall the recommendations of the review are consistent with strategies in place for the payroll portfolio and Queensland Health is committed to implementing all recommendations.

Ernst & Young Review of Financial Control Program

Queensland Health commenced a project to design a framework to meet the obligations of the *Financial Accountability Act 2009* (FAA) in respect of the payroll processes. The FAA Payroll Project Phase 2 has identified and examined the design of key controls within the payroll processes and payroll hubs. A key outcome of Phase 2 is that, where applicable, control gaps and control design issues identified are collated and remediation activities recommended. This will enable Queensland Health to determine its approach to the detailed testing of the effectiveness of payroll controls.

Related entities

Hospital foundations

Hospital foundations are constituted as statutory bodies under the *Hospitals Foundations Act 1982*. They aim to acquire, manage and apply property and any associated income to continuing projects within or associated with their respective hospitals. The following hospital foundations report directly to the Minister for Health:

- Bundaberg Health Services Foundation
- Children's Health Foundation Queensland (established 9 February 2012)
- Far North Queensland Hospital Foundation
- Gold Coast Hospital Foundation
- Ipswich Hospital Foundation
- Mackay Hospital Foundation
- Princess Alexandra Research Foundation
- Redcliffe Hospital Foundation
- Royal Brisbane and Women's Hospital Foundation
- Royal Children's Hospital Foundation (amalgamated with Children's Health Foundation Queensland on 9 February 2012)
- Sunshine Coast Health Foundation
- The Prince Charles Hospital Foundation
- Toowoomba Hospital Foundation
- Townsville Hospital Foundation.

Council of the Queensland Institute of Medical Research

The council is established under the *Queensland Institute of Medical Research Act 1945* as a statutory body. Its function is to ensure the proper control and management of the Queensland Institute of Medical Research (QIMR), established for conducting research into any branch or branches of medical science.

Health Consumers Queensland—Ministerial Advisory Committee

The committee is established under the *Health Services Act 1991* to contribute to the continued development and reform of health systems and services in Queensland by giving the Minister for Health information and advice from a consumer (patient) perspective, and supporting and promoting consumer engagement and advocacy.

Health Practitioner Registration Boards

Four health practitioner registration boards are supported by the Office of Health Practitioner Registration Boards. Each board is established under individual legislation as a statutory body with the primary function of registering their professional group and ensuring healthcare is delivered by registrants in a professional, safe and competent way. The office is also established as a statutory body to provide quality administrative and operational services to the boards. The four boards are:

- Dental Technicians Board of Queensland
- Medical Radiation Technologists Board of Queensland
- Occupational Therapists Board of Queensland
- Speech Pathologists Board of Queensland.

From 1 July 2012, medical radiation technologists and occupational therapists will transition to the National Registration and Accreditation Scheme under the administration of the Australian Health Practitioner Regulation Agency.

Health Quality and Complaints Commission (HQCC)

The commission is established under the *Health Quality and Complaints Commission Act 2006* and is responsible for monitoring quality and safety in all public and private health services, and for addressing complaints from anyone in relation to health service delivery.

Clinical Advisory Committee

The committee is established under the *Health Quality and Complaints Commission Act 2006* to advise the commission about clinical matters relevant to the commission's functions.

Consumer Advisory Committee

The committee is established under the *Health Quality and Complaints Commission Act 2006* to advise the commission on consumers' concerns about health services and other matters relevant to the commission's functions.

HIV/AIDS, Hepatitis C and Sexual Health—Ministerial Advisory Committee

The Queensland Ministerial Advisory Committee on HIV/AIDS, Hepatitis C and Sexual Health was established in 2008 under the *Health Services Act 1991* to contribute towards a broader advisory process of monitoring, reviewing, evaluating and reporting on the *Queensland HIV, Hepatitis C and Sexually Transmissible Infections Strategy 2005–2011* as well as to provide independent advice to the Minister for Health on key issues related to the sector.

Mental Health Court

The Mental Health Court is a superior court of Queensland established under the *Mental Health Act 2000*. Its primary function is to determine issues such as criminal responsibility and fitness for trial. The court is the appeal body to the Mental Health Review Tribunal with special powers of inquiry into the lawfulness of detention of people in authorised mental health services.

Mental Health Review Tribunal

The Mental Health Review Tribunal is established under the *Mental Health Act 2000* and its primary role is to independently review people subject to involuntary detention and treatment under the Act.

Panels of Assessors

Panels of Assessors are established under the *Health Practitioners (Professional Standards) Act 1999* and may assist the Queensland Civil and Administrative Tribunal (QCAT) with disciplinary matters about a registrant, other than disciplinary matters that may, if proved, provide grounds for suspending or cancelling the registrant's registration.

Queensland Fluoridation Committee

The committee is established under the *Water Fluoridation Act 2008* and provides for promotion of good oral health in Queensland by the safe fluoridation of public potable water supplies.

Radiation Advisory Council

The council is established under the *Radiation Safety Act 1999*. Its functions are to examine, and make recommendations to the Minister for Health about the operation and application of the Act, proposed amendments, radiation safety standards, issues on radiation; and research into radiation practices, and transport of radioactive materials in Queensland.

Table 11: Statutory entities' annual reporting arrangements

Body	Constituting Act	Reporting arrangements
Council of the Queensland Institute of Medical Research	*Queensland Institute of Medical Research Act 1945*	Annual report to parliament
Dental Technicians Board of Queensland	*Dental Technicians Registration Act 2001*	Annual report to parliament
Health Consumers Queensland—Ministerial Advisory Committee	*Health Services Act 1991*	Annual report to the Minister for Health
Health Quality and Complaints Commission (HQCC) • Clinical Advisory Committee • Consumer Advisory Committee	*Health Quality and Complaints Commission Act 2006*	Annual report to parliament
Hospital Foundations (13)	*Hospitals Foundations Act 1982*	Annual report to parliament
Medical Radiation Technologists Board of Queensland	*Medical Radiation Technologists Registration Act 2001*	Annual report to parliament
Director of Mental Health (1) Mental Health Court (1) Mental Health Review Tribunal (1)	*Mental Health Act 2000*	Annual report to parliament
Occupational Therapists Board of Queensland	*Occupational Therapists Registration Act 2001*	Annual report to parliament
Office of the Health Practitioner Registration Boards	*Health Practitioners Registration Boards (Administration) Act 1999*	Annual report to parliament
Panels of Assessors (17)	*Health Practitioners (Professional Standards) Act 1999*	Annual report to the Minister for Health
Radiation Advisory Council	*Radiation Safety Act 1999*	Annual Report to the Minister for Health
Speech Pathologists Board of Queensland	*Speech Pathologists Registration Act 2001*	Annual report to Parliament

Cost of statutory authorities

The table below outlines costs associated with those bodies in the health portfolio that are not required to prepare separate financial statements.

Table 12: Cost of statutory authorities 2011–2012

Authority	Cost ($)
Health Consumers Queensland—Ministerial Advisory Committee	25 248.08
HIV/AIDS, Hepatitis C and Sexual Health—Ministerial Advisory Committee	0.00
Mental Health Court	310 842.00
Mental Health Review Tribunal	3 460 764.00
Panels of Assessors	5 132.00
Queensland Civil and Administrative Tribunal	11 682.00
Queensland Fluoridation Committee	0.00
Radiation Advisory Council	517.94
Total	**3 814 186.02**

Acts and subordinate legislation

Dental Technicians Registration Act 2001

Dental Technicians Registration Regulation 2002

Food Act 2006

Food Regulation 2006

Health Act 1937

Health Regulation 1996

Health (Drugs and Poisons) Regulation 1996

Health and Hospitals Network Act 2011

Health Practitioner Registration Boards (Administration) Act 1999

Health Practitioner Regulation National Law Act 2009

Health Practitioner Regulation National Law Regulation

Health Practitioner Regulation National Law (Transitional) Regulation 2010

Health Practitioners (Professional Standards) Act 1999

Health Practitioners (Professional Standards) Regulation 2010

Health Practitioners (Special Events Exemption) Act 1998

Health Practitioners (Special Events Exemption) Regulation 2009

Health Quality and Complaints Commission Act 2006

Health Services Act 1991

Health Services Regulation 2002

Hospitals Foundations Act 1982

Hospitals Foundations Regulation 2005

Mater Public Health Services Act 2008

Medical Radiation Technologist Registration Act 2001

Medical Radiation Technologists Registration Regulation 2002

Mental Health Act 2000

Mental Health Regulation 2002

Mental Health Review Tribunal Rule 2009

Occupational Therapists Registration Act 2001

Occupational Therapists Registration Regulation 2001

Pest Management Act 2001

Pest Management Regulation 2003

Pharmacy Business Ownership Act 2001

Private Health Facilities Act 1999

Private Health Facilities Regulation 2000

Private Health Facilities (Standards) Notice 2000

Public Health Act 2005

Public Health Regulation 2005

Public Health (Infection Control for Personal Appearance Services) Act 2003

Public Health Infection Control for Personal Appearance Services Regulation 2003

Queensland Institute of Medical Research Act 1945

Radiation Safety Act 1999

Radiation Safety Regulation 2010

Radiation Safety (Radiation Safety Standards) Notice 2010

Research Involving Human Embryos and Prohibition of Human Cloning For Reproduction Act 2003

Research Involving Human Embryos and Prohibition of Human Cloning Regulation 2003

Speech Pathologists Registration Act 2001

Speech Pathologists Registration Regulation 2001

Tobacco and Other Smoking Products Act 1998

Tobacco and Other Smoking Products Regulation 2010

Transplantation and Anatomy Act 1979

Transplantation and Anatomy Regulation 2004

Water Fluoridation Act 2008

Water Fluoridation Regulation 2008

Glossary of terms

Accessible	Accessible healthcare is characterised by the ability of people to obtain appropriate healthcare at the right place and right time, irrespective of income, cultural background or geography.
Activity based funding (ABF)	A management tool with the potential to enhance public accountability and drive technical efficiency in the delivery of health services by: • capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery • creating an explicit relationship between funds allocated and services provided • strengthening management's focus on outputs, outcomes and quality • encouraging clinicians and managers to identify variations in costs and practices so they can be managed at a local level in the context of improving efficiency and effectiveness • providing mechanisms to reward good practice and support quality initiatives.
Acute	Having a short and relatively severe course.
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.
Acute hospital	Is generally a recognised hospital that provides acute care and excludes dental and psychiatric hospitals.
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).
Admitted patient	A patient who undergoes a hospital's formal admission process as an overnight-stay patient or a same-day patient.
Allied health staff	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; leisure therapy; medical imaging; music therapy; nuclear medicine technology; occupational therapy; orthoptics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work.
Benchmarking	Involves collecting performance information to undertake comparisons of performance with similar organisations.
Best practice	Cooperative way in which organisations and their employees undertake business activities in all key processes, and use benchmarking that can be expected to lead to sustainable world class positive outcomes.
Clinical governance	A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical practice	Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/or manage illness, together with associated professional activities for patient care.
Clinical workforce	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.
Decision support system (DSS)	Consolidates data suitable for finance, human resources, pharmacy and pathology related information for decision-support purposes.
Emergency department waiting time	Time elapsed for each patient from presentation to the emergency department to start of services by the treating clinician. It is calculated by deducting the date and time the patient presents from the date and time of the service event.
Full-time Equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
Health outcome	Change in the health of an individual, group of people or population attributable to an intervention or series of interventions.
Health reform	Response to the *National Health and Hospitals Reform Commission Report (2009)* that outlined recommendations for transforming the Australian health system, the National Health and Hospitals Network Agreement (NHHNA) signed by the Commonwealth and states and territories, other than Western Australia, in April 2010 and the National Health Reform Heads of Agreement (HoA) signed in February 2010 by the Commonwealth and all states and territories amending the NHHNA.
Hospital	Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.
Hospital and Health Boards	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to managing a complex health care organisation.

Hospital and Health Service	Hospital and Health Service (HHS) is a separate legal entity established by Queensland Government to deliver public hospital services. The first HHSs will commence on 1 July 2012. Queensland's 17 HHSs will replace existing health service districts.
Hospital-in-the-home	Provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.
Immunisation	Process of inducing immunity to an infectious agency by administering a vaccine.
Incidence	Number of new cases of a condition occurring within a given population, over a certain period of time.
Indigenous health worker	An Aboriginal and/or Torres Strait Islander person who holds the specified qualification and works within a primary healthcare framework to improve health outcomes for Indigenous Australians.
Long wait	A 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for a category 1 patient, more than 90 days for a category 2 patient and more than 365 days for a category 3 patient.
Medicare Locals	Will be established by the Commonwealth to coordinate primary health care services across all providers in a geographic area. Will work closely with HHSs to identify and address local health needs. Will be selected and funded by the Commonwealth. Will be rolled out progressively from 1 July 2011.
Medical practitioner	A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.
Non-admitted patient	A patient who does not undergo a hospital's formal admission process.
Non-admitted patient services	An examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service facility.
Nurse practitioner	A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes 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.
Population health	Promotion of healthy lifestyles, prevention or early detection of illness or disease, prevention of injury and protection of health through organised population-based programs and strategies.
Private hospital	A private hospital or free-standing day hospital, and either a hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients or insurers patients admitted to private hospitals are treated by a doctor of their choice.
Public patient	A public patient is one who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.
Public hospital	Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.
Registered nurse	An individual registered under national law to practice in the nursing profession as a nurse, other than as a student.
Statutory bodies	A non-departmental government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.
Sustainable	A health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs, for example, research and monitoring within available resources.
Telehealth	Delivery of health-related services and information via telecommunication technologies, including: • live, audio and or/video inter-active links for clinical consultations and educational purposes • store-and-forward Telehealth, including digital images, video, audio and clinical (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists • teleradiology for remote reporting and clinical advice for diagnostic images • Telehealth services and equipment to monitor people's health in their home.
Triage category	Urgency of a patient's need for medical and nursing care.
Wayfinding	Signs, maps and other graphic or audible methods used to convey locations and directions.

Glossary of acronyms

ABF	Activity based funding
AHMAC	Australian Health Ministers Advisory Council
AHPRA	Australian Health Practitioner Regulation Agency
AMS	Antimicrobial Stewardship
ANZSOG	Australia and New Zealand School of Government
ARP	Acute Resuscitation Plan
BRiTA	Building Resilience in Transcultural Australians
CAF	Clinical Academic Fellowship
CALD	Culturally and linguistically diverse
CaSS	Clinical and Statewide Services
CCU	Community Care Unit
CCTV	Closed Circuit Television
CDA	Clinical Document Architecture
CEPS	Clinical Educator Preparation and Support
CFO	Chief Finance Officer
CHI	Centre for Healthcare Improvement
CHO	Chief Health Officer
CIMHA	Consumer Integrated Mental Health Application
CIMR	Capital Infrastructure Minimum Requirements Manual
CIO	Chief Information Officer
COAG	Council of Australian Governments
CQU	Central Queensland University
CSCF	Clinical Services Capability Framework
CSRP	Clinical Services Redesign Program
DBE	Developing Business Excellence
DON	Director of Nursing
DoRA	Database of Research Activity
DSS	Decision Support Services
ECHO	Emergency Capacity Hospital Overview System
EDIS	Emergency Department Information System
EFP	Executive Fellow Program
EMPA	Executive Master of Public Administration
EMT	Executive Management Team
ESISS	Endoscopy Services Information System Solution
FAA	Financial Accountability Act
FIO	Forensic Investigation Order
FPL	Finance Procurement and Legal Services Division
FRMS	Fatigue Risk Management System
FSS	Forensic and Scientific Services
FTE	Full-time Equivalent
GCUH	Gold Coast University Hospital
GP	General Practitioner
HASP	Housing and Support Program
HCQ	Health Consumers Queensland
HHS	Hospital and Health Service
HHSPF	Hospital and Health Services Performance Framework
HI	Health Identifier
HIPEC	Health Infrastructure and Projects Executive Committee
HITH	Hospital-in-the-Home
HMP	Health Management Protocol
HPID	Health Planning and Infrastructure Division
HPI-O	Healthcare Provider Identifier – Organisation
HQCC	Health Quality and Complaints Commission
HR	Human Resources
HREC	Human Resources Executive Committee
HRF	Health Research Fellowships
HRS	Human Resource Services Division
HTA	Health Technology Assessment
HUS	Haemolytic Uraemic Syndrome
ICF	Internal Control Framework
ICT	Information and Communications Technology
ICTEC	Information and Communication Technology Executive Committee
ICU	Intensive Care Unit
ieMR	Integrated electronic Medical Record
IGA	Intergovernmental Agreement
IHI	Individual Healthcare Identifier
IHPA	Independent Hospital Pricing Authority
IMAR	Interim Medication Administration Record
IPPEC	Integrated Policy and Planning Executive Committee
IR	Industrial Relations
IRMPF	Integrated Risk Management Policy Framework
JCU	James Cook University
KPI	Key Performance Indicators
LAM	List of Approved Medicines
LSOP	Long Stay Older Patients
MBS	Medicare Benefits Schedule
MEDAI	Metropolitan Emergency Department Access Initiative

MICE	Multidisciplinary Introduction to Clinical Education
MNBML	Metro North Brisbane Medicare Local
MOU	Memorandum of Understanding
MPHS	Multipurpose Health Service
NEAT	National Emergency Access Target
NeHTA	National eHealth Transition Authority
NHIRF	National Health Information Regulatory Framework
NHMRC	National Health and Medical Research Council
NHREC	National Health Reform Executive Committee
NPA	National Partnership Agreement
NPAEV	National Partnership Agreement on Essential Vaccines
NPAIPHS	National Partnership Agreement on Improving Public Hospital Services
NPAPH	National Partnership Agreement on Preventative Health
NSQHS	National Safety and Quality Health Service
OOAC	Outpatient Operational Advisory Committee
ORMIS	Operating Room Management Information System
PAH	Princess Alexandra Hospital
PandA	Performance and Accountability Division
PCEHR	Personally Controlled Electronic Health Record
PFS	Patient Flow Strategy
PHC	Primary Healthcare Centre
PIHAP	Palm Island Health Action Plan
PIP	Pressure Injury Prevention Program
PPP	Public Private Partnership
PSC	Public Service Commission
PSMP	Public Sector Management Program
PSQEC	Patient Safety and Quality Executive Committee
PSR	Policy, Strategy and Resourcing Division
PUMP	Pathology Utilisation Medical Program
QAIHC	Queensland Aboriginal and Islander Health Council
QCAT	Queensland Civil and Administrative Tribunal
QCH	Queensland Children's Hospital
QCSP	Queensland Cervical Screening Program
QEII	Queen Elizabeth II Jubilee Hospital
QEOC	Queensland Emergency Operations Centre
QGIF	Queensland Government Insurance Fund
QHPMF	Queensland Health Performance Management Framework
QH Risk	Queensland Health Risk Management Information System
QHSSP	Queensland Health Shared Service Partner
QHVSS	Queensland Health Victim Support Service
QiiT	Queensland incidents in Transfusion
QIMR	Queensland Institute of Medical Research
QRiS	Queensland Radiology information System
QWFP	Queensland Water Fluoridation Program
RBWH	Royal Brisbane and Women's Hospital
RCH	Royal Children's Hospital
REC	Resource Executive Committee
REP	Regional Enhancement Program
RMAC	Risk Management Advisory Committee
RRS	Radiographer Relief Service
SCRF	Senior Clinical Research Fellowship
SCUH	Sunshine Coast University Hospital
SOHSIP	School Oral Health Service Information Project
STEC	Shiga toxin-producing e.coli
STI	Sexually Transmissible Infection
TIA	Transient Ischaemic Attack
TPCH	The Prince Charles Hospital
TRI	Translational Research Institute
UV	Ultraviolet
VLAD	Variable Life Adjusted Display
VMO	Visiting Medical Officer
VTE	Venous Thromboembolism
WAU	Weighted Activity Unit
WEHO	Workplace Equity and Harassment Officer

Compliance checklist—Annual Report

The characteristics of a quality annual report are that it:

- complies with statutory and policy requirements
- presents information in a concise manner
- is written in plain English
- provides a balanced account of performance – the good and not so good.

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

Table 13

Summary of requirement		Basis for requirement	Annual report reference
Accessibility	• Table of contents • Glossary	ARRs – section 8.1	Page 2 Page 118
	• Public availability	ARRs – section 8.2	Inside front cover
	• Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 8.3	Inside front cover
	• Copyright notice	*Copyright Act 1968* ARRs – section 8.4	Inside front cover
	• Government Information Licensing Framework (GILF) Licence	*Government Information Licensing Framework (GILF) QGEA Policy* ARRs – section 8.5	Inside front cover
Letter of compliance	• A letter of compliance from the accountable officer or statutory body to the relevant Minister(s)	ARRs – section 9	Page 1
General information	• Introductory Information	ARRs – section 10.1	Page 4
	• Agency role and main functions	ARRs – section 10.2	Pages 6-7
	• Operating environment	ARRs – section 10.3	Pages 3-5; 8-12
	• External scrutiny	ARRs – section 10.4	Pages 112-113
	• Machinery of government changes	ARRs – section 10.5	Pages 22-23
	• Review of proposed forward operations	ARRs – section 10.6	Page 26
Non-financial performance	• Government objectives for the community	ARRs – section 11.1	Pages 4; 6-7; 28; 38; 54; 62; 70
	• Other whole-of-government plans/specific initiatives	ARRs – section 11.2	Pages 31-35
	• Council of Australian Government (COAG) initiatives	ARRs – section 11.3	Pages 36-37; 51-53; 60-61; 69
	• Agency objectives and performance indicators	ARRs – section 11.4	Pages 7; 28; 38-39; 49; 54; 62-63; 70-71
	• Agency service areas, service standards and other measures	ARRs – section 11.5	Pages 106-111
Financial performance	• Summary of financial performance	ARRs – section 12.1	Pages 23-25
	• Chief Finance Officer (CFO) statement	ARRs – section 12.2	Page 26

Summary of requirement		Basis for requirement	Annual report reference
Governance – management and structure	• Organisational structure	ARRs – section 13.1	Pages 88-89
	• Executive management	ARRs – section 13.2	Pages 80-86
	• Related entities	ARRs – section 13.3	Pages 114-115
	• Schedule of statutory authorities or instrumentalities	ARRs – section 13.4	Pages 115-116
	• Boards and committees	ARRs – section 13.5	Pages 90-100
	• *Public Sector Ethics Act 1994*	*Public Sector Ethics Act 1994* (section 23 and Schedule) ARRs – section 13.6	Page 101
Governance – risk management and accountability	• Risk management	ARRs – section 14.1	Page 102
	• Audit committee	ARRs – section 14.2	Page 99
	• Internal Audit	ARRs – section 14.3	Page 104
Governance – human resources	• Workforce planning, attraction and retention	ARRs – section 15.1	Pages 70-79
	• Early retirement, redundancy and retrenchment	Directive No.17/09 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	Page 72
	• Voluntary Separation Program	ARRs – section 15.3	Page 72
Financial statements	• Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 16.1	Pages 124-177
	• Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 16.2	Pages 176-177
	• Remuneration disclosures	*Financial Reporting Requirements for Queensland Government Agencies* ARRs – section 16.3	Pages 164-169
Disclosure of additional information	• Additional information to be reported online	ARRs – section 17	Inside front cover

Queensland Health Financial statements 2011–12

General Information

The Department of Health is a Queensland Government department established under the *Public Service Act 2008* and its registered trading name is Queensland Health

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

The principal address of the department is:
147-163 Charlotte Street
Brisbane QLD 4000

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

For information in relation to Queensland Health's financial statements:

- email FIN_Corro@health.qld.gov.au or
- visit the Queensland Health website at: www.health.qld.gov.au

Amounts shown in these financial statements may not add to the correct subtotals or totals due to rounding.

Queensland Health
Statement of Comprehensive Income
For the year ended 30 June 2012

	Notes	2012 $'000	2011 $'000
Income from continuing operations			
Departmental services revenue	4	10,053,900	9,440,684
User charges	5	901,457	778,498
Grants and other contributions	6	329,977	296,403
Other revenue	7	39,732	29,993
Total revenue		**11,325,066**	**10,545,578**
Gains	8	3,419	871
Total income from continuing operations		**11,328,485**	**10,546,449**
Expenses from continuing operations			
Employee expenses	10	7,297,934	6,737,186
Supplies and services	11	2,471,769	2,434,901
Grants and subsidies	12	920,439	900,765
Depreciation and amortisation	13	371,944	337,890
Impairment losses	14	47,718	36,021
Appropriation returned	4	67,559	-
Other expenses	15	137,382	123,637
Total expenses from continuing operations		**11,314,745**	**10,570,400**
Share of profit from associates	9	28,596	26,236
Operating result from continuing operations		**42,336**	**2,285**
Other comprehensive income			
Decrease in asset revaluation surplus	28	(147,344)	(62,111)
Total other comprehensive income		**(147,344)**	**(62,111)**
Total comprehensive income		**(105,008)**	**(59,826)**

The accompanying notes form part of these statements.

Queensland Health
Statement of Financial Position
As at 30 June 2012

	Notes	2012 $'000	2011 $'000
Current assets			
Cash and cash equivalents	16	(64,741)	(30,188)
Loans and receivables	17	636,886	547,332
Inventories	18	130,086	121,803
Assets held for sale	23	75	-
Other	21	111,618	93,996
Total current assets		**813,924**	**732,943**
Non-current assets			
Loans and receivables	17	20,911	10,715
Intangible assets	22	149,464	121,595
Property, plant and equipment	23	8,384,794	7,178,564
Other financial assets	19	20,000	20,000
Investment in associate	20	69,192	40,923
Other	21	7,629	3,066
Total non-current assets		**8,651,990**	**7,374,863**
Total assets		**9,465,914**	**8,107,806**
Current liabilities			
Payables	24	496,560	407,033
Accrued employee benefits	25	406,523	330,530
Unearned revenue	27	466	463
Total current liabilities		**903,549**	**738,026**
Non-current liabilities			
Other financial liabilities	26	194,398	59,977
Unearned revenue	27	2,536	1,075
Total non-current liabilities		**196,934**	**61,052**
Total liabilities		**1,100,483**	**799,078**
Net assets		**8,365,431**	**7,308,728**
Equity			
Contributed equity		4,984,167	3,815,959
Accumulated surplus		2,436,803	2,400,964
Asset revaluation surplus	28	944,461	1,091,805
Total equity		**8,365,431**	**7,308,728**

The accompanying notes form part of these statements.

Queensland Health
Statement of Changes in Equity
For the year ended 30 June 2012

	Notes	2012 $'000	2011 $'000
Accumulated surplus			
Balance at the beginning of the financial year		2,400,964	2,397,181
Operating result from continuing operations		42,336	2,285
Transactions with owners as owners			
Correction of (asset)/liability previously recognised		(6,498)	1,498
Balance at the end of the financial year		**2,436,802**	**2,400,964**
Asset revaluation surplus			
Balance at the beginning of the financial year		1,091,805	1,153,916
Total other comprehensive income			
Decrease in asset revaluation surplus		(147,344)	(62,111)
Balance at the end of the financial year	28	**944,461**	**1,091,805**
Contributed equity			
Balance at the beginning of the financial year		3,815,959	2,759,878
Transactions with owners as owners			
Equity injections		1,405,046	1,199,835
Equity withdrawals		(260,991)	(209,304)
Net equity injection	4	**1,144,055**	**990,531**
Non-appropriated equity transfer		24,154	-
Net machinery of Government transfers			
Assets received		-	80,289
Liability received		-	(14,739)
Balance at the end of the financial year		**4,984,168**	**3,815,959**
Total equity		**8,365,431**	**7,308,728**

The accompanying notes form part of these statements.

Queensland Health
Statement of Cash Flows
For the year ended 30 June 2012

	Notes	2012 $'000	2011 $'000
Cash flows from operating activities			
Inflows			
Departmental services receipts		10,053,900	9,470,897
User charges		783,110	634,284
Grants and other contributions		322,673	272,349
Interest received		6,075	5,177
GST collected from customers		45,419	30,975
GST input tax credits		476,712	434,491
Other		33,216	22,992
Outflows			
Employee expenses		(7,249,547)	(6,739,784)
Supplies and services		(2,464,440)	(2,377,871)
Grants and subsidies		(918,362)	(903,390)
Insurance		(90,407)	(75,167)
GST paid to suppliers		(475,008)	(435,216)
GST remitted		(43,389)	(32,944)
Other		(50,674)	(46,943)
Net cash provided by (used in) operating activities	29	**429,278**	**259,850**
Cash flows from investing activities			
Inflows			
Sales of property, plant and equipment		11,854	3,364
Loans and advances redeemed		5,255	27,770
Outflows			
Payments for property, plant and equipment		(1,722,850)	(1,296,031)
Payments for intangible assets		(44,080)	(41,059)
Loans and advances made		(16,640)	(32,210)
Net cash provided by (used in) investing activities		**(1,766,461)**	**(1,338,166)**
Cash flows from financing activities			
Inflows			
Equity injections		1,429,200	1,199,835
Finance lease advanced		134,421	42,742
Outflows			
Equity withdrawals		(260,991)	(227,517)
Net cash provided by (used in) financing activities		**1,302,630**	**1,015,060**
Net increase/(decrease) in cash and cash equivalents		(34,553)	(63,256)
Cash and cash equivalents at the beginning of the financial year		(30,188)	33,068
Cash and cash equivalents at the end of the financial year	16	**(64,741)**	**(30,188)**

The accompanying notes form part of these statements.

Queensland Health

Statement of Comprehensive Income by Major Departmental Services and Shared Service Partner

For the year ended 30 June 2012

	Prevention, Promotion, Protection		Primary Health Care		Ambulatory Care		Acute Care		Rehabilitation and Extended Care		Integrated Mental Health Services		Subtotal All Major Departmental Services	
	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000
Income from continuing operations														
Departmental services revenue	497,984	459,719	627,083	595,727	2,085,972	1,956,289	5,079,688	4,805,023	700,532	620,200	920,123	868,837	**9,911,382**	**9,305,795**
User charges	18,053	19,255	2,657	1,934	144,023	127,382	677,576	573,688	42,468	40,825	16,248	15,005	**901,025**	**778,089**
Grants and other contributions	12,741	12,487	22,487	16,274	17,450	14,953	40,007	33,081	232,632	215,419	4,660	4,187	**329,977**	**296,401**
Other revenue	13,451	4,178	878	968	5,787	5,170	17,880	17,644	858	1,011	939	1,011	**39,793**	**29,982**
Revenue	**542,229**	**495,639**	**653,105**	**614,903**	**2,253,232**	**2,103,794**	**5,815,151**	**5,429,436**	**976,490**	**877,455**	**941,970**	**889,040**	11,182,177	10,410,267
Gains	95	20	228	50	571	132	1,721	407	533	192	251	61	**3,399**	**862**
Total income from continuing operations	**542,324**	**495,659**	**653,333**	**614,953**	**2,253,803**	**2,103,926**	**5,816,872**	**5,429,843**	**977,023**	**877,647**	**942,221**	**889,101**	11,185,576	10,411,129
Expenses from continuing operations														
Employee expenses	264,843	245,132	427,282	395,141	1,433,351	1,309,031	3,610,767	3,352,517	657,331	609,190	745,578	683,965	**7,139,152**	**6,594,976**
Supplies and services	144,983	143,418	140,116	137,024	575,962	549,695	1,295,094	1,296,371	191,330	178,006	138,173	140,301	**2,485,658**	**2,444,815**
Grants and subsidies	66,175	79,309	51,947	50,064	163,463	157,362	570,052	542,904	48,188	47,658	20,614	23,468	**920,439**	**900,765**
Depreciation and amortisation	18,265	16,330	20,731	18,513	74,271	66,685	195,484	176,781	33,943	31,963	26,507	24,980	**369,201**	**335,252**
Impairment losses	2,228	2,894	2,240	1,994	7,168	5,985	20,904	16,531	3,878	3,191	11,300	5,426	**47,718**	**36,021**
Appropriation returned	3,346	-	4,214	-	14,017	-	34,134	-	4,707	-	6,183	-	**66,601**	**-**
Other expenses	15,704	9,773	13,243	13,868	21,545	19,866	59,880	56,429	10,681	9,822	15,954	13,549	**137,007**	**123,307**
Total expenses from continuing operations	**515,544**	**496,856**	**659,773**	**616,604**	**2,289,777**	**2,108,624**	**5,786,315**	**5,441,533**	**950,058**	**879,830**	**964,309**	**891,689**	11,165,776	10,435,136
Share of profit/(loss) in associates	**1,470**	**1,349**	**1,609**	**1,477**	**5,696**	**5,226**	**14,848**	**13,622**	**2,431**	**2,230**	**2,542**	**2,332**	28,596	26,236
Operating result from continuing operations	**28,250**	**152**	**(4,831)**	**(174)**	**(30,278)**	**528**	**45,405**	**1,932**	**29,396**	**47**	**(19,546)**	**(256)**	48,396	2,229
Other comprehensive income														
Increase/(decrease) in asset revaluation surplus	(6,359)	(2,960)	(8,136)	(3,670)	(28,180)	(12,560)	(71,242)	(32,414)	(11,714)	(5,239)	(11,844)	(5,308)	**(137,475)**	**(62,151)**
Total other comprehensive income	**(6,359)**	**(2,960)**	**(8,136)**	**(3,670)**	**(28,180)**	**(12,560)**	**(71,242)**	**(32,414)**	**(11,714)**	**(5,239)**	**(11,844)**	**(5,308)**	(137,475)	(62,151)
Total comprehensive income	**21,891**	**(2,808)**	**(12,967)**	**(3,844)**	**(58,458)**	**(12,032)**	**(25,837)**	**(30,482)**	**17,682**	**(5,192)**	**(31,390)**	**(5,564)**	(89,079)	(59,922)

The accompanying notes form part of these statements.

