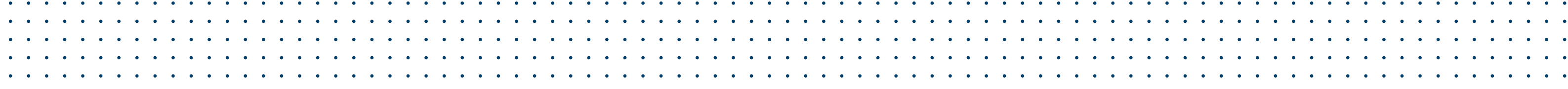

Annual Report 2013–2014

Great state. Great opportunity.

Queensland Government

Report objective

This annual report fulfils Wide Bay Hospital and Health Service's reporting requirements to the community and to the Minister for Health. It summarises the health service's results, performance, outlook and financial position for 2013/14.

The annual report outlines the health service's performance against key objectives identified in the Wide Bay Hospital and Health Service's strategic planning, and against the Queensland Government's objectives for the community and its Blueprint for Better Healthcare in Queensland.

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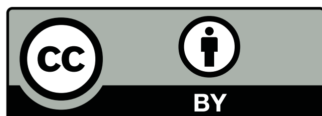

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annual report 2013/14

If you have an enquiry regarding this annual report please contact Wide Bay Hospital and Health Service on (07) 4325 6528

Public availability statement

This annual report can be viewed on Wide Bay Hospital and Health Service website at:

http://www.health.qld.gov.au/widebay/documents/annual-report-14.pdf

Hard copies of the annual report can also be obtained by phoning the office of the Wide Bay Hospital and Health Service Chief Executive on (07) 4150 2020.

Interpreter service statement

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding this annual report, you can contact the Wide Bay Hospital and Health Service on (07) 3176 5882 to assist in arranging an interpreter to communicate the report to you.

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Wide Bay Hospital and Health Service

2013/14 Annual Report

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Letter of compliance

25/8/2014

The Honourable Lawrence Springborg MP
Minister for Health
Level 19, Queensland Health Building
147-163 Charlotte Street
Brisbane QLD 4000

Dear Minister

I am pleased to present the Annual Report 2013/14 and financial statements for Wide Bay Hospital and Health Service.

I certify that this Annual Report complies with:

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

A checklist outlining the annual reporting requirements can be found at page 96 of this annual report or accessed at http://www.health.qld.gov.au/widebay/documents/annual-report-14.pdf

Yours sincerely

Dominic Devine
Chair
Wide Bay Hospital and Health Board

Wide Bay Hospital & Health Board

Chairman's overview

I am pleased to present the 2013/14 Annual Report for the Wide Bay Hospital and Health Service. This is our second annual report since the WBHHS was established in July 2012.

During 2013/14, