Darling Downs Hospital and Health Service

2012–13 **Annual Report**

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Queensland Government

Darling Downs Hospital and Health Service
Annual Report 2012-13

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Interpreter Service Statement

Darling Downs Hospital and Health Service 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) 4699 8412 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 2012-13 and financial statements for Darling Downs Hospital and Health Service.

I certify that this Annual Report complies with:

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

A checklist outlining the annual reporting requirements can be found on page 48 of this annual report or accessed at http://www.health.qld.gov.au/darlingdowns/pdf/ddhhs-annualreport-2013.pdf.

Yours sincerely

Mr Mike Horan AM
Chair
Darling Downs Hospital and Health Board

09/09/2013

Our vision

To be trusted to deliver excellence in rural and regional healthcare.

Our purpose

Delivering quality healthcare in partnership with our communities.

Our strategic directions

We have four key strategic directions, which will help us to achieve our vision:

- Deliver quality healthcare
- Ensure resources are sustainable
- Ensure processes are clear
- Ensure dedicated trained staff

Our values

Our values guide how we work and support us to achieve our goals. They are:

- **Caring** – We deliver care, we care for each other and we care about the service we provide.
- **Doing the right thing** – We respect the people we serve and try our best. We treat each other respectfully and we respect the law and standards.
- **Openness to learning and change** – We continually review practice and the services we provide.
- **Being safe, effective and efficient** – We will measure and own our performance and use this information to inform ways to improve our services. We will manage public resources effectively, efficiently and economically.
- **Being open and transparent** – We work for the public and we will inform and consult with our patients, clients, staff, stakeholders and community.

Acknowledgement of Traditional Owners

Darling Downs Hospital and Health Service respectfully acknowledges the traditional owners of the land on which its sites stand.

Contents

Welcome

Darling Downs Hospital and Health Service provides a comprehensive range of high-quality acute, sub-acute, palliative care, mental health, drug and alcohol, oral health, residential care, and community health services for the people and communities of our area. We deliver clinical services to approximately 300,000 people from 26 locations.

Our services are located across 90,000 square kilometres to the west of Brisbane. We deliver services from the New South Wales border south of Stanthorpe to west of Goondiwindi, Taroom in the north, and east to Murgon, including the major regional centre of Toowoomba. We are the largest employer in the Darling Downs, employing more than 4,700 people, and manage a budget of more than $570 million annually.

Manner of establishment

On 1 July 2012, in accordance with the National Health Reform Agreement and Queensland's *Hospital and Health Boards Act 2011*, the former Darling Downs Health Service District became the Darling Downs Hospital and Health Service (DDHHS).

The DDHHS is an independent statutory body, overseen by a local hospital and health Board (the Board), which reports to the Minister for Health, the Honourable Lawrence Springborg MP. The functions of the Board of directors are outlined in *the Act* and include establishing, maintaining and monitoring the performance of systems to ensure the health service meets community needs.

Our role

Geographically, we cover 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 DDHHS provides public hospital and healthcare services as defined in the service agreement with the Department of Health as the manager of the public hospital system.

Our services

The DDHHS provides a comprehensive range of hospital services, as well as community and primary health services including: aged care assessment, Aboriginal and Torres Strait Islander health programs, child and maternal health services, alcohol and other drug services, home care services, community health, sexual health service, allied health services, oral health, and public health programs.

DDHHS operates an integrated mental health service which provides specialist services across the following clinical programs:

- Child and youth inpatient and community services
- Adult acute inpatient and community services
- Older people's inpatient and community services
- Extended mental health inpatient services for consumers who require extended treatment and rehabilitation, extended secure treatment, have an acquired brain injury, dual diagnosis involving mental illness and intellectual disability, or are older people requiring extended treatment.

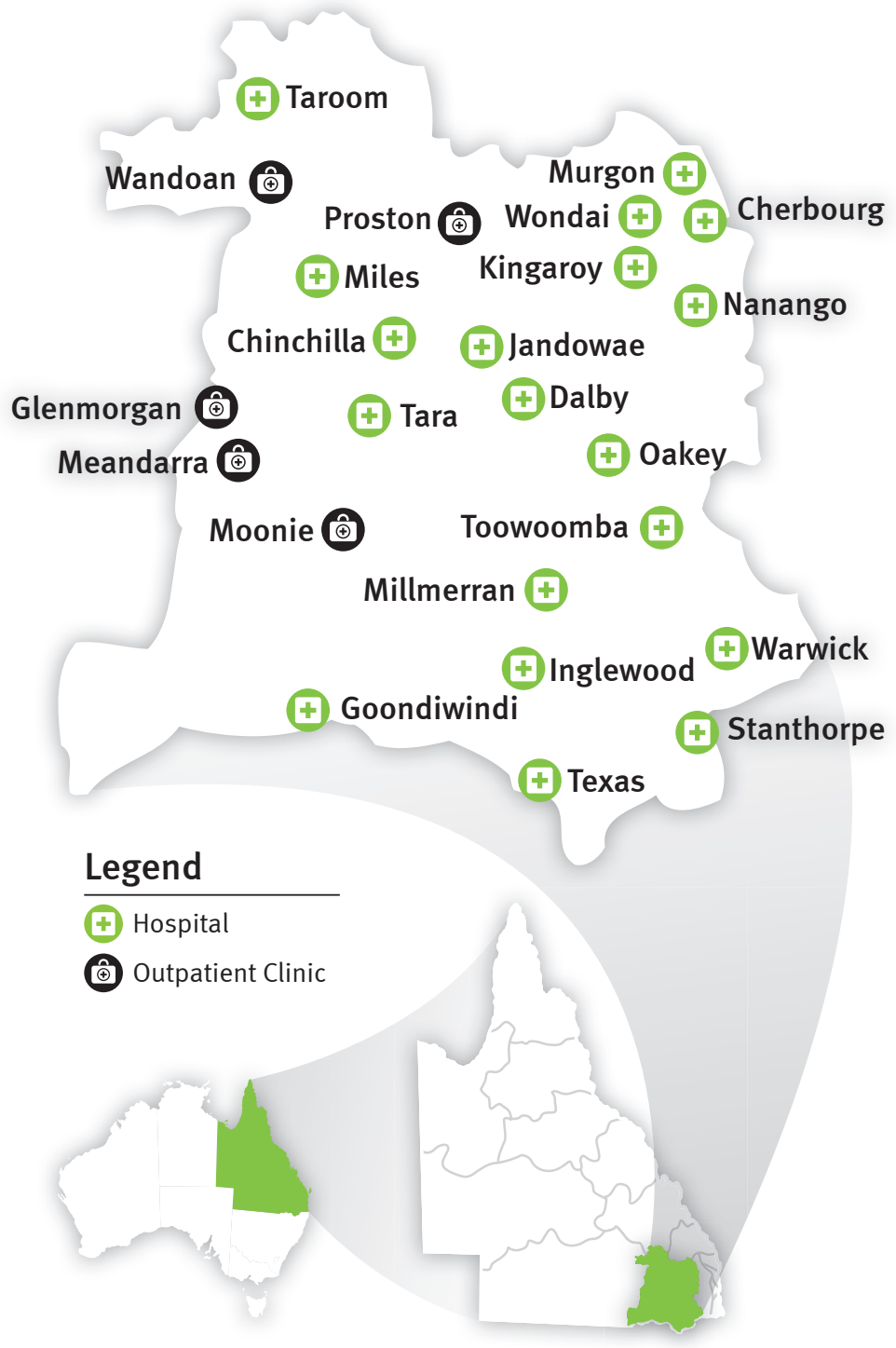
These services are provided from Toowoomba Hospital, Baillie Henderson Hospital and a range of rural community centres.

DDHHS operates six residential aged care services located at Dalby - Karingal Nursing Home , Miles - Milton House, Toowoomba - Mt Lofty Heights, Oakey - Dr EAF McDonald Nursing Home, Warwick - The Oaks Nursing Home and Wondai - Forest View Aged Care Facility.

The majority of the residents in our region receive public hospital inpatient care at our facilities, either at their local hospital or at Toowoomba Hospital. Patients are at times required to travel to Brisbane to access some types of specialist services only offered at tertiary facilities.

Our sites

The Darling Downs Hospital and Health Board is responsible for the oversight of the facilities within the DDHHS's geographical boundaries which includes the regional hospital in Toowoomba, district hospitals in Kingaroy, Dalby, Warwick, and rural hospitals, residential aged care, multipurpose health services, community and primary care facilities:



Board Chair

Message from the Board Chair

It is with great pleasure that, on behalf of the Board, I present the first annual report for the Darling Downs Hospital and Health Service (DDHHS) as an independent statutory authority. While we have many successes to celebrate, we will continue to have many challenges to deliver contemporary health services across such a large region.

I am very pleased that the Minister has chosen to appoint a Board that is truly representative of the diverse region we serve, with members from the South Burnett, Southern Downs, Toowoomba, and the Western Downs, as well as a nursing representative.

I pay tribute to the diligence and professionalism of each of the Board members who have worked hard to represent their local areas and the health service as a whole. I firmly believe the community engagement we've been able to do as a Board and individually in our local areas has provided a robust base for our decision making over the past year.

As well as its regular monthly meetings of the Board and its committees, the Board undertook two strategic planning meetings during the year. These meetings established the priorities of the service based on our combined local knowledge and community engagement.

> **"As a Board we appreciate the amazing talents and levels of human kindness that our staff provide in such a range of circumstances."**

I thank Ms Danielle Causer who resigned from the Board due to her spouse's work commitments in another part of Queensland, for her contribution. In her place, we welcomed Ms Trish Leddington-Hill from Chinchilla. Ms Megan O'Shannessy was appointed to provide nursing experience around the Board table.

The Board acts in a governing capacity and all management is undertaken by the executive and staff of the service. On behalf of the Board, I sincerely thank Chief Executive Dr Peter Bristow for the caring expertise he has brought to the position. Under his leadership and the commitment of all our staff, the DDHHS has continued to provide quality service to our patients and communities.

All major activity that we are contracted to do under a service agreement with the Department of Health has been achieved. In addition, the service has made considerable savings which are able to be delivered as a community dividend to fund additional elective surgery, endoscopy and capital improvements to a number of our hospitals.

Some specific achievements included:

- we are achieving the National Emergency Access Target (NEAT) set for Queensland
- we are well on the way to meeting the National Elective Surgery Target (NEST)
- the new Regional Cancer Centre became operational
- we opened the new Adolescent Mental Health Unit.

For these outstanding results I thank Dr Peter Bristow and all our staff.

As a Board we appreciate the amazing talents and levels of human kindness that our staff provide in such a range of circumstances.

We look forward with confidence to the challenges of the future, particularly improving elective surgery, outpatient and dental waiting lists, embarking on a large repairs and maintenance program, and providing an enhanced staff training and development program.

Mr Mike Horan AM
Chair
Darling Downs Hospital and Health Board

Chief Executive

Message from the Chief Executive

This is the first annual report of the Darling Downs Hospital and Health Service recording the activities and work of the service since its establishment as a statutory body in July 2012.

I believe the most important attribute of the service is its care. Our staff live in the communities of the Darling Downs and deliver great care across our many facilities, professionally providing healthcare services with heart, compassion and respect. This year has presented new challenges, and I thank our staff for all their work and their professionalism in adapting to change and performing their duties for the public.

It goes without saying that delivering healthcare to the communities of the Darling Downs needs to be done in a sustainable way. To achieve this, we have re-examined our processes to ensure we are delivering these services in ways that provide the best value to taxpayers.

One key tenet of the DDHHS is that care should be delivered safely and be of high quality. During 2012-13, the independent Australian Council on Healthcare Standards re-accredited the Toowoomba Hospital, Mental Health Service and our rural hospitals for the next four years.

Our engagement with communities and clinicians to ensure we are meeting local needs has been an important part of the service's activities. The Board has brought new abilities to listen to our communities and their concerns. We have also developed new methods to ensure clinicians can provide feedback on, and understand, issues affecting the service.

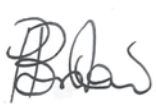
Capital works achievements of the year included the opening of the new Regional Cancer Centre at Toowoomba Hospital. With capital costs funded by the Australian Government, this 24-bed ward provides much-improved amenity for cancer and palliative care patients. The Yannanda Adolescent Mental Health Unit allows teenagers to be treated in a dedicated ward with access to onsite schooling. The new Community Health building in Cherbourg allows local staff to work more closely with the hospital team to tackle the serious chronic disease challenges facing Aboriginal people.

The re-establishment of generalist surgical services in Kingaroy in February was a significant highlight. As a result, in 2012-13 elective surgical procedures performed equalled the total done in Kingaroy for the previous two years. In elective surgery at Toowoomba Hospital, by 30 June 2013 there were no patients waiting longer than the recommended time who had been booked for urgent (category 1) or semi-urgent (category 2) surgery. Most impressively, for the six months to 30 June, 77 per cent of patients attending the emergency department at Toowoomba Hospital were either admitted, transferred, or discharged within four hours of their arrival. All this work is a credit to the staff involved.

The Board intends to build on this work by re-investing the surplus achieved in 2012-13 to benefit the people who need our care as community dividends. Already the Board has announced:

- a $1.1 million refurbishment of the Stanthorpe Hospital maternity area
- $200,000 for refurbishments at Goondiwindi Hospital for a palliative care area in the main ward
- the funding of 200 extra endoscopies which have been done
- and up to $3 million extra for Toowoomba Hospital to ensure that by 31 December 2013 no patients booked for routine (category 3) surgery wait in excess of the recommended time of one year.

I thank the Board for its support, but most especially the staff for their work during the year. Coming from a clinical background to the role of Chief Executive, I believe 2012-13 was a successful year and I have a strong sense of optimism and hope for the future.



Dr Peter Bristow FRACP FCICM FRACMA GCM GAICD
Chief Executive
Darling Downs Hospital and Health Service

Strategic directions

The *Darling Downs Hospital and Health Service Strategic Plan 2012-16* set a new direction for the delivery of health care to Darling Downs communities. The Darling Downs Hospital and Health Board's vision is to be trusted to deliver excellence in rural and regional healthcare. The strategic plan identifies the key strategies to achieve this goal, and the organisational values that will underpin its success.

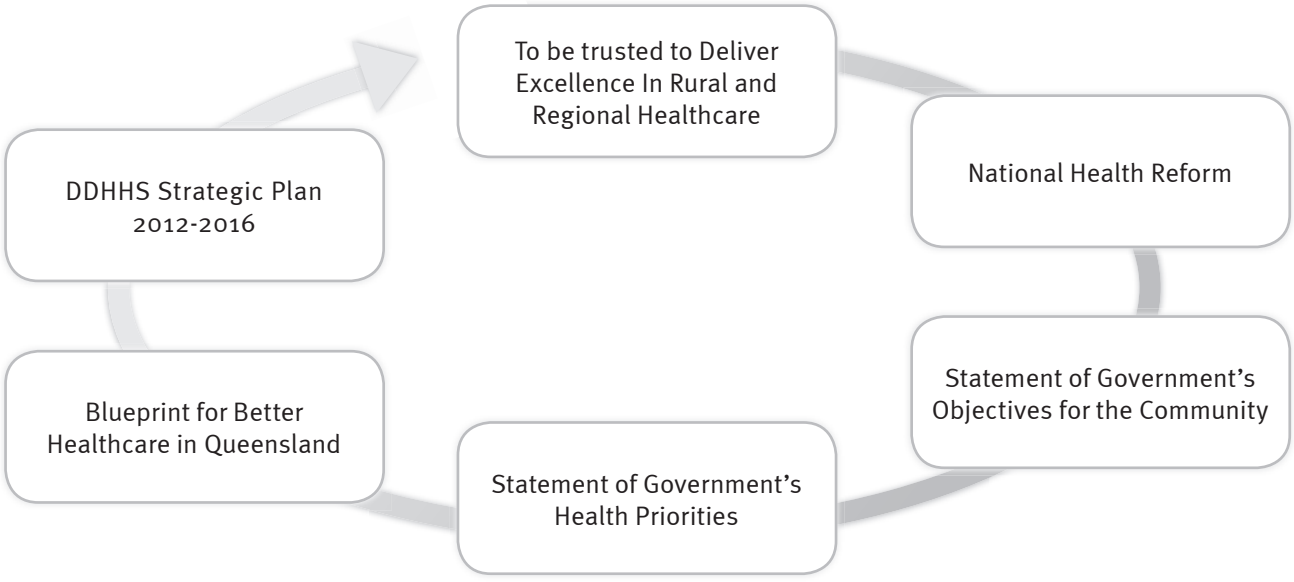
The plan outlines four strategic directions:

- Deliver quality healthcare (delivering core health services; improving access to services; reducing the impact of chronic disease; ensuring safe and quality health outcomes and increasing confidence in health systems);
- Ensure resources are sustainable (balanced operating position; ensuring appropriate costs; maximising revenue; leveraging other providers and optimising asset usage);
- Ensure processes are clear (collaboration with primary health care and other service providers; deliver more care locally; effective operational planning; review and improve care; increase use of clinical evidence-based decision making and engage the community and health care consumers);
- Ensure dedicated trained staff (embed a values based culture; develop, educate and train; plan, recruit and retain an appropriately skilled workforce; engage clinicians to improve the service).

Our strategic plan supports the commitments outlined in the Queensland Government's "Getting Queensland Back on Track – statement of objectives for the community" and is aligned with National Health Reform, Statement of Government Health priorities, and the Blueprint for better healthcare in Queensland.

During 2012-13 the DDHHS has had a strong focus on:

- Providing better access to health services
- Providing more care locally
- Supporting Government commitments to revitalise frontline services for families and deliver better infrastructure
- Enhancing engagement and developing closer working relationships with patients, families, community groups, GPs and other primary health providers.



Year at a glance

Surgeries performed 7,040	**Community health attendances** 35,420
Separations (discharges) 60,837	**Xray and ultrasound attendances** 112,554
Bed days 263,773	**Mental health consultations** 240,416
Same day admissions 25,804	**Adult dental treatments** 23,619
Emergency department presentations 145,073	**Child/school-based dental treatments** 21,676
Babies born 3,108	**Breastscreens** 17,682
Number of outpatient attendances 181,504	**Pharmacy items dispensed** 45,270

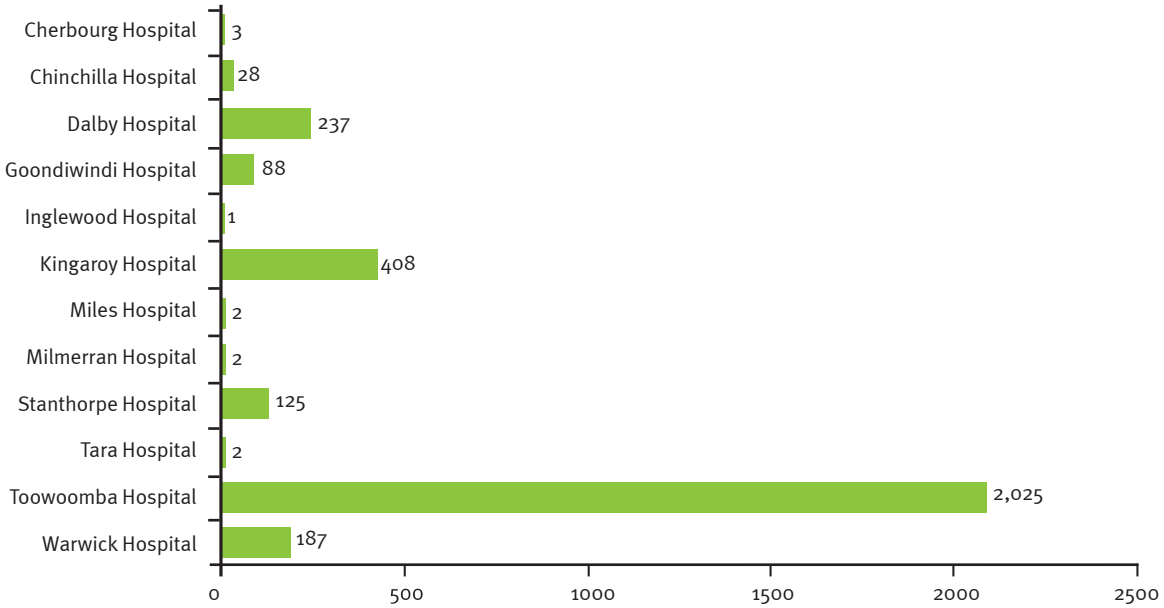
Our performance in delivering healthcare

Providing better access to health services

Thanks to the dedication of staff and a realignment of priorities, the DDHHS has made significant inroads to achieving a higher level of service in number of key areas. Highlights included:

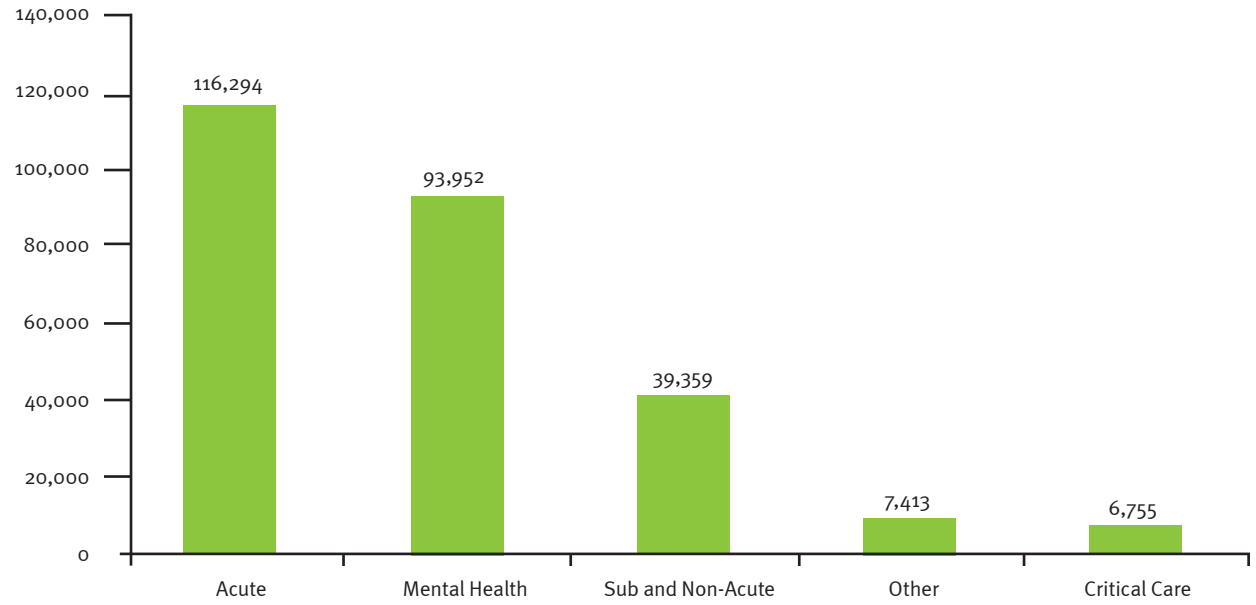
- Targets were exceeded for all categories of patients to be seen in our emergency departments within recommended timeframes.
- National Emergency Access Target (NEAT) performance at Toowoomba Hospital for this calendar year is 77.6 per cent meeting the target of 77 per cent to be discharged, transferred, or admitted from the ED within four hours.
- 17,682 breastscreens were delivered in 2012-13 compared with 16,962 in the previous year.
- 186,040 Oral Health Weighted Occasions of Service (WOOS) were delivered compared to 167,752 in 2011-12.
- Endoscopy volume increased from 2,249 to 2,470 cases. A further 273 were outsourced as a result of the community dividend announced by the Board.
- As at the end of June 2013 there were no patients waiting longer than clinically recommended timeframes for category one (surgery in 30 days) and category two (surgery in 90 days) at Toowoomba Hospital. The DDHHS hopes to have no one waiting longer than the clinically recommended timeframes for surgery, (including routine category three cases) by 31 December 2013.
- Telehealth consultations increased to 1,531 up from 943 in the previous year.
- 67.8 per cent of clients discharged from the acute mental health in-patient unit were followed up within seven days of discharge, exceeding the target of 55 per cent.

Total births by facility, 1 July 2012 – 30 June 2013*



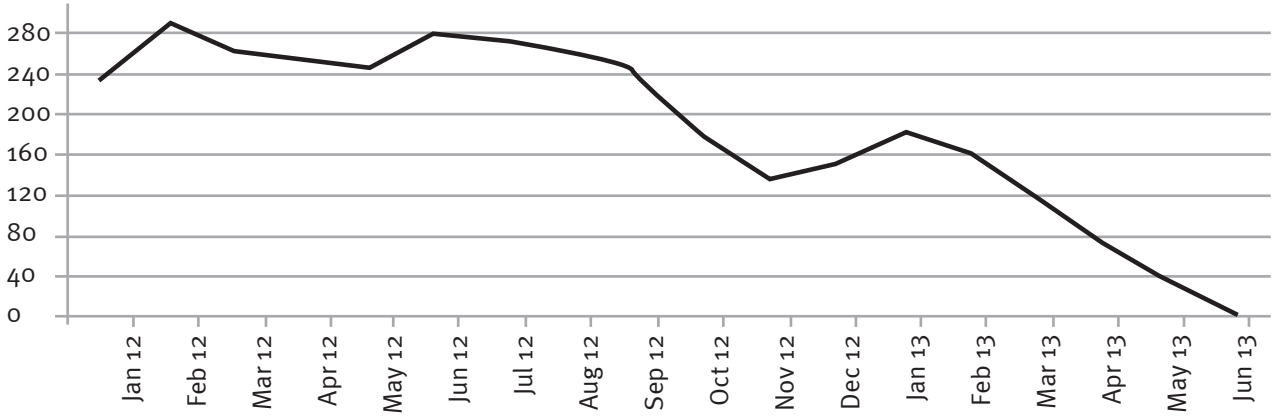
*Kingaroy Hospital is one of the busiest non-specialist birthing services in the state, with 408 births for 2012-13.

Occupied beds days – DDHHS wide*



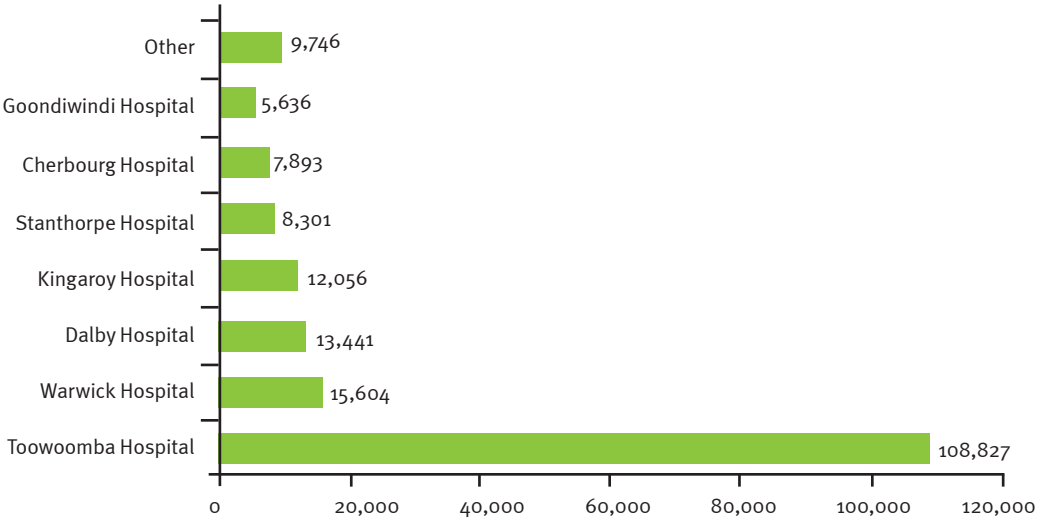
*Number of bed days used to provide various categories of care.

Elective surgery category 2 - long waits (target 0)*

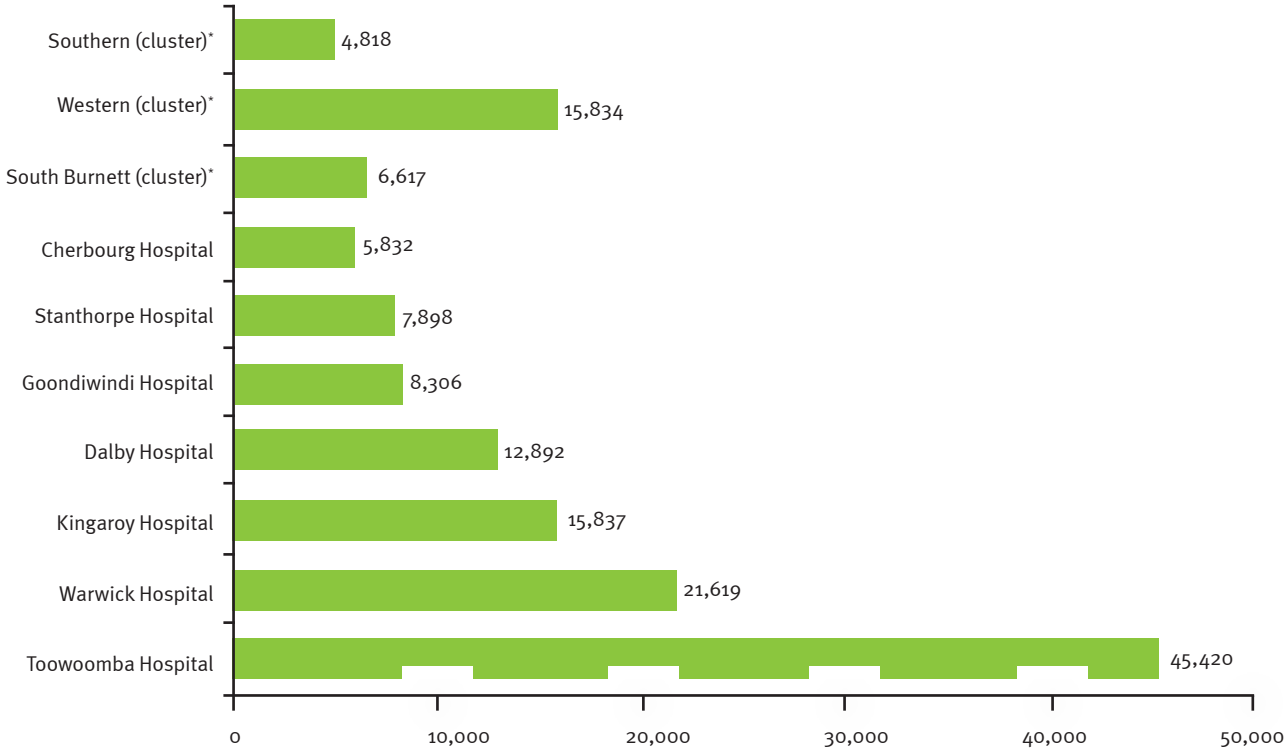


*Number of people waiting longer than the recommended time of 90 days from booking for operation to procedure performed for semi-urgent (Category Two) elective surgery.

Outpatients department attendance by facility



Emergency department attendances – DDHHS wide



* Southern cluster includes Inglewood, Millmerran, and Texas; Western cluster includes Chinchilla, Jandowae, Miles, Oakey, Tara, Taroom, and Wandoan; South Burnett cluster includes Murgon, Nanango, and Wondai.

With the support and efforts of our staff, there has been a significant improvement in our overall performance providing safe and reliable care, waiting times for emergency care, elective surgery, and in our financial position.

Photo by Sonia Wood

The Horizon and Macro NEAT teams focused on clinical service redesign to improve emergency access times at Toowoomba Hospital. The Macro NEAT Project team, left to right: Ann Fullerton (Project Admin Officer), Lisa Hillis (Project Officer), Dr Luke Gaffney (Director of Medicine), Christopher Hombsch (Project Officer).

Delivering more care locally

This year the DDHHS has had a strong focus on providing more care locally to improve service the communities of the Darling Downs. Achievements have included:

- Officially opening the Regional Cancer Centre at Toowoomba Hospital in July 2012. This 24-bed unit was complemented with the expansion of the Oncology Day Therapy Unit by four places. There were 998 admissions plus 11,416 non-admitted occasions of service, including chemotherapy, other oncology treatments/consultations, and palliative care.
- Opening the Adolescent Mental Health Unit 'Yannanda' in August 2012 has meant 222 young people have been able to access inpatient treatment in Toowoomba. Previously they would have been transferred to Brisbane. The service has partnered with Education Queensland to provide schooling on-site by qualified teachers to assist our young people to maintain their education while receiving treatment.
- Sub-acute services have been enhanced with the recruitment of a staff specialist geriatrician and the provision of geriatric outpatient clinics, stroke service, falls clinic and chronic disease clinics.
- Restarting general surgical services at Kingaroy Hospital has meant 96 elective surgical procedures were performed locally - equal to the total number of procedures in the two previous years.
- Six more patients will be able to access renal dialysis three times a week in Kingaroy thanks to the transfer of dialysis places from Toowoomba. This will increase Kingaroy's capacity from 12 to 18 places as chronic kidney disease is a major health risk in the South Burnett.
- Toowoomba Hospital introduced an innovative new service called a 23-hour ward. It is an extended stay unit for those patients who are recovering from specific kinds of surgery who may not feel well enough to go home when they wake from surgery but are ready to leave after a night of care and observation. They are then discharged in the morning, usually after a 23-hour stay.

Supporting government commitments to revitalise frontline services for families and deliver better infrastructure

In line with delivering better care locally, a number of infrastructure and service improvements were achieved during the year. Highlights included:

- The Cherbourg Community Health Service relocated to a newly renovated building located on the Cherbourg Hospital campus. The Community Health building was officially opened in August 2012. The building was named after Ms Christine Stewart, a local community member in recognition of 37 years with Queensland public health services and the significant contribution she made to the health and wellbeing of the local indigenous community.
- Griffith University teaching and student accommodation facilities were opened in Stanthorpe, Kingaroy and Warwick on health service land.
- The Inglewood Dental Facility - MacIntyre Dental Practice was opened in May 2013. This service represents an innovative solution to the long-standing problem of finding and keeping dental health professionals for rural and remote communities. Engagement with private dentists will go a long way towards reducing the waiting lists for dental treatment and building a better oral health service for the Southern Downs.
- The Southern Downs Mental Health Service at Warwick Hospital has improved clinic and office space as a result of a $120,000 donation from the Warwick Returned Services League (RSL). The refurbished facility was officially opened in May 2013.
- At Chinchilla Hospital $900,000 of works have been completed, including the upgrade of the staff accommodation, hospital roadway repairs, and replacement of floor coverings in outpatient areas.
- Looking forward, $1.1 million funding was announced in May 2013 for the refurbishment of maternity services at Stanthorpe and $200,000 for the refurbishment of the palliative care suite at Goondiwindi Hospital.
- In the Western Downs construction of the Wandoan Primary Healthcare Centre is nearing completion in partnership with Xstrata Coal, and will be a great boost to health care in this town.
- In Dalby the Community Health Centre is being rebuilt after a fire at a cost of approximately $850,000.

Enhancing engagement and developing closer working relationships with patients, families, community groups, GPs and other primary health providers

The establishment of the Darling Downs Hospital and Health Service (DDHHS) as a statutory authority has provided more opportunity for engagement with local stakeholders to ensure our services are relevant and meet the top priorities for patients and communities.

The DDHHS has many established engagement processes through hospital auxiliaries, support groups, community meetings, volunteer involvement, advisory networks and partnerships with non-government organisations.

Specific groups have been and will continue to be established to ensure a high degree of consumer and community engagement in planning new services, capital works and models of care. Planning started this year to undertake the inaugural Health Service Plan for 2013-23. The purpose of the plan is to provide the strategic service directions to inform future delivery of public health services.

The plan will support delivery of safe and sustainable health services which are in line with state and commonwealth strategic decisions and are responsive to changing patterns of need. The DDHHS has commissioned Price Waterhouse Coopers to research and develop the plan in consultation with staff and community members and organisations. Formal consultation will start in August 2013.

Engagement activities in 2013-13 have included:

- The DDHHS Board held every second monthly meeting in a regional location so Board members could see first hand the work of the local health facilities, meet staff, and engage with local community stakeholders.
- The Board has also met formally with stakeholders at each Board meeting as well as through one-on-one meetings with members of parliament, regional councils, health interest groups and universities. Full details can be viewed on page 37.
- A protocol was developed between the DDHHS and Darling Downs-South West Queensland Medicare Local, an Australian Government body that was established to coordinate primary health care delivery, tackle local health needs and fill identified service delivery gaps. The purpose of this protocol is to promote the cooperation between the DDHHS and Medicare Local in the planning and delivery of services. Key areas for collaboration and development of optimal patient care outcomes include: health service integration, the protection and promotion of public health, health service planning and design, and local clinical governance arrangements.
- Three clinical leaders' forums were held throughout the year, providing a valuable professional development and feedback platform for senior clinical staff.
- Four Toowoomba Hospital staff forums were held since they were re-established in December 2012. The purpose of the staff forums is to provide staff with regular updates regarding the performance of the hospital and the health service against the service agreement key performance indicators. It is also a vehicle to communicate significant information relevant to staff. Staff are also given an opportunity to ask questions directly of the Executive Director Toowoomba Hospital.
- Each local health facility was encouraged to facilitate input from the local community through consultative committees or other avenues. Examples included engagement with a mothers' group in Stanthorpe to plan the refurbishment of the local maternity service.
- Mental health consumer advisory groups are now operating in Toowoomba, Dalby, Warwick and Kingaroy. These groups provide valuable insight and advice to the service in relation to carer concerns and issues. Two significant outcomes have been the development of a carer information and support pack containing relevant information collated by the carer group and the establishment of a formal part-time Carer Consultant position within the service. The consumers of the service received additional input and support from our Consumer Companions and Peer Support workers who work directly with our in-patients.
- The DDHHS encourages consumer feedback about the services they receive. During 2012-13 compliments accounted for 51 per cent of all feedback (1,524 occasions), with 49 per cent (1,287 occasions) complaints received. Fifty-six per cent of complaints were able to be resolved at the time they were raised and 82 per cent within 35 days, which is above the benchmark target of 80 per cent.

Service Delivery Statements - 2012-13 Performance Statement

Darling Downs Hospital and Health Service - Service Standards	Notes*	2012-13 Target	2012-13 Est Actual	2012-13 Actual
Percentage of patients attending emergency departments seen within recommended timeframes				
Category 1 (within 2 minutes)		100%	100%	100%
Category 2 (within 10 minutes)		80%	93%	93%
Category 3 (within 30 minutes)		75%	77%	77%
Category 4 (within 60 minutes)		70%	74%	74%
Category 5 (within 120 minutes)		70%	85%	85%
All categories	1		77%	77%
Percentage of emergency department attendances who depart within four hours of their arrival in the department	2	74%	70%	73%
Median wait time for treatment in emergency departments (minutes)		20	21	20
Median wait time for elective surgery (days)		25	28	27
Percentage of elective surgery patients treated within clinically recommended times:				
Category 1 (30 days)		95%	90%	93%
Category 2 (90 days)		84%	51%	57%
Category 3 (365 days)	3	93%	78%	76%
Percentage of specialist outpatients waiting within clinically recommended timeframes:				
Category 1 (within 30 days)		New measure	64%	65%
Category 2 (within 90 days)		New measure	20%	19%
Category 3 (within 365 days)	4	New measure	46%	47%
Total weighted activity units:				
Acute Inpatients		37,303	39,558	39,874
Outpatients		7,036	7,137	6,810
Sub acute		6,145	5,311	5,116
Emergency Department		13,199	13,701	13,827
Mental Health		14,912	21,811	20,817
Interventions and Procedures	5, 6, 7	4,755	4,025	4,571
Average cost per weighted activity unit for Activity Based Funding facilities		New measure	$4,398	$4,308
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	8	New measure	0.9	0.9
Number of in-home visits, families with newborns	9, 10	New measure	2,646	2,324
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit		55%	67.2%	67.8%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge		10% - 14%	14.3%	15%
Ambulatory mental health service contact duration	11, 12	New measure	49,189	58,769

* Please refer to p14 for further details

Notes for Service Delivery Statement - 2012-13 Performance Statement :

1. A target is not included as there is no national benchmark for all triage categories, however the service standard has been included (without a target) as it is a nationally recognised standard measure.
2. 2012-13 finance year target is the average of calendar-year targets for 2012 (70 per cent) and 2013 (77 per cent).
3. DDHHS allocated a community dividend of up to $3 million to undertake additional category 2 and category 3 elective surgery commencing in May 2013.
4. There is no nationally agreed target for these measures. Targets are based on maintenance of 2012-13 estimated actual performance for categories 1 and 2, and on the target set by the *Blueprint for better healthcare in Queensland* of 90% for category 3. 2012-13 estimated actual is based on preliminary data as at 1 May 2013.
5. The existing 'Total weighted activity units' (WAUs) measure has been amended to reflect the continued refinement of the Activity Based Funding (ABF) model and implementation of the national ABF model. WAUs relating to Interventions and Procedures have been added; these include services which may be delivered in inpatient or outpatient settings, for example chemotherapy, dialysis and endoscopies.
6. The 2012-13 Target/Est. has been amended to reflect Phase 16 ABF model WAUs to enable comparison with 2012-13 Est. Actuals
7. The significant variance between the 2012-13 Target/Est. and 2012-13 Est. Actual Mental Health WAUs relates to fluctuations in recorded activity at the tertiary mental health facility Baillie Henderson Hospital based on separations and does not represent real growth in service levels.
8. Staphylococcus aureus are bacteria commonly found on around 30% of people's skin and noses and often cause no adverse effects. Infections with this organism can be serious, particularly so when they infect the bloodstream. The data reported for this service standard are for bloodstream infections with Staphylococcus aureus (including MRSA) and are reported as a rate of infection per 10,000 patient days aggregated to DDHHS level.
9. The 2012-13 Est. Actual is based on preliminary data sets using comparable data collections from the previous four years and an increase in home visiting numbers with the implementation of the Queensland Government 'Mums and Bubs' election commitment.
10. Hospital and Health Services started implementation of this initiative from January 2013 with data collection commencing April 2013. The 2012-13 Actual is based on an average half year data informed by the preliminary data set from the previous four years and by doubling the reported quater data from April - June2013.
11. The previous measure 'Number of ambulatory service contacts (mental health)' has been amended to 'Ambulatory mental health service contact duration', which is considered a more robust measure of services delivered.
12. Targets have been set based on methodologies utilised in other jurisdictions. This more clearly articulates performance expectations based on state and national investment in the provision of community mental health services. Due to issues associated with the capture of data there may be under reporting of current activity, however improvements in reporting practices are expected in 2013-14

Celebrating our staff achievements

Supporting our staff

The DDHHS provides quality healthcare that is delivered by a range of highly committed and professional people. DDHHS acknowledges that the commitment and accomplishments of our staff are an integral part of the organisation's culture and contribute to creating a positive work environment.

In early 2013, 1321 DDHHS employees were recognised for between five and 55 years of service (in five-year increments) in presentation ceremonies held across the organisation. Throughout this year many staff have been awarded and acknowledged for their professional achievements.

Years of Service	Number Awarded
55	1
50	1
45	4
40	19
35	56
30	55
25	99
20	158
15	184
10	211
5	533

In a display of the high calibre of staff who work for the DDHHS, Toowoomba Hospital midwife Katy Fitzgibbon was named Queensland Midwife of the Year at the Australian College of Midwives statewide awards in Brisbane in May. Ms Fitzgibbon has been a midwife for nearly 40 years and she has been at the forefront of maternity care at Toowoomba Hospital for most of those years.

Toowoomba Hospital Indigenous maternity service Boomagam Caring was named a finalist in the "addressing inequalities in midwifery care" category as part of the statewide awards.

Cherbourg Aboriginal Health Worker Dallas Robinson was awarded the Aboriginal and Torres Strait Islander Student of the Year Award in 2012 at the Queensland Training awards, Darling Downs South West region.

The award was as a result of Ms Robinson's studies in Certificate III in Aboriginal and Torres Strait Islander Primary Health Care. The Cherbourg Health Service staff and the whole of the organisation were proud of Ms Robinson's achievements and appreciate her commitment to delivery of health services to her clients.

Dr Sheree Conroy and Ms Kate Jurd from Medical Education were joint winners of the 2012 National Clinical Educator of the Year award for their unique approach and commitment to junior doctor training at Toowoomba Hospital. The prestigious award was presented to Dr Conroy and Ms Jurd in Perth by the Confederation of Postgraduate Medical Education Councils (CPMEC).

Dr Conroy and Ms Jurd initiated a number of innovative ideas including:

- eOrientation for Interns - online mandatory training and intern orientation resources
- eLectures – Registered Medical Officers (RMO) weekly education sessions recorded and available online
- Online Department Orientation
- online stress reduction program/mindfulness training
- mobile learning initiative - learning packages/ clinical guidelines developed and delivered via mobile device to support point of care learning

They also created very practical face-to-face programs such as the intern orientation case presentation (case-based workshop) and interprofessional learning workshops (simulation scenarios with doctors and nurses). The Toowoomba Hospital executive were congratulated on providing a supportive working environment for the award recipients.

In early 2013 Toowoomba Hospital Renal Unit Nurse Unit Manager Josie Skewes, Stanthorpe Hospital Nurse Unit Manager Carol Batterham and Team Leader (Recovery and Resilience) Geoffrey Argus received a Queensland Government Australia Day Award.

The award recipients were nominated by their colleagues and many staff members throughout the DDHHS for their commitment and dedication to their respective roles.

In 2013-14 DDHHS will continue to encourage staff to develop innovative services and promote their hard work and achievements locally, regionally and nationally to ensure outstanding achievements are recognised.

Photo by Sonia Wood

2013 Australia Day Award recipients DDHHS, left to right: Toowoomba Hospital Renal Unit Nurse Unit Manager Josie Skewes, Team Leader (Recovery and Resilience) Geoffrey Argus, Stanthorpe Hospital Nurse Unit Manager Carol Batterham with Deputy Chair Darling Downs Hospital and Health Board Dr Dennis Campbell.

Our organisation

The establishment of Darling Downs Hospital and Health Service as an independent statutory body has been a major change in how we run the business of delivering healthcare services to local communities.

Among the first tasks, while continuing to operate day-to-day services, was to implement frameworks and governance processes to ensure the hospital and health service meets its obligations under *the Act*.

In its establishment year, the health service has worked to ensure effective financial control frameworks, systems, processes and practices are also in place. This included introducing an internal audit function to help ensure the service's financial and operational controls are operating in an efficient, effective and ethical way, as well as improving business performance. A strategic risk and assurance framework was also developed to record risks to the hospital and health service, as well as what controls can, or have been implemented.

A major difference to how the health service has operated previously is the introduction of Activity Based Funding (ABF). An important part of this evolution was to set up mechanisms to monitor clinical activity, manage performance and support decision making, as well as producing accurate, timely and focused data and reports to assist the operational management and strategic positioning of the health service.

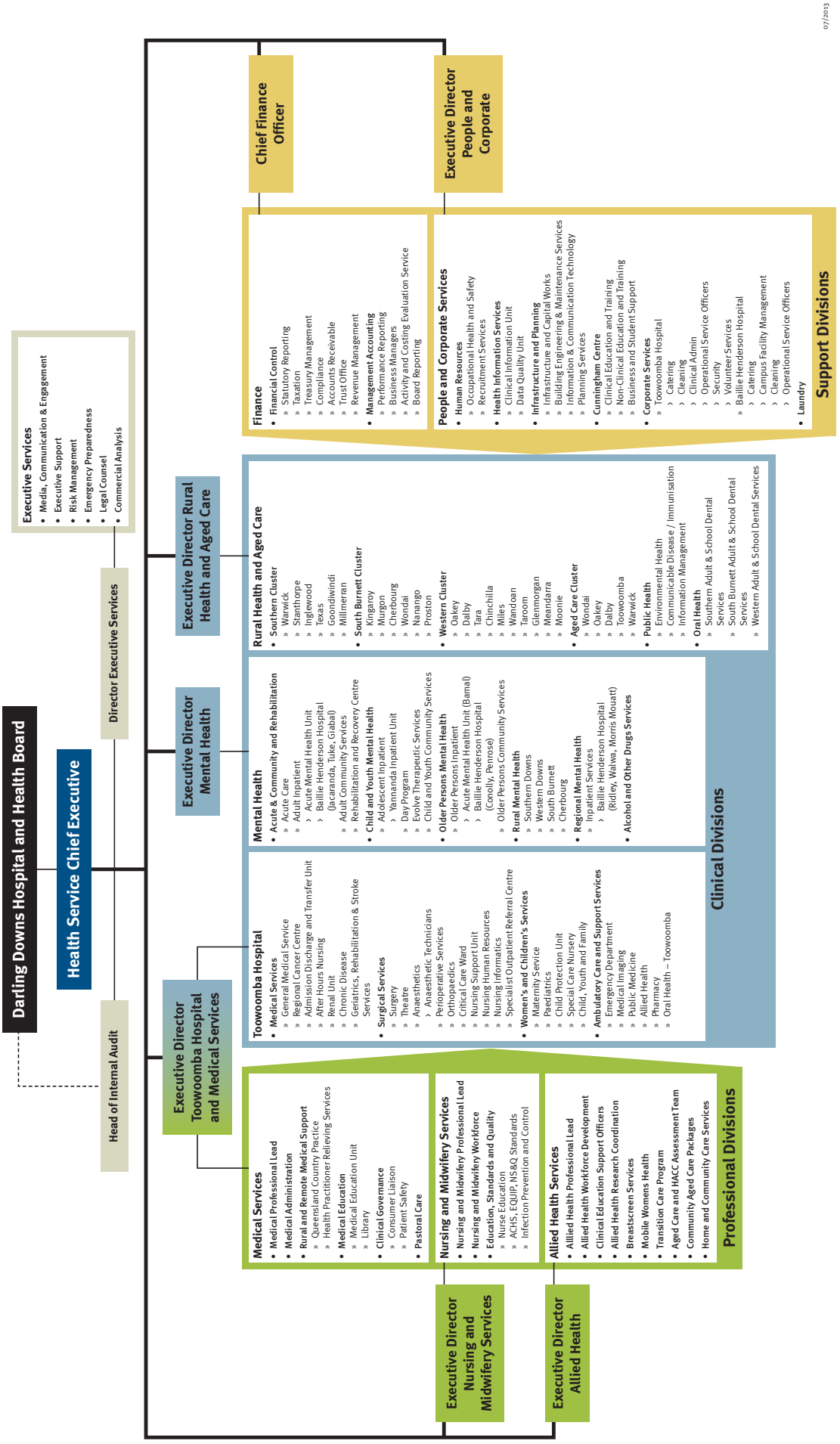
Throughout 2012-13 the DDHHS has undertaken a process for cascading the key performance metrics from the service agreement with the Department of Health throughout the organisation and formally embedding accountability mechanisms, performance measurement and performance management.

The executive is focused on performance and accountability and have used a balanced scorecard approach to ensure key performance indicators in the executive performance agreements are directly linked to the DDHHS's key strategies and goals.

Our organisational structure assists the DDHHS to meet its responsibilities in delivering health services to our communities.

Specifically, the organisational structure is a mechanism within the overall governance framework to ensure the DDHHS is functionally and structurally aligned to achieve our objectives.

DDHHS - Structure of Services and Functions 2013



Our divisions

The Darling Downs Hospital and Health Service operates under a divisional structure. The following reports highlight their main activities and achievements.

Toowoomba Hospital and Medical Services

Toowoomba Hospital and Medical Services Division is committed to achieving the strategic initiatives of the Darling Downs Hospital and Health Service. The division attained many key deliverables in 2012-13 in a challenging fiscal environment, with a focus on flexible and efficient service delivery.

Toowoomba Hospital made excellent progress against the National Emergency Access Target (NEAT). We achieved each progressive target and this is due to the hard work, innovation and positive approach of our staff in the emergency department and throughout the hospital. Horizon and macro NEAT clinical redesign projects were completed and contributed to Toowoomba Hospital becoming a leader in patient flow management.

The challenging targets for National Elective Surgery Target (NEST) were actively pursued in 2012-13. Significant accomplishments to reduce long waits included:

- Zero long wait category one's achieved and maintained since March 2013.
- Zero long wait category two's achieved in June 2013.

The Scalpel Clinical Process Redesign Project started in May 2013 and aims to review and redesign processes in the surgical service that are obstacles to achieving NEST targets. The current goal is to have noone waiting longer than the clinically recommended timeframe for routine (category 3) surgery by 31 December 2013.

In May 2013 the Toowoomba Hospital was restructured to create four distinct service groups. This ensured a flatter management structure, each with a single accountable service manager reporting operationally to the Executive Director Toowoomba Hospital and Medical Services.

Aboriginal and Torres Strait Islander closing the gap targets were addressed through the Toowoomba Hospital indigenous maternity service Boomagam Caring. Boomagam Caring was named a finalist in the "addressing inequalities in midwifery care" category of the Australian College of Midwives statewide awards.

Other key achievements for Toowoomba Hospital and Medical Services include:

- Enhanced sub acute service with the recruitment of a staff specialist geriatrician. Excellent results were achieved in the Stroke thrombolysis program for Toowoomba Hospital between September 2012 and May 2013.
- Increased cancer care services with the recruitment of two staff specialist haematologists and two additional staff specialist oncologists.
- The 23-Hour Extended Stay Unit started in April 2013 and is functioning well.

In October 2012 the Toowoomba Hospital received the findings of the Coroner's Inquest into a death in 2009. The DDHHS was accountable for implementation for two of the recommendations and these have been completed.

Rural and Remote Medical Support

The Rural and Remote Medical Support (RRMS) team transitioned from the Department of Health to the Darling Downs Hospital and Health Service during this year. The DDHHS was chosen because of its large number of rural facilities and history of support for the rural generalist medical training program.

The functions of this office are to provide support and strategic advice about rural medical services to all hospital and health services across Queensland; and to provide augmented workforce relieving services to rural and remote facilities. The team is often simply referred to as Queensland Country Practice (QCP).

To deliver excellence in rural and regional healthcare we need to have enough sufficiently skilled and supported practitioners to provide care. QCP is a mechanism by which we can ensure those practitioners have some advice, support and relief.

The role of QCP has been expanded to increase the range of services available this year and has delivered:

- Rural Generalist strategic planning and workforce advice to hospital and health services across the State;
- 30 senior doctors available to relieve country doctors, covering 173 weeks of leave this year throughout rural Queensland;
- 350 junior doctors rotating through country positions, providing 1,700 weeks of leave relief this year across the state;
- 42 health practitioners such as radiographers, pharmacists, physiotherapists, social workers, occupational therapists and psychologists available to provide services covering 1,100 weeks of services or relief this year in rural areas;
- 14 x-ray operator training courses, training 73 new x-ray operators to enable x-rays to be taken in small towns throughout rural Queensland;
- the management of the Queensland Health Bonded Medical Scholarship Scheme which will provide 229 doctors into communities in areas of need, of which 65 are still at university.

Rural Health and Aged Care Division

The Division of Rural Health and Aged Care operates 18 hospitals, of which three are multi-purpose health services, six residential aged care facilities (Farr Home at Kingaroy closed in 2013), and five outpatient clinics.

During the past year the Rural Health and Aged Care Division provided:

- 99,649 emergency department occasions of service
- 69,444 admitted patient bed days
- 72,677 outpatient department occasions of service
- 48,612 community-based occasions of service

The division has undergone significant changes in structure and scope of responsibility during 2012-13. This included taking responsibility for DDHHS oral health services and public health services for DDHHS and the South West Hospital And Health Service, which were transferred from the Department of Health. Additionally, a discrete cluster was established within the division for aged care. A temporary aged care cluster operations manager was appointed to work with the residential aged care facilities to develop consistent standards of access, care and administrative processes across all facilities.

An Australian Council on Healthcare Standards (ACHS) alignment survey was conducted in November 2012, and the division was awarded full accreditation against the ACHS standards. All DDHHS aged care facilities are accredited under the National Aged Care Standards.

In 2009, a new residential aged care facility was built at Wondai to enhance aged care services to the South Burnett community. As part of the capital committment it was envisaged that Farr Home would eventually close.

Given the requirement for new fire safety standards in September 2014, the Board decided in December 2012 that the 12 residents should be advised that Farr Home would not operate past that date. Subsequently, residents secured alternative living arrangements, and the Farr Home Nursing Care Unit closed in 2013.

A Rural Emergency Department Information System (Rural EDIS) has been rolled out in Warwick, Kingaroy, Stanthorpe and Cherbourg. This allows staff to electronically record details of patients who present requiring emergency care and to measure timeliness of care.

This information is being used to highlight the performance of our local hospitals on the Department of Health's hospital performance website. The data available online also includes the number babies born, number of outpatient services, number of emergency patient presentations and the length of waiting times for each category.

In line with the Board's priority for providing more services locally, general surgical services were increased at Kingaroy Hospital. Planning for additional increased renal dialysis has commenced, and this change will see a total of 18 patients being dialysed in Kingaroy in the future.

The amalgamation of Dalby and Jandowae Health Services under a single management structure took effect in May. This allows for better management of beds with under-used bed days in Jandowae used for interim care patients while beds in Dalby are able to be used for patients who can be transferred back earlier from Toowoomba Hospital. This change has allowed local people to be cared for closer to home whilst recovering. This benefits not only the patients but also their families with decreased travel.

Patient Travel Subsidy Scheme - 2013 first quarter summary

Number of patients 3,847
Number of claims 4,931
Number of nights 7,289
Total reimbursement $800,295

The DDHHS enthusiatically adopted the government's improved patient travel subsidies. We organised increased training to ensure claims were processed as soon as possible. Data on the scheme's uptake was supplied to the department.

In Cherbourg the community health services have been united under a common management structure.

In January 2013 the Cherbourg Hospital received the findings of the Coroner's Inquest into a death at the hospital in 2006. There were no recommendations arising from the report following implementation of changes after 2006.

Public Health Unit

The Public Health Unit transitioned from being managed by the Department of Health to the DDHHS in 2012-13. The service has a number of work units including environmental health, communicable diseases, and immunisation management.

The unit contributed to a Department of Health report examining any possible health effects related to coal seam gas extraction. The unit and the senior managers from the Rural Health Division attended community meetings to discuss residents' concerns.

Mental Health Division

Over the year the Mental Health Community Ambulatory Service provided 240,416 occasions of service across the catchment area. On any one day, an average of 657 services are provided.

The adult acute in-patient unit had 1,209 admissions which represents 16,216 occupied bed days.

The Yannanda Adolescent Unit, which admitted its first patient in August 2012, has had 222 admissions. This represents 1,351 occupied bed days, days our young people have not been required to be in Brisbane receiving treatment, away from family, supports and networks.

Baillie Henderson Hospital has had 59,038 occupied bed days which represents 85.66 per cent occupancy.

Over the year, the Mental Health Service has performed well on a number of statewide performance indicators of note:

- 67.8 per cent of our clients discharged from an acute in-patient unit are followed up within seven days of discharge. This is well above the target of 55 per cent and the state average of 62.5 per cent.
- 93 per cent of our clients have a nominated general practitioner. This again is above the state average of 88 per cent.
- 4.3 per cent of our admitted clients required seclusion at least once during admission. This is well below the target of less than 10 per cent. This is heading in the right direction in terms of the national agenda for reduction of seclusion and restraint.

Accreditation

Following the Australian Council on Healthcare Standards (ACHS) survey in September 2012, the Mental Health Service was awarded a full four-year accreditation against both the ACHS Standards of Care and the Mental Health Service Standards.

Perinatal Service

The Mental Health Service has established a perinatal service which provides specialist assessment, brief intervention and referral, in partnership with primary care providers for women who are at risk of or experiencing moderate to severe perinatal mental health disorders. During the year, there were 249 referrals to the perinatal service.

Acute Care Team became a 24 hour service

In January 2013, the Acute Care Team, in response to mental health needs of the community, increased access for the community to specialised mental health care was provided by the implementation of a 24-hour, seven days a week service, located in and working closely with the emergency department at Toowoomba Hospital. Previously there had been an on-call registrar. This 24x7 team also provides assistance and advice to doctors and nurses in hospitals throughout the DDHHS and the south west.

Alcohol and other drugs

The former Darling Downs Alcohol Tobacco and Other Drugs service have now been amalgamated and fully integrated to become one service under the Division of Mental Health for the DDHHS. A recent whole-of-service planning day has identified several priorities for the service to address including services to emergency department, and consultations and liaison services.

Cherbourg Mental Health Services

The Mental Health and Alcohol and Others Drugs services at Cherbourg have been amalgamated and fully integrated under the division of Mental Health. The team will continue to closely work with the community and the Cherbourg Health Service, however this new structure will strenghten the clinical support and services to the community.

Allied Health Division

Allied health professions represented in the division include: occupational therapy, physiotherapy, nutrition and dietetics, speech pathology, podiatry, social work and psychology.

A number of procedures have been developed and implemented across our allied health workforce to support clinical governance and mitigate risk including allied health professional support, health professional (health practitioner) registration, credentialing and defining scope of clinical practice, recruitment of allied health professionals working in multidisciplinary teams and performance appraisal and development for allied health professionals working in multidisciplinary teams.

The allied health workforce is employed across the three clinical divisions. Within Toowoomba Hospital a total of 19,231 occasions of service were delivered by 72 FTE health practitioners in the 2012-13 year.

Clinical placements across the DDHHS were provided for 141 students which comprised 4,960 clinical placement days. Four research grants were awarded to clinical staff, and a range of research activity was continued with one randomised controlled trial in speech pathology concluding (feeding outcomes in preterm babies in the special care nursery with the introduction of an oral stimulation program).

Four health practitioner models of care projects were implemented, of which two have now been evaluated and supported to continue. The Allied Health Clinical Leader, Acute Medical role was trialled in the Medical Assessment And Planning Unit (MAPU), Toowoomba Hospital. A Randomised Controlled Trial was subsequently undertaken to assess the impact of the role on a number of metrics including length of stay, re-presentation rates and patient outcomes. Results identified that the role contributed significantly to efficient and effective management of patients admitted through MAPU.

The position of Rural Generalist Allied Health Clinical Leader, at Warwick Hospital emergency department started in trial phase in January 2013. Results documented from the evaluation identified that the role impacted positively on the department's capacity to meet its National Emergency Access Targets, the patient experience, and the timely coordination of allied health intervention.

Breastscreen and mobile women's health services

Achievements for Breastscreen services in 2012-13 included the installation of two new state-of-the-art digital mammography machines and the introduction of soft copy reading, a new mobile van to operate across sites in the Darling Downs, South West and West Moreton Hospital And Health Services, construction of a new ultrasound room, and the achievement of four years accreditation through the BreastScreen Australia Quality Improvement Program.

During 2012-13 17,682 women were screened, the highest screening number since the service began in 1992. The Mobile Women's Health Service began offering simultaneous clinics at a number of locations which enables women to have both breast and pap smear screenings carried out at the same time.

Home and Community Care (HACC) services

During 2012-13 HACC services saw the integration of the previously named Mt Lofty Community Aged Care Packages (CACPs) program with Darling Downs Home Care, and the implementation of a reporting structure which provides for single point of accountability.

The Time Recording and Client Care System (TRACCS) reporting program was introduced across our HACC services during the year. TRACCS provides a single point of data collection for activity outputs, allows for the sharing of a single client record, management of rostering, complaints and compliments, and training records.

Aged Care and HACC Assessment Team (ACHAT)

In 2012-13, 100 per cent of priority 1 clients, 99 per cent of priority 2 clients and 96 per cent of priority 3 clients were seen on time. The average timeframe for an aged care assessment was three days for acute hospital inpatients and four days for other inpatient settings such as Baillie Henderson Hospital.

Transition Care Program (TCP)

In 2012-13 TCP saw the implementation of client journey pathways for nursing, allied health and case management. Occupancy packages for Toowoomba over the year achieved 93 per cent with an average length of stay of six weeks. The program also now occupies 10 beds of a local residential aged care facility.

Nursing and Midwifery Division

The DDHHS employs more than 2,300 nurses and midwives across the three clinical divisions – Toowoomba Hospital, Mental Health and Rural and Aged Care.

Approximately 72 per cent of nurses are employed as Registered Nurses (RNs) or midwives across the service. In January 2013, the service employed 17 new graduates – first-year Registered Nurses - across all divisions.

In the South Burnett a new rotation program was introduced with the first-year RNs gaining experience in indigenous health at Cherbourg, aged care at Wondai and acute care at Kingaroy and Murgon health services.

All services provide support and facilitation to undergraduate nurses at degree and diploma level. Toowoomba Hospital has been working closely with its partner the University of Southern Queensland in developing a "Nursing Student Placement Model" to increase the number of undergraduate nursing students provided with facilitated support.

During the 2012-13 year 346 undergraduate nursing, 37 diploma and nine direct-entry midwifery students were placed across the wards and units at Toowoomba Hospital. Students were also provided support across the rural hospitals of the service.
With the establishment of the DDHHS came the opportunity for the appointment of a Nursing Director education, standards and quality. This role is undertaking a full review of the education services provided to nurses and midwives with the view to move to a more contemporary education model including an online education and training environment.

The division has implemented a nursing mandatory training resource with links to online education and in line with the National Safety and Quality Health Service Standards requirements.

A resident-focused care framework in the DDHHS residential aged care facililties in line with Aged Care Accreditation Standards has been introduced. This has supported the maintenance of compliance and re-accreditation for all aged care facilities across the organisation.

Nurses and midwives across our service have achieved further qualifications including nurse practitioner, post graduate qualifications in midwifery, graduate certificates in areas including diabetes and diploma – enrolled nurse. Nurses have also undertaken the requirements for a licenced 1B X-ray operator – to enable the radiology service to be provided in facilities without radiographers. This allows better access of services for patients who would otherwise have to travel to another facility.

Wandoan Primary Health Care underwent a change to its model of care. This change followed the retirement of the Director of Nursing who had provided services to this community for more than 30 years. The service is now provided by a Director of Nursing with Nurse Practitioner qualifications.

New Directors of Nursing have been appointed at Cherbourg and Miles health services.

People and Corporate Division

The Division of People and Corporate in DDHHS has undergone significant change in structure and scope of responsibility over the past financial year. These changes occurred in response to a growing range of accountabilities, stemming mainly from:

- the inheritance of business responsibilities previously provided by centralised Department of Health units,
- growth in legislated accountabilities and reporting requirements, and
- the requirement to redesign business models to improve efficiency and effectiveness.

A new organisational structure for the division enabled the implementation of a more integrated approach to the management of non-clinical support services. The services include human resources, infrastructure and assets, information and communications, corporate services (Toowoomba), health information services and the Cunningham Centre (a registered training organisation).

Toowoomba Corporate Services

Auxiliary services (including wards person services, bed cleaning and equipment cleaning) were reorganised. This included the implementation of a computer-based task assignment system to support the enhancement of frontline services and achievements of service targets.

Laundry services previously operated by the Health Services Support Agency (HSSA) were transitioned from the HSSA to the DDHHS. The Board's decision to operate its own laundry service has enabled the service to recognise local productivity gains that can be reinvested into the operations of the business. In the 2013-14 financial year, the DDHHS operated laundry will start providing a service to DDHHS South Burnett facilities currently served by the Group Linen Services, HSSA.

There was an improved focus on clinical administration, realising an increased conversion rate of compensable patients which improved revenue by approximately $2.7 million.

Human Resources

There was a review of the Human Resources (HR) Directorate and a new integrated organisational structure was implemented. The change included the integration of functions previously provided by the Department of Health including recruitment services, and official misconduct assessment and reporting.

The HR Directorate was integral to supporting the organisation through the government's Establishment Management Program, including the provision of advice on change management processes and staff voluntary redundancies.

Occupational Health and Safety (OHS) was integrated into the directorate. The service performs well against its peers in metrics and was listed as one of the top two HHSs in Queensland for OHS indicators, in the Department of Health, *Safety Assurance Key Indicators Report, Quarter Three (January-March 2013).*

Occupational health, safety and injury management performance for Quarter 3 (January-March 2013)	KPI target	DDHHS
Workcover absenteeism Hours lost (WorkCover hours) versus Occupied FTE (staff currently working in a position)	‹0.40	0.31
Sick leave absenteeism Total hours lost (paid and unpaid sick leave) over the award standard hours per fortnight versus Occupied FTE (staff currently working in a position)	‹3.5%	3.33%
Average days lost per approved WorkCover claim (YTD) (Average paid days, full and parial, per claims per financial year)	‹26.55	15.07
Average days to first return to work (YTD) (Average days to secure any form of Return To Work- time lost claims only)	‹23.70	14.22

Infrastructure and planning

A review of the governance of building, engineering and maintenance services across the DDHHS resulted in the implementation of a new organisational structure. The change allowed for a refocus of services to deliver increased planned maintenance projects rather than reactive repairs.

In 2012-13 condition assessments of building and critical equipment across the DDHHS were completed and the Computerised Maintenance Management System (CMMS) data cleansed to provide an accurate profile of building and equipment assets.

$3.2 million in capital works projects were delivered including Cherbourg Community Health Centre refurbishment, relocation of Evolve Therapeutic Services to Fountain House (Toowoomba Hospital) and the near-completion of the Wandoan Primary Healthcare Centre. These are in addition to the Regional Cancer Care Centre and the Yannanda Adolescent Unit.

Cunningham Centre (registered training organisation)

Since its establishment in 1989, the Cunningham Centre has been involved in high quality training, education, research and support of health personnel in Queensland.

The main office is located on the Toowoomba Hospital campus with other offices in Cairns, Innisfail, Townsville, Brisbane, Roma and Stanthorpe.

There were many notable achievements for the service in 2012-13. These included:

- a statewide evaluation of the Rural Generalist Pathway program was conducted, resulting in recommendations for the program to be established in other states and territories;
- inaugural preparatory workshop for Rural Generalist Trainees in Anaesthetics;
- 360 junior doctors received preparatory training for rural relief rotations through the Clinical Rural Skills Enhancement Workshop series;
- 50 nurses completed Rural Isolated Practice Registered Nurse course enabling them to apply for endorsement to supply scheduled medicines to their patients;
- advanced clinical skills programs were delivered to 282 rural and remote nurses (158 nurses attended the DDHHS workshop);
- achieved accreditation for a new immunisation program;
- launched a new rural development program for allied health professionals.

The Cunningham Centre delivered a number of training courses and programs including: Spirometry Training Program, Certificate II in Health Support Services; Certificate III in Pathology; Certificate IV in Multicultural Health; Certificate IV in Child and Youth (Aboriginal and Torres Strait Islander); Certificate III and IV in Aboriginal and Torres Strait Islander Primary Health (in collaboration with TAFE).

Health Information Services

A new organisational structure and governance framework for Health Information Services was implemented to ensure an appropriate level of service to the new health service.

Non-current Toowoomba Hospital medical records were transitioned to off-site storage as part of a health service-wide project to improve the management and storage of medical records. As part of this project there was the implementation of a service-wide standard for the process of culling clinical records, in line with the requirements of the State Archivist.

Records Management

The Right to Information Act (2009) and *Information Privacy Act (2009)* grants the public a legally enforceable right to access documents in the possession of government agencies, including clinical and non-clinical records. DDHHS processes all requests for access to documents in accordance with the provisions the Acts and Administration Access legislation using staff with advanced health information services skills.

As part of the Machinery of Government changes there was a transfer of clinical records and administrative records to our service. DDHHS ensures records are maintained through application of the State Archives-approved retention schedule.