Queensland Health

Statement of Comprehensive Income by Major Departmental Services and Shared Service Partner

For the year ended 30 June 2012

	Subtotal All Major Departmental Services		Queensland Health Shared Service Partner		Inter-Departmental Services Elimination		Total	
	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000
Income from continuing operations								
Departmental services revenue	**9,911,382**	**9,305,795**	142,518	134,889	-	-	**10,053,900**	**9,440,684**
User charges	**901,025**	**778,089**	35,783	33,224	(35,351)	(32,815)	**901,457**	**778,498**
Grants and other contributions	**329,977**	**296,401**	-	2	-	-	**329,977**	**296,403**
Other revenue	**39,793**	**29,982**	(61)	11	-	-	**39,732**	**29,993**
Revenue	**11,182,177**	**10,410,267**	**178,240**	**168,126**	**(35,351)**	**(32,815)**	**11,325,066**	**10,545,578**
Gains	**3,399**	**862**	20	9	-	-	**3,419**	**871**
Total income from continuing operations	**11,185,576**	**10,411,129**	**178,260**	**168,135**	**(35,351)**	**(32,815)**	**11,328,485**	**10,546,449**
Expenses from continuing operations								
Employee expenses	**7,139,152**	**6,594,976**	158,782	142,210	-	-	**7,297,934**	**6,737,186**
Supplies and services	**2,485,658**	**2,444,815**	20,976	22,222	(34,865)	(32,136)	**2,471,769**	**2,434,901**
Grants and subsidies	**920,439**	**900,765**	-	-	-	-	**920,439**	**900,765**
Depreciation and amortisation	**369,201**	**335,252**	2,743	2,638	-	-	**371,944**	**337,890**
Impairment losses	**47,718**	**36,021**	-	-	-	-	**47,718**	**36,021**
Appropriation returned	**66,601**	**-**	958	-	-	-	**67,559**	**-**
Other expenses	**137,007**	**123,307**	861	1,062	(486)	(732)	**137,382**	**123,637**
Total expenses from continuing operations	**11,165,776**	**10,435,136**	**184,320**	**168,132**	**(35,351)**	**(32,815)**	**11,314,745**	**10,570,400**
Share of profit/(loss) in associates	**28,596**	**26,236**	**-**	-	-	-	**28,596**	**26,236**
Operating result from continuing operations	**48,396**	**2,229**	**(6,060)**	**3**	**-**	**-**	**42,336**	**2,285**
Other comprehensive income								
Increase/(decrease) in asset revaluation surplus	**(137,475)**	**(62,151)**	(9,869)	40	-	-	**(147,344)**	**(62,111)**
Total other comprehensive income	**(137,475)**	**(62,151)**	**(9,869)**	**40**	**-**	**-**	**(147,344)**	**(62,111)**
Total comprehensive income	**(89,079)**	**(59,922)**	**(15,929)**	**43**	**-**	**-**	**(105,008)**	**(59,826)**

The accompanying notes form part of these statements.

Queensland Health

Statement of Assets and Liabilities by Major Departmental Services and Shared Service Partner

As at 30 June 2012

	Prevention, Promotion, Protection		Primary Health Care		Ambulatory Care		Acute Care		Rehabilitation and Extended Care		Integrated Mental Health Services		Subtotal All Major Departmental Services	
	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000
Current assets														
Cash and cash equivalents	(3,911)	(1,530)	(5,004)	(1,898)	(17,330)	(6,492)	(43,810)	(16,755)	(7,203)	(2,709)	(7,283)	(2,745)	**(84,541)**	**(32,129)**
Loans and receivables	29,304	26,008	37,496	32,258	129,868	110,381	328,322	284,878	53,978	46,048	54,578	46,652	**633,546**	**546,225**
Assets held for sale	3	-	4	-	16	-	39	-	7	-	6	-	**75**	**-**
Inventories	6,017	5,799	7,699	7,193	26,665	24,614	67,415	63,526	11,084	10,269	11,206	10,402	**130,086**	**121,803**
Other	5,162	4,475	6,606	5,551	22,880	18,994	57,845	49,024	9,510	7,924	9,615	8,028	**111,618**	**93,996**
Total current assets	**36,575**	**34,752**	**46,801**	**43,104**	**162,099**	**147,497**	**409,811**	**380,673**	**67,376**	**61,532**	**68,122**	**62,337**	**790,784**	**729,895**
Non-current assets														
Loans and receivables	967	510	1,237	632	4,287	2,166	10,837	5,589	1,782	903	1,801	915	**20,911**	**10,715**
Intangible assets	6,877	5,762	8,800	7,147	30,477	24,457	77,052	63,119	12,667	10,202	12,808	10,336	**148,681**	**121,023**
Property, plant and equipment	386,566	340,009	494,624	421,707	1,713,115	1,442,981	4,330,959	3,724,159	712,040	601,973	719,938	609,872	**8,357,242**	**7,140,701**
Other financial assets	925	952	1,183	1,181	4,100	4,042	10,365	10,431	1,705	1,686	1,722	1,708	**20,000**	**20,000**
Investment in associate	3,200	1,948	4,095	2,417	14,183	8,270	35,858	21,343	5,896	3,450	5,960	3,495	**69,192**	**40,923**
Other	352	145	452	181	1,563	619	3,956	1,601	649	258	657	262	**7,629**	**3,066**
Total non-current assets	**398,887**	**349,326**	**510,391**	**433,265**	**1,767,725**	**1,482,535**	**4,469,027**	**3,826,242**	**734,739**	**618,472**	**742,886**	**626,588**	**8,623,655**	**7,336,428**
Total assets	**435,462**	**384,078**	**557,192**	**476,369**	**1,929,824**	**1,630,032**	**4,878,838**	**4,206,915**	**802,115**	**680,004**	**811,008**	**688,925**	**9,414,439**	**8,066,323**
Current liabilities														
Payables	22,872	19,243	29,266	23,867	101,365	81,670	256,266	210,779	42,132	34,070	42,599	34,518	**494,500**	**404,147**
Accrued employee benefits	18,316	15,501	23,436	19,227	81,170	65,788	205,216	169,791	33,738	27,444	34,112	27,806	**395,988**	**325,557**
Other liabilities payable	22	22	28	27	96	94	240	242	40	39	40	39	**466**	**463**
Total current liabilities	**41,210**	**34,766**	**52,730**	**43,121**	**182,631**	**147,552**	**461,722**	**380,812**	**75,910**	**61,553**	**76,751**	**62,363**	**890,954**	**730,167**
Non-current liabilities														
Other financial liabilities	8,991	2,855	11,506	3,542	39,848	12,120	100,744	31,281	16,563	5,057	16,746	5,122	**194,398**	**59,977**
Other liabilities payable	116	51	150	63	518	218	1,318	561	216	91	218	91	**2,536**	**1,075**
Total non-current liabilities	**9,107**	**2,906**	**11,656**	**3,605**	**40,366**	**12,338**	**102,062**	**31,842**	**16,779**	**5,148**	**16,964**	**5,213**	**196,934**	**61,052**
Total liabilities	**50,317**	**37,672**	**64,386**	**46,726**	**222,997**	**159,890**	**563,784**	**412,654**	**92,689**	**66,701**	**93,715**	**67,576**	**1,087,888**	**791,219**
Net assets	**385,145**	**346,406**	**492,806**	**429,643**	**1,706,827**	**1,470,142**	**4,315,054**	**3,794,261**	**709,426**	**613,303**	**717,293**	**621,349**	**8,326,551**	**7,275,104**

The accompanying notes form part of these statements.

Queensland Health

Statement of Assets and Liabilities by Major Departmental Services and Shared Service Partner

As at 30 June 2012

	Subtotal All Major Departmental Services		Queensland Health Shared Service Partner		Inter-Departmental Services Elimination		Total	
	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000
Current assets								
Cash and cash equivalents	**(84,541)**	**(32,129)**	19,800	1,941	-	-	**(64,741)**	**(30,188)**
Loan and receivables	**633,546**	**546,225**	3,340	1,107	-	-	**636,886**	**547,332**
Assets held for sale	**75**	**-**	-	-	-	-	**75**	**-**
Inventories	**130,086**	**121,803**	-	-	-	-	**130,086**	**121,803**
Other	**111,618**	**93,996**	-	-	-	-	**111,618**	**93,996**
Total current assets	**790,784**	**729,895**	**23,140**	**3,048**	**-**	**-**	**813,924**	**732,943**
Non-current assets								
Loans and receivables	**20,911**	**10,715**	**-**	-	-	-	**20,911**	**10,715**
Intangible assets	**148,681**	**121,023**	783	572	-	-	**149,464**	**121,595**
Property, plant and equipment	**8,357,242**	**7,140,701**	27,552	37,863	-	-	**8,384,794**	**7,178,564**
Other financial assets	**20,000**	**20,000**	-	-	-	-	**20,000**	**20,000**
Investment in associate	**69,192**	**40,923**	-	-	-	-	**69,192**	**40,923**
Other	**7,629**	**3,066**	-	-	-	-	**7,629**	**3,066**
Total non-current assets	**8,623,655**	**7,336,428**	**28,335**	**38,435**	**-**	**-**	**8,651,990**	**7,374,863**
Total assets	**9,414,439**	**8,066,323**	**51,475**	**41,483**	**-**	**-**	**9,465,914**	**8,107,806**
Current liabilities								
Payables	**494,500**	**404,147**	2,060	2,886	-	-	**496,560**	**407,033**
Accrued employee benefits	**395,988**	**325,557**	10,535	4,973	-	-	**406,523**	**330,530**
Other liabilities payable	**466**	**463**	-	-	-	-	**466**	**463**
Total current liabilities	**890,954**	**730,167**	**12,595**	**7,859**	**-**	**-**	**903,549**	**738,026**
Non-current liabilities								
Other financial liabilities	**194,398**	**59,977**	-	-	-	-	**194,398**	**59,977**
Other liabilities payable	**2,536**	**1,075**	-	-	-	-	**2,536**	**1,075**
Total non-current liabilities	**196,934**	**61,052**	**-**	**-**	**-**	**-**	**196,934**	**61,052**
Total liabilities	**1,087,888**	**791,219**	**12,595**	**7,859**	**-**	**-**	**1,100,483**	**799,078**
Net assets	**8,326,551**	**7,275,104**	**38,880**	**33,624**	**-**	**-**	**8,365,431**	**7,308,728**

The accompanying notes form part of these statements.

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

1 Objectives and strategic priorities of Queensland Health

Queensland Health's objective is to provide dependable health care and better health for all Queenslanders. To achieve this, it is essential that services are well planned and organised and that they evolve and change in line with changing practice and community needs. This is reflected in the following four strategic priorities:

- *Making Queenslanders healthier* with a focus on prevention, promotion and protection as effective interventions in addressing the rates of chronic disease;
- *Meeting Queenslanders' healthcare needs safely and sustainably* by addressing the challenge of meeting the healthcare needs of Queenslanders across the continuum of care;
- *Reducing health service inequities across Queensland* which seeks to provide improved equity of access to health services for specific population groups most at risk; and
- *Developing our staff and enhancing organisational performance* which values the role of people and resources in our organisation while maximising our achievement of these strategic priorities.

Queensland Health is predominantly funded for the major departmental services it delivers by parliamentary appropriations and by grants from the Australian Government. It also provides health services on a fee for service basis mainly for inpatient care.

2 Summary of significant accounting policies

(a) Statement of compliance

The financial statements have been prepared in compliance with section 42 of the *Financial and Performance Management Standard 2009*. These financial statements are general purpose financial statements. These have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations applicable to not-for-profit entities as Queensland Health is a not-for-profit entity. In addition, the financial statements comply with Queensland Treasury and Trade's Minimum Reporting Requirements for the year ended 30 June, and other authoritative pronouncements. Except where stated, the historical cost convention is used.

(b) The reporting entity

Queensland Health is managed through a corporate office which undertakes a range of state-wide services. Direct service delivery is provided by a network of seventeen Health Service Districts (Districts). Districts provide a large range of health care activities and operate hospital facilities, community, mental and residential health centres. Districts are not separate reporting entities. In the process of reporting on the department as a single economic entity, all transactions and balances internal to the economic entity including the Queensland Health Shared Service Partner (Shared Service Partner, SSP), Districts and other Divisions have been eliminated in full. The major departmental services undertaken by Queensland Health and the activities of the Shared Service Partner are disclosed in Note 3. The financial statements include the value of all assets, liabilities, equity, revenues and expenses of Queensland Health.

The Mater Misericordiae Public Hospital (Mater Hospital), although treated as a District for operational purposes, does not form part of Queensland Health. As such, its operations are not included in the financial statements except to the extent that an annual amount is paid by way of a grant to the Mater Hospital for the provision of public hospital services in accordance with a binding Service Agreement.

(c) Investments in associates

The associated entities are those entities over which Queensland Health has significant influence but no control, and are neither subsidiaries nor joint ventures. Significant influence is the power to participate in the financial and operating policy decisions of the investee but is not control or joint control over those policies. As at 30 June 2012, Queensland Health has two associates - *Translational Research Institute Pty Ltd* and *Translational Research Institute Trust* (TRI). See Notes 20 and 33.

Investments in associates are accounted for using the equity method in accordance with AASB 128 *Investments in Associates*. Under the equity method, investments in associates are carried in the Statement of Financial Position at cost plus post-acquisition changes in Queensland Health's share of net assets. Queensland Health's share of post-acquisition profits or losses is recognised in the Statement of Comprehensive Income. Changes in the associates' other comprehensive income are recognised in Queensland Health's Other Comprehensive Income. Queensland Health's share of income, expenses and equity movements of equity accounted investees are adjusted to align the accounting policies of the investee with those of Queensland Health.

Queensland Health holds a 43% shareholding in the Queensland Children's Medical Research Institute (QCMRI). As Queensland Health has no rights to the net assets of QCMRI and no economic benefit is expected to flow to Queensland Health, an investment in associate asset has not been recognised.

When Queensland Health transacts with an associate, profits and losses resulting from the transactions with the associate are recognised in the financial statements only to the extent of interests in the associate that are not related to Queensland Health. Dividends receivable from associates are recognised in the Statement of Comprehensive Income as a component of other income. Queensland Health has reinvested all distributions from TRI in accordance with the TRI Trust Deed.

When the share of losses in an associate equals or exceeds its interest in the associate, including any unsecured long-term receivables and loans, Queensland Health does not recognise further losses, unless it has incurred obligations or made payments on behalf of the associate.

(d) Administered transactions and balances

Queensland Health administers, but does not control, certain resources on behalf of the Government. In doing so, it has responsibility and is accountable for administering related transactions and items, but does not have the discretion to deploy the resources for the achievement of its objectives. These transactions and balances are not significant in comparison to Queensland Health's overall financial performance and financial position and are disclosed in Note 40.

(e) Trust transactions and balances

Queensland Health acts in a fiduciary trust capacity in relation to patient trust accounts. Consequently, these transactions and balances are not recognised in the financial statements. Although patient funds are not controlled by Queensland Health, trust activities are included in the audit performed annually by the Auditor-General of Queensland. Note 35 provides additional information on the balances held in patient trust accounts.

(f) Major departmental services revenue and administered revenue

Appropriations provided under the Annual Appropriation Act are recognised as revenue when received or as a receivable when approved by Queensland Treasury and Trade. Amounts appropriated to Queensland Health for transfer to other entities in accordance with legislative or other requirements are reported as an administered appropriation item.

(g) User charges, fees and fines

User charges and fees are controlled by Queensland Health when they can be deployed for the achievement of departmental objectives. User charges and fees controlled by Queensland Health comprise of hospital fees, sales of goods and services and rental income. Hospital fees mainly consist of private patient hospital fees, interstate patient revenue and Department of Veterans' Affairs revenue.