The clinical record disposal schedule is a standard process in place across all DDHHS facilities to cull their clinical records. The service has assigned formal responsibility for administrative records and clinical records to senior staff. From the clinical perspective, medical records staff participate in ongoing training in records management and handling, while the training program for administrative staff in clinical areas is being reviewed.

Information security is considered in collaboration with the Health Services Information Agency of the Department of Health.

In line with the government's commitment to open data, the DDHHS has published the following information through the Queensland Government Open Data website http://www/qld/gov.au/data.

- Consultancies
- Overseas Travel
- Queensland Multicultural Policy - *Queensland Multicultural Action Plan 2011-14*

Internal Audit

In 2012-13 the Darling Downs Hospital and Health Service established an internal audit function. The internal audit function provides independent, objective assurance and consulting activity designed to add value and enhance DDHHS operations. The head of internal audit reports directly to the Board and attends all Board and Executive Audit and Risk Committee meetings where he reports on the unit's activities and audit findings.

The unit's purpose, authority and responsibility are defined in its charter which is reviewed by the Board Audit and Risk Committee, and approved by the Board. Strategic and annual audit plans were developed and direct the unit's activities and provide a framework for it to operate effectively.

Our financial performance

Darling Downs Hospital and Health Service finished its first financial year as a statutory authority with an operating surplus of $14.249 million on revenue of $575.8 million while still delivering on agreed major services safely and improving access quality indicators.

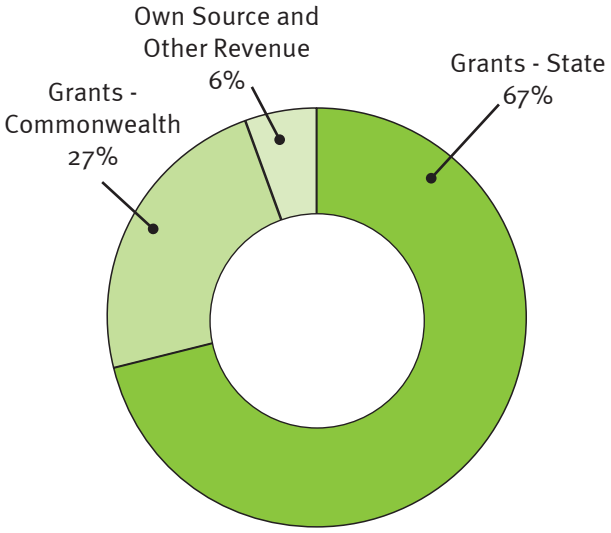
This occurred despite a $6.1 million reduction in Australian Government funding during the financial year and is largely as a result of continued productivity improvements as well as increasing own-source revenue.

Where the money comes from

DDHHS income is predominantly from government grants comprising:

- State Government grants for activity-based and block funded services.
- Australian Government contribution paid through Queensland Treasury for activity-based and block-funded services.
- Other state and Australian Government specific purpose grants such as home and community care and nursing home revenue.
- Own source revenue generated from user charges and recoveries from other agencies.

Revenue by funding source*



* Details these funding sources for 2012-13 financial year. DDHHS total income from continuing operations for 2012-13 was $575.8million. Of this, the state contribution was $384.5million (67%), Commonwealth contribution was $157.1 million (27%), and own source and other revenue was $34.1million (6%).

Where the money goes

DDHHS operates a complex group of services. The below table represents the proportion of the budget spent on services within DDHHS.

Seventy-six per cent of expenditure in the service is for employee expenses both internal and external. Twenty-one per cent of expenditure is spent on non-labour expenses such as clinical supplies, drugs, prosthetics, pathology, catering, repairs and maintenance, communication and energy. Three per cent of expenditure is related to depreciation of our fixed asset base.

Budget distribution 2012-13

Toowoomba Hospital	36%
Rural health and aged care	33%
Mental health	14%
Oral health	2%
Professional services	1%
People and corporate services	9%
Other support services	5%

2012-13 in review

DDHHS produced a surplus of $14.2m in its first year as a statutory authority, while delivering total activity purchased by the Department of Health. This was achieved mainly as a result of:

1. Productivity Improvements – given 76 per cent of DDHHS expenditure is labour-related it is not surprising that the most significant contribution to the surplus has been through increased productivity. The chart on the following page shows the productivity improvements in DDHHS as measured in weighted activity units per full time equivalent staff member.

In addition to Weighted Activity Units the DDHHS produces activity in other areas including community health, aged care, and oral health. DDHHS has delivered a 3.4 per cent productivity improvement in 2012-13. This is in addition to the 3.2 per cent productivity improvement in the 2011-12 year – the first year operating under the new boundaries.

Productivity - WAU per FTE*

* 12 month moving average

2. Own-source revenue – another significant contributor to improved performance has been an increased focus on maximising all sources of revenue, including maximising revenue from patients electing to be treated privately, bulk billing for Medicare-eligible services and improvements in aged care revenue. Through improvements over the past two financial years this has added $10 million to the operating income for DDHHS.

Fiscal recovery program

A program of redundancies was implemented during 2012-13. During the period, 95 employees received redundancy packages at a cost of $7,094,596.

This amount was funded by previously accrued leave payments and Queensland Treasury. Employees who did not accept an offer of a redundancy were offered case management for a set period of time, where reasonable attempts were made to find alternative employment placements.

At the conclusion of this period, and where it was determined that continued attempts of ongoing placement were no longer appropriate, employees yet to be placed were to be terminated and paid a retrenchment package. However, during the period, no employees received retrenchment packages.

A voluntary separation program was implemented during 2011-12. The program ceased during 2011-12; no employees received voluntary separation packages during 2012-13.

2013-14 an outlook

In spite of the result achieved by DDHHS in 2012-13, the outlook for 2013-14 remains tight and the financial sustainability of services in DDHHS remains a close focus given the expected increase in demand for services over the next 5-10 years. Our Board and management remain vigilant in ensuring maximum services are achieved within the finite resources of the DDHHS and we continue to develop strategies to strengthen the financial sustainability of our service.

Chief Finance Officer statement

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

The DDHHS is not specifically required to comply with this provision as a statutory authority, however in the interest of good governance for the year ending 30 June 2013, a statement assessing DDHHS's financial internal controls has been provided by the CFO to the Chair of the Board and the Board Audit and Risk Committee. This included reliance on representations from the Department of Health in relation to shared systems such as general ledger, accounts payable and payroll.

Comparison of actual financial results with budget

DDHHS actual result in comparison to its budget (as published in the State Budget Papers 2012-13 Queensland Health Service Delivery Statements) are presented in the following tables with accompanying notes.

Income Statement for the year ended 30 June 2013

Darling Downs Hospital and Health Service	Notes	2012-13 Budget $'000	2012-13 Act. $'000
Income			
User charges	1	27,499	29,587
Grants and other contributions	2	512,911	541,870
Other revenue	3	512	4,342
Gains on sale/revaluation of property, plant and equipment and investments		..	53
Total income		**540,922**	**575,852**
Expenses			
Employee expenses		1,874	2,068
Supplies and services	4	514,083	537,644
Department of Health – Health Service Employees	5	*403,529*	*411,117*
Grants and subsidies	6	2,304	1,339
Depreciation and amortisation	7	19,615	18,688
Finance/borrowing costs		..	..
Other expenses		1,767	1,018
Losses on sale/revaluation of property, plant and equipment and investments	8	1,279	846
Total expenses		**540,922**	**561,603**
OPERATING SURPLUS/(DEFICIT)	9	..	**14,249**

Notes:

1. Increase represents continued focus on improving revenue from other sources such as right of private practice revenues, revenue from private patients and other reimbursements. Actual performance exceeded budget which included a stretch target.
2. The increase is mainly due to amendments to the Service Agreement with the Department of Health. The 2012-13 financial year saw a considerable devolution of cost previously borne by the Department of Health, such as Queensland Government Insurance Fund (QGIF) premiums and functions previously performed by the Department of Health, such as Queensland Country Practice, Public Health and relief programs for Pharmacy, Medical Imaging, Radiographers and other Allied Health, now managed on a Statewide basis by Darling Downs DDHHS. In addition, funding to cover backpay of enterprise bargaining agreements finalised in the financial year and reimbursement of the costs of the voluntary redundancy scheme are included in this amount.
3. Increase represents an accounting change for labour recoveries. Previously this was accounted for as a negative labour expenditure. As staff are no longer reflected in salaries and wages but rather supplies and services, recoveries of these items from external agencies is now reflected as other revenue. This is offset in higher Health Service Employees costs
4. Additional expenditure reflects the amendments in the Service Agreement between DDHHS and the Department of Health, primarily as a result of devolution of costs and services previously borne/provided by the Department of Health. See note 2.
5. Increase due in part to change in accounting treatment of labour recoveries (offsetting note 3) and also reflective of the services being devolved to DDHHS by Department of Health including public health and statewide services.
6. Decrease is due to change in accounting treatment for aeromedical fixed wing services. These were previously accounted for as a grant but now charged to the DDHHS by the Department of Health through supplies and services.
7. Decrease due to review of useful lives of some assets following transfer of asset accounting function to DDHHS.
8. Decrease due to lower than forecast write off of receivables.
9. The 2012-13 surplus is a one-off effect. The surplus is being invested in non-recurrent items to benefit DDHHS patients and communities.

Statement of financial position as at 30 June 2013

Darling Downs Hospital and Health Service	Notes	2012-13 Budget $'000	2012-13 Act. $'000
CURRENT ASSETS			
Cash assets	1	10,447	38,852
Receivables	2	5,283	12,430
Inventories		5,044	4,764
Other		272	168
Total current assets		**21,046**	**56,214**
NON-CURRENT ASSETS			
Property, plant and equipment	3	315,277	310,467
Other		3	..
Total non-current assets		**315,280**	**310,467**
TOTAL ASSETS		**336,326**	**366,681**
CURRENT LIABILITIES			
Payables	4	19,180	38,523
Accrued employee benefits		11	73
Other		..	5
Total current liabilities		**19,191**	**38,601**
TOTAL LIABILITIES		**19,191**	**38,601**
NET ASSETS/(LIABILITIES)		**317,135**	**328,080**
EQUITY			
Capital/contributed equity	5	314,215	296,427
Accumulated surplus/(accumulated deficit)	6	..	14,249
Asset revaluation surplus	7	2,920	17,404
TOTAL EQUITY		**317,135**	**328,080**

Notes:

1. Increase in cash assets as a result of operating surplus together with movement of pay date by one week offset in payables.
2. Increase due to accrual of revenue at year end relating to Service Agreement amendments with the Department of Health.
3. Decrease represents lower value of assets actually commissioned and transferred to DDHHS on 1 July 2012 than originally budgeted, offset partly by higher than budgeted revaluation increment.
4. Increase largely as a result of accrued supplies and services representing unpaid Health Service Employee costs at year end due to the movement of the pay date. Partly offsets higher cash balance in note 1.
5. Decrease due to finalisation of opening balances to be transferred from Department of Health to DDHHS. Actual represents the net value of assets and liabilities transferred on 1 July 2012 less withdrawal of depreciation funding.
6. Represents current year surplus not budgeted.
7. Increase represents higher than forecast revaluation increment, mainly as a result of a high proportion of DDHHS assets not being revalued in previous three financial years by Department of Health.

Governing our organisation

The Darling Downs Hospital and Health Board is comprised of 10 non-executive members appointed by the Governor in Council on the recommendation of the Minister for Health, and in accordance with *the Act*.

Back (left to right): Ms Marie Pietsch, Ms Patricia (Trish) Leddington-Hill, Ms Cheryl Dalton. Middle (left to right) Dr Jeffrey Prebble OAM, Ms Megan O'Shannessy, Dr Ian Keys. Front (left to right): Dr Ross Hetherington, Mr Terry Fleischfresser, Mr Mike Horan AM, Dr Dennis Campbell

Our Board

Mr Mike Horan AM

Chair, Darling Downs Hospital and Health Board
Chair, Board Executive Committee
Chair, Queensland Hospital and Health Board Chairs Forum
Member, Toowoomba Hospital Foundation
Member, Queensland Clinical Senate

Mr Horan was the Member for Toowoomba South in the Queensland Parliament from 1991 to 2012. He served as Minister for Health, Leader of the National Party, Leader of the Opposition, and held shadow ministry responsibility for Health, Police, Attorney-General, Primary Industries, Business and State Development.

Mr Horan was appointed as Chair of the Darling Downs Hospital and Health Board (DDHHB) in May 2012 and appointed inaugural Chair of the Queensland Hospital and Health Board Chairs in June 2012. In his role as Chair of the DDHHB he also serves on the Board of the Toowoomba Hospital Foundation.

Mr Horan was General Manager of The Royal Agricultural Society of Queensland (1978-1991) and was instrumental in the purchase and development of the new Toowoomba Showgrounds.

In June 2013 Mr Horan was awarded a Member (AM) in the General Division of the Order of Australia for significant service to the Parliament of Queensland and to the community of the Darling Downs.

Mr Horan is also Chair of Downs Rugby Ltd, and a Board member of the Toowoomba Police Citizens Youth Club, Village on the Downs Ltd, Icon Cancer Care Network and the Queensland Catholic Education Advisory Committee.

Dr Dennis Campbell

Deputy Chair, Darling Downs Hospital and Health Board (Toowoomba)
Chair, Board Finance Committee
Chair, Board Audit and Risk Committee
Member, Board Executive Committee

Dr Dennis Campbell has held Chief Executive Officer positions in the public and private health sectors, as the Assistant and Acting Regional Director in the Queensland Department of Health and CEO at St Vincent's Hospital, Toowoomba for 10 years. Previous positions held include Corporate Director with Legal Aid, as well as other executive positions within the Department of Education and Department of Aboriginal and Islander Advancement.

Dr Campbell has legal and health qualifications and is involved in organisational health consulting. He serves as a member of a number of boards and advisory committees, representing both public and private health sectors, a trustee of the Queensland Museum Foundation, Chairperson of the Management Advisory Committee of Toowoomba Cobb & Co Museum, and Deputy Chairman of the Board of Heritage Bank.

In 2007, he was awarded an Australia Day Medallion for services to the Australian College of Health Service Executives. In 2008, he was awarded the Gold Medal for Leadership and Achievement in Health Services Management. He is involved in the college's mentoring program and on a number of national committees and is committed to making a contribution to the college and its members.

Dr Jeffrey Prebble OAM

Board Member, Darling Downs Hospital and Health Board (Toowoomba)
Chair, Board Quality and Safety Committee
Member, Board Executive Committee

Dr Jeff Prebble is a highly respected paediatrician with extensive medical experience in public and private hospitals across Toowoomba and Brisbane.

Dr Prebble is a member of several health-related committees and professional organisations and has published numerous papers.

Dr Prebble has been awarded a number of awards including the Order of Australia Medal in 2002 for services to paediatric medicine as a practitioner, educator and advocate for clinical care and practice standards for paediatrics. He was awarded the Australian Centenary Medal in 2003 for distinguished service to the medical profession.

Ms Cheryl Dalton

Board Member, Darling Downs Hospital and Health Board (South Burnett)
Member, Board Finance Committee
Member, Board Audit and Risk Committee

Ms Cheryl Dalton has most recently been a councillor for the South Burnett Regional Council and has extensive local government experience as well as long-standing membership of the Department of Natural Resources and Mines Queensland Resource Operating Plan and Moratorium Panel.

Ms Dalton is currently Managing Director of Dalton Agribusiness.

Mr Terry Fleischfresser

Board Member, Darling Downs Hospital and Health Board (South Burnett)
Member, Board Finance Committee
Member, Board Audit and Risk Committee

Mr Terry Fleischfresser is a local business owner and operator in the Kingaroy and South Burnett Region. He has a strong background in the public sector and in community engagement in the Darling Downs region over the past 37 years.

Mr Fleischfresser currently holds the appointment of Local Government Association of Queensland (LGAQ) Representative to Health Workforce Ltd. Queensland.

Dr Ross Hetherington

Board Member, Darling Downs Hospital and Health Board (Southern Downs)
Member, Board Finance Committee
Member, Board Audit and Risk Committee

Dr Ross Hetherington is a medical practitioner and Designated Aviation Medical Examiner (DAME).

Dr Hetherington has been in private practice as a GP in Warwick since 1996. He is Board Chair of Health Workforce Queensland which supports the regional, rural and remote health workforce in Queensland and is Board Chair of RHealth.

Dr Hetherington is also a Darling Downs and South West Queensland Medicare Local Board member and a Fellow of the Australian Institute of Company Directors.

Ms Marie Pietsch

Board Member, Darling Downs Hospital and Health Board (Southern Downs)
Member, Board Quality and Safety Committee

Ms Marie Pietsch has extensive healthcare experience across the Darling Downs region and has held positions on numerous councils and committees, including Chair of the Minister's Rural Health Advisory Council and Chair Southern Downs Health Community Council.

Ms Pietsch's work in representing health consumers in her region earned her a 2003 Centenary Medal for distinguished service to the community.

Ms Megan O'Shannessy

Board Member, Darling Downs Hospital and Health Board (Registered Nurse)
Member, Board Quality and Safety Committee

Ms Megan O'Shannessy is a Registered Nurse and midwife. Over a 25-year rural nursing career she has been the Director of Nursing at Thargomindah, Cunnamulla, Dirranbandi, St George and Warwick hospitals.

Ms O'Shannessy was a member of the Queensland Nursing Council from 1998 to 2000. She completed a Bachelor of Nursing at the University of Southern Queensland in 1996 and is completing her Masters in Public Health at the James Cook University.

She is now the Director of Prevocational General Practice Program at Queensland Rural Medical Education, a general practice education and training provider.

Dr Ian Keys

Board Member, Darling Downs Hospital and Health Board (Western Downs)
Member, Board Quality and Safety Committee

Dr Ian Keys is a retired medical practitioner with experience at the Princess Alexandra Hospital, Barcaldine Hospital and Private Rural Medical Practice in Dalby.

Dr Keys is a well-known identity in Dalby and held a private rural medical practice in the area for close to 40 years, before retiring in 2008. Dr Keys now breeds thoroughbred horses

Ms Patricia (Trish) Leddington-Hill

Board Member, Darling Downs Hospital and Health Board (Western Downs)
Member, Board Quality and Safety Committee

Ms Patricia (Trish) Leddington-Hill worked for more than 10 years with RHealth, a primary health care organisation servicing the Darling Downs and South West Queensland.

Ms Leddington-Hill completed a Bachelor of Science and Bachelor of Laws at the University of Queensland in 2000.

More recently, Ms Leddington-Hill's work has focused on promoting improvements to the health and community services sectors through partnerships and workforce planning and development.

Ms Danielle Causer

Board Member, Darling Downs Hospital and Health Board (Western Downs)
Member, Board Quality and Safety Committee

Ms Causer holds a nursing degree from Newcastle University, Graduate Certificate of Nursing from University of the Sunshine Coast and Nursing Registration with the Queensland Nursing Council.

Ms Causer has extensive experience as a nurse working in the Hunter region, Crows Nest, Toowoomba and Chinchilla townships. Ms Causer has worked in front line roles as a School Based Youth Health Nurse and as a one-to-one client consultant for Alcohol, Tobacco and Other Drugs Services.

Ms Causer was a Project Manager for the Energy 4 Energy Project. The Energy 4 Energy Project supports employee lifestyle programs involving educational and physical activities.

Board meetings

The full Board meets monthly, with every second meeting being held in a rural area. The Health Service Chief Executive and Director Executive Services attend as standing invitees at each Board meeting. During 2012-13 Board meetings were held in Wondai, Dalby, Warwick, Kingaroy and Taroom as well as Toowoomba. While meeting in the rural areas the Board routinely took the opportunity to visit all of the local hospitals and community health centres, as well as meet with staff and key stakeholders within the local communities.

The members of the DDHHS Board have experience in governance, management, healthcare delivery and most importantly strong local knowledge.

There are two Board directors representing the four different regions of the hospital and health service area – Southern Downs, Western Downs, South Burnett and Toowoomba and a director with nursing experience.

Throughout the course of the year, changes to members of the Board occurred as a result of the relocation and resignation of a Board member and requirement for representation from the nursing profession as directed by the Premier.

In 2012-13 collectively the Board travelled in excess of 38,000 km throughout the 90,000 sq km of the DDHHS to attend Board meetings and undertake site visits. A summary of Board activities for 2012-13 is provided at on page 37.

Board committees

To support the Board in its functions the Board has established the following committees:

- Executive committee
- Finance committee
- Quality and safety committee
- Audit and risk committee

Executive Committee: supports the Board in its role, working with the Chief Executive to progress strategic issues and ensure accountability in the delivery of health services by the service.

Finance Committee: provides assurance and assistance to the Board, through oversight of the financial position, integrity and policies of the DDHHS.

Quality and Safety Committee: provides assurance and assistance to the Board on quality, safety, clinical governance frameworks and strategies of the service. The Executive Director Toowoomba Hospital & Medical Services, and the Executive Director Nursing and Midwifery attend each meeting in an advisory capacity.

Audit and Risk Committee: operates with due regard for the Treasury's *Audit Committee Guidelines,* and provides assurance and assistance to the Board on:

- the service's risk, control and compliance frameworks, and
- the service's 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*

This committee has an oversight role and does not replace management's primary responsibilities for the management of risks including fraud risk, the operations of the internal audit and risk management functions, the follow up of internal and external audit findings or governance of the DDHHS generally.

During the 2012-13 financial year, meetings were held quarterly. The membership of the committee comprised Dr Dennis Campbell (Chair), Dr Ross Hetherington, Ms Cheryl Dalton and Mr Terry Fleischfresser. Also attending meetings in advisory capacities were the Health Service Chief Executive, Chief Finance Officer, Head Internal Audit and representatives of Queensland Audit Office.

The committee oversaw:

- establishment of the Internal Audit Unit, including approval of the Internal Audit Charter
- endorsement of an annual risk-based audit plan
- completion of fieldwork for two areas of risk priority in line with the plan, and
- the preparation of the Annual Financial Statements.

In 2012-13 the Board also provided oversight in the development of a risk and assurance framework for the Darling Downs Hospital and Health Service. The framework articulates the strategic risks and opportunities facing the DDHHS and provides the context for alignment of strategic and operational planning. The framework also describes how risks are monitored to provide the Board with confidence that the risks will not adversely affect the DDHHS achieving its vision.

Board and Board Committee meetings 2012-13

The table shows the number of meetings of the Board or Board Committees attended by Board members during 2012-13

Name	Term of Appointment	Board Meeting	Executive Committee	Finance Committee	Audit and Risk	Quality and Safety
Mr Mike Horan AM – Chair	18 May 2012 – 17 May 2016	12	8	N/A	N/A	N/A
Dr Dennis Campbell – Deputy Chair	29 June 2012 – 17 May 2016	10	9	11	4	N/A
Dr Jeffrey Prebble	29 June 2012 – 17 May 2016	12	7	N/A	N/A	7
Ms Cheryl Dalton	29 June 2012 – 17 May 2014	10	N/A	11	4	N/A
Mr Terry Fleischfresser	29 June 2012 – 17 May 2016	10	N/A	10	3	N/A
Dr Ross Hetherington	29 June 2012 – 17 May 2014	12	N/A	9	4	N/A
Ms Marie Pietsch	29 June 2012 – 17 May 2016	11	N/A	N/A	N/A	7
Dr Ian Keys	29 June 2012 – 17 May 2014	12	N/A	N/A	N/A	7
Ms Patricia (Trish) Leddington – Hill	9 November 2013 – 17 May 2014*	7	N/A	N/A	N/A	4
Ms Megan O'Shannessy	18 May 2013 – 17 May 2016*	2	N/A	N/A	N/A	1
Ms Danielle Causer	29 June 2012 – 31 December 2012*	5	N/A	N/A	N/A	3

* Three Board members were not engaged as a member for full duration of 2012-13 and as such their attendance at meetings correlates to their term of appointment.

General Meetings & Consultations

Auditor-General
Aust Pacific LNG Project - Pipelines, Origin Energy
Australian Medical Association (AMA), Qld
Banana Shire Council
Centacare
Central Telegraph
Chair Mater Health
CheckUP Australia (Primary Healthcare)
Chief Nurse (Department of Health)
Chinchilla Mothers Group
Clubhouse Toowoomba
CWA (Warwick)
Cystic Fibrosis Association
Dalby Chamber of Commerce
Dalby Hospital Auxiliary
Darling Downs South West Queensland Medicare Local
Drug Arm (Toowoomba)
GasFields Commission QLD
General Practice Queensland
Glennon House Toowoomba
GP Connections
HACC-Service Coordinator (Taroom)
Health Consumers Queensland
Independent Retirees Association
Kingaroy Hospital Auxiliary
Kumbia Kindergarten
Lifeline (Toowoomba)
Magistrates Court / QGAP Office (Taroom)
Mums & Bubs/Kindergarten Group Taroom
MUMSS Group (Stanthorpe)
Nanango Hospital Auxiliary
National Senior's Group (Warwick)
Neighbourhood Centre Stanthorpe
Office of Rural and Remote Health
Orana Aged Care Facility (Kingaroy)
Qld Clinical Senate
Qld Police Service (Taroom)
Qld Ambulance Service (Toowoomba)
Qld Fire and Rescue Service (Toowoomba)
Queensland Nurses Union
Queensland Police Service (Toowoomba)
Rural Doctors Association, Queensland
South Burnett Private Hospital
South Burnett Community Consultative Committee
Southern Queensland Institute of TAFE
St Andrews Hospital Toowoomba
St Vincents Hospital Toowoomba
Stanthorpe Community Consultative Committee
State Emergency Service (Toowoomba)
Sunrise Way
Taroom District Development Assoc.
Taroom Shire Cancer & Palliative Care Group
Toowoomba & Darling Downs Local Medical Assoc.
Toowoomba Chamber of Commerce
Toowoomba Chronicle
Toowoomba Garden City Probus Club
Toowoomba Hospice
Toowoomba Hospital Foundation
Toowoomba Hospital Volunteers
University of Qld - Rural Clinical School
University of Southern Queensland
Wallangara Community Association
Warwick RSL
Wondai Chamber of Commerce

Members of Parliament

Member for Condamine
Member for Groom
Member for Maranoa
Member for Nanango
Member Toowoomba North
Member Toowoomba South
Member for Southern Downs
Member for McKellar, NSW
Senator for Queensland

Local Government

Banana Shire Council
Cherbourg Aboriginal Shire Council
Goondiwindi Regional Council
South Burnett Regional Council
Southern Downs Regional Council
Toowoomba Regional Council
Western Downs Regional Council

Forums and Events

DDHHS Clinical Leaders Forum
Queensland Clinical Senate
Check Up - Health Leaders Forum
Health Consumers Queensland
Hospital and Health Board Chairs Forum
Rural Maternity Summit
Statewide Surgical Forum

Forums and Events

RHealth Headspace Forum
Statewide Rural and Remote Clinical Network Forum

Facility Visits

Baillie Henderson
Cherbourg
Chinchilla
Dalby
Farr Home Aged Care Facility
Goondiwindi
Inglewood
Jandowae
Karingal Aged Care Facility
Kingaroy
Miles
Millmerran
Milton House Aged Care Facility
Murgon
Nanango
Oakey
Stanthorpe
Tara
Taroom
Texas
The Oaks Aged Care Facility
Toowoomba
Wandoan Primary Health Centre
Warwick

Official Events

Opening of Regional Cancer Centre
Opening of Adolescent Mental Health Unit
Opening of Christine Stewart Community Health Building Cherbourg
Opening Warwick Mental Health
Opening of Inglewood Dental Clinic

Staff Awards

Australia Day Awards Ceremony
Millmerran Long Service Awards
Goondiwindi Long Service Awards
Stanthorpe Long Service Awards
Jandowae Long Service Awards
Dalby Long Service Awards
Oakey Long Service Awards
KingaroyLong Service Awards
Mental Health Division Long Service Awards
Tara Long Service Awards
Toowoomba Long Service Awards

Our executive

Dr Peter Bristow

FRACP FCICM FRACMA GCM GAICD

Health Service Chief Executive

Dr Peter Bristow was appointed as Chief Executive of the Darling Downs Hospital and Health Service in August 2012.

Dr Bristow had been Acting Chief Executive Officer of the Darling Downs Health Service District from June 2011 and had previously worked in the role of Executive Director of Medical Services from November 2004. He has a strong background in hospital medicine and is an Intensive Care specialist, previously working as the Intensive Care Unit Director in Toowoomba. He has been a doctor for 30 years and worked in New South Wales and Victoria before coming to Queensland.

He has presented and published in medical literature with his main research interests being severity of illness scoring systems and predictive algorithms. He is an Associate Professor of the University of Queensland.

Mr Scott McConnel

Chief Finance Officer

Mr McConnel is an accountant with extensive management and finance experience and perspective from a diverse range of industries including mining, information technology, education and banking and finance, including seven years in financial services in London.

With experience across both the public and private sectors he has a track record of leading continuous improvement and in engendering a more commercial focus in non-for-profit settings.

Mr McConnel holds a Bachelor of Commerce with first class honours from the University of Queensland and is a member of the Australian Society of Certified Practising Accountants and Graduate of the Australian Institute of Company Directors

Dr Peter Gillies

Executive Director Toowoomba Hospital and Medical Services

Dr Gillies came to Toowoomba in 2009 to take up the role of Director Medical Services following his employment as the Director of Medical Services for Hunter New England Health in Armidale, New South Wales.

Dr Gillies is a Fellow of the Royal Australasian College of Medical Administrators and has a Masters of Business Administration from Otago University. He is also a Graduate of the Australian Institute of Company Directors.

He has a background in general management, previously working as the general manager of a health software company and as the regional manager for a not-for-profit private hospital group in Auckland, New Zealand.

He has been a doctor for 19 years and has worked in South Africa and the UK in both hospital and general practice roles prior to immigrating to New Zealand in 1995.

Ms Shirley Wigan

Executive Director Mental Health

Ms Wigan has extensive experience in the delivery of mental healthcare services, having worked at Mackay Hospital, West Moreton, Princess Alexander Hospital, Royal Brisbane Women's Hospital and Bayside as the Executive Director of Mental Health Services for seven years.

Ms Wigan has a social work background and graduated from the University of Queensland in 1970 with a Bachelor of Social Work. She went on to complete a Graduate Diploma in Public Health and Masters of Business Administration in 1995.

Ms Wigan was appointed Executive Director Mental Health for the Darling Downs in 2008. She has a strong background in community development, consumer and community engagement and innovative service delivery models inline with national and international imperatives and trends.

She is a member of the International Mental Health Leadership Network and is committed to a safe quality consumer focused service within a recovery framework.

Mr Michael Bishop

Executive Director Rural Health and Aged Care

Mr Bishop is a founding member of the Mental Health Council of Australia, the National Rural Health Alliance, the Australian National Art Therapy Association, Mackay Centre for Research On Children and Community Services, The Australian College for Child and Family Protection Practitioners and Services for Australian Rural and Remote Allied Health (SARRAH).

Mr Bishop graduated with a Bachelor of Occupational Therapy from the University of Queensland in 1983 and a Masters degree in Health Services Management from the University of New South Wales in 1996. He has undertaken postgraduate study in both profession-specific areas as well as social economics.

He has worked nationally and internationally with health services aimed at improving both the scope and quality of allied health professional services. As a result of this development and review work, he is acknowledged as an allied health professional leader by peers (the Queensland SARRAH Network Coordinator, and Australian Chair, AHLANZ).

He has a Human Rights Commendation for work in destigmatising mental illness. Michael was chair of the Editorial Boards of the Australian Journal of Rural Health, Communities, and Families and Children Australia and convened several Australian Rural and Remote Scientific Health Conferences. Michael is the Deputy Chair of the Darling Downs and South West Medicare Local.

Ms Judy March

Executive Director Nursing and Midwifery

Ms March has worked for the Queensland public hospital system for over 40 years.

Ms March was appointed as the Director of Nursing (DON) Toowoomba Hospital and the Executive Director of Nursing from 2000 to 2008. Judy was then appointed to the role of Clinical Operations Manager for the Rural Division during the time of the amalgamation of Darling Downs and West Moreton, Health Service Districts.

Prior to moving to Toowoomba Judy was employed at the Gold Coast Health Service for 19 years, in positions from Midwifery Student, Registered Nurse, Nurse Manager and Nursing Director (ND) for Surgical Services.

In her current role she is the professional head of nursing and midwifery for the DDHHS – and works closely with the DONs and NDs across the service.

Ms March has a Nursing Degree and Masters in Health Administration.

Ms March has been awarded two Queensland Health Australia Day Awards, the first, in 1997 for Services to the Surgical Services at the Gold Coast Hospital and in 2010 for Nursing Leadership. She was also the recipient of the inaugural Outstanding Leadership in Nursing Award from the Association of Queensland Nurse Leaders in 2008.

Ms Megan Morse

Executive Director Allied Health

Before joining the DDHHS in July 2012, Ms Morse worked as an Allied and Community Health Manager and Director for 10 years in the public and not-for-profit sectors in Tasmania and Victoria.

In her role Ms Morse provided high level leadership, strategic direction and advocacy in the professional management of allied health services across the DDHHS, including contribution to state-wide initiatives.

Ms Morse has a Bachelor of Podiatry with Honours, Master of Education and Master of Business Administration, Graduate Certificate in Health Economics and Professional Certification in Health Systems Management. She is also a member of the Australian Institute of Company Directors.

Mr Stewart Gordon

Executive Director People and Corporate

Mr Gordon has worked for the public health system in Queensland for approximately 20 years. He has a Business Degree (Human Resources and Marketing) and a background in rural health service delivery. He has worked in a number of locations, including in Roma as District Manager of the South West Health Service District and also spent time working in the Department of Health head office.

Having grown up in rural south west Queensland, Mr Gordon is passionate about rural health and advocates access to an appropriate range of services for people in rural areas.

Mr Gordon took up the post of Executive Director Rural Services for the former Toowoomba and Darling Downs Health Service District in October 2007 before moving into the role of Executive Director Rural Health & Aged Care during the time of the amalgamation of Darling Downs and West Moreton, Health Service Districts.

After a period of long service leave he returned to the Darling Downs Health Service District in February 2012 to take up the newly created position of Executive Director People & Corporate Services.

Our workforce

Our workforce comprises over 4,700 individuals. The clinical workforce includes doctors, nurses, and a wide range of allied health professionals. To ensure our services are delivered we also employ cooks, cleaners, ward clerks, orderlies, gardeners, financial professionals, and others. In fact, about one in sixty people in the Darling Downs work for us. These individuals add to our collective story. A summary of the statistics describing our employees is below.

Our staff in numbers

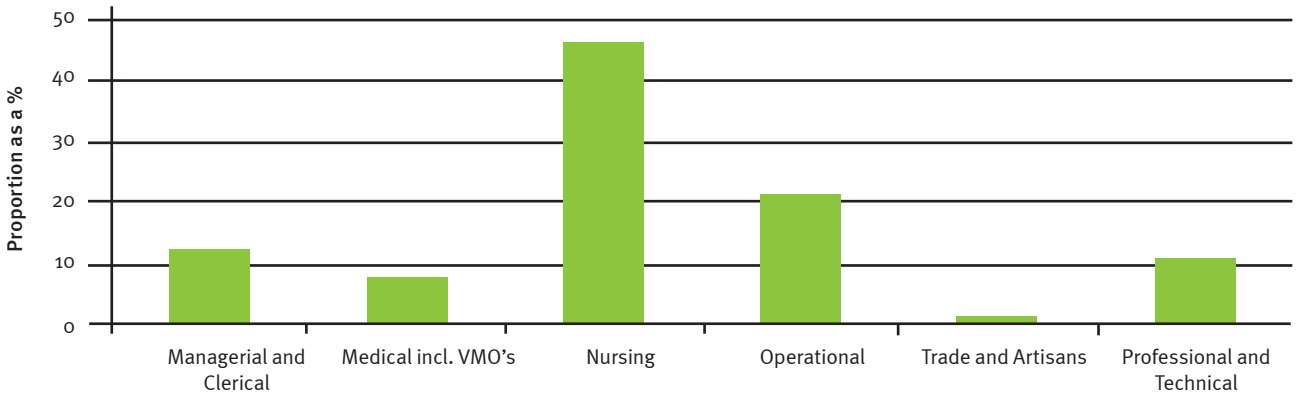
Employed staff by service areas as at 30 June 2013	MOHRI Occupied FTE	MOHRI Occupied Headcount
Toowoomba Hospital	1,194	1,537
Rural Health and Aged Care	1,307	1,797
Mental Health	565	638
People and Corporate Services	458	510
Oral Health	104	130
Professional Services	61	64
Other Support Services	79	83
Total DDHHS	**3,768**	**4,761**

Employment type	MOHRI Occupied FTE	MOHRI Occupied Headcount
Casual	133	343
Permanent	3,044	3,618
Temporary	591	800
Total DDHHS	**3,768**	**4,761**

The retention rate for permanent staff within the DDHHS for 2012-13 was 90.97 per cent, with a separation rate of 8.17 per cent.

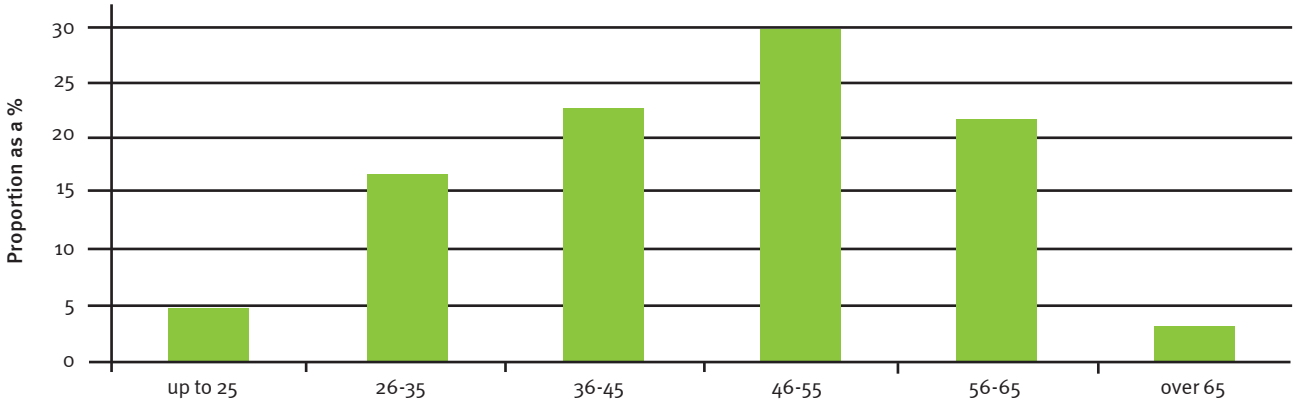
The following graph shows the occupational stream as a proportion for the 2012-13 financial year:

DDHHS workforce by occupational stream (2012-13)



DDHHS staff age by percentage (2012-13)

The percentage age graph for this financial year clearly shows that those 'at risk' of retirement or changing work committments represents a significant percentage of the DDHHS workforce.



Future challenges

Our ageing workforce and potential impending retirement rates have highlighted a need to adopt processes to ensure corporate knowledge and current skill mixes are maintained. This can be achieved through the use of the transition to retirement program, rotation of staff to enable capacity building of future workforce and early identification of risk areas and locations in order to implement strategies.

At the same time, the health service operates within a challenging environment that is characterised by increased demands for flexibility, responsiveness and performance improvement and innovation in service delivery, tightening labour markets, skills shortages as well as an ageing workforce.

Thus, there is a requirement to build a workforce that can adapt to changes in health care needs and service models that are a likely consequence of new technologies, scientific and therapeutic advances. A review of our existing relationships with universities and TAFE colleges has been completed and work has also started on supply projections for our workforce within various disciplines and specialties.

Finally, staffing requirements depend on the range of services to be provided under the Service Agreement with the Department of Health. The Department of Health is also responsible for industrial arrangements. The DDHHS will continue to work with the Department of Health to respond to these workforce challenges.

Equal employment opportunity training and values

DDHHS complies with Equal Employment Opportunity principles in relation to recruitment and employment.

A review of training requirements for occupational health and safety, orientation, induction, and other training was undertaken in 2012-13. In future a number of non-clinical training programs will be offered in online formats. It is envisaged that providing the mandatory training courses for staff online will ensure our staff receive required information in a more timely manner, provide a smoother transition for new staff into the organisation, result in increase efficiency and assist the DDHHS to meet its legislative requirement and compliance obligations.

Work has started to comprehensively review and improve the performance management system for DDHHS employees with the aim to provide a robust performance and improvement framework and develop a culture that is not dependent on discrete performance review and management procedures.

The values contained in the *DDHHS Strategic Plan 2012-2016* were mapped to the 'Code of Conduct for the Queensland Public Service' (the code). The DDHHS values were developed with regard to specific elements of the code:

- Caring - 1.3 & 1.5 in the code
- Doing the right thing - 1.1, 1.2, 2.2, 3.1, 4 in the code
- Openness to learning and change - 2.1 & 4.5 in the code
- Being safe, effective and efficient - 4.3 & 4.5 in the code
- Being open and transparent - 1.3, 1.4, 2.2, 2.3, 3.1, 4.1, 4.2, 4.4 in the code

The code's principles of integrity and accountability are integrated into the DDHHS' strategic objectives through the themes of 'ensuring resources are sustainable', 'ensuring processes are clear' and 'ensuring staff are dedicated and trained'. Within these themes, and with regard to integrity and accountability, the current strategic plan particularly emphasises efforts to:

- increase confidence in the health system
- achieve a balanced operating position
- conduct effective operational planning
- engage the community, health care consumers, and clinicians to improve services
- embed a values-based culture.

The service's values are promoted through the orientation training package and induction delivered for all staff starting with the DDHHS. Staff are also reminded of the values and their responsibilities regularly through internal communications channels:

- Professional Appraisal and Development (PAD) planning,
- Intranet,
- Screensavers,
- Staff newsletter, and
- Through one-on-one management meetings.

Glossary of terms

Term	Meaning
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).
Aged Care and HACC Assessment Team (ACHAT)	ACHAT provides comprehensive assessments for the needs of frail older people and facilitates access to available care services appropriate to their needs.
Allied Health Clinical Leader - Acute Medical	This role provides clinical leadership on behalf of allied health within the Acute Medical Services. It is undertaken by an advanced practice Occupational Therapist or Physiotherapist, who can also operate within an extended scope framework to deliver allied health services to patients which previously would have been delivered by another professional group eg. Speech Pathology, Nutrition and Dietetics.
Allied Health Clinical Leader - Rural Generalist	This role provides clinical leadership on behalf of allied health within the Emergency Department. It is undertaken by an advanced practice Physiotherapist, who can also operate within an extended scope framework to deliver allied health services to patients which previously would have been delivered by another professional group eg. Occupational Therapy, Speech Pathology, Nutrition and Dietetics.
Allied Health staff (Health Practitioners)	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; medical imaging; nuclear medicine technology; occupational therapy; orthoptics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work.
Ambulatory	Care provided to patients who are not admitted to the hospital, such as patients of emergency departments, outpatient clinics and community based (non-hospital) healthcare services.
Balanced Scorecard	A tool to align metrics with the strategic plan.
Benchmarking	Involves collecting performance information to undertake comparisons of performance with similar organisations.
Block Funded	Block funding is typically applied for small public hospitals where there is an absence of economies of scale that mean some hospitals would not be financially viable under Activity Based Funding (ABF), and for community based services not within the scope of Activity Based Funding.

Term	Meaning
Chronic Disease	Chronic disease: Diseases which have one or more of the following characteristics: (1) is permanent, leaves residual disability; (2) is caused by non-reversible pathological alteration; (3) requires special training of the individual for rehabilitation, and/or may be expected to require a long period of supervision, observation or care.
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 Redesign	Clinical process redesign is concerned with improving patient journeys by making them simpler and better coordinated. The redesign process is patient focused, led by clinical staff, systematic and methodical and quick with tight timeframes.
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.
Community Health	Community health provides a range of services to people closer to their home. Some of these services include children's therapy services, pregnancy and postnatal care, rehabilitation and intervention services, and programs that focus on the long-term management of chronic disease.
Compensable Patient	One who receives care and/or treatment for an injury, illness or disease and receives, or is entitled to receive, compensation that covers the cost of hospital treatment.
Consumer Companion	Consumer Companions are people with lived experience of mental illness who have undergone specific training to undertake their role as a companion to people experiencing an acute hospital admission.
Department of Health	The Department of Health is responsible for the overall management of the public sector health system, and works in partnership with Hospital and Health Services to ensure the public health system delivers high quality hospital and other health services.
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.
Endoscopy	Internal examination of either the upper or lower gastro intestinal tract.
Environmental Health	Environmental Health programs are related human health issues that are affected by the physical, chemical, biological and social factors that are present in the environment.
Evolve	Evolve Therapeutic Services are part of Evolve Interagency Services (Evolve) that provide therapeutic and behaviour support services for children and young people on child protection orders and in out-of-home care who have psychological and behavioural problems. The services are provided through a collaborative partnership between the Department of Communities, Department of Health and the Department of Education and Training.
Full-time equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
Governance	Governance is aimed at achieving organisational goals and objectives, and can be described as the set of responsibilities and practices, policies and procedures used to provide strategic direction, ensure objectives are achieved, manage risks, and use resources responsibly and with accountability.
GP (General Practitioner)	A general practitioner is a registered medical practitioner who is qualified and competent for general practice in Australia. General practioners operate predominantly through private medical practices.
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, including the National Health and Hospitals Network Agreement (NHHNA), the National Health Reform Heads of Agreement (HoA),and the National Healthcare Agreement 2012. This last agreement was signed by the Commonwealth and then all states and territories and sets out future directions on prevention, primary and community care, hospital and related care, and aged care.
Home and Community Care (HACC)	The Commonwealth funded HACC Program provides services which support frail older people and their carers, who live in the community and whose capacity for independent living are at risk of premature or inappropriate admission to long term residential care.
Hospital	Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.
Hospital and Health Board	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to managing a complex health care organisation.
Hospital and Health Service	Hospital and Health Service (HHS) is a separate legal entity established by Queensland Government to deliver public hospital services.
Hospital in the home	Provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.

Term	Meaning
Indigenous health worker	An Aboriginal and/or Torres Strait Islander person who works to improve health outcomes for Indigenous Australians.
Inpatient	A patient who is admitted to a hospital or health service for treatment that requires at least one overnight stay.
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 an urgent (category 1) operation, more than 90 days for a semi-urgent (category 2) operation and more than 365 days for a routine (category 3) operation.
Medical Assessment and Planning Unit (MAPU)	MAPU focuses on optimising patient flow, while providing specialist care for patients, MAPU coordinates the work of multidisiplinary team members to minimise delays for patients requiring access to medical beds from the emergency department.
Medical practitioner	A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.
Medicare Local	Established by the Commonwealth to coordinate primary health care services across all providers in a geographic area. Works closely with HHSs to identify and address local health needs.
Minimum Obligatory Human Resource Information (MOHRI)	MOHRI is a whole of Government (WoG) methodology for producing an Occupied Full Time Equivalent (FTE) and headcount value sourced from the Queensland Health payroll system data for reporting and monitoring.
Models of Care	Model of Care and Models of Service Delivery broadly defines the way that clinical and non-clinical services will be delivered.
Multidisciplinary team	Health professionals employed by a public health service who work together to provide treatment and care for patients. They include nurses, doctors, allied health and other health professionals.
Multipurpose Health Service (MPHS)	Provide a flexible and integrated approach to health and aged care service delivery for small rural communities. They are funded through pooling of funds from Hospital and Health Services (HHS) and the Australian Government Department of Health and Ageing.
NEAT	National Emergency Access Target. NEAT is a National Performance Benchmark for public hospitals. NEAT commenced in January 2012, with annual increment targets over the next four years for all patients presenting to a public hospital Emergency Department (ED) to either physically leave the ED for admission to hospital, be transferred to another hospital for treatment, or be discharged, within four hours.
NEST	National Elective Surgery Target. NEST is a National Performance Benchmart for public hospitals. The objectives of NEST are to improve patient care by: Increasing the percentage of elective surgery patients seen within the clinically recommende time, and reducing the number of patients who have waited longer than the clinically recommended time.
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.
Occupied Bed Days	Is the occupancy of a bed or bed alternative by an admitted patient as measured at midnight of each day, for any period of up to 24 hours prior to that midnight.
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.
Outreach	Services delivered to sites outside of the service's base to meet or complement local service needs.
Overnight stay patient	A patient who is admitted to, and separated from, the hospital on different dates (not same-day patients).
Own Source Revenue	Own Source Revenue (OSR) is revenue generated by the agency, generally through the sale of goods and services. Examples of OSR include revenue generated through privately insured inpatients, private outpatients, and Medicare ineligible patients (overseas visitors).
Palliative Care	Palliative care is an approach that improves quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychological and spiritual.
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.
Patient Travel Subsidy Scheme (PTSS)	The Patient Travel Subsidy Scheme (PTSS) provides assistance to patients, and in some cases their carers, to enable them to access specialist medical services that are not available locally.
Peer Support Worker	In Mental Health, peer support has been defined as: a system of giving and receiving help founded on key principles of respect, shared responsibility , and mutual agreement about what is helpful.
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.