Private patient hospital fees revenue is recognised when invoices are raised. Interstate patient revenue and Department of Veterans' Affairs revenue are recognised based on estimates. Fees and fines collected, but not controlled, by Queensland Health are recognised and reported as administered revenue in Note 40.

(h) Grants and other contributions

Grants, contributions, donations and gifts that are non-reciprocal in nature are recognised as revenue in the year in which Queensland Health obtains control over them. This includes amounts received from the Australian Government for programs that have not been fully completed at the end of the financial year. Where grants are received that are reciprocal in nature, revenue is recognised over the term of the funding arrangements.

Contributed assets are recognised at their fair value. Contributions of services are recognised only when a fair value can be determined reliably and the services would be purchased if they had not been donated.

(i) Finance and borrowing costs

Finance and borrowing costs are recognised as an expense in the period in which they are incurred. Borrowing costs include interest on short-term and long-term borrowings, and ancillary administration charges.

(j) Cash and cash equivalents

Cash includes all cash on hand and in banks, cheques receipted but not banked at the reporting date, call deposits and cash debit facility. Restricted assets are disclosed in Note 34.

(k) Loans and receivables

Trade debtors are recognised at their face value less any impairment. The recoverability of trade debtors is reviewed on an ongoing basis at an operating unit level. Trade receivables are generally settled within 60 days, while other receivables may take longer than twelve months. Any allowance for impairment is based on loss events disclosed in Note 17. All known bad debts are written off when identified.

Payroll receivables include interim cash payments made to employees and salary overpayments. Queensland Health has commenced a process to recover these balances by working with the individuals affected. Refer Notes 3, 17 and 42.

Advances include insurance claims, property purchases, long service leave reimbursements, amounts advanced to employees to align the payment of salaries and wages to a uniform pay day throughout Queensland Health and amounts advanced to entities for services to be performed. No collateral is held for advances made and no interest is charged on outstanding amounts.

Loans to other entities are financial assets with fixed or determinable payments that are not quoted in an active market. These are recognised at amortised cost, using the effective interest method. Refer Notes 17 and 38.

These loans are approved by the Treasurer under the *Financial Accountability Act 2009*, as Queensland Health does not have the capacity to grant loans to other entities. Approval also exists to the extent of the financial arrangements for funding the public hospital component of the redevelopment of the Mater Hospital. These balances are regarded as administered and are recorded at book value with no interest charged. Refer Note 40. Approval also exists to the extent of a Transaction Agreement between Queensland Health and Telstra for the relocation of the South Brisbane Telephone Exchange as part of the Queensland Children's Hospital Development. Refer Note 17.

(l) Inventories

Inventories consist mainly of medical supplies held for distribution to hospitals. These inventories are provided to the hospitals for no or nominal consideration. Inventories are measured at weighted average cost, adjusted for obsolescence. Unless material, inventories do not include supplies held for ready use in the wards throughout the hospital facilities and are expensed on issue from Queensland Health's main storage facilities.

(m) Property, plant and equipment

Queensland Health holds property, plant and equipment in order to meet its core objective of providing dependable health care and better health for all Queenslanders.

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

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

Property, plant and equipment are initially recorded at consideration plus any other costs directly incurred in bringing the asset ready for use. Items or components that form an integral part of an asset are recognised as a single (functional) asset. The cost of items acquired during the financial year has been judged by management to materially represent the fair value at the end of the reporting period.

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

Land and buildings are measured at fair value in accordance with AASB 116 *Property, Plant and Equipment* and *Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector*. Land is measured at fair value each year using independent revaluations, desktop market revaluations or indexation by the State Valuation Service within the Department of Natural Resources and Mines. Independent revaluations are performed with sufficient regularity to ensure assets are carried at fair value.

Buildings are measured at fair value utilising either independent revaluation or applying an interim revaluation methodology developed by the external registered valuer. Assets under construction are not revalued until they are ready for use. Reflecting the specialised nature of Queensland Health buildings (health service buildings and on hospital-site residential facilities), fair value is determined using depreciated replacement cost methodology. Depreciated replacement cost is determined as the replacement cost less the cost to bring to current standards.

In determining the depreciated replacement cost of each building, the independent valuers consider a number of factors such as age, functionality and physical condition. The percentage of replacement cost indicates the reduction that would be applied to the replacement cost as a result of the building's condition assessment.

Category	Condition	Reduction in replacement cost
5	New construction, completed within the last 12 months with no work required to meet current standards.	0%
4	The asset has been completed within the last 5 years and maintained in an 'as new' condition.	5%
3	Well maintained building which is fully operational (by visual assessment only) and has no evident faults.	50%
2	A building which is nearing the end of its effective life, or is housed in an inappropriate building.	71%
1	A building which has no effective life remaining and requires replacement or redevelopment.	100%

For interim revaluations, Queensland Health uses an index developed by the Department of Public Works called the Building Price Index (BPI). Davis Langdon was engaged in 2011 to review the BPI and found strong correlation between the index and major projects.

In addition, a 'Health Design Factor' (HDF) was developed in consultation with Davis Langdon to account for factors such as building design code and building standard changes in the application of the interim valuation index. The interim valuations for the following sub-classes are to be annually adjusted by applying the HDF for the duration of the current program:

4 percent to major, regional and rural hospitals sites; and

2 percent to residential, on-site accommodation at hospital sites.

Revaluation increments are 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.

Queensland Health has adopted the gross method of reporting comprehensively revalued assets. This method restates separately the gross amount and related accumulated depreciation of the assets comprising the class of revalued assets. Accumulated depreciation is restated proportionally in accordance with the independent advice of the appointed valuers/quantity surveyors. The proportionate method has been applied to those assets that have been revalued by way of indexation.

Non-current assets held for sale consist of those assets that management has determined are available for immediate sale in their present condition, for which their sale is highly probable in the next twelve months. These assets are measured at the lower of their carrying amounts and fair values less costs to sell and are not depreciated.

Plant and equipment (other than major plant and equipment) is measured at cost net of accumulated depreciation and any impairment in accordance with *Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector*.

Included in the class of plant and equipment are 23 (15 in 2010-11) artworks valued at $0.681 million (2010-11: $0.413 million). These items are not depreciated as their value is not expected to diminish over time. Artwork assets form part of the plant and equipment class and are not disclosed separately as they are not considered material to the total assets held. Heritage buildings are included in the buildings asset class as they are held primarily for the purpose of service delivery.

Depreciation

Property, plant and equipment are depreciated on a straight-line basis. Annual depreciation is based on fair values and Queensland Health's assessments of the useful remaining life of individual assets. Land is not depreciated. Assets under construction (work-in-progress) are not depreciated until they are ready for use.

Any expenditure that increases the capacity or service potential of an asset is capitalised and depreciated over the remaining useful life of the asset. Major spares purchased specifically for particular assets are capitalised and depreciated on the same basis as the asset to which they relate.

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

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

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

Leased plant and equipment

Operating lease payments, being representative of benefits derived from the leased assets, are recognised as an expense of the period in which they are incurred. Queensland Health had no finance lease assets as at the reporting dates.

Impairment of non-current assets

All non-current and intangible assets are assessed for indicators of impairment on an annual basis in accordance with AASB 136 *Impairment of Assets*. If an indicator of impairment exists, Queensland Health 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.

An impairment loss is recognised immediately in the Statement of Comprehensive Income, unless the asset is carried at a revalued amount, in which case the impairment loss is offset against the asset revaluation surplus of the relevant class to the extent available.

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

(n) Intangible assets

Intangible assets are only recognised if they satisfy recognition criteria in accordance with AASB 138 *Intangible Assets*. Intangible assets are recorded at cost, which is consideration plus costs incidental to the acquisition, less accumulated amortisation and impairment losses. An intangible asset is recognised only if its cost is equal to or greater than $100,000. Internally generated software cost includes all direct costs associated with development of that software. All other costs are expensed as incurred.

Intangible assets are amortised on a straight-line basis over their estimated useful life with a residual value of zero. The estimated useful life and amortisation method are reviewed periodically, with the effect of any changes in estimate being accounted for on a prospective basis.

Software is amortised from the time of acquisition or, in respect of internally developed software, from the time the asset is completed and held ready for use. The amortisation rates for Queensland Health's software are between 10 per cent and 20 per cent.

Intellectual property

Queensland Health controls both registered intellectual property in the form of patents, designs and trademarks and other unregistered intellectual property in the form of copyright. At the reporting dates these intellectual property assets do not meet the recognition criteria.

(o) Arrangements for the provision of public infrastructure by other entities

Queensland Health has entered into a number of contractual arrangements with private sector entities for the construction and operation of public infrastructure facilities for a period of time on departmental land. After an agreed period of time, ownership of the facilities will pass to Queensland Health (see Note 36). Arrangements of this type are known as Public Private Partnerships (PPP).

Although the land on which the facilities have been constructed remains an asset of Queensland Health, Queensland Health does not control the facilities associated with these arrangements. Therefore these facilities are not recorded as assets. Queensland Health receives rights and incurs obligations under these arrangements, including:

- rights to receive the facility at the end of the contractual terms; and
- rights and obligations to receive and pay cash flows in accordance with the respective contractual arrangements, other than those which are received by the respective Hospital Foundations under a Deed of Assignment.

The arrangements have been structured to minimise risk exposure for Queensland Health. Queensland Health has not recognised any rights or obligations that may attach to those arrangements, other than those recognised under generally accepted accounting principles.

(p) Collocation agreements

Queensland Health has entered into a number of contractual arrangements with private sector entities for the construction and operation of private health facilities for a period of time on departmental land. After an agreed period of twenty-five years, ownership of the facilities will pass to Queensland Health.

As with PPP type agreements, Queensland Health does not recognise these facilities as assets. Consequently, Queensland Health has not recognised any rights or obligations that may attach to those agreements, other than those recognised under generally accepted accounting principles. Current collocation agreements in operation are listed in Note 37.

(q) Other financial assets

Queensland Health has fixed rate deposits with Queensland Treasury Corporation approved by the Treasurer. Each investment has known receipts and fixed maturity dates. Queensland Health has the ability and intention to continue to hold investments until maturity as the investments contribute towards the Government's objective of promoting high quality health research under the Smart State Research Grants Program. Refer Notes 19 and 38.

(r) 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 are unsecured and normally settled within 60 days.

(s) Other financial liabilities

Finance lease advanced

Leases are classified as finance leases when the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee. Finance lease payments received in advance are recorded as liabilities. Refer Note 26.

Administered borrowings

Queensland Health is responsible for administration of the Mater Hospital redevelopment loan. There is no financial benefit derived from the transactions by Queensland Health. The financial risk associated with the public component of the project has been covered by the State Government and is treated as an administered balance. Refer Note 40.

(t) Financial instruments

A financial instrument is any contract that gives rise to both a financial asset of one entity and a financial liability or equity instrument of another entity. Queensland Health holds financial instruments in the form of cash, call deposits, loans, receivables and payables. Queensland Health accounts for its financial instruments in accordance with AASB 139 *Financial Instruments: Recognition and Measurement* and reports instruments under AASB 7 *Financial Instruments: Disclosures*. Queensland Health does not enter into transactions for speculative purposes, or for hedging. Financial assets and financial liabilities are recognised in the Statement of Financial Position when Queensland Health becomes a party to the contractual provisions of the financial instrument.

Financial instruments are classified and measured as follows: cash and cash equivalents – held at fair value through profit or loss; receivables – held at amortised cost; loans to other entities – held at amortised cost; payables – held at amortised cost.

Loans to other entities are initially recognised at fair value plus directly attributable transaction costs. They are subsequently recorded at amortised cost, using the effective interest method, net of any allowance for impairment. The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of a financial instrument (or, when appropriate, a shorter period) to the net carrying amount of that instrument.

Financial assets, other than those held at fair value through profit or loss, are assessed for indicators of impairment at the end of each reporting period. For certain categories of financial asset, such as trade receivables, assets that are assessed not to be impaired individually are additionally assessed for impairment on a collective basis. For financial assets carried at amortised cost, the amount of the impairment loss recognised is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the financial asset's original effective interest rate. When a trade receivable is considered uncollectible, it is written off against the allowance account. Subsequent recoveries of amounts previously written off are credited against the allowance account. Changes in the carrying amount of the allowance account are recognised in profit or loss.

Financial assets (excluding cash) and liabilities held by Queensland Health are classified as level 3 in the fair value hierarchy. Fair values are derived from data not observable in a market. Other disclosures relating to the measurement and financial risk management of other financial instruments are included in Note 38.

(u) Employee benefits

Queensland Health classifies salaries and wages, rostered days-off, sick leave, annual leave and long service leave levies and employer superannuation contributions as employee benefits in accordance with AASB 119 *Employee Benefits* (Note 10). Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at current salary rates.

Under the Queensland Government's Annual Leave Central Scheme (established on 30 June 2008) and Long Service Leave Central Scheme (established on 1 July 1999), levies are payable by Queensland Health to cover the cost of employees' annual leave (including leave loading and on-costs) and long service leave. The provisions for these schemes are reported on a Whole-of-Government basis pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting.* These levies are expensed in the period in which they are paid or payable. Amounts paid to employees for annual leave and long service leave are claimed from the schemes quarterly in arrears. Refer Note 25. Non-vesting employee benefits such as sick leave are recognised as an expense when taken.

Employer superannuation contributions are paid to QSuper, the superannuation scheme for Queensland Government employees, at rates determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are paid or payable and Queensland Health's obligation is limited to its contribution to QSuper. The QSuper scheme has defined benefit and defined contribution categories. The liability for defined benefits is held on a Whole-of-Government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting.*

(v) Allocation of overheads to major departmental services

The revenues and expenses of Queensland Health's corporate services are allocated to departmental services on the basis of the services they primarily support and are included in the Statement of Comprehensive Income by Major Departmental Services and Shared Service Partner. Refer Note 3.

(w) Insurance

Property and general losses above a $10,000 threshold are insured through the Queensland Government Insurance Fund (QGIF). Health litigation payments above a $20,000 threshold and associated legal fees are also insured through QGIF. Premiums are calculated by QGIF on a risk assessed basis. Queensland Health pays premiums to WorkCover Queensland in respect of its obligations for employee compensation.

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

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

(y) Contributed equity

Non-reciprocal transfers of assets and liabilities between wholly-owned Queensland State Public Sector entities as a result of machinery-of-Government changes are adjusted to Contributed Equity in accordance with Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities.* Appropriations for equity adjustments are similarly designated.

(z) Taxation

Queensland Health is a State body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). FBT and GST are the only Commonwealth taxes recognised by Queensland Health. Refer Note 17.

(aa) Issuance of financial statements

The financial statements are authorised for issue by the Director-General and the Deputy Director-General, System Support Services, at the date of signing the Management Certificate.

(bb) 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. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant, and are reviewed on an ongoing basis. Actual results may differ from these estimates. Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

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

User charges – Note 2(g)

Loans and receivables – Note 17

Property, plant and equipment – Note 23

Contingencies – Note 32

Credit risk exposure – Note 38(c)

(cc) Rounding and comparatives

Amounts included in the financial statements are in Australian dollars and have been rounded to the nearest $1,000 or, where the amount is $500 or less, to zero unless the disclosure of the full amount is specifically required. Comparative information has been restated where necessary to be consistent with disclosures in the current reporting period.

(dd) New and revised accounting standards

Queensland Health did not voluntarily change any of its accounting policies during 2011-12 and is not permitted to early adopt accounting standard unless approved by Queensland Treasury and Trade. Accounting Standards effective for the first time in the current year have had no effect on the reported results or financial position. Those standards having a minor impact on presentation and disclosure are: AASB 2010-4 *Further Amendments to Australian Accounting Standards arising from the Annual Improvements Project*, AASB 1054 *Australian Additional Disclosures* and AASB 2011-1 *Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project*.

The following Accounting Standards in issue but not yet effective are expected to impact Queensland Health in future periods. The potential effect of the revised Standards and Interpretations on Queensland Health's financial statements has not yet been determined.

Standards effective for annual periods beginning on or after 1 July 2012:

- *AASB 101 Presentation of Financial Statements* amendments require that items of other comprehensive income are grouped into: (a) items that will not be reclassified subsequently to profit or loss; and (b) items that will be reclassified subsequently to profit or loss when specific conditions are met.

Standards effective for annual periods beginning on or after 1 January 2013:

- *AASB 10 Consolidated Financial Statements* requires that the only basis for consolidation is control and includes a new definition of control that contains three elements: (a) power over an investee, (b) exposure, or rights, to variable returns from its involvement with the investee, and (c) the ability to use its power over the investee to affect the amount of the investor's returns.