Term	Meaning
Perinatal Mental Health	Perinatal and infant mental health is described as the emotional and psychological wellbeing of women, their infants, partners and family, including the impact on the parent-infant relationship, commencing from preconception through pregnancy and up to 36 months postpartum.
Primary Health Care	Primary health care services include health promotion and disease prevention, acute episodic care not requiring hospitalisation, continuing care of chronic diseases, education and advocacy.
Public hospital	Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.
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.
Registered nurse (RN)	An individual registered under national law to practice in the nursing profession as a nurse, other than as a student.
Registered Training Organisation (RTO)	A Registered Training Organisation, is a vocational education organisation that provides students with training that results in qualifications and statements of attainment that are recognised and accepted by industry and other educational institutions throughout Australia
Renal Dialysis	Renal dialysis is a medical process of filtering the blood with a machine outside of the body.
Risk management	A process of systematically identifying hazards, assessing and controlling risks, and monitoring and reviewing activities to make sure that risks are effectively managed.
Rural Generalist	A Rural Generalist is defined as a rural medical practitioner who is credentialed to serve in: • Hospital-based and community-based primary medical practice; and • Hospital-based secondary medical practice in at least one specialist medical discipline (commonly but not limited to obstetrics, anaesthetics and surgery); and without supervision by a specialist medical practitioner in the relevant disciplines.
Statutory bodies / authorities	A non-departmental government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees / councils.
Sub-acute	Sub-acute care focuses on continuation of care and optimisation of health and functionality.
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 • Telehealth services and equipment to monitor people's health in their home.
Tertiary Hospitals	Tertiary Hospitals provide care which requires highly specialized equipment and expertise.
Thrombolysis	The pharmacological process of breaking up and dissolving blood clots.
Transition Care Program (TCP)	The Transition Care Program (TCP) aims to provide time limited and therapy focussed support and active management for older people at the interface of the acute/sub-acute and residential aged care sectors, in a residential or community setting.
Transition to Retirement	The Transition to Retirement program identifies and allows individuals to move into retirement gradually through a voluntary reduction in work with a commensurate reduction in pay or to move to a position which may involve mentoring, preceptorship, etc. It will also provide an opportunity to workforce plan for the replacement of long term colleagues in advance of their actual full retirement.
Triage category	Urgency of a patient's need for medical and nursing care.
Visiting Medical Officer	A medical practitioner who is employed as an independent contractor or an employee to provide services on a part time, sessional basis.
Weighted activity Unit	A single standard unit used to measure all activity consistently. Phase 16 is the current version of the Queensland Health Activity Based Funding Model.
Weighted Occasions Of Service (WOOS)	A WOOS is a unit of measure of oral health services activity based on the oral health care delivered to a client as indicated by treatment items.

Compliance checklist

Compliance Checklist			
Summary of Requirement		**Basis for requirement**	**Annual report reference**
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister	ARRs – section 8	i
Accessibility	Table of contents	ARRs – section 10.1	1
	Glossary	ARRs – section 10.1	44
	Public availability	ARRs – section 10.2	Inside front cover
	Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 10.3	Inside front cover
	Copyright notice	*Copyright Act 1968* ARRs – section 10.4	Inside front cover
	Information licensing	*Queensland Government Enterprise Architecture – Information licensing* ARRs – section 10.5	Inside front cover
General information	Introductory Information	ARRs – section 11.1	ii, 2-3
	Agency role and main functions	ARRs – section 11.2	2-3, 51, 65, 66
	Operating environment	ARRs – section 11.3	6-28, 42
	Machinery of Government changes	ARRs – section 11.4	19, 21, 22, 24, 25
Non-financial performance	Government objectives for the community	ARRs – section 12.1	6-13
	Other whole-of-government plans / specific initiatives	ARRs – section 12.2	66, 67
	Agency objectives and performance indicators	ARRs – section 12.3	6-13
	Agency service areas, service standards and other measures	ARRs – section 12.4	13, 28, 29
Financial performance	Summary of financial performance	ARRs – section 13.1	26-29
	Chief Finance Officer (CFO) statement	ARRs – section 13.2	27

Compliance Checklist			
Summary of Requirement		Basis for requirement	Annual report reference
Governance – management and structure	Organisational structure	ARRs – section 14.1	18, 82
	Executive management	ARRs – section 14.2	31-34, 38-40
	Related entities	ARRs – section 14.3	N/A
	Boards and committees	ARRs – section 14.4	35-37
	Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* (section 23 and Schedule) ARRs – section 14.5	43
Governance – risk management and accountability	Risk management	ARRs – section 15.1	17, 35, 78, 79
	External Scrutiny	ARRs – section 15.2	19, 21
	Audit committee	ARRs – section 15.3	35
	Internal Audit	ARRs – section 15.4	25
	Public Sector Renewal Program	ARRs – section 15.5	27
	Information systems and recordkeeping	ARRs – section 15.7	25
Governance – human resources	Workforce planning, attraction and retention and performance	ARRs – section 16.1	41-42
	Early retirement, redundancy and retrenchment	*Directive No.11/12 Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	27
	Voluntary Separation Program	ARRs – section 16.3	27
Open Data	Open Data	ARRs – section 17	25
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	89
	Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	90-91
	Remuneration disclosures	*Financial Reporting Requirements for Queensland Government Agencies* ARRs – section 18.3	83-84

Financial statements

Darling Downs Hospital and Health Service
ABN 64 109 516 141

Financial Statements - 30 June 2013

Darling Downs Hospital and Health Service
Financial Report
30 June 2013

Contents

General information

Darling Downs Hospital and Health Service is a Queensland Government statutory body established under the *Hospital and Health Boards Act 2011* and its registered trading name is Darling Downs Hospital and Health Service.

Darling Downs Hospital and Health Service is controlled by the State of Queensland which is the ultimate parent entity.

The principal address of the Hospital and Health Service is:

Jofre
Baillie Henderson Hospital
Cnr Hogg & Tor Streets
Toowoomba QLD 4350

A description of the nature of the Hospital and Health Service's operations and its principal activities are included in the notes to the financial statements.

For information in relation to Darling Downs Hospital and Health Service's financial statements, email MD08-Darling Downs-HSD@health.qld.gov.au or visit the Darling Downs Hospital and Health Service website at http://www.health.qld.gov.au/darlingdowns/default.asp

Darling Downs Hospital and Health Service
Statement of Comprehensive Income
For the year ended 30 June 2013

	Notes	2013 $'000
Income from Continuing Operations		
User charges	5	29,587
Grants and other contributions	6	541,870
Other revenue	7	4,342
Total Revenue		575,799
Gains	8	53
Total Income from Continuing Operations		**575,852**
Expenses from Continuing Operations		
Employee expenses	9	(2,068)
Supplies and services	10	(537,644)
Grants and subsidies	11	(1,339)
Depreciation	12	(18,688)
Impairment losses	13	(333)
Other expenses	14	(1,531)
Total Expenses from Continuing Operations		**561,603**
Operating Result from Continuing Operations	22	14,249
Other Comprehensive Income		
Items that will not be reclassified subsequently to Operating Result		
Increase in asset revaluation surplus	21	17,404
Total items that will not be reclassified subsequently to Operating Result		**17,404**
Total Other Comprehensive Income		**17,404**
Total Comprehensive Income		**31,653**

The accompanying notes form part of these statements.

Darling Downs Hospital and Health Service
Statement of Financial Position
As at 30 June 2013

	Notes	2013 $'000
Current Assets		
Cash and cash equivalents	15	38,852
Receivables	16	12,430
Inventories	17	4,764
Prepayments		168
Total Current Assets		**56,214**
Non-Current Assets		
Property, plant and equipment	18	310,467
Total Non-Current Assets		**310,467**
Total Assets		**366,681**
Current Liabilities		
Payables	19	38,523
Accrued employee benefits	20	73
Unearned revenue		5
Total Current Liabilities		**38,601**
Total Liabilities		**38,601**
Net Assets		**328,080**
Equity		
Contributed equity		296,427
Asset revaluation surplus	21	17,404
Retained surplus	22	14,249
Total Equity		**328,080**

The accompanying notes form part of these statements.

Darling Downs Hospital and Health Service
Statement of Changes in Equity
For the year ended 30 June 2013

	Accumulated Surplus	Asset Revaluation Surplus (Note 21)	Contributed equity	Total equity
	$'000	$'000	$'000	$'000
Operating result from continuing operations	14,249			14,249
Other Comprehensive Income				
- Increase in asset revaluation surplus		17,404		17,404
Total Comprehensive Income for the Year	14,249	17,404		31,653
Transactions with Owners as Owners				
- Equity contributed on 1 July 2012 (Note 4)			303,518	303,518
- Appropriated equity injections (Note 2(x))			6,999	6,999
- Equity withdrawals (Note 2(x))			(18,656)	(18,656)
- Non appropriated equity asset transfers (Note 2(x))			4,566	4,566
Balance as at 30 June 2013	**14,249**	**17,404**	**296,427**	**328,080**

The accompanying notes form part of these statements.

Darling Downs Hospital and Health Service
Statement of Cash Flows
For the year ended 30 June 2013

	Notes	2013 $'000
Cash flows from operating activities		
Inflows:		
User charges		28,990
Grants and other contributions		523,196
Interest received		154
GST input tax credits from ATO		5,663
GST collected from customers		568
Other		4,188
Outflows:		
Employee expenses		(2,006)
Supplies and services		(514,989)
Grants and subsidies		(1,339)
Insurance		(45)
GST paid to suppliers		(6,429)
GST remitted to ATO		(521)
Other		(1,486)
Net cash provided by operating activities	**30**	**35,944**
Cash flows from investing activities		
Inflows:		
Sales of property, plant and equipment		53
Outflows:		
Payments for property, plant and equipment		(11,142)
Net cash used in investing activities		**(11,089)**
Cash flows from financing activities		
Inflows:		
Proceeds from machinery-of-Government change (1 July 2012)		2,432
Proceeds from equity injections		6,999
Movements in equity - other		4,566
Net cash used in financing activities		**13,997**
Net increase in cash and cash equivalents		38,852
Cash and cash equivalents at end of financial year	**15**	**38,852**

The accompanying notes form part of these statements.

Darling Downs Hospital and Health Service
Notes to and forming part of the financial statements
30 June 2013

Darling Downs Hospital and Health Service
Notes to and forming part of the financial statements
30 June 2013

Note 1. Objectives and Strategic Priorities of Darling Downs Hospital and Health Service

On 1 July 2012, in accordance with the *National Health Reform Agreement* and Queensland's *Hospital and Health Boards Act 2011*, the former Darling Downs Health Service District became the Darling Downs Hospital and Health Service.

The Darling Downs Hospital and Health Service is an independent statutory body, overseen by a local Hospital and Health Board with responsibility for providing public health services to a population of almost 300,000 people covering a predominantly rural area. The Darling Downs Hospital and Health Service provides public hospital and healthcare services as defined in the Service Agreement with Department of Health as manager of the public hospital system.

The Darling Downs Hospital and Health Service is responsible for the oversight of the services within the Darling Downs Hospital and Health Service's geographical boundaries which includes rural hospitals, multipurpose health services, community and primary care facilities, aged care facilities and mental health services.

The Darling Downs Hospital and Health Service strategic plan supports the Government commitments as outlined in the Queensland Government's "Getting Queensland Back on Track – statement of objectives for the community", to revitalise frontline services for families and deliver better infrastructure.

The Darling Downs Hospital and Health Service plan incorporates these priorities in its strategies and initiatives. A number of the strategies and initiatives also derive from the priorities and undertakings in the *National Healthcare Agreement 2012*, and the legislation establishing the Darling Downs Hospital and Health Service, the *Hospital and Health Boards Act 2011* and *Hospital and Health Boards Regulation 2012*.

The Darling Downs Hospital and Health Service has a strong focus on:

- providing better access to health services;
- addressing and improving key population health challenges and risks;
- supporting the Government commitments to revitalise frontline services for families and deliver better infrastructure; and
- enhancing engagement and developing closer working relationships with patients, families, community groups, general practitioners and other primary health providers.

Note 2. Summary of Significant Accounting Policies

(a) New and Revised Accounting Standards

Certain new Australian accounting standards and interpretations have been published that are not mandatory for 30 June 2013 reporting period.

Darling Downs Hospital and Health Service is not permitted to early adopt an accounting standard unless approved by Queensland Treasury and Trade. Consequently, Darling Downs Hospital and Health Service has not applied any Australian Accounting Standards and Interpretations that have been issued but not yet effective. Darling Downs Hospital and Health Service applies standards and interpretations in accordance with their respective commencement dates.

Australian Accounting Standards applicable for the first time for 2012-13 had minimal effect on Darling Downs Hospital and Health Service financial statements as the Darling Downs Hospital and Health Service is reporting for the first time in this financial year.

- AASB 2011-9 Amendments to Australian Accounting Standards - Presentation of Items of Other Comprehensive Income [AASB 1, 5, 7, 101, 112, 120, 121, 132,133, 134, 1039 & 1049] became effective from reporting periods beginning on or after 1 July 2012. Darling Downs Hospital and Health Service has adopted this standard in its presentation of Other Comprehensive Income.

As at 30 June 2013, the following Accounting Standards had been issued by the AASB but were not yet effective. They may impact Darling Downs Hospital and Health Service in future periods. The potential effect of the revised Standards and Interpretations on Darling Downs Hospital and Health Service financial statements has not yet been determined.

Note 2. Summary of Significant Accounting Policies (continued)

At the date of authorisation of the financial statements the following Australian Accounting Standards have been issued with future commencement dates:

- *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.

- *AASB 13 Fair Value Measurement* applies from reporting period beginning on or after 1 January 2013. AASB 13 sets out a new definition of fair value as well principals to be applied when determining the fair value of assets and liabilities. The new requirements will apply to all of Darling Downs Hospital and Health Service assets and liabilities that are measured and disclosed at fair value. The potential impacts of AASB13 relate to the fair value measurement methodologies used and financial statement disclosure made in respect of assets and liabilities. While Darling Downs Hospital and Health Service is yet to complete a review of the impact of this standard, no substantial changes are anticipated based on the fair value methodologies presently used.

- AASB13 will require an increased amount of information to be disclosed in relation to fair value measurement for both assets and liabilities. To the extent of fair value measurement for an asset or liability uses data that is not 'observable' outside the Hospital and Health Service, the amount of information to be disclosed will be relatively greater.

- *AASB 119 Employee benefits* – revised version applies from reporting period beginning on or after 1 January 2013. The revised AASB 19 is generally to be applied retrospectively. The impact of the standard is to clarify the concept of termination benefits and the note that recognition criteria for termination benefits will be different. If termination benefits meet the criteria for "short term employee benefits" they will be measured in accordance with AASB 119 requirements for "short term employee benefits". Otherwise termination benefits will need to be measured in accordance with AASB 119 requirements for "other long-term employee benefits". Under the revised standard, the recognition and measurement of employer obligations for "other long-term benefits" will need to be accounted for according to most of the requirements for defined benefit plans.

All other Australian accounting standards and interpretations with new or future commencement dates are either not applicable to Darling Downs Hospital and Health Service's activities or have no material impact on Darling Downs Hospital and Health Service.

(b) Statement of Compliance
The Darling Downs Hospital and Health Service has prepared these financial statements in compliance with Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board ('AASB') and in compliance with section 62 (1) of the *Financial Accountability Act 2009* and section 43 of the *Financial and Performance Management Standard 2009*.

These financial statements are general purpose financial statements and have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations. The financial statements comply with Queensland Treasury and Trade's *Minimum Reporting Requirements* for the year ending 30 June 2013, and other authoritative pronouncements.

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

Note 2. Summary of Significant Accounting Policies (continued)

(c) The Reporting Entity
Darling Downs Hospital and Health Service was created as a separate reporting entity on 1 July 2012. The Department of Health purchases health services from Darling Downs Hospital and Health Service under a service agreement. Darling Downs Hospital and Health Service provides a large range of health care activities and operates hospital facilities, community, mental and residential health centres. The services undertaken by Darling Downs Hospital and Health Service are disclosed at Note 4. The financial statements include the value of all assets, liabilities, equity, revenues and expenses of Darling Downs Hospital and Health Service.

(d) Basis of preparation
Critical accounting estimates
The preparation of the financial statements requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the Hospital and Health Service's accounting policies. The areas involving a higher degree of judgement or complexity, or areas where assumptions and estimates are significant to the financial statements, are disclosed in Note 3.

(e) Fiduciary trust transactions and balances
Darling Downs Hospital and Health Service acts in a fiduciary trust capacity in relation to patient fiduciary funds (formerly known as patient trust accounts) and Right of Private Practice trust accounts. Consequently, these transactions and balances are not recognised in the financial statements. Although patient funds are not controlled by Darling Downs Hospital and Health Service, trust activities are included in the audit performed annually by the Auditor-General of Queensland. Note 28 provides additional information on the balances held in patient fiduciary funds and Right of Private Practice trust accounts.

(f) Revenue recognition
Revenue is recognised when it is probable that an economic benefit will flow to the Hospital and Health Service and the revenue can be reliably measured. Revenue is measured at the fair value of the consideration received or receivable.

(g) User charges, fees and fines
User charges and fees are controlled by Darling Downs Hospital and Health Service when they can be deployed for the achievement of Darling Downs Hospital and Health Service objectives. User charges and fees are recognised as revenues when earned and can be measured reliably with a sufficient degree of certainty. This involves either invoicing for related goods, services and/or the recognition of accrued revenue.

User charges and fees controlled by Darling Downs Hospital and Health Service consist mainly of hospital fees (in-patients, out-patients, and non-patients), and other income including residential care fees; reimbursement of pharmaceutical benefits; and sales of goods and services.

(h) Grants and contributions
Grants, contributions, donations and gifts that are non-reciprocal in nature are recognised as revenue in the year in which the Hospital and Health Service 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.

Darling Downs Hospital and Health Service is predominantly funded by a non-reciprocal grant from the Department of Health through a Service Agreement. This agreement is reviewed periodically in line with Queensland Treasury and Trade's budget timetable and updated for changes in activities and the price of services delivered by Darling Downs Hospital and Health Service.

Note 2. Summary of Significant Accounting Policies (continued)

(i) Special Payments
Special payments include ex-gratia expenditure and other expenditure that the Darling Downs Hospital and Health Service is not contractually or legally obligated to make to other parties. In compliance with the *Financial and Performance Management Standard 2009*, the Darling Downs Hospital and Health Service maintains a register setting out details of special payments approved by Darling Downs Hospital and Health Service delegates in accordance with approved financial delegations. The total of all special payments (including those of $5,000 or less) is disclosed separately within Other Expenses (Note 14). However, descriptions of the nature of special/ex-gratia payments are only provided for special payments greater than $5,000.

(j) Taxation
Darling Downs Hospital and Health Service 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 Darling Downs Hospital and Health Service.

Both the Darling Downs Hospital and Health Service and the Department of Health satisfy section 149-25(e) of the A New Tax System (Goods and Services) Act 1999 (Commonwealth) (the GST Act) and were able, with other Hospital and Health Services, to form a “group” for GST purposes under Division 149 of the GST Act. This means that any transactions between the members of the "group" do not attract GST. However, all entities are responsible for the payment or receipt of any GST for their own transactions. As such, GST credits receivable from and payable to the Australian Taxation Office (ATO) are recognised and accrued. Refer Note 16 (Receivables).

(k) Cash and cash equivalents
For the purpose of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques receipted but not banked as at 30 June as well as deposits at call with financial institutions.

Darling Downs Hospital and Health Service bank accounts form part of the whole-of-Government banking arrangements with the Commonwealth Bank of Australia. Under this arrangement, Darling Downs Hospital and Health Service has access to the whole-of-Government debt facility with limits approved by Queensland Treasury and Trade

(l) Receivables
Trade debtors are recognised at the amounts due at the time of sale or service delivery i.e. the agreed purchase/contract price. Settlement of these amounts is generally required within 30 days from invoice date. The collectability of receivables is assessed periodically with provision being made for impairment. All known bad debts were written-off as at 30 June.

(m) Inventories
Inventories consist mainly of medical supplies and drugs held for distribution to hospitals or residential aged care facilities within Darling Downs Hospital and Health Service. These inventories are provided to the facilities at cost. Darling Downs Hospital and Health Service provides a central store enabling the distribution of supplies to other Hospital and Health Services. Inventories are measured at weighted average cost, adjusted for obsolescence.

Unless material, inventories do not include supplies held ready for use in the wards throughout the hospital facilities. These are expensed on issue from the Darling Downs Hospital and Health Service’s central store. Items held on consignment are not treated as inventory, but are expensed when utilised in the normal course of business.

Stock on hand is stated at the lower of cost and net realisable value. Cost comprises purchase and delivery costs, net of rebates and discounts received or receivable.

(n) Acquisition of Assets
Actual cost is used for the initial recording of all non-current physical and intangible asset acquisitions. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use, including architect’s fees and engineering design fees. However, any training costs are expensed as incurred.

Note 2. Summary of Significant Accounting Policies (continued)

Where assets are received free of charge from another Queensland Government entity (whether as a result of a machinery-of-Government change or other involuntary transfer), the acquisition cost is recognised as the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation.

Assets acquired at no cost or for nominal consideration, other than from an involuntary transfer from another Queensland Government entity, are recognised at their fair value at the date of acquisition in accordance with *AASB 116 Property, Plant and Equipment*.

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

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

Actual cost is used for the initial recording of all non-current physical and intangible asset acquisitions. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use, including architect's fees and engineering design fees. However, any training costs are expensed as incurred. Where assets are received for no consideration from another Queensland Government entity (whether as a result of a machinery-of-Government change or other involuntary transfer), the acquisition cost is recognised as the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation. Assets acquired at no cost or for nominal consideration, other than from an involuntary transfer from another Queensland Government entity, are initially recognised at their fair value at the date of acquisition in accordance with *AASB 116 Property, Plant and Equipment*.

Land and buildings are measured at fair value in accordance with *AASB 116 Property, Plant and Equipment* and Queensland Treasury and Trade's Non-Current Asset Policies for the Queensland Public Sector. In respect of these asset classes, the cost of items acquired during the financial year have been judged by management to materially reflect the fair value at the end of the reporting period.

Land is measured at fair value each year using independent revaluations, desktop market revaluations or indices provided 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. In 2012-13, Darling Downs Hospital and Health Service engaged the State Valuation Service to provide indices for an 87 per cent sample of land holdings (based on fair value) as at 30 June 2013 excluding properties which do not have a liquid market, for example properties under Deed of Grant (recorded at a nominal value of $1).

Buildings are measured at fair value utilising either independent revaluation or applying an interim revaluation methodology developed by the external independent expert. Assets under construction are measured at cost and not revalued until they are ready for use. Reflecting the specialised nature of 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.

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.

The Darling Downs Hospital and Health Service 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 experts. The proportionate method has been applied to those assets that have been revalued by way of indexation.

Note 2. Summary of Significant Accounting Policies (continued)

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 and Trade's Non-Current Asset Policies for the Queensland Public Sector.

(p) Depreciation
Property, plant and equipment are depreciated on a straight-line basis. Annual depreciation is based on fair values and the entity's assessments of the remaining useful life of individual assets. Assets with a useful life of less than two years were reviewed to ensure that the remaining service potential of the assets was reflected in the accounts. Land is not depreciated as it has an unlimited useful life. Assets under construction are not depreciated until 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 components 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	0.76% - 3.85%
Plant and Equipment	2.0% - 20.0%

(q) Leased property, 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. Darling Downs Hospital and Health Service has no finance lease assets as at the reporting date.

Darling Downs Hospital and Health Service has a Deed of Lease arrangement with the Department of Health for assets transferred to the Hospital and Health Service in the Transfer Notice effective 1 July 2012. For recognition under *AASB 117 Leases*, there must be consideration paid under the lease for assets to be recognised as Leased Assets, and this is not the case in the current arrangements therefore assets transferred are recognised as Property, Plant and Equipment rather than leased assets.

(r) 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, Darling Downs Hospital and Health Service 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.

(s) Payables
Trade creditors are recognised upon receipt of the goods or services ordered and are measured at the nominal amount i.e. agreed purchase/contract price, gross of applicable trade and other discounts. Amounts owing are unsecured and generally settled in accordance with the vendors' terms and conditions but within 60 days.

Note 2. Summary of Significant Accounting Policies (continued)

(t) Financial Instruments
Financial assets, other than those held at fair value through the Statement of Comprehensive Income, 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 Statement of Comprehensive Income.

Other disclosures relating to the measurement and financial risk management of other financial instruments are included in Note 23.

(u) Employee benefits

In accordance with Part 5 of the *Hospital and Health Boards Act 2011*, the Hospital and Health Service only has the ability to directly appoint Health Executive employees. All other employees working for the Hospital and Health Service that are not Health Executives remain employees of the Department of Health (Health Service Employees).

For further details on the Health reform that resulted in this arrangement, refer to Note 4.

(i) Health Service Employees
Under the provisions of the *Hospital and Health Boards Act 2011*, the Department of Health provides employees to perform work for the Hospital and Health Service, and the Department of Health acknowledges and accepts its obligations as the employer of these employees. Delegations from the Department of Health enable the Darling Downs Hospital and Health Service to perform functions and exercise powers to ensure the delivery of its operational plan. The Hospital and Health Service is responsible for the day to day management of the employees, and the Hospital and Health Service reimburses the Department of Health for the salaries and on-costs of these employees.

As a result of these provisions, Darling Downs Hospital and Health Service treats the reimbursements to the Department of Health for their employees in these financial statements as Supplies and Services expenses, rather than as Employee Expenses. These payments are disclosed at Note 10 under the heading "Health Service Employee Costs".

(ii) Health Executives
In addition to the employees contracted from the Department of Health, the Hospital and Health Service has engaged employees directly. The information detailed below relates specifically to the directly engaged employees.

Darling Downs Hospital and Health Service 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* (refer to Note 9 Employee Expenses). Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at current salary rates as Accrued Employee Benefits. Non-vesting employee benefits such as sick leave are recognised as an expense when taken.

Payroll tax and workers' compensation insurance are a consequence of employing employees, but are not counted in an employee's total remuneration package. They are not employee benefits and are recognised separately as employee related expenses.

Key Management Personnel and Remuneration
Key management personnel and remuneration disclosures are made in accordance with section 5 of the *Financial Reporting Requirements for Queensland Government Agencies* issued by Queensland Treasury and Trade. Refer to Note 24 for the disclosures on key executive management personnel and remuneration. These may include both Health Executives and Health Service Employees.

Note 2. Summary of Significant Accounting Policies (continued)

Annual leave and Long service leave
Darling Downs Hospital and Health Service is part of the Annual Leave Central Scheme (ALCS) and the Long Service Leave Scheme (LSLS).

Under the Queensland Government's Annual Leave Central Scheme and Long Service Leave Central Scheme, levies are payable by Darling Downs Hospital and Health Service 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. This is currently facilitated by the Department of Health on behalf of Darling Downs Hospital and Health Service.

Superannuation
Employer superannuation contributions are paid to QSuper, the superannuation scheme for Queensland Government employees, at rates determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are paid or payable and the Hospital and Health Service'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*.

Darling Downs Hospital and Health Service complies with *The Superannuation Guarantee (Administration Act) 1992* (Superannuation Guarantee) which requires the Hospital and Health Service to provide a minimum superannuation cover for all eligible employees. The minimum level of superannuation cover under the Superannuation Guarantee was 9 per cent of each eligible employee's earnings base as at 30 June 2013. Contributions are expensed in the period in which they are paid or payable. The Hospital and Health Service obligation is limited to its contribution to the superannuation fund. Therefore no liability is recognised for accruing superannuation benefits in Darling Downs Hospital and Health Service's financial statements.

(v) Insurance
Darling Downs Hospital and Health Service is covered by Department of Health insurance policies with Queensland Government Insurance Fund (QGIF) and WorkCover Queensland, and pays a fee to the Department of Health as a fee for service arrangement. This is included in supplies and services (refer Note 10).

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

(w) Services received free of charge or for nominal value
Contributions of services are recognised only if the services would have been purchased if they had not been donated and their fair value can be measured reliably. When this is the case, an equal amount is recognised as revenue and an expense.

(x) Contributed equity
Non-reciprocal transfers of assets and liabilities between wholly-owned Queensland Government 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. See Note 4 - Opening Balances for details of the opening balance transfers.

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

(y) Issuance of financial statements
The financial statements are authorised for issue by the Chair of the Board and the Chief Finance Officer, as at the date of signing the Management Certificate.

Note 2. Summary of Significant Accounting Policies (continued)

(z) Rounding of amounts
Amounts in this report have been rounded off to the nearest thousand dollars, or in certain cases, the nearest dollar.

(aa) Comparatives
There are no comparatives reported from prior years as Darling Downs Hospital and Health Service is a new entity established as at 1 July 2012. Refer Note 4 for Health reform information.

Note 3. Critical accounting judgements, estimates and assumptions

The preparation of the financial statements requires management to make judgements, estimates and assumptions that affect the reported amounts in the financial statements. Management continually evaluates its judgements and estimates in relation to assets, liabilities, contingent liabilities, revenue and expenses. Management bases its judgements, estimates and assumptions on historical experience and on other various factors, including expectations of future events. The resulting accounting judgements and estimates will seldom equal the related actual results. The judgements, estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities (refer to the respective notes) within the next financial year are discussed below.

Provision for impairment of receivables
The provision for impairment of receivables assessment requires a degree of estimation and judgement. The level of provision is assessed by taking into account the recent revenue transaction experience, the ageing of receivables, historical collection rates and specific knowledge of the individual debtor's financial position.

Fair value and hierarchy of financial instruments
The Darling Downs Hospital and Health Service is required to classify financial instruments, measured at fair value, using a three level hierarchy, being:

- Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities;
- Level 2: Inputs other than quoted prices included within level 1 that are observable for the asset or liability, either directly (as prices) or indirectly (derived from prices); and
- Level 3: Inputs for the asset or liability that is not based on observable market data (unobservable inputs). An instrument is required to be classified in its entirety on the basis of the lowest level of valuation inputs that is significant to fair value.

Considerable judgement is required when determining fair value and the relevant reportable category.

Estimation of useful lives of assets
The Darling Downs Hospital and Health Service determines the estimated useful lives and related depreciation on charges for its property, plant and equipment. The useful lives could change significantly as a result of technical innovations or some other event. The depreciation charge will increase where the useful lives are less than previously estimated lives, or technically obsolete or non-strategic assets that have been abandoned or sold will be written off or written down.

Note 4. Major services, activities and other events

Major Services

The Darling Downs Hospital and Health Service is an independent statutory body, overseen by a local Hospital and Health Board, with responsibility for providing public health services to a population of almost 300,000 people covering a predominantly rural area. The Health Service extends from the New South Wales border to west of Goondiwindi, north to Taroom and east to Murgon and then south to Stanthorpe including the major regional centre of Toowoomba.

The Darling Downs Hospital and Health Service provides public hospital and healthcare services as defined in the service agreement with the Department of Health as manager of the public hospital system.

The Darling Downs Hospital and Health Service is responsible for the oversight of health services within the Darling Downs Hospital and Health Service's graphical boundaries which includes rural hospitals, multipurpose health services, community and primary care facilities, aged care facilities and mental health services.

Note 4. Major Services, Activities and Other Events (continued)

The Hospital and Health Service provides a comprehensive range of community and primary health services, including aged care assessment; Aboriginal and Torres Strait Islander health programs; child and maternal health services; alcohol, tobacco and other drug services; mental health services; home care services; community health nursing; sexual health services; allied health services; oral health; and health promotion programs.

These services reflect Darling Downs Hospital and Health Service's planning priorities as articulated in Darling Downs Hospital and Health Service Strategic Plan 2012-2016 and supports investment decision-making based on the health continuum. These strategic directions are set by the Darling Downs Hospital and Health Service and the Darling Downs Hospital and Health Service implements and develops initiatives in accordance with these strategic directions.

Darling Downs Hospital and Health Service's purpose is to deliver quality healthcare in partnership with the community and its vision is to be trusted as a leader in regional healthcare.

These strategies include:

- Delivering quality healthcare (delivering core health services; improving access to services; reducing the impact of chronic disease; ensuring safe and quality health outcomes and increasing confidence in health systems);
- Sustainable resources (balanced operating position; leverage other providers; ensure appropriate costs; maximise revenue and optimise asset usage);
- Clarity of process (collaboration with primary health care and other service providers; deliver more care locally; effective operational planning; review and improve care; increase use of clinical evidence-based decision making and engage the community and health care consumers); and
- Dedicated trained staff (embed a values based culture; develop, educate and train; plan, recruit and retain an appropriately skilled workforce; engage clinicians to improve the service).

Major activities

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 took effect 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 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 Hospital and Health Services; 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 Hospital and Health Services and healthcare facilities.

The *Health and Hospitals Network Act 2011* (HHNA), which was passed by the Queensland Parliament in October 2011, enabled the establishment of the new health service entities and the System Manager role for the health department in Queensland. On 17 May 2012, the Minister for Health introduced amending legislation into the Parliament to expand the functions of Hospital and Health Services under the HHNA. The amended legislation is known as the *Hospital and Health Boards Act 2012* (HHBA).

Information is also available on the Department of Health website at: http://www.health.qld.gov.au/health-reform/

Note 4. Major Services, Activities and Other Events (continued)

Funding Reforms
Funding is provided to the Darling Downs Hospital and Health Service in accordance with Service Agreements.

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

An Independent Hospital Pricing Authority (IHPA) has been established independently from the Commonwealth to develop and specify national classifications to be used to classify activity in public hospitals for the purposes of Activity Based Funding.

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

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

Overdraft Facility
Hospital and Health Service bank accounts form part of the whole-of-Government banking arrangement with the Commonwealth Bank of Australia.

Under this arrangement, Hospital and Health Services have access to the whole-of-Government debit facility with limits assigned to Department of Health and individual Hospital and Health Services which are approved by Queensland Treasury and Trade.

Darling Downs Hospital and Health Service has an approved debt facility of $6 million under whole-of-Government banking arrangements to manage any short term cash shortfalls.

Balances Transferred in on 1 July 2012
On 1 July 2012, certain balances were transferred from the Department of Health to Darling Downs Hospital and Health Service. This was affected via a transfer notice signed by the Minister for Health, designating that the transfer be recognised as a contribution by owners through equity. The “Opening Balance Transfers Hospital and Health Services Form” was approved by the Chair, Darling Downs Hospital and Health Board, Health Service Chief Executive and the Director-General of Department of Health.

Balances transferred to Darling Downs Hospital and Health Service materially reflected the closing balances of Darling Downs Health Service District as at 30 June 2012. These balances became the opening balances of Darling Downs Hospital and Health Service. The cash balance transferred to Darling Downs and Hospital Health Service was the amount required to ensure the entity commenced operations with a balanced working capital position.

The value of assets and liabilities transferred to Darling Downs Hospital and Health Service on 1 July 2012 are detailed below:

Note 4. Major Services, Activities and Other Events (continued)

	1 July 2012 $'000
Cash and cash equivalents	15
Trade receivables	11,434
Inventories	4,684
Trust - Net Assets	2,417
Other asset	172
Plant and equipment	301,101
Trade payables	(16,305)
Net assets acquired	**303,518**

Other Events

Natural Disaster Relief and Recovery Arrangements
The National Disaster Relief and Recovery Arrangements (NDRRA), a joint Commonwealth/State program, has provided funding to the Queensland Reconstruction Authority (the Authority) to assist with the natural disaster relief and recovery costs. The Authority coordinates the distribution of funding for NDRRA claims to enable Darling Downs Hospital and Health Service to claim eligible costs in relation to declared natural disaster events. For 2012-13, Darling Downs Hospital and Health Service has incurred $156,781 of costs to be claimed through the NDRRA arrangements.

Voluntary Redundancies
In 2012-13 Darling Downs Hospital and Health Service, in line with whole of Government initiatives, conducted a Voluntary Redundancy program offering bona-fide redundancy packages to selected Department of Health staff. 95 voluntary redundancies were accepted in accordance with the terms of the Queensland Public Service Commission's *Directive 11/12 Early Retirement, Redundancy and Retrenchment.*

Note 5. User Charges

	2013 $'000
Sale of goods and services	3,070
Hospital fees	20,530
Pharmaceutical Benefits Scheme Reimbursement	5,987
Total	**29,587**

Note 6. Grants and Other Contributions

	2013 $'000
State Government Grants	
Activity Based Funding	
State share	126,314
Commonwealth share	65,137
	191,451
Block funding	
State share	132,271
Commonwealth share	56,851
	189,122
Training, teaching and research	
State share	13,876
Commonwealth share	6,036
	19,912
Other	112,071
Total State Government grants	**512,556**
Australian Government Grants	
Nursing home grants	15,849
Other specific purpose recurrent grants	13,281
Total Australian Government Grants	**29,130**
Donations non-current physical assets	18
Donations other	166
Total	**541,870**

Note 7. Other Revenue

	2013 $'000
Health Service Employee Cost Recoveries	
Government Departments	253
External	2,583
Workcover	695
Total Health Service Employee Cost Recoveries	**3,531**
Rental income	36
Interest	154
Non-labour recoveries	281
Other	340
Total	**4,342**

Note 8. Gains

	2013 $'000
Gain on sale of property, plant and equipment	53
Total	**53**

Note 9. Employee Expenses

	2013 $'000
Employee Benefits	
Wages and salaries	1,422
Employer superannuation contributions	163
Annual leave expense	150
Long service leave levy	25
Redundancies	189
Employee related expenses	
Workers' compensation premium	21
Payroll tax	37
Other employee related expenses	61
Total	**2,068**

The number of employees includes full-time employees and part-time directly-engaged employees measured on a full-time equivalent basis is:

Number of Employees (Full Time Equivalents) as at 30 June 2013: 4.8

Key executive management and personnel are reported in Note 24.

Note 10. Supplies and Services

	2013 $'000
Health Service Employees Costs	411,117
Consultants and Contractors	12,877
Rates, water and utility costs	6,701
Patient travel	4,123
Other travel	1,374
Building services	995
Insurance premiums (paid to Department of Health)	6,604
Motor vehicles	640
Inter-entity supplies (paid to Department of Health)	9,519
Computer Services and Communications	6,752
Repairs and maintenance	8,641
Expenses relating to capital works	888
Operating lease rentals	3,039
Pathology and laboratory supplies	11,292
Drugs	16,633
Clinical supplies and services	21,126
Catering and domestic supplies	8,241
Other	7,082
Total	**537,644**

Health Service Employees Costs
Darling Downs Hospital and Health Service, through service arrangements with the Department of Health, has engaged full-time equivalent persons, as calculated by reference to the minimum obligatory human resources information (MOHRI). Refer to Note 2 for further details on the contractual arrangements.

Number of Employees (Full Time Equivalents) as at 30 June 2013: 3,763

Note 11. Grants and Subsidies

	2013 $'000
Grants to other Hospital and Health Services for	
Rural Generalist Pathway	1,150
Medical research programs	131
Other	58
Total	**1,339**

Note 12. Depreciation

	2013 $'000
Buildings	13,509
Plant and equipment	5,179
Total	**18,688**

Refer Note 18 and Note 2.

Note 13. Impairment Losses

	2013 $'000
Impairment losses on receivables	(74)
Bad debts written off	407
Total	**333**

Refer Note 16.

Note 14. Other Expenses

	2013 $'000
External audit fees	205
Bank fees	14
Insurance	45
Inventory written off	91
Losses from the disposal of non-current assets	422
Special payments - ex-gratia payments	56
Other legal costs	246
Journals and subscriptions	116
Advertising	84
Interpreter fees	137
Other	115
Total	**1,531**

Total audit fees recognised as payable to the Queensland Audit Office relating to the 2012-13 financial year are estimated at $205K. There are no non-audit services included in this amount.

Insurance costs represent excess amounts under motor vehicle insurance claims and costs of insurance for motor vehicle fleet managed by the Darling Downs Hospital and Health Service. Certain losses of public property and health litigation costs are insured with the Queensland Government Insurance Fund. Insurance premiums are paid via fee for service arrangements to the Department of Health (refer Note 2 (u) *Insurance*) and disclosed at Note 10 (Supplies and Services).

Special payments (ex-gratia payments) greater than $5,000 include payments to a member of the public for $9,530 in relation to claims lodged through the Health Quality and Complaints Commission; and a compensation payment of $10,000 to a member of the public.

Note 15. Cash and Cash Equivalents

	2013 $'000
General trust cash at bank	501
Operating cash on hand and at bank	35,448
General trust at call deposits	2,903
Total	**38,852**

Darling Downs Hospital and Health Service's operating bank accounts are grouped as part of a Whole-of-Government (WoG) banking arrangement with the Queensland Treasury Corporation, and does not earn interest on surplus funds nor is it charged interest or fees for accessing its approved cash debit facility (See note 4 for details). Any interest earned on the Whole-of-Government fund accrues to the Consolidated Fund.

General trust cash at bank accounts and at call deposits do not form part of the WoG banking arrangement and incur fees as well as earn interest. Interest earnt from general trust accounts is used in accordance with the terms of the trust.

Cash deposited at call with Queensland Treasury Corporation earns interest, calculated on a daily basis reflecting market movements in cash funds. Annual effective interest rates (payable monthly) achieved throughout the year ranged between 3.61% to 4.68%.

Note 16. Receivables

	2013 $'000
Trade receivables	4,191
Payroll receivables	11
Less: Provision for impairment of receivables	(564)
	3,638
GST input tax credits receivable	766
GST payable	(47)
	719
Accrued revenue from Department of Health	6,528
Other accrued revenue	1,495
Other	50
Total	**12,430**

Payroll receivables represent interim cash payments and salary overpayments for executive staff.

Impairment of receivables
Darling Downs Hospital and Health Service has recognised a loss of $0.3M in respect of impairment of receivables for the current reporting period. Throughout the year, the Darling Downs Hospital and Health Service continually reassessed the impairment risk of debtors by facility/unit and category. The allowance for impairment reflects the Hospital and Health Service's assessment of the credit risk associated with receivables balances and is determined based on a combination of individual debtor assessment and historical rates of bad debts and management judgement. Refer Note 23 for details of the ageing of impaired receivables.

Note 17. Inventories

	2013 $'000
Medical supplies and equipment	2,308
Drugs	2,072
Other	384
Total	**4,764**

Note 18. Property, Plant and Equipment

	2013 $'000
Land - at independent valuation	42,169
	42,169
Buildings - at independent valuation	619,284
Less: Accumulated depreciation	(379,709)
	239,575
Plant and equipment - at cost	60,135
Less: Accumulated depreciation	(32,649)
	27,486
Capital works in progress - at cost	1,237
	1,237
Total property, plant and equipment	**310,467**

Reconciliation
Reconciliations of the written down values at the beginning and end of the current financial year are set out below:

	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Assets transferred in 1 July 2012	41,467	229,581	28,166	1,887	301,101
Transfers between classes		2,696		(2,696)	0
Donations			18		18
Additions	702	3,404	4,990	2,046	11,142
Disposals		(1)	(509)		(510)
Revaluation increments		17,404			17,404
Depreciation		(13,509)	(5,179)		(18,688)
Carrying amount at 30 June 2013	**42,169**	**239,575**	**27,486**	**1,237**	**310,467**

Valuations of Land and Buildings

Land
Land is measured at fair value 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. In 2012-13, the State Valuation Service were engaged to provide indices for 87 per cent of land holdings as at 30 June 2013 excluding properties which do not have a liquid market, for example properties under Deed of Grant (recorded at a nominal value of $1). Indices are based on actual market movements for the relevant location and asset category and were applied to the fair value of land transferred from the Department of Health on 1 July 2012.

Note 18. Property, Plant and Equipment (continued)

These land holdings were comprehensively revalued by the State Valuation Office in 2010-11 with indices from independent sources applied in 2011-12 by the Department of Health.

The indexation results were not considered material in the current reporting period and therefore no changes were posted to the carrying amount of land.

Buildings
An independent revaluation of 86 per cent of the gross value of the building portfolio was performed during 2012-13 by independent experts Davis Langdon. The balance of assets in this class has had indexation applied based on independent indices developed by Davis Langdon.

The buildings valuations for 2012-13 resulted in a net increment to the entity's building portfolio of $17.4M.

The basis of the valuer's methodology is the Depreciated Replacement Cost (DRC) of the asset which is calculated as follows: Replacement Cost less Cost to bring asset to current standards.

The methodology applied by the valuer is a financial simulation in lieu of 'Market Value' as these assets cannot be bought and sold on the open market. A Replacement Cost is estimated by creating a cost plan (cost estimate) of the asset through the measurement of key quantities such as:

- Gross Floor Area (GFA);
- Number of floors;
- Girth of the building;
- Height of the building; and
- Number of lifts and staircases.

The model developed by the valuer creates an elemental cost plan using these quantities and the model includes multiple building types and is based on the valuer's experience of cost managing construction contracts.

The cost model is updated each year and tests are done to compare the model outputs on actual recent projects to ensure it produces a true representation of the cost of replacement. The costs are at Brisbane prices and published location indices are used to adjust the pricing to suit local market conditions. Live project costs from across the state are also assessed to inform current market changes that may influence the published factors.

The key assumption on the replacement cost is that our estimate is based on replacing the current function of the building with a building of the same form (size and shape). This assumption has a significant impact if an asset's function changes.

The 'Cost to Bring to Current Standards' is the estimated cost of refurbishing the asset to bring it to current standards and a new condition. For each of the five condition ratings the estimate is based on professional opinion as well as having regard to historical project costs.

In assessing the cost to bring to current standard, a condition rating is applied based upon the following information:

- Visual inspection of the asset;
- Asset condition data provided by the Department of Health;
- Verbal guidance from the asset manager; and
- Previous report and inspection photographs if available (to show the change in condition over time).

Note 18. Property, Plant and Equipment (continued)

Condition Ratings		
Category	**Condition**	**Criteria**
1	Very Good Condition	Only normal maintenance required
2	Minor Defects Only	Minor maintenance required
3	Maintenance required to return to accepted level of service	Significant maintenance required (up to 50% of capital replacement cost)
4	Requires Renewal	Complete renewal of the internal fit out and engineering services required (up to 70% of capital replacement cost)
5	Asset Unserviceable	Complete asset replacement required.