- *AASB 13 Fair Value Measurement* provides a new definition of fair value, establishes a framework for measuring fair value, and requires extensive disclosures about fair value measurements. Quantitative and qualitative disclosures based on the three-level fair value hierarchy currently required for financial instruments only under AASB 7 *Financial Instruments: Disclosures* will be extended to cover all assets and liabilities within the scope of AASB 13.

Standards effective for annual periods beginning on or after 1 January 2015:

- *AASB 9 Financial Instruments* requires all financial assets to be subsequently measured at amortised cost or fair value. Financial assets can only be measured at amortised cost if: (a) the asset is held within a business model whose objective is to hold assets in order to collect contractual cash flows; and (b) the contractual terms of the asset give rise to cash flows that are solely payments of principal and interest. For financial liabilities which are designated as at fair value through profit or loss, the amount of change in fair value that is attributable to changes in the liability's credit risk will be recognised in other comprehensive income.

3 Major services, activities and other events

Major services

Queensland Health has six major departmental services and the Shared Service Partner (SSP). These reflect Queensland Health's planning priorities as articulated in the Queensland Statewide Health Services Plan 2007-2012 and supports investment decision-making based on the health continuum. The identity and purpose of each major departmental service undertaken by Queensland Health during the reporting period is summarised as follows:

Prevention, Promotion, Protection

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

Primary Health Care

Address health problems or established risk factors of individuals and small targeted groups providing curative, promotive, preventative and rehabilitation services. The services include early detection and intervention services and risk factor management programs.

Ambulatory Care

Aims to provide equitable access to quality emergency and outpatient services provided by Queensland's public hospitals and incorporate activities of Queensland public hospitals outpatient department as well as emergency medical services provided in the public hospital emergency departments.

Acute Care

Aims to increase equity and access to high quality acute hospital services for patients on a Statewide basis and includes the provision of medical, surgical and obstetric service in Queensland hospitals.

Rehabilitation and Extended Care

Aims to improve the functional status of patients with an impairment or disability slow the progression of a person's health condition and assist them to maintain and better manage their health condition. This major departmental service predominantly targets the needs of people with long-term conditions that have chronic consequences.

Integrated Mental Health Services

This major departmental service spans the health continuum through the provision of mental health promotion, community based illness prevention activities, acute mental health services, outpatient treatment and mental health support services as well as the extended treatment services provided through designated mental health units.

Shared Service Partner

Queensland Health's Shared Service Partner provides a standard suite of corporate services to Queensland Health, linen services and some additional out of scope services.

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

Major activities

Payroll system

Queensland Health introduced a new payroll system on 24 March 2010 which resulted in significant disruptions to payroll activities, pay issues for employees and a backlog of unprocessed payroll forms.

Following these disruptions, Queensland Health undertook a number of key steps to address these issues including:

- employing additional payroll staff on a temporary basis;
- ensuring access to emergency financial assistance for all employees, where required;
- developing and rolling out a localised payroll operating model to re-establish working relationships between employees and payroll hubs;
- resolving many of the critical system issues and implementing arrangements to address the remaining problems on a priority basis; and
- engaging Ernst and Young to independently review Queensland Health's current payroll and rostering systems.

The Auditor-General of Queensland issued two major reports in 2010 in regards to Queensland Health's payroll implementation as follows:

- the Auditor-General of Queensland Report to Parliament No. 7 for 2010 'Information systems governance and control', including the Queensland Health Implementation of Continuity Project; and
- the Auditor-General of Queensland Report to Parliament No. 13 for 2010 'Results of audits at 31 October 2010. This was a general financial statements audit which highlighted a number of findings relating to Queensland Health payroll.

Queensland Health accepted all of the Auditor-General's recommendations and developed a comprehensive plan for their implementation.

Furthermore, Queensland Health committed to deliver the recommendations from Ernst and Young's review of the Queensland Health payroll system, including immediate initiation of the Queensland Health Payroll Foundation Program (the Program) which included:

- development of a blueprint to improve the underlying technology platforms and to establish a business requirements and processing baseline for a long term, optimised payroll solution;
- establishing a robust governance arrangement based on clear roles and responsibilities, defined key deliverables and performance indicators under the direction of a new program steering committee – as recommended by the QAO;
- using lessons learnt from the implementation of the project and incorporating these learnings into future planning activities;
- reviewing existing contractual arrangements for system development and support and more rigorous and robust arrangements where required;
- mobilising a project team to undertake the scope of work of the Program, whilst maintaining ongoing stabilisation and system improvement activities and resources;
- identifying opportunities for quick wins with the payroll system and operational processing and managing their implementation as a priority;
- undertaking, as part of the program's priorities, an assessment of the gap between business requirements and the implemented solution.

In late 2011, all payroll activities were consolidated under a new Payroll Portfolio following a recommendation from KPMG. This has provided significant benefit and economies of scale and the Portfolio is now progressively implementing the recommendations from a Payroll Audit undertaken by KPMG in May and June 2012 which include initiation of a number of major programs of work over several years.

Queensland Health has undertaken a significant amount of work to stabilise the Queensland Health payroll and rostering systems to ensure employees receive their correct pay and entitlements. Queensland Health remains committed to resolving staff payroll issues as soon as possible and will continue working towards delivering a payroll system which meets the needs of our staff.

Overpayments recovery

On 30 May 2012 the Minister for Health announced the lifting of the moratorium on the recovery of overpayments. Queensland Health has commenced a process to recover overpayments by working with the individually affected employees. Given the large number of staff affected, this is a considerable process and is expected to take some time. As a government department, Queensland Health has a responsibility to taxpayers to recover overpaid monies to staff. As at 30 June 2012, Queensland Health is not aware of any significant level of outstanding underpayments.

Refer Note 42 for further information regarding corrective measures undertaken.

Overpayments receivables and waiver

Included in receivables is an amount of $86.368 million (2010-11: $59.449 million) relating to salary overpayments and $8.177 million (2010-11: $9.599 million) relating to interim cash payments made to staff who required immediate financial assistance. As at 30 June 2012, approximately $17.8 million of total overpayments to date has been voluntarily repaid. Refer Note 17.

Employees overpaid between 1 July 2011 and 13 May 2012 by a cumulative amount up to and including $200 will have their overpayments waived, similar to the previous financial year. This amount was selected as the cost of recovery was determined to outweigh the overpayment amount. This waiver will benefit approximately 26 thousand (23 thousand in 2010-11) employees at a cost of approximately $1.9 million ($2.2 million in 2010-11).

Other events

Voluntary Separation Payments

In 2011-12 the Queensland Government announced a program of Voluntary Separation Packages (VSPs) for non-frontline staff across the public sector to contribute savings and reprioritise spending to frontline service delivery. In 2011-12, 853 VSPs were accepted in accordance with the terms of the *Queensland Public Service Commission's Voluntary Separation Program Handbook*. The VSP program ceased in May 2012 and no further offers were made to employees. Employees who have previously accepted a VSP, but are yet to cease employment, will continue to separate as planned.

Alleged fraud and Queensland Health response

During 2011-12, Queensland Health management became aware of an incident of alleged fraud involving misappropriated grants expense. This matter was referred immediately to the Queensland Police Service (QPS) and the Crime and Misconduct Commission (CMC). Queensland Health continues to assist both the QPS and CMC in their investigations.

The estimated loss to Queensland Health is approximately $16 million, of which $11.275 million relates to the 2011-12 financial year and the remainder relates to prior periods. Prior period comparatives have been adjusted to reflect this loss.

Queensland Health's immediate response to the alleged fraud was to implement a new Internal Control Framework (ICF). The new ICF includes increased controls for certifying expenditure, vendor creation and cost centre management. Ongoing improvement strategies include a review and rationalisation of delegations across the State, development of exception reports through data analysis tools as additional detective controls, a review and analysis of District spend profiles and a review of purchasing methods.

The Ernst and Young Report on Fraud Prevention and Control, resulting from the review of Fraud Control within Queensland Health contained recommendations relating to fraud risk awareness training, fraud risk planning and fraud risk assessment. Queensland Health has established the Fraud Risk and Control Improvement Project to deliver the following key initiatives:

- development of a standard fraud risk awareness training program;
- development of a generic fraud risk management; and
- development of a fraud risk register.

Queensland Health also participated in an inter-governmental group to develop training and awareness material focusing on internal controls, delegations and accountability and cost centre management. An implementation strategy for the state-wide roll out of internal controls training has been completed.

Queensland Health will continue to improve fraud prevention and corruption control strategies to ensure the effective and efficient management of public resources.

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

		2012 $'000	2011 $'000
4	**Reconciliation of payments from Consolidated Fund to departmental services revenue recognised in Statement of Comprehensive Income**		
	Budgeted departmental services appropriation*	9,935,644	9,092,426
	Transfers from other headings	59,972	200,684
	Unforeseen expenditure	58,284	177,787
	Total departmental services receipts	10,053,900	9,470,897
	Less: Opening balance of departmental services revenue receivable	-	30,213
	Departmental services revenue recognised in Statement of Comprehensive Income*	**10,053,900**	**9,440,684**

* Departmental services revenue includes Australian Government contributions of $2,816 million (2010-11: $2,522 million) appropriated through Queensland Treasury and Trade.

Departmental services revenue includes $67.559 million payable to Queensland Treasury and Trade in 2011-12

	Reconciliation of payments from Consolidated Fund to equity adjustment recognised in Contributed Equity (Statement of Changes in Equity)		
	Budgeted equity adjustment appropriation	1,203,991	1,173,292
	Transfers to other headings	(59,936)	(200,974)
	Equity adjustment receipts	1,144,055	972,318
	Plus: Opening balance of equity withdrawal payable	-	18,213
	Less: Closing balance of equity withdrawal payable	-	-
	Equity adjustment recognised in Contributed Equity	**1,144,055**	**990,531**

5 User charges

Hospital fees	620,660	485,221
Sale of goods and services	272,130	285,175
Rental income	8,667	8,102
	901,457	**778,498**

6 Grants and other contributions

Australian Government grants		
Nursing home grants	64,343	57,197
Other specific purpose recurrent grants	118,647	74,690
Other specific purpose capital grants	6,500	6,419
Total Australian Government grants	189,490	138,306
Other grants	127,446	129,317
Donations other	5,738	4,726
Donations inventory*	6,035	6,042
Donations non-current physical assets	593	17,082
Other	675	930
	329,977	**296,403**

* Inventory is donated by the Australian Government as part of the Australia wide vaccinations initiative.

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

		2012 $'000	2011 $'000
7	**Other revenue**		
	Interest	6,065	5,189
	Sale proceeds of non-capitalised assets	202	407
	Licences and registration charges	2,686	2,448
	Recoveries	11,524	12,955
	Grants returned	10,487	1,476
	Other	8,768	7,518
		39,732	**29,993**
8	**Gains**		
	Gain on sale of property, plant and equipment	**3,419**	**871**
9	**Other income**		
	Share of profit from associates	**28,596**	**26,236**
10	**Employee expenses**		
	Employee benefits		
	Wages and salaries	5,643,608	5,289,028
	Employer superannuation contributions	595,765	550,831
	Annual leave expense	643,436	608,526
	Long service leave levy	122,022	115,138
	Termination payments	100,263	4,851
	Employee related expenses		
	Workers' compensation premium	82,167	63,293
	Payroll tax	40,268	35,164
	Other employee related expenses	70,405	70,355
		7,297,934	**6,737,186**

	30 June 2012	30 June 2011
Number of employees		
Health Service Districts	60,114	58,350
Queensland Health State-wide Services	5,274	5,404
Queensland Health Corporate	3,476	4,194
	68,864	**67,948**

The number of employees includes full-time employees and part-time employees measured on a full-time equivalent basis. Key executive management and personnel are reported in Note 39.

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

	2012 $'000	2011 $'000
11 Supplies and services		
Consultants and contractors	351,965	382,363
Electricity and other energy	69,610	65,340
Patient travel	52,112	46,922
Other travel	54,927	61,903
Water	10,602	9,420
Building services	17,156	15,386
Computer services	98,575	93,894
Motor vehicles	12,152	11,001
Communications	63,612	65,405
Repairs and maintenance	207,285	185,358
Expenses relating to capital works	27,087	26,177
Operating lease rentals	130,450	119,668
Drugs	417,340	403,291
Clinical supplies and services	697,860	689,577
Catering and domestic supplies	142,644	147,109
Other	118,392	112,087
	2,471,769	**2,434,901**
12 Grants and subsidies		
Public hospital support services	723,464	671,330
Home, community and rural health services	129,986	155,016
Mental health services	3,831	6,744
Medical research programs	57,286	63,350
Other	5,872	4,325
	920,439	**900,765**
13 Depreciation and amortisation		
Buildings and land improvements	206,788	190,421
Plant and equipment	147,788	133,325
Software purchased	4,301	2,771
Software developed	13,067	11,373
	371,944	**337,890**
14 Impairment losses		
Impairment losses on receivables*	26,088	12,519
Bad debts written off	21,630	23,502
	47,718	**36,021**

* Refer Notes 17 and 38(c).

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

	2012 $'000	2011 $'000
15 Other expenses		
External audit fees*	1,593	1,596
Bank fees	536	480
Insurance**	75,754	62,906
Inventory written off	5,121	2,519
Losses from the disposal of non-current assets	5,013	5,855
Losses		
Public monies	11,275	5,389
Public property	4	38
Special payments		
Donations/gifts	23	68
Ex-gratia payments	1,367	5,577
Other legal costs	7,359	8,121
Journals and subscriptions	7,899	8,940
Advertising	12,954	14,556
Interpreter fees	5,114	4,765
Other	3,370	2,827
	137,382	**123,637**

*Total audit fees paid to the Queensland Audit Office relating to the 2011-12 financial year are $1,592,809 (2010-11: $1,595,874). There are no non-audit services included in this amount.

** Certain losses of public property and health litigation costs are insured with the Queensland Government Insurance Fund. Refer Note 2(w).

16 Cash and cash equivalents		
Cash at bank and on hand	(146,876)	(100,654)
24 hour call deposits	82,135	70,466
	(64,741)	**(30,188)**

Queensland Health's bank accounts are grouped within the Whole-of-Government set-off arrangement with the Queensland Treasury Corporation. As part of the above Whole-of-Government banking arrangements, Queensland Health has an approved working debit facility of $500 million. As at 30 June 2012, Queensland Health had accessed $147 million of this facility. Queensland Health does not earn interest on surplus funds and is not charged interest or fees for accessing its approved cash debit facility as it is part of the Whole-of-Government banking arrangements.

Interest earned on the aggregate set-off arrangement balance accrues to the Consolidated Fund. Cash deposited at call with the Queensland Treasury Corporation earns interest at a rate of 3.95% (2010-11: 5.34%).

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

	2012 $'000	2011 $'000
17 Loans and receivables		
Current		
Trade debtors	366,610	293,863
Payroll receivables	94,484	69,048
Less: Allowance for impairment	59,615	33,527
	401,479	329,384
GST input tax credits receivable	62,095	63,799
GST payable	(4,340)	(2,310)
Net receivable	57,755	61,489
Annual leave reimbursements	141,260	126,585
Long service leave reimbursements	23,782	18,848
Advances	12,014	10,825
Other	596	201
	636,886	**547,332**
Non-current		
Loans to other entities	20,911	10,715
	20,911	**10,715**
	657,798	**558,047**
Movements in the allowance for impairment loss		
Current		
Balance at the beginning of the year	33,527	21,008
Amounts written off during the year	(21,608)	(23,481)
Amount recovered during the year	(22)	(21)
Increase/(decrease) in allowance recognised in operating result	47,719	36,021
Balance at the end of the year	**59,615**	**33,527**

Trade debtors includes outstanding receivables of $62.09 million (2010-11: $63.412 million) from the Commonwealth Department of Veteran Affairs for patient revenue and $147.81 million ($95.358 million in 2010-11) from the NSW Government for treatment of interstate patients.

Payroll receivables includes $8.177 million (2010-11 $9.599 million) relating to interim cash payments and $86.368 million (2010-11 $59.448 million) for salary overpayments.

The loan receivable forms part of a Transaction Agreement between Queensland Health and Telstra for the relocation of the South Brisbane Telephone Exchange.

Impairment of financial assets

At the end of each reporting period, Queensland Health 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 60 days.

The allowance for impairment reflects Queensland Health's assessment of the credit risk associated with receivables balances and is determined based on consideration of objective evidence of impairment, past experience and management judgement. The current year allowance is affected by the following loss events:

- $26.493 million (2010-11: $17.372 million) relating to payroll receivables and interim cash payments; overseas patients treated in public hospitals where the cost was unrecoverable amounting to $5.486 million (2010-11: $5.762 million);

17 Loans and receivables (continued)

- debts including general private patients $9.557 million (2010-11: $8.459 million);
- unrecoverable debts from private businesses $0.517 million (2010-11: $0.057 million); and
- unrecoverable third party claim settlements from patients involved in motor vehicle accidents $2.081 million (2010-11: $0.639 million).

The allowance for impairment on payroll receivables has increased in line with the payroll receivables balance and represents management's best estimate as at 30 June 2012, based on the current process for the recovery of overpayments. Management's estimate reflects an assessment of a number of factors including the current status of their employees, the aging of the overpayment receivables and also takes into account the lifting of the overpayments recovery moratorium on 30 May 2012. As with all management estimates, outcomes within the next financial year could result in adjustments to the carrying amount of the receivables balance, including the progression of overpayment recovery actions, legislative changes and other policy decisions. Refer Notes 3 and 42.

18 Inventories

	2012 $'000	2011 $'000
Inventories held for distribution		
Medical supplies and equipment	127,482	117,560
Catering and domestic	2,741	1,638
	130,223	119,198
Loss of service potential	(3,347)	(480)
	126,876	118,718
Engineering	1,916	1,851
Other	1,294	1,234
	130,086	**121,803**

19 Other financial assets

Fixed rate deposit	**20,000**	**20,000**

The Treasurer approved the investment of $20 million with Queensland Treasury Corporation with the interest earned being used for the funding of the Smart State Research Grants Program. Interest earned from this investment totalled $1.109 million (2010-11: $0.990 million). As at 30 June 2012 there is one deposit with QTC worth $20 million. Refer Note 38.

20 Investments in associates

(a) Movements in the carrying amount of investments in associates

Translational Research Institute Trust		
Balance at the beginning of the financial year	40,596	14,534
Share of profit in associate after income tax	28,596	26,062
Balance at the end of the year	**69,192**	**40,596**

Comparative balance for 2010-11 excludes $326,000 for Queensland Health's share of profit for Queensland Children's Medical Research Institute. Refer Note 2(c).

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

	2012 $'000	2011 $'000
20 Investments in associates (continued)		
(b) Summarised financial information		
Translational Research Institute Trust		
Current assets	121,168	105,904
Non-current assets	198,302	63,110
	319,470	**169,014**
Current liabilities	144,576	105,871
Non-current liabilities	12,500	5,000
	157,076	**110,871**
Net assets	**162,394**	**58,143**
Net asset percentage share	25%	25%
Share of associates' net assets	**40,599**	**14,536**
Revenue	116,738	105,142
Net profit	114,383	104,250
(c) Share of associates' profit and net asset percentage		
Translational Research Institute Pty Ltd	25%	25%
Translational Research Institute Trust	25%	25%
21 Other assets		
Current		
Insurance premium prepayment	90,407	75,167
Other prepayment	21,211	18,829
	111,618	**93,996**
Non-current		
Prepayments	**7,629**	**3,066**
22 Intangible assets		
Software purchased		
At cost	27,660	26,614
Less: Accumulated amortisation	16,399	14,041
	11,261	**12,573**
Software internally generated		
At cost	231,487	222,120
Less: Accumulated amortisation	180,547	167,454
	50,940	**54,666**
Software work in progress		
At cost	**87,263**	**54,356**
	149,464	**121,595**

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

22 Intangible assets (continued)

Intangible assets reconciliation

	Software purchased		Software internally generated		Software work in progress		Total	
	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000	2012 $'000	2011 $'000
Opening carrying value	**12,573**	**10,323**	**54,666**	**44,548**	**54,356**	**41,982**	**121,595**	**96,853**
Acquisitions	2,756	3,958	1,575	10,121	38,609	26,979	**42,940**	**41,058**
Disposals	-	-	-	-	-	-	**-**	**-**
Transfer between classes	233	1,063	7,767	11,370	(5,702)	(14,605)	**2,298**	**(2,172)**
Transfers in/(out)	-	-	-	-	-	-	**-**	**-**
Amortisation charge for the year	(4,301)	(2,771)	(13,068)	(11,373)	-	-	**(17,369)**	**(14,144)**
Closing carrying value	**11,261**	**12,573**	**50,940**	**54,666**	**87,263**	**54,356**	**149,464**	**121,595**

Queensland Health's Hospital Based Corporate Information System (HBCIS) has an original cost of $0.952 million or 0.43% of the total gross value of the class of assets. HBCIS has been written down to zero and is still being used in the provision of services. It is anticipated that this module will be replaced in the next five to seven years.

Costs associated with projects in the research phase of the software development program were mainly classified as salaries and wages expenses in 2011-12. The total balance of these costs is $2.175 million (2010-11:$5.811 million).

23 Property, plant and equipment

	2012 $'000	2011 $'000
Land		
At fair value	**1,084,256**	**1,112,805**
Buildings		
At fair value	6,857,621	6,398,158
Less: Accumulated depreciation	2,996,031	2,678,731
	3,861,590	**3,719,427**
Plant and equipment		
At cost	1,609,094	1,506,815
Less: Accumulated depreciation	797,433	745,395
	811,661	**761,420**
Capital works in progress		
At cost	**2,627,362**	**1,584,912**
Less: Assets held for sale	75	-
Total property, plant and equipment	**8,384,794**	**7,178,564**

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

23 Property, plant and equipment (continued)

Land

Land was fair valued using the following methodologies:

- In 2011-12, the majority of land was indexed using the appropriate indices sourced from the State Valuation Service. These indices are based on actual market movements for the relevant location and asset category. Desktop market valuations were performed on six land parcels which were previously not re-valued as they were below the department's valuation threshold. Desktop market valuations take into consideration valuation indicators such as location, size, zoning and recent market sales.
- In 2010-11, an independent market revaluation was performed on all land with a value greater than $0.415 million by the State Valuation Service. For all land under $0.415 million, a desktop market valuation was performed.

The revaluation program resulted in a decrement of $26.074 million (an increment of $0.227 million in 2010-11) to the carrying amount of land.

Buildings

An independent revaluation of 22 per cent of the gross value of the building portfolio was performed during 2011-12. For buildings not subject to independent revaluations during 2010-11, the Department of Public Works Building Price Index was assessed as nil for the year and a Health Design Factor of either 2 per cent or 4 per cent was applied on all specialised buildings. Refer Note 2(m).

The buildings valuations for 2011-12 resulted in a net decrement to the Department's building portfolio of $54.551 million (2010-11: $52.241 million decrement). This is a decrease of 3.1per cent to the building portfolio as at 30 June 2012.

Queensland Health has plant and equipment with an original cost of $14.324 million (2010-11: $15.242 million) or 0.9% (2010-11: 1.0%) of total plant and equipment gross value and a written down value of zero still being used in the provision of services.

	Land	Buildings	Plant and equipment	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000
As at 30 June 2010	**1,074,121**	**3,364,645**	**727,848**	**1,023,656**	**6,190,270**
Acquisitions	22,728	211,635	155,539	906,129	**1,296,031**
Donation received	16,529	60	492	-	**17,081**
Disposals	(707)	(996)	(6,163)	-	**(7,866)**
Donations made	-	-	(177)	-	**(177)**
Transfer between classes	8	339,059	16,062	(352,957)	**2,172**
Transfers in	72	57,610	1,144	8,084	**66,910**
Revaluation Increments/(decrements)	294	(56,135)	-	-	**(55,841)**
Impairment decrement	(240)	(6,030)	-	-	**(6,270)**
Depreciation charge for the year	-	(190,421)	(133,325)	-	**(323,746)**
As at 30 June 2011	**1,112,805**	**3,719,427**	**761,420**	**1,584,912**	**7,178,564**
Acquisitions	5,154	159,484	206,358	1,350,649	1,721,645
Donation received	-	-	644	-	644
Disposals	(7,969)	(472)	(6,068)	-	(14,509)
Donations made	-	(55)	(9)	-	(64)
Transfer between classes	393	310,773	(2,967)	(308,199)	-
Transfers in	4	437	70	-	511
Held for sale	(75)	-	-	-	(75)
Revaluation Increments/(decrements)	(26,074)	(54,551)	-	-	(80,625)
Impairment decrement	(57)	(66,662)	-	-	(66,719)
Depreciation charge for the year	-	(206,791)	(147,787)	-	(354,578)
As at 30 June 2012	**1,084,181**	**3,861,590**	**811,661**	**2,627,362**	**8,384,794**

Included in the valuation of buildings are 78 heritage buildings held at gross value of $108.213 million (2010-11: 72 buildings at gross value of $109.676 million).

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

	2012 $'000	2011 $'000
24 Payables		
Trade creditors	419,588	403,215
Appropriations payable	67,559	-
Other creditors	9,413	3,818
	496,560	**407,033**
25 Accrued employee benefits		
Salaries and wages accrued	218,690	135,949
Other employee entitlements payable	11,314	10,140
Annual leave levy payable	142,155	151,457
Long service leave levy payable	34,364	32,984
	406,523	**330,530**
26 Other liabilities		
Non-current		
Finance lease advanced*	**194,398**	**59,977**

*This is the advanced lease payments from the *Translational Research Institute Trust*.

27 Unearned revenue		
Current		
Unearned other revenue	**466**	**463**
Non-current		
Unearned other revenue	**2,536**	**1,075**

* Unearned revenue represents revenue received in advance for services yet to be delivered at year end.

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

	2012 $'000	2011 $'000
28 Asset revaluation surplus by class		
Land		
Balance at the beginning of the financial year	688,229	688,175
Revaluation increment/(decrement)	(26,074)	227
Asset revaluation prior year	-	67
Impairment losses through equity*	(57)	(240)
Balance at the end of the financial year	**662,098**	**688,229**
Buildings		
Balance at the beginning of the financial year	403,576	465,741
Revaluation increment/(decrement)	(54,551)	(52,241)
Asset revaluation prior year	-	(3,894)
Impairment losses through equity**	(66,662)	(6,030)
Balance at the end of the financial year	**282,363**	**403,576**
Balance at the end of the financial year	**944,461**	**1,091,805**

The asset revaluation surplus represents the net effect of revaluation movements in assets.

* The land impairment loss of $0.06 million recognised in 2011-12 (2010-11: $0.2 million) related to unusable land leases. The impairment loss recognised in 2010-11 related to 15 land parcels previously held at market value that were identified as being held by traditional owners through a Deed of Grant in Trust.

** The building impairment loss of $66.662 million recognised in 2011-12 (2010-11: $6.030 million) predominantly related to buildings with shorter than expected useful lives located on the site of health facility redevelopments. The majority of the buildings impaired have been demolished as at reporting date.

29 Reconciliation of operating surplus to net cash flows from operating activities		
Operating result from continuing operations	42,336	2,285
Non-cash items:		
Depreciation expense	354,577	323,746
Amortisation expense	17,369	14,144
Assets written off/scrapped	(327)	520
Contributed assets and other non-cash donations	(7,303)	(25,982)
Loss on sale of property, plant and equipment	6,074	5,374
Gain on sale of property, plant and equipment	(3,419)	(871)
Share of profits in associates	(28,596)	(26,236)
Other non-cash supplies	6,035	6,963
Other non-cash items	937	1,733
Changes in assets and liabilities:		
Increase in departmental services revenue payable	67,559	-
Increase in departmental services revenue receivable	-	30,213
(Increase)/decrease in trade and payroll receivables	(72,102)	(106,131)
(Increase)/decrease in GST input tax credits receivable	3,734	(2,695)
(Increase)/decrease in LSL reimbursement receivable	(4,934)	(2,260)
(Increase)/decrease in annual leave reimbursement receivables	(14,676)	(20,439)
(Increase)/decrease in inventories	(8,283)	(1,616)
(Increase)/decrease in recurrent prepayments	(22,184)	(4,296)
Increase/(decrease) in unearned revenue	1,467	(1,957)
(Increase)/decrease in accrued salaries and wages	76,363	47,585
Increase/(decrease) in annual leave payable	1,173	1,364
Increase/(decrease) in payables	21,800	43,811
Increase/(decrease) in annual leave levy payable	(9,303)	(33,143)
Increase/(decrease) in LSL levy payable	1,380	7,738
(Increase)/decrease in other receivables	(399)	-
Net cash generated by operating activities	**429,278**	**259,850**

30 Non-cash financing and investing activities

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

31 Commitments for expenditure

(a) Non-cancellable operating leases

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

	2012 $'000	2011 $'000
Not later than one year	73,180	60,384
Later than one year and not later than five years	155,549	147,814
Later than five years	28,318	29,984
	257,047	**238,182**

Queensland Health has non-cancellable operating leases relating predominantly to office and residential accommodation and office equipment. 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) Expenditure and other commitments

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

Capital works*	3,224,555	2,484,331
Supplies	28,408	28,119
Repairs and maintenance	40,744	45,701
Employment	4,420	469
Other	68,994	54,361
	3,367,121	**2,612,981**
Not later than one year	1,269,558	1,233,278
Later than one year and not later than five years	2,097,563	1,373,469
Later than five years	-	6,234
	3,367,121	**2,612,981**

* Includes capital expenditure for the development of three new tertiary hospitals and continuing redevelopment and refurbishment of existing hospitals and health care facilities. Capital projects are delivered under a partnering agreement between Queensland Health and the Department of Public Works, Project Services Division. These projects have been approved by the Cabinet Budget Review Committee and have been included as commitments for the total project amounts. Each of these projects is currently at a different stage of the contractual cycle. The contracted commitments for the approved projects are $11.591 million.

(c) Grants and other contributions

Grants and contribution commitments inclusive of anticipated GST, committed to at reporting date, but not recognised in the accounts are payable as follows:

Not later than one year	167,064	186,831
Later than one year and not later than five years	45,841	106,549
	212,905	**293,380**

Grant and other contribution commitments include Queensland Health's contribution to the Translational Research Institute Facility. Refer Notes 2(c) and 33.

32 Contingencies

(a) Guarantees and undertakings

As at 30 June 2012, Queensland Health held the following guarantees and undertakings from third parties. These amounts have not been recognised as assets in the financial statements.

	2012 $'000	2011 $'000
Guarantees	2,192	2,192
Undertakings	11,453	10,912
	13,645	**13,104**

(b) Litigation in progress

	2011 cases	Increase cases	Decrease cases	2012 cases
Cases have been filed with the courts as follows:				
Supreme Court	**21**	-	4	**17**
District Court	**5**	6	-	**11**
Magistrates Court	**1**	1	-	**2**
Tribunals, commissions and boards	**158**	-	81	**77**
	185	**7**	**85**	**107**

	2010 cases	Increase cases	Decrease cases	2011 cases
Supreme Court	**3**	18	-	**21**
District Court	**1**	4	-	**5**
Magistrates Court	**1**	-	-	**1**
Tribunals, commissions and boards	**151**	7	-	**158**
	156	**29**	**-**	**185**

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). Queensland Health's liability in this area is limited to an excess per insurance event. Refer Note 2(w). Queensland Health's legal advisers and management believe it would be misleading to estimate the final amounts payable (if any) in respect of the litigation before the courts at this time.

The introduction of the *Personal Injuries Proceedings Act 2002* has resulted in fewer cases appearing before the courts. These matters are usually resolved at the pre-proceedings stage.

From 1 July 2010, the management of all Queensland Health indemnified claims have been managed by QGIF. As at 30 June 2012 there were 377 (362 as at 30 June 2011) claims managed by QGIF, some of which may never be litigated or result in payments to claims. The maximum exposure to Queensland Health under this policy is up to $20,000 for each insurable event.

The special claims management process ("the special process") established by Government in 2005 to expeditiously resolve claims as a result of healthcare treatment provided by Dr Patel has continued. The key features of the special process are an acceptance of liability by the State, payment of the cost of medical assessment, a contribution to the claimants' legal fees and payment of the cost of mediation (if required). These features are a significant departure from the prevailing legislative scheme. As at 30 June 2012 and 30 June 2011, 387 special process claims had been received with three of these claims remaining unresolved. Claims which remain outstanding are included in the above table.

(c) Native Title

The Queensland Government Native Title Work Procedures were designed to ensure that native title issues are considered in all of Queensland Health's land and natural resource management activities.

All dealings pertaining to land held by or on behalf of Queensland Health must take native title into account before proceeding. These dealings include disposal, acquisition, development, redevelopment, clearing, fencing and the granting of leases, licences or permits and so on. Dealings may proceed on department owned land where native title continues to exist, provided native title holders or claimants receive the necessary procedural rights.

In accordance with State Government Land Policies, when native title over a particular holding has been cleared, Queensland Health is required to convert the tenure to freehold ownership.

32 Contingencies (continued)

Queensland Health has completed 55.01% of native title assessments of department land holdings and 83.44% have now been converted to freehold tenure.

With the assistance of Crown Law, Queensland Health is currently negotiating with a number of *Indigenous Land Use Agreements* (ILUA) with native title holders. These ILUAs will provide trustee leases to validate the tenure of current and future facilities.

The National Title Tribunal reported a total of 16 native title claims in 2011-12 (2010-11: 8 claims).

(d) Other contingencies

The following liabilities are contingent upon future Government and management decisions and cannot be estimated with reasonable certainty at balance date.

Costs to rectify payroll system

Measures will continue to be undertaken to resolve outstanding issues and stabilise the Queensland Health payroll system (refer Note 3).

eHealth

The objective of the eHealth program is to provide integrated and accurate clinical information to support safe, timely and high quality care with the key component an integrated electronic medical record (ieMR). The rollout of these programs is likely to require additional ICT infrastructure and necessitate implementation costs.

Property maintenance backlog

This represents the total cost of repairs, maintenance and assets due for replacement, with these activities to occur over future years. The total liability due to be incurred in the next 12 months is contingent on an assessment of maintenance requirements and priorities.

33 Associated entities

Translational Research Institute Pty Ltd

The Translational Research Institute Pty Ltd (the Company) was registered as an Australian proprietary company, limited by shares, on 12 June 2009. Queensland Health is one of four founding shareholders, each holding 25 shares at $1 per share in the Company. The Company does not trade and its sole purpose is to act as trustee of the Translational Research Institute Trust (TRI Trust). There were no transactions recorded in this entity in the period 1 July 2011 to 30 June 2012. As the Company is a non-trading entity, it has not prepared financial statements for the financial year ended 30 June 2012. Refer Notes 2(c), 20 and 31(c).

Translational Research Institute Trust

The Translational Research Institute Trust (TRI Trust) was created as a Discretionary Unit Trust on 16 June 2009. Queensland Health is one of four founding members, each holding 25 units in the TRI Trust and equal voting rights. The objectives of the TRI Trust are to:

(i) design, construct and maintain the Translational Research Institute Facility (TRI Facility); and

(ii) operate and manage the TRI Facility to promote medical study, research and education.

The Trust's annual reporting period is on a calendar year basis. Audited financial statements were prepared for the financial year ending 31 December 2011. A set of Board endorsed Management Accounts were prepared for the period 1 January 2012 to 30 June 2012. Refer Notes 2(c), 20 and 31(c).

34 Restricted assets

Queensland Health receives cash contributions primarily from private practice clinicians and from external entities to provide for education, study and research in clinical areas. Contributions are also received from benefactors in the form of gifts, donations and bequests for stipulated purposes. At 30 June 2012, amounts of $85.993 million (2010-11: $72.640 million) in General Trust and $9.046 million (2010-11: $8.846 million) for Clinical Drug Trials are set aside for the specified purposes underlying the contribution.

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

35 Fiduciary trust transactions and balances

Queensland Health 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.

	2012 $'000	2011 $'000
Fiduciary trust receipts and payments		
Receipts		
Patient trust receipts	34,368	32,920
Total receipts	**34,368**	**32,920**
Payments		
Patient trust related payments	34,078	32,916
Total payments	**34,078**	**32,916**
Increase/(decrease) in net patient trust assets	290	4
Increase/(decrease) in net refundable deposits	(25)	12
Fiduciary trust assets		
Current assets		
Cash		
Patient trust deposits	5,003	4,713
Other refundable deposits	98	123
Total current assets	**5,101**	**4,836**

36 Arrangements for the provision of public infrastructure by other entities

Public Private Partnership (PPP) arrangements operating for all or part of the financial year are as follows. Refer Note 2(o).

Note that all of the following are Build-Own-Operate-Transfer (BOOT) arrangements.

Facility	Health Service District	Counterparty	Term of Agreement	Commencement Date
Butterfield Street Car Park	Metro North	International Parking Group Pty Limited	25 years	January 1998
Bramston Terrace Car Park	Children's Health Services	International Parking Group Pty Limited	25 years	November 1998
The Prince Charles Hospital Car Park	Metro North	International Parking Group Pty Limited	22 years	November 2000
The Prince Charles Hospital Early Education Centre	Metro North	Queensland Child Care Services Pty Ltd	20 years	April 2007
Noosa Hospital and Specialist Centre	Sunshine Coast Wide Bay	Ramsay Health Care	20 years	September 1999
Townsville Hospital Support Facilities Building and Walkway	Townsville	Trilogy Funds Management Ltd	25 years	April 2002
Childcare Centre	Townsville	Trilogy Funds Management Ltd	25 years	September 2004
The Princess Alexandra Hospital Multi Storey Car Park	Metro South	International Parking Group Pty Limited	25 years	February 2008

36 Arrangements for the provision of public infrastructure by other entities (continued)

Assets and liabilities

The land where the facilities have been constructed is recognised as departmental land, subject to an operating lease. Queensland Health has not recognised any rights or obligations relating to these facilities other than those associated with land rental and the provision of services under the agreements.

	2012 $'000	2011 $'000
Accrued expenses		
Current	2,155	2,050
Unearned revenue		
Current	71	62

Revenues and expenses
Revenues and expenses recognised in relation to these arrangements:

User charges	451	438
Grants and other contributions	25,020	24,475

Butterfield Street Car Park

A $2.5 million up-front payment for rental of land on which the car park has been built was received at the commencement of car park operations in January 1998. This amount is being recognised over the term of the agreement. Rent of $0.3 million per annum is also received from the car park operator up to January 2019 increasing to $0.6 million for the remainder of the lease period. Queensland Health staff are entitled to concessional rates when using the car park.

Bramston Terrace Car Park

A $1.32 million upfront payment for rent of land on which the car park has been built was received on commencement of car park operations in November 1998. This amount was fully recognised in the year of receipt. Rent of $1 is paid each year over the term of the agreement and Queensland Health staff are entitled to concessional rates when using the car park.

The Prince Charles Hospital Car Park

A $1.0 million up-front payment for rental of land on which the car park has been built was received at the commencement of car park operations in November 2000. This amount is being recognised over the term of the agreement. Rent of $0.05 million per annum is also received from the car park operator. Under the agreement, Queensland Health staff are entitled to concessional rates when using the car park.

The Prince Charles Hospital Early Education Centre

The developer constructed a 150 place early education centre in April 2007 on site at the hospital. The developer operates and maintains the facility at its sole cost and risk. Under the agreement staff on site are given priority access to child care. Rent of $0.07 million per annum is charged for the land and is adjusted for CPI annually.

Noosa Hospital and Specialist Centre

This agreement has been structured to transfer substantially all the risks associated with the operation of public hospital to a private sector entity. The Noosa Hospital and Specialist Centre commenced operations in September 1999. Under this arrangement, Queensland Health funds the operators for the provision of services to public patients. The level of services and the amount paid is subject to annual review. A capital recovery charge is paid to the operator as part of the service agreements for the purpose of maintaining public infrastructure. An estimate of the value of the assets to be transferred on completion of the agreements has not yet been determined. The operator is not permitted to charge any fees to public patients other than those normally charged for a service in a public hospital.

Townsville Support Facilities Building, Walkway and Childcare Centre

Under this arrangement, a support facilities building and childcare centre have been constructed on the department's land with a walkway linking the support facilities building to the Townsville Hospital. This facility has been in operation since April 2002. Annual rent of $0.035 million is charged for the land, varying with tenant turnover figures and adjusted for CPI annually.

The Princess Alexandra Hospital Multi Storey Car Park

The developer has constructed a 1,403 space multi storey car park on site at the hospital. Rent of $0.295 million per annum escalated for CPI annually will be received from the car park operator up to February 2033. The developer operates and maintains the facility at its sole cost and risk. Queensland Health staff are entitled to concessional rates when using the car park.

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

36 Arrangements for the provision of public infrastructure by other entities (continued)

PPP arrangements with Queensland Health cash flows (indicative)

	The Prince Charles Hospital Early Education Centre $'000	Noosa Hospital & specialist Centre $'000	Townsville Support Facilities $'000	The Princess Alexandra Hospital multi storey car park $'000	Total $'000
Inflows					
Up to 1 year	83	-	48	334	465
More than 1 year but less than 5 years	358	-	206	1,438	2,002
More than 5 years but less than 10 years	511	-	294	2,054	2,859
Later than 10 years	593	-	283	5,141	6,017
Outflows					
Not later than 1 year	-	(29,252)	-	-	(29,252)
Later than 1 year but not later than 5 years	-	(127,611)	-	-	(127,611)
Later than 5 years but not later than 10 years	-	(107,917)	-	-	(107,917)
Net indicative cash flow	**1,545**	**(264,780)**	**831**	**8,967**	**(253,437)**

The indicative cash flows are prepared by applying an uplift factor for inflation to the notional cash flows, which are based on the underlying contracts with third parties.

37 Collocation arrangements

Collocation arrangements operating for all or part of the financial year are as follows. Refer Note 2(p).

Facility	Health Service District	Counterparty	Term of Agreement	Commencement Date
Caboolture Private Hospital	Metro North	Affinity Health Ltd	25 years	September 1997
Redlands Private Hospital	Metro South	Sister of Mercy	25 years	August 1999
Holy Spirit Northside Private Hospital	Metro North	The Holy Spirit Northside Private Hospital Limited	25 years	July 2001

38 Financial instruments

(a) Categorisation of financial instruments
Queensland Health has the following categories of financial assets and financial liabilities:

	2012 $'000	2011 $'000
Financial assets		
Cash and cash equivalents	(64,741)	(30,188)
Loans and receivables	657,798	558,047
Held-to-maturity investment fixed rate deposit	20,000	20,000
	613,057	547,859
Financial liabilities		
Measured at amortised cost Payables	429,001	407,033
	429,001	**407,033**

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

38 Financial instruments (continued)

(b) Financial risk management

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

Financial risk is managed in accordance with Queensland Government and departmental policies. Queensland Health's policies provide written principles for overall risk management and aim to minimise potential adverse effects of risk events on the financial performance of the department.

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

(c) Credit risk exposure

Credit risk is the potential for financial loss arising from a counterparty defaulting on its obligations. The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any allowance for impairment. The carrying amount of receivables represents the maximum exposure to credit risk. As such, receivables are not included in the disclosure below. Refer Note 2(t) and Note 17 for further information.

Credit risk is considered minimal given all Queensland Health deposits are held by the State through Queensland Treasury Corporation.

Maximum exposure to credit risk

	2012 $'000	2011 $'000
Cash	(64,741)	(30,188)
Fixed rate deposits	20,000	20,000
	(44,741)	**(10,188)**

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

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

Financial assets past due but not impaired 2011-12

	Overdue $'000				
	Less than 30 days	30-60 days	61-90 days	More than 90 days	Total
2011-12					
Loans and receivables	601,449	14,165	5,854	36,329	657,797
2010-11					
Loans and receivables	511,560	10,065	14,514	21,908	558,047

Individually impaired financial assets 2011-12

	Overdue $'000				
	Less than 30 days	30-60 days	61-90 days	More than 90 days	Total
2011-12					
Loans and receivables	1,427	928	2,657	53,525	59,076
2010-11					
Loans and receivables	18,043	767	1,427	13,290	33,527

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

38 Financial instruments (continued)

(d) Liquidity risk

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

Queensland Health is exposed to liquidity risk through its trading in the normal course of business. The department aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times. Queensland Health has an approved debt facility of $500 million under Whole-of-Government banking arrangements to manage any short term cash shortfalls.

(e) 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. Queensland Health has interest rate exposure on the 24 hour call deposits and there is no interest rate exposure on its cash and fixed rate deposits. Queensland Health does not undertake any hedging in relation to interest rate risk. Changes in interest rate have a minimal effect on the operating result of the department.

.

(f) Interest rate sensitivity analysis

Liquidity and interest rate risk 2011-12

	Maturity date					
	1 year or less	1 to 5 years	More than 5 years	Non-interest bearing	Total	Weighted average rate
	$'000	$'000	$'000	$'000	$'000	%
Financial assets						
Cash	-	-	-	(146,876)	(146,876)	
24 hour call deposits	82,135	-	-	-	82,135	3.95
Loans and receivables	-	-	-	657,798	657,798	
Fixed rate deposits	20,000	-	-		20,000	4.28
	102,135	**-**	**-**	**510,922**	**613,057**	
Financial liabilities						
Payables	**-**	**-**	**-**	**496,560**	**496,560**	

Liquidity and interest rate risk 2010-11

	Maturity date					
	1 year or less	1 to 5 years	More than 5 years	Non-interest bearing	Total	Weighted average rate
	$'000	$'000	$'000	$'000	$'000	%
Financial assets						
Cash	-	-	-	(100,654)	(100,654)	
24 hour call deposits	70,466	-	-	-	70,466	5.34
Loans and receivables	-	-	-	558,047	558,047	
Fixed rate deposits	20,000	-	-		20,000	5.03
	90,466	**-**	**-**	**457,393**	**547,859**	
Financial liabilities						
Payables	-	-	-	**407,033**	**407,033**	

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

39 Key executive management personnel and remuneration

The following details for key executive management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of Queensland Health during 2011-12. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management. Effective 1 July 2012, Queensland Health's Corporate Office has undergone a significant restructure as part of its transition to the role of System Manager (refer Note 42). The positions below do not reflect the revised corporate structure. Note the function of Chief Finance Officer was carried out in 2011-12 by the Deputy Director-General, Finance, Procurement and Legal Services.

(a) Key executive management personnel

Name and position of current incumbents	Responsibilities	Contract classification and appointment authority	Appointment date
Director-General - Dr Anthony O'Connell	Responsible for the overall management of Queensland Health through major functional areas to ensure the delivery of key government objectives in improving the health and well being of all Queenslanders.	s92 Contract/CEO Governor in Council/Public Service Act 2008	23/06/2011
Deputy Director-General, Human Resource Services Division - Lyn Rowland	Responsible for providing strategic leadership in relation to all human resource functions, including industrial relations, across Queensland Health.	s24 & s28E Contract/HES 3 Chief Executive/Health Services Act 1991	07/02/2012 to 30/06/2012
Deputy Director-General, Policy Strategy and Resourcing Division - Professor Michael Cleary	Lead the development of policy, strategy and clinical workforce development to meet current and future health challenges.	s24 & s28E Contract/HES 4 Chief Executive/Health Services Act 1991	10/05/2010
Deputy Director-General, Health Planning and Infrastructure Division - Glenn Rashleigh	Provide strategic leadership and advice in the management of health infrastructure and assets throughout their lifecycle.	Relieving/higher duties arrangement/CEO 5	04/04/2012
Deputy Director-General, Performance and Accountability Division - Terry Mehan	Lead and manage the functions relating to accountability and governance across Queensland Health. Responsible for developing governance, strategic planning and performance management frameworks.	s24 & s28E Contract/HES 4 Chief Executive/Health Services Act 1991	19/11/2008
Deputy Director-General, Finance Procurement and Legal Services - Susan Middleditch	Strategic responsibility for developing, implementing, managing and monitoring the financial framework, corporate financial systems and budget administration of Queensland Health.	s24 & s28E Contract/HES 4 Chief Executive/Health Services Act 1991	14/05/2012
Chief Executive Officer, Centre for Healthcare Improvement - Jan Phillips	Lead and manage the implementation of Queensland Health's reform agenda in the areas of clinical governance, information transparency, patient access and organisational culture, ensuring optimal levels of health service delivery and patient safety.	Relieving/higher duties arrangement/CEO 5	17/10/2011

39 Key executive management personnel and remuneration (continued)

Name and position of current incumbents	Responsibilities	Contract classification and appointment authority	Appointment date
Chief Health Officer - Dr Jeannette Young	Lead and manage the development of strategic policy, regulation, legislative frameworks and programs for public health function, including, mental health, population health and health service regulation as well as the provision of advice to the Minister and government relating to emergencies such as pandemics, epidemics, or major disasters.	s24 & s28E Contract/HES 4 Chief Executive/Health Services Act 1991	8/10/2007
Chief Information Officer - Raymond Brown	Provide leadership and strategic direction for the provision of information management and information communication technology services to Queensland Health.	s24 & s28E Contract/HES 4 Chief Executive/Health Services Act 1991	2/06/2008
Chief Executive Officer, Clinical and Statewide Services - Kathleen Byrne	Responsible for managing the strategic functions relating to the Clinical and Statewide Service provided by Queensland Health, including Pathology, Medication Services, Radiology, Forensic and Scientific Services, Biomedical Technology Services and Queensland Blood Management.	s24 & s28E Contract/HES 4 Chief Executive/Health Services Act 1991	2/06/2009

The position of Deputy Director-General, Corporate Services Division has not had anyone in the position since 28 January 2012. Following a restructure, two new positions were created including:

- the position of Deputy Director-General, Human Resource Services Division created on 8 October 2011; and
- the position of Deputy Director-General, Finance Procurement and Legal Services created on 8 October 2011.

(b) Remuneration

Remuneration policy for Queensland Health's key executive management personnel is set by the Queensland Public Service Commission as provided for under the *Public Service Act 2008*. The remuneration and other terms of employment for the key executive management personnel are specified in employment contracts. For the 2011-12 year, the remuneration of key executive management personnel increased by 2.5% in accordance with government policy. Remuneration packages for key executive management personnel comprise the following components:

- Short-term employee benefits which include:
    - Base – 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 vehicle together with fringe benefits tax applicable to the benefit.
- Long term employee benefits include long service leave accrued.
- 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.
- There were no performance bonuses paid in the 2011-12 financial year.
- Total fixed remuneration is calculated on a 'total cost' basis and includes the base and non-monetary benefits, long term employee benefits and post employment benefits.

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

39 Key executive management personnel and remuneration (continued)

Total fixed remuneration is calculated on a 'total cost' basis and includes the base and non-monetary benefits, long term employment benefits and post employment benefits.

1 July 2011 – 30 June 2012

Position	Short terms benefits $'000		Long term benefits $'000	Post-employment benefits $'000	Termination benefits $'000	Total remuneration $'000
	Base	Non-monetary benefits				
Director-General - Dr Anthony O'Connell (from 23 June 2011 to present)	406	26	10	41	-	483
Deputy Director-General, Human Resource Services Division - Lyn Rowland (from 7 February 2012 to 30 June 2012)	111	-	2	12	-	125
Deputy Director-General, Human Resource Services Division - John Cairns (from 1 July 2011 to 30 March 2012)	214	5	5	25	5	254
Deputy Director-General, Policy Strategy and Resourcing Division - Professor Michael Cleary (from 10 May 2010 to present)	382	29	9	47	-	467
Deputy Director-General, Health Planning and Infrastructure Division - Glenn Rashleigh (from 4 April 2012 to present)	85	1	2	9	-	97
Deputy Director-General, Health Planning and Infrastructure Division - Johnn Glaister (from 24 January 2011 to 3 April 2012)	241	27	5	39	-	312
Deputy Director-General, Performance and Accountability Division - Terry Mehan (from 19 November 2008 to present)	355	41	9	44	-	449
Deputy Director-General, Finance Procurement and Legal Services - Susan Middleditch (from 14 May 2012 to present)	45	-	1	4	-	50

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

39 Key executive management personnel and remuneration (continued)

1 July 2011 – 30 June 2012

Position	Short terms benefits $'000		Long term benefits $'000	Post-employment benefits $'000	Termination benefits $'000	Total remuneration $'000
	Base	Non-monetary benefits				
Deputy Director-General, Finance Procurement and Legal Services - Tony Hendry (from 4 April 2012 to 30 May 2012)	24	3	1	2	-	30
Deputy Director-General, Finance Procurement and Legal Services - Neil Castles (from 24 January 2011 to 30 April 2012)	300	6	7	43	-	356
Chief Executive Officer, Centre for Healthcare Improvement - Jan Phillips (from 17 October 2011 to present)	118	11	3	11	-	143
Chief Executive Officer, Centre for Healthcare Improvement – Dr Michael Daly (from 25 July 2011to 16 October 2011)	69	1	1	30	-	101
Chief Executive Officer, Centre for Healthcare Improvement - Jason Currie (from 9 to 24 July 2011 and 11 January to 25 January 2012)	16	-	-	2	-	18
Chief Executive Officer, Centre for Healthcare Improvement- Wayne Howard (from 1 July 2011 to 7 July 2011)	7	-	1	1	-	9
Chief Health Officer - Dr Jeannette Young (from 8 October 2005 to present)	436	27	11	54	-	528
Chief Information Officer - Raymond Brown (from 2 June 2008 to present)	274	18	6	34	-	332
Chief Executive Officer, Clinical and Statewide Services - Kathleen Byrne (from 2 June 2009 to present)	275	16	7	33	-	331

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

39 Key executive management personnel and remuneration (continued)

1 July 2010 – 30 June 2011

Position	Short terms benefits $'000		Long term benefits $'000	Post-employment benefits $'000	Termination benefits $'000	Total remuneration $'000
	Base	Non-monetary benefits				
Director-General - Michael Reid (from 23 June 2008 to 22 June April 2011)	453	13	-	52	129	647
Deputy Director-General, Corporate Services Division - Michael Walsh (from 31 July 2010 to 28 January 2011)	176	2	3	17	152	350
Deputy Director-General, Corporate Services Division - Michael Kalimnios (from 12 January 2009 to 30 July 2010)	26	7	1	3	222	259
Deputy Director-General, Policy Strategy and Resourcing Division - Professor Michael Cleary (from 10 May 2010 to present)	410	14	12	32	-	468
Deputy Director-General, Health Planning and Infrastructure Division[3] - John Glaister (from 24 January 2011 to 3 April 2012)	152	3	-	16	-	171
Deputy Director-General, Health Planning and Infrastructure Division - Faileen James (from 19 April 2010 to 20 December 2010)	141	2	-	8	-	151
Deputy Director-General, Health Planning and Infrastructure Division - Michael Walsh (from 23 June 2008 to 30 July 2010)	44	-	3	2	-	49
Deputy Director-General, Performance and Accountability Division - Terry Mehan (from 19 November 2008 to present)	351	12	10	37	-	410

Queensland Health
Notes to the Financial Statements
For the year ended 30 June 2012

39 Key executive management personnel and remuneration (continued)

1 July 2010 – 30 June 2011

Position	Short terms benefits $'000		Long term benefits $'000	Post-employment benefits $'000	Termination benefits $'000	Total remuneration $'000
	Base	Non-monetary benefits				
Deputy Director-General, Human Resource Services Division - John Cairns (from 1 July 2011 to 30 March 2012)	118	1	2	12	-	133
Deputy Director-General, Finance Procurement and Legal Services - Neil Castles (from 24 January 2011 to 30 April 2012)	150	1	3	13	-	167
Chief Executive Officer, Centre for Healthcare Improvement - Dr Anthony O'Connell (from 17 August 2009 to 22 June 2011)	344	8	8	37	-	397
Chief Health Officer- Dr Jeannette Young (from 8 October 2005 to present)	482	13	19	52	-	566
Chief Information Officer - Raymond Brown (from 2 June 2008 to present)	273	3	19	52	-	347
Chief Executive Officer, Clinical and Statewide Services - Kathleen Byrne (from 2 June 2009 to present)	275	3	-	31	-	309

40 Administered transactions and balances

Administered transactions and balances are comprised primarily of Health Quality and Complaints Commission (HQCC) and Mater Hospital related transactions.

The HQCC provides assurance to the community that health care services providers in Queensland provide the highest possible standard in the quality of care.

The Mater Hospital redevelopment was completed in June 2008 with funding provided from Government borrowings managed as administered transactions. Further details on this arrangement are outlined below.

The Administered transactions and balances for 2011-12 are as follows.

	2012 $'000	2011 $'000
Administered revenues		
Administered item appropriation	25,272	25,288
Taxes, fees and fines	294	201
Total	**25,566**	**25,489**
Administered expenses		
Grants	18,746	18,212
Borrowing costs	6,527	7,076
Taxes, fees and fines	293	201
Total	**25,565**	**25,489**
Administered assets		
Current		
Cash	21	11
Receivables	9,441	8,869
Non-current		
Receivables	86,028	95,462
Total	**95,490**	**104,342**
Administered liabilities		
Current		
Payables	29	32
Other financial liabilities	9,433	8,848
Non-current		
Other financial liabilities	86,028	95,462
Total	**95,490**	**104,342**

Receivables

Receivables reflect the passing on of funds to the Mater Hospital for the redevelopment of the public hospital component. The receivable for this will be extinguished by repayment over ten years after the completion of the redevelopment by the Government.

Payables

Borrowings are provided by Queensland Treasury Corporation. The interest rate on borrowings is fixed at 6.46%. The repayment term is ten years.

The market value of the debt as notified by Queensland Treasury Corporation at 30 June 2012 was $104.009 million (2010-11: $108.927 million). This represents the value of the debt if the department repaid the debt at 30 June 2012.

An amount of $6.527 million (2010-11: $7.076 million) comprising interest on funds and administration fees from Queensland Treasury Corporation has been recognised as an expense in the reporting period

41 Reconciliation of payments from Consolidated Fund to administered revenue

	2012 $'000	2011 $'000
Budgeted appropriation	25,309	24,998
Transfers from other headings	(36)	290
Administered revenue recognised in Note 40	**25,273**	**25,288**

42 Events after the reporting period

(a) *Health reform*

On 2 August 2011, Queensland, as a member of the Council of Australian Governments signed the National Health Reform Agreement, committing to major changes in the way that health services in Australia are funded and governed. These changes are effective from 1 July 2012 and include:

- moving to a purchaser-provider model, with health service delivery to be purchased from legally independent hospital networks (statutory bodies to be known as Hospital and Health Services (HHSs) in Queensland)
- introducing national funding models and a national efficient price for services, with the majority of services to be funded on an activity unit basis into the future
- defining a refocused role for state governments in managing the health system, including:
    - the use of purchasing arrangements and other levers to drive access and clinical service improvements within and across the HHSs; and
    - a responsibility to intervene to remediate poor performance, either at the state's initiative or in response to prompting by the National Health Performance Authority, which will publicly report on performance of the HHSs and healthcare facilities.

The Health and Hospitals Network Act 2011 (HHNA), enabling the establishment of the new health service entities and the System Manager role for the health department in Queensland, was passed by the Queensland Parliament in October 2011. On 17 May 2012, the Minister for Health introduced amending legislation into the Parliament to expand the functions of HHSs under the HHNA. The amended legislation is known as *the Hospital and Health Boards Act 2012* (HHBA).

Information is also available on the Queensland Health website at: www.health.qld.gov.au/health-reform.

System Manager

Under the new arrangements, the role of Queensland Health's current corporate office will change. Corporate office will transition to the System Manager role and will purchase services from the HHSs under publicly available Service Agreements negotiated between the two entities. Service Agreements for 2012-13 have been set by the Director-General of Queensland Health under the transitional provisions in the HHBA. The System Manager will not be involved in the day-to-day functioning of health services, and will devolve responsibility for frontline service delivery to the HHSs unless there is a significant economic or similar benefit to maintaining a state-wide function.

Given the devolution of functions to the HHSs, the System Manager will have responsibility for:

- developing system-wide strategy, policy and standards.
- focusing the direction of activities of the health system in Queensland by interpreting wider public health objectives, understanding the needs of Queensland's health consumers, and setting system-wide objectives and targets in line with government policy direction.
- planning and forecasting the delivery of health services required by the Queensland population, guided by policy and strategy objectives.
- integrating workforce, infrastructure, health technology and finance needs to ensure aligned planning across the HHSs, which will deliver services under a contractual, service agreement arrangement.

42 Events after the reporting period (continued)

- acting as the purchaser and contract manager on behalf of the state managing the relationship with the National Health Funding Pool Administrator and Independent Hospital Pricing Authority.
- managing enterprise bargaining arrangements at a state-wide level, while devolving other day-to-day decisions in relation to human resource management to the HHSs, based on their performance.

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

Debit Facility

HHS bank accounts will form part of the Whole-of-Government banking arrangement with the Commonwealth Bank of Australia. Under this arrangement, HHSs will have access to the Whole-of-Government debit facility. The debit facility limits assigned to the System Manager and individual HHSs are yet to be approved by Queensland Treasury and Trade. The facility limit will reflect forecast cash flow requirements and is designed to mitigate liquidity risk.

Opening Balances

Certain balances were transferred from Queensland Health to HHSs effective 1 July 2012. This was effected via a transfer notice signed by the Minister for Health, designating that the transfer be recognised as a contribution by owners through equity. The transfer notices will be approved by the Director-General of Queensland Health and the Chairman and Chief Executive Officer of each Hospital and Health Board in coming months. Balances transferred to HHSs materially reflect the closing balances of HSDs as at 30 June 2012. These balances will become the opening balances of HHSs, and will be recorded as such in the individual financial statements of the HHSs at 30 June 2013. The cash balance transferred to individual HHSs is the amount required to ensure entities commence operations with a balanced working capital position.

42 Events after the reporting period (continued)

The following balances were transferred from Queensland Health to HHSs on 1 July 2012.

	$'000
Current assets	
Cash and cash equivalents	78,749
Loans and receivables	213,636
Inventories	72,981
Other	9,072
Total current assets	**374,438**
Non-current assets	
Intangible assets	4,598
Property, plant and equipment	5,317,405
Other	179
Total non-current assets	**5,322,182**
Total assets	**5,696,620**
Current liabilities	
Payables	294,964
Accrued employee benefits	492
Other	366
Total current liabilities	**295,822**
Non-current liabilities	
Other	300
Total non-current liabilities	**300**
Total liabilities	**296,122**
Net assets	**5,400,498**
Equity	
Contributed equity	5,400,498
Total equity	**5,400,498**

42 Events after the reporting period (continued)

(b) *Carbon pricing*

The Australian government passed the *Clean Energy Act 2011* with a start date of 1 July 2012. The legislation will result in the introduction of a price on carbon emissions produced by approximately 500 of Australia's largest emitters from 1 July 2012 with the price of permits will be fixed at $23 per tonne of carbon dioxide. The flow-on effect of these measures is expected to result in increases in operational costs for future periods.

(c) *Payroll initiatives*

Change in pay date

Most current payroll underpayments and overpayments occur because there is insufficient time to submit, approve and process many payroll forms before the pay run starts. Queensland Health will transition to a new pay period from October 2012. The change in pay date will allow payroll staff additional time to process and review pay forms, and will improve the accuracy of future staff pays. To ensure no staff member is financially disadvantaged by this change, staff will be provided with a transitional loan equal to two weeks' net pay. Staff members may opt out of this loan or repay the balance early. Alternatively, loans will be recovered automatically when staff members leave Queensland Health. Changing the pay date was a key recommendation from the recent independent review of the payroll system undertaken by KPMG. Refer Notes 3 and 17.

Auto-recovery of payroll overpayments

Queensland Health has moved to reinstate procedures to enable the auto-recovery of future overpayments. Overpayments recovery was a feature of the previous payroll system decommissioned in 2010. This reinstated function will not be used to recover any of the existing overpayments, but only those that occur after the auto-recovery system is implemented.

Other improvements

From September 2012, the former practice of accepting retrospective pay claims up to six years old will cease, replaced instead with a three month cut-off. This provision mirrors current practice elsewhere in the public and private sector and is expected to reduce the number of variations processed each pay run. Changes have also been made to pay slips to assist employees in understanding their pay data.

Queensland Health

Management Certificate

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

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

(b) the statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of the Department of Health for the financial year ended 30 June 2012 and of the financial position of the department at the end of that year.

Susan Middleditch
Deputy Director-General
System Support Services

28 / 9 / 12

Dr Tony O'Connell
Director-General

28 / 9 / 12

INDEPENDENT AUDITOR'S REPORT

To the Accountable Officer of Queensland Health

Report on the Financial Report

I have audited the accompanying financial report of Queensland Health, which comprises the statement of comprehensive income, the statement of financial position as at 30 June 2012, statement of changes in equity, statement of cash flows, statement of assets and liabilities by major departmental services and SSP, and statement of comprehensive income by major departmental services and SSP for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the certificates given by the Director-General and the Deputy Director-General, System Support Services.

The Accountable Officer's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

Independence

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

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

Opinion

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

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

(b) in my opinion -

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

(ii) the financial report presents a true and fair view, in accordance with the prescribed accounting standards, of the transactions of Queensland Health for the financial year 1 July 2011 to 30 June 2012 and of the financial position as at the end of that year.

Other Matters - Electronic Presentation of the Audited Financial Report

This auditor's report relates to the financial report of Queensland Health for the year ended 30 June 2012. Where the financial report is included on Queensland Health's website the Accountable Officer is responsible for the integrity of Queensland Health's website and I have not been engaged to report on the integrity of Queensland Health's website. The auditor's report refers only to the subject matter described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements or otherwise included with the financial report. If users of the financial report are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial report to confirm the information contained in this website version of the financial report.

These matters also relate to the presentation of the audited financial report in other electronic media including CD Rom.

A M GREAVES FCA FCPA
Auditor-General of Queensland

Queensland Audit Office
Brisbane