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

The valuer's methodology in 2012-13 has changed from prior year revaluations conducted by the Department of Health in that category 2 and category 3 condition ratings were significantly influenced by the age of the asset. In 2012-13, this condition criteria has been replaced with a standardised condition curve approach to more accurately reflect an asset's condition through it's life. The financial effect on depreciated replacement cost values from this change in condition criteria has been modelled and has been assessed as immaterial (i.e. in the range of 1% and 2%).

The standard life of a health facility is generally 30 years and is adjusted for those assets in extreme climatic conditions have historically shorter lives, or where assets such as residences generally have longer lives.

Estimates of remaining life are based on the assumption that the asset remains in it's current function and will be maintained.

No allowance has been provided for significant refurbishment works in our estimate of remaining life as any refurbishment should extend the life of the asset.

Buildings have been valued on the basis that there is no residual value.

Plant and Equipment
Plant and equipment assets are valued at original cost and replacement decisions are based on a periodic physical assessment of the condition and utility of the asset.

Note 19. Payables

	2013 $'000
Trade payables	3,505
Payable to Department of Health	26,468
Accrued expenses	8,519
Other payables	31
Total	**38,523**

Refer to note 23 for further information on financial instruments.

Note 20. Accrued Employee Benefits

	2013 $'000
Salaries and wages accrued	73
Total	**73**

Note 21. Asset Revaluation Surplus by Class

	2013 $'000
Asset revaluation surplus reserve - buildings	17,404
Total	**17,404**

Revaluation surplus reserve
The asset revaluation surplus represents the net effect of revaluation movements in assets (Refer Note 18).

Note 22. Retained Surpluses

	2013 $'000
Retained surpluses at the beginning of the financial year	0
Surplus for the year	14,249
Retained surpluses at the end of the financial year	**14,249**

Note 23. Financial Instruments

(a) Categorisation of Financial Instruments

Darling Downs Hospital and Health Service has the following categories of financial assets and financial liabilities:

Category	2013 $'000
Financial Assets	
Cash and cash equivalents	38,852
Receivables	12,430
Total	**51,282**
Financial Liabilities	
Financial liabilities measured at amortised cost:	
Payables	38,523
Total	**38,523**

Note 23. Financial Instruments (continued)

(b) Financial Risk Management Objectives

The Hospital and Health Service's activities expose it to a variety of financial risks: market risk (including foreign currency risk, price risk and interest rate risk), credit risk and liquidity risk.

Darling Downs Hospital and Health Service measures risk exposure using a variety of methods as follows:

Risk Exposure	Measurement Method
Credit risk	Ageing analysis, earnings at risk
Liquidity risk	Monitoring cash flows by management of accrual accounts, sensitivity analysis
Market risk	Interest rate sensitivity analysis

Financial risk is managed in accordance with Queensland Government and Darling Downs Hospital and Health Service policy. These policies provide written principles for overall risk management, as well as policies covering specific areas, and aim to minimise potential adverse effects of risk events on the financial performance of Darling Downs Hospital and Health Service.

(c) Credit Risk Exposure

Credit risk exposure refers to the situation where the Darling Downs Hospital and Health Service may incur financial loss as a result of another party to a financial instrument failing to discharge their obligation.

Credit risk on receivables is considered minimal given that $7.5M (61%) of total receivables is receivable from the Department of Health. Refer Note 16 for further information.

Credit risk on cash and cash equivalents is considered minimal given all Darling Downs Hospital and Health Service deposits are held through the Commonwealth Bank of Australia and by the State through Queensland Treasury Corporation. No financial assets have had their terms renegotiated 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:

2013 Financial Assets Past Due But Not Impaired

	Not yet due $'000	Less than 30 days $'000	30-60 days $'000	60-90 days $'000	More than 90 days $'000	Total $'000
Receivables	10,068	1,092	317	228	714	12,419
Payroll Receivables	4				7	11
Total	**10,072**	**1,092**	**317**	**228**	**721**	**12,430**

Unimpaired debts are represented by amounts for hospital admissions that have been referred to health insurers for settlement. These unimpaired debts are expected to be fully recoverable upon completion of health insurer's processing requirements, in line with industry experience.

2013 Impaired Financial Assets

		Overdue				
	Not yet due $'000	Less than 30 days $'000	30-60 days $'000	60-90 days $'000	More than 90 days $'000	Total $'000
Receivables (gross)	0	64	76	66	358	564
Allowance for impairment	0	(64)	(76)	(66)	(358)	(564)
Carrying amount	0	0	0	0	0	0

Note 23. Financial Instruments (continued)

Movements in Allowance for Impairment

	2013 $'000
Balance at 1 July 2012	638
Increase in allowance recognised in operating result	333
Amounts written-off during the year	(407)
Balance at 30 June 2013	**564**

(d) Liquidity Risk

Liquidity risk refers to the situation where Darling Downs Hospital and Health Service may encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivering cash or another financial asset.

Darling Downs Hospital and Health Service is exposed to liquidity risk through its trading in the normal course of business, and manages liquidity risk through the use of a liquidity management strategy. This strategy aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations as they fall due. This is achieved by ensuring that minimum levels of cash are held within the various bank accounts so as to match the expected duration of the various employee and supplier liabilities.

Darling Downs Hospital and Health Service has an approved debt facility of $6 million under Whole-of-Government banking arrangements to manage any short term cash shortfalls (See Note 4 - *Debit Facility*).

The following table sets out the liquidity risk of financial liabilities held by the Darling Downs Hospital and Health Service. It represents the contractual maturity of financial liabilities, calculated based on undiscounted cash flows relating to the liabilities at reporting date. The undiscounted cash flows in these tables differ from the amounts included in the Statement of Financial Position that are based on discounted cash flows.

		2013 Payable in			
	Note	1 year $'000	1-5 years $'000	> 5 years $'000	Total $'000
Financial Liabilities					
Payables	19	38,523	-	-	38,523
Total		**38,523**	**-**	**-**	**38,523**

(e) Market Risk

The Darling Downs Hospital and Health Service does not trade in foreign currency and is not materially exposed to commodity price changes. Darling Downs Hospital and Health Service is exposed to interest rate exposure on the 24 hour call deposits and there is no interest rate exposure on its cash and fixed rate deposits.

Darling Downs Hospital and Health Service does not undertake any hedging in relation to interest rate risk and manages its risk as per the Darling Downs Hospital and Health Service liquidity risk management strategy articulated in the Darling Downs Hospital and Health Service's Financial Management Practice Manual. Changes in interest rate have a minimal effect on the operating result of the Hospital and Health Service.

(f) Interest Rate Sensitivity Analysis

The following interest rate sensitivity analysis depicts the outcome on net income if interest rates would change by +/- 1% from the year end rates applicable to the Darling Downs Hospital and Health Service's financial assets.

Note 23. Financial Instruments (continued)

With all other variables held constant, the Darling Downs Hospital and Health Service would have a surplus and equity increase or decrease of $29K. This is mainly attributable to exposure to variable interest rates on general trust at call deposits with the Queensland Treasury Corporation.

Financial Instruments	Carrying Amount (Note 15)	**2013 Interest rate risk**			
		-1%		+1%	
		Profit	Equity	Profit	Equity
Financial Assets					
Cash and Cash Equivalents					
General trust cash at bank	501	-	-	-	-
Operating cash on hand and at bank	35,448	-	-	-	-
General trust at call deposits	2,903	(29)	(29)	29	29
Potential Impact	**38,852**	**(29)**	**(29)**	**29**	**29**

Operating cash at bank is not subject to interest due to existing Whole-of-Government banking arrangements. Refer to Note 15 for details.

Note 24. Key Executive Management Personnel and Remuneration

Board members
The following details for Board members include those positions that had authority and responsibility for planning, directing and controlling the activities of Darling Downs Hospital and Health Service during 2012-13. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Name and position of current incumbents	**Responsibilities**	**Contract classification & appointment authority**	**Appointment date**
Mike Horan *AM* Chair	Accountable for the performance of the Darling Downs Hospital and Health Service in purchasing and providing health services to meet local priorities and national standards.	Government Board B1	18 May 2012
Dr Dennis Campbell Deputy Chair	Board member	Government Board B1	29 June 2012
Danielle Causer Board member	Board member	Government Board B1	29 June 2012 (ceased 31 December 2012)
Cheryl Dalton Board member	Board member	Government Board B1	29 June 2012
Terry Fleischfresser Board member	Board member	Government Board B1	29 June 2012
Dr Ross Hetherington Board member	Board member	Government Board B1	29 June 2012
Dr Ian Keys Board member	Board member	Government Board B1	29 June 2012
Patricia Leddington-Hill Board member	Board member	Government Board B1	9 November 2012
Marie Pietsch Board member	Board member	Government Board B1	29 June 2012
Dr Jeffrey Prebble ***OAM*** Board member	Board member	Government Board B1	29 June 2012
Megan O'Shannessy Board member	Board member	Government Board B1	18 May 2013

Note 24. Key Executive Management Personnel and Remuneration (continued)

Executive
The following details for key executive management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of Darling Downs Hospital and Health Service during 2012-13. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Darling Downs Hospital and Health Service Executives (employed under contract by the Darling Downs Hospital and Health Service)

Name and position of current incumbents	Responsibilities	Contract classification & appointment authority	Appointment date
Dr Peter Bristow Health Service Chief Executive	Responsible for the overall management of Darling Downs Hospital and Health Service through major functional areas to ensure the delivery of key government objectives in improving the health and well-being of all Darling Downs residents.	S24 and S70 contract	6 August 2012 *
Scott McConnel Chief Finance Officer	Provides single point accountability and leadership for the Finance Division and coordinates the Health Service's financial management consistent with relevant legislation and policy directions to support high quality health care delivery within the Darling Downs Hospital and Health Service.	HES2-3 Contract	12 December 2011
Stewart Gordon Executive Director People and Corporate Services	Provides single point accountability and leadership for the Division of People and Corporate Services within the Darling Downs Hospital and Health Service. This includes the functions of human resources management, occupational health & safety, workforce planning and development, infrastructure and planning (including service planning, capital works planning and delivery, facility engineering and maintenance), operational and administrative support services in Toowoomba and the provision of oversight of these support services in rural areas of the Health Service.	HES2-3 Contract	27 January 2012
Michael Bishop Executive Director Rural Health and Aged Care	Provides single point accountability and leadership for the Division of Rural Health and Aged Care within the Darling Downs Hospital and Health Service. This Division includes 19 hospitals and health care services, including co-located residential aged care services, and Mt Lofty Heights Residential Aged Care Facility.	HES2-3 Contract	28 May 2012

Note 24. Key Executive Management Personnel and Remuneration (continued)

Name and position of current incumbents	Responsibilities	Contract classification & appointment authority	Appointment date
Shirley Wigan Executive Director Mental Health	Provides single point accountability and leadership for the Darling Downs Hospital and Health Service mental health services, including acute in-patient services at Toowoomba Hospital, extended in-patient services at Baillie Henderson Hospital and ambulatory care services located throughout the Health Service.	HES2-3 Contract	22 November 2012
Brigid Loughnane (ceased 11 January 2013) - Executive Director Toowoomba Hospital	Single point of accountability for Toowoomba Hospital operations.	HES2-3 Contract	19 March 2012

* Dr Peter Bristow was engaged as Acting Health Service Chief Executive from 1 July 2012 to date of appointment whilst employed by the Department of Health under Award arrangements.

Darling Downs Hospital and Health Service Executives employed by the Department of Health under Award

Name and position of current incumbents	Responsibilities	Contract classification & appointment authority	Appointment date
Dr Peter Gillies Executive Director Medical Services & Toowoomba Hospital	Provides professional leadership for the medical services of the Darling Downs Hospital and Health Service and Toowoomba Hospital. Leads the development and implementation of strategies that will ensure the medical workforce is aligned with identified service delivery needs, and appropriately qualified, competent and credentialed workforce is maintained. In addition the EDMS oversights Medical Research and clinical governance including patient safety and quality. Single point of accountability for Toowoomba Hospital.	Medical - MMOI2	Acting
Judith March Executive Director of Nursing and Midwifery Services	Provides professional leadership for the nursing services of the Darling Downs Hospital and Health Service. The position leads the development and implementation of strategies that will ensure the nursing and midwifery workforce is aligned with identified service delivery needs.	Nursing and Midwifery – NRG12-1	22 May 2012
Megan Morse Executive Director Allied Health	Provides single point accountability and leadership for the Division of Allied Health within the Hospital and Health Service. In addition the role functions as the Director Allied Health for Toowoomba Hospital. The position provides high level leadership, strategic direction and advocacy in the professional management of allied health services across the Hospital and Health Service, including contribution to state-wide initiatives.	Health Practitioner - HP7-1	4 July 2012

Note 24. Key Executive Management Personnel and Remuneration (continued)

Remuneration – Board Members
The Governor in Council approves the remuneration arrangements for Hospital and Health Board Chair, Deputy Chairs and Members.

Chairs, Deputy Chairs and Members are paid an annual salary consistent with the Government policy titled: R*emuneration of Part-time Chairs and Members of Government Boards, Committees and Statutory Authorities*.

2013	**Short-term benefits**	**Post- employment benefits**	**Total**
Name and position	**Directors Fees and allowances**		
Mike Horan *AM* Chair	74	6	80
Dr Dennis Campbell Deputy Chair	33	3	36
Danielle Causer Board member (ceased 31 December 2012)	19	1	20
Cheryl Dalton Board member	31	3	34
Terry Fleischfresser Board member	32	3	35
Dr Ross Hetherington Board member	35	3	38
Dr Ian Keys Board member	32	3	35
Patricia Leddington-Hill Board member	22	2	24
Megan O'Shannessy Board member	4	1	5
Marie Pietsch Board member	37	3	40
Dr Jeffrey Prebble *OAM* Board member	31	3	34

Remuneration - Executive
Remuneration policy for Darling Downs Hospital and Health Service's key Health Executive personnel is set by the Director-General, Department of Health, as provided for under the *Hospital and Health Boards Act 2011*. The remuneration and other terms of employment for the key executive management personnel are specified in employment contracts. For the 2012-13 year, the remuneration of key executive management personnel increased by 2.5% in accordance with government policy.

Remuneration packages for 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.
    - 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 amounts expensed in respect of employer superannuation obligations.
- Redundancy payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu of notice on termination, regardless of the reason for termination.

Note 24. Key Executive Management Personnel and Remuneration (continued)

- There was no performance bonuses paid in the 2012-13 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.

Darling Downs Hospital and Health Service Executives (employed under contract by the Darling Downs Hospital and Health Service)

2013	Short-term benefits		Post-employment benefits	Long-term benefits	Termination benefits	Total
Name and position	**Base**	**Non-monetary**				
Dr Peter Bristow Health Service Chief Executive	466	28	50	10		554
Scott McConnel Chief Finance Officer	180		20	4		204
Stewart Gordon Executive Director People and Corporate Services	144		17	3		164
Michael Bishop Executive Director Rural Health and Aged Care	155	25	20	3		203
Shirley Wigan Executive Director Mental Health	161	3	20	3		187
Brigid Loughnane (ceased 11 January 2013) - Executive Director Toowoomba Hospital	93		10	2	189	293

Darling Downs Hospital and Health Service Executives employed by the Department of Health under Award

2013	Short-term benefits		Post-employment benefits	Long-term benefits	Termination benefits	Total
Name and position	**Base**	**Non-monetary**				
Dr Peter Gillies Executive Director Medical Services & Toowoomba Hospital	454	23	34	10		521
Judith March Executive Director of Nursing and Midwifery Services	179		25	4		208
Megan Morse Executive Director Allied Health	145		18	3		166

Non-monetary benefits includes the notional value of motor vehicles provided to key management personnel.

Note 25. Contingencies

(a) Litigation in Progress

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). Darling Downs Hospital and Health Service's liability in this area is limited to an excess per insurance event (Refer Note 2(u) "Insurance"). Darling

Note 25. Contingencies (continued)

Downs Hospital and Health Service'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* (PIPA) has resulted in fewer cases appearing before the courts. These matters are usually resolved at the pre-proceedings stage.

As at 30 June 2013 there were 13 claims managed by QGIF, some of which may never be litigated or result in payments to claims (note that this figure excludes Initial Notices under PIPA). The maximum exposure to Darling Downs Hospital and Health Service under this policy is up to $20,000 for each insurable event. As at 30 June 2013, the following cases were filed in the courts naming the State of Queensland acting through the Darling Downs Hospital and Health Service as defendant:

Litigation in progress 2012-13	**Number of cases**
Supreme Court	2
Tribunals, commissions and boards	1
Total cases as at 30 June 2013	3

(b) Native Title Claims over Darling Downs Hospital and Health Service Land

The Queensland Government Native Title Work Procedures were designed to ensure that native title issues are considered in all of Darling Downs Hospital and Health Service's land and natural resource management activities.

All business pertaining to land held by or on behalf of Darling Downs Hospital and Health Service must take native title into account before proceeding. Such activities include disposal, acquisition, development, redevelopment, clearing, fencing of real property including the granting of leases, licences or permits.

Real Property Dealings may proceed on Darling Downs Hospital and Health Service owned land where native title continues to exist, provided native title holders or claimants receive the necessary procedural rights.

Darling Downs Hospital and Health Service undertakes native title assessments over real property when required and as required will negotiate Indigenous Land Use Agreements (ILUA) with native title holders. These ILUAs will provide trustee leases to validate the tenure of current and future health facilities. The National Native Title Tribunal has reported no native title claims for Darling Downs Hospital and Health Service as at the reporting date.

(c) Other Contingencies

The following liabilities are contingent upon future Government and management decisions and cannot be estimated with reasonable certainty at the reporting date.

(i) *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. The current estimate of all property maintenance backlog costs is $50M as at the reporting date.

Department of Health announced (post 30 June 2013) that $37M of additional capital works funding has been provided in the 2013-14 budget allocation to address the property maintenance backlog of the Darling Downs Hospital and Health Service.

Note 26. Commitments for Expenditure

	2013 $'000
Capital Expenditure and Commitments	
Committed at the reporting date but not recognised as liabilities, payable:	
Repairs & maintenance	552
Supplies & services	17
Capital works *	1,941
Other	103
Total	**2,613**
Capital Expenditure and Commitments	
Committed at the reporting date but not recognised as liabilities, payable:	
Within one year	**2,613**

* Material classes of capital expenditure commitments inclusive of anticipated GST, contracted for at reporting date but not recognised in the accounts are included. Capital projects are included as commitments for the total project amounts. Each of these projects is currently at a different stage of the contractual cycle.

Non-Cancellable Operating Leases

Committed at the reporting date but not recognised as liabilities, payable:	
Within one year	90
One to five years	269
More than five years	660
Total	**1,019**

Commitments under operating leases at reporting date are inclusive of anticipated GST. Darling Downs Hospital and Health Service has non-cancellable operating leases relating predominantly to offices. 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.

Note 27. Restricted Assets

Darling Downs Hospital and Health Service 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. As at 30 June 2013, amounts are set aside for clinical trials ($185,640); clinical research ($32,206); health research ($23,845) and other purposes ($87,144) for the specific purposes underlying the contribution.

Note 28. Fiduciary Trust Transactions and Balances

(a) Patient Fiduciary Funds

Darling Downs Hospital and Health Service acts in a custodial role in respect of patient fiduciary fund (formerly known as patient trust accounts) transactions and balances (refer Note 2(e)). As such, they are not recognised in the financial statements, but are disclosed below for information purposes.

Note 28. Fiduciary Trust Transactions and Balances (continued)

	2013 $'000
Patient Fiduciary Fund receipts and payments	
Receipts	
Patient fiduciary fund receipts	7,901
Total receipts	**7,901**
Payments	
Patient fiduciary fund payments	8,001
Total payments	**8,001**
Fiduciary fund assets	
Current Assets	
Cash - Patient fiduciary fund deposits	584
Total current assets	**584**

(b) **Right of Private Practice (RoPP) scheme**

Under the Australian Government's National Health Reform Agreement with the states and territories, patient choice is facilitated by the right of private practice (RoPP) scheme, which provides for senior medical officers (SMOs) who are employed in the public health system to also treat those patients who come into the public system and elect to be treated as private patients.

The Queensland RoPP scheme was approved to capture privately insured patients receiving treatment as public patients, and to assist in the recruitment and retention of full time specialist staff in the public hospital system. Public patients were not to be affected adversely by the introduction of scheme options.

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

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

A third model is a combination of the assignment and revenue sharing models. It is available only to pathologists and is known as Option P.

Darling Downs Hospital and Health Service acts in an agency role in respect of the transactions and balances of the Private Practice (RoPP) bank accounts. Transactions relating to Option B revenue are managed in an agency capacity, except for payments to Darling Downs Hospital and Health Service for recoverable costs which are recognised as controlled revenue in Darling Downs Hospital and Health Service accounts and payment of SERTA funds to the General Trust bank account operated by Darling Downs Hospital and Health Service (refer Note 15 - Cash and Cash Equivalents). At balance date any monies remaining in the RoPP bank account that represent Darling Downs Hospital and Health Service revenue is accrued as revenue in Darling Downs Hospital and Health Service accounts. As such, the Right of Private Practice funds are not controlled by Darling Downs Hospital and Health Service but the activities are included in the annual audit performed by the Auditor-General of Queensland.

Note 28. Fiduciary Trust Transactions and Balances (continued)

Right of Private Practice (RoPP) Trust receipts and payments	2013 $'000
Receipts	
Medical Practice receipts	5,237
Bank interest	8
Total receipts	**5,245**
Payments	
Payments to Medical Officers	785
Payments to Hospital and Health Service	3,612
Payments to Hospital and Health Service General Trust	749
Total payments	**5,146**
Increase in net private practice assets	**99**
Current Assets	
Cash - RoPP	507
Total current assets	**507**
Current Liabilities	
Payments to Medical Officers	49
Payments to Hospital and Health Service	371
Payments to Hospital and Health Service General Trust	87
Total current liabilities	**507**

Note 29. Events After the Reporting Period

No matter or circumstance has arisen since 30 June 2013 that has significantly affected, or may significantly affect the Hospital and Health Service's operations, the results of those operations, or the Hospital and Health Service 's state of affairs in future financial years.

Note 30. Reconciliation of Operating Surplus to Net Cash from Operating Activities

	2013 $'000
Surplus for the year	14,249
Adjustments for:	
Depreciation and amortisation	18,688
Write off of assets	510
Net gain on disposal of non-current assets	(53)
Assets donated revenue - non-cash	(18)
Depreciation grant funding – non-cash	(18,656)
Change in operating assets and liabilities:	
Increase in trade and other receivables	(1,577)
Increase in GST receivables	(719)
Increase in inventories	(79)
Decrease in accrued revenue	1,300
Decrease in prepayments	3
Increase in trade and other payables	16,499
Increase in employee benefits	73
Increase in other operating liabilities	5,724
Net cash from operating activities	**35,944**

CERTIFICATE OF THE DARLING DOWNS HOSPITAL AND HEALTH SERVICE

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

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

b) the statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Darling Downs Hospital and Health Service for the financial year ended 30 June 2013 and of the financial position of Darling Downs Hospital and Health Service at the end of that year.

Mr Mike Horan *AM*
Chair
Darling Downs Hospital and Health Board
27/ 8/ 13

Mr Scott McConnel (CPA)
Chief Finance Officer
Darling Downs Hospital and Health Service
27/ 8/ 2013

INDEPENDENT AUDITOR'S REPORT

To the Board of Darling Downs Hospital and Health Service

Report on the Financial Report

I have audited the accompanying financial report of Darling Downs Hospital and Health Service, which comprises the statement of financial position as at 30 June 2013, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and certificates given by the Chair and the Chief Finance Officer.

The Board's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

Independence

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

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

Opinion

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

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

(b) in my opinion –

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

(ii) the financial report presents a true and fair view, in accordance with the prescribed accounting standards, of the transactions of the Darling Downs Hospital and Health Service for the financial year 1 July 2012 to 30 June 2013 and of the financial position as at the end of that year.

Other Matters - Electronic Presentation of the Audited Financial Report

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

QUEENSLAND
29 AUG 2013
AUDIT OFFICE

D R Adams FCPA
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane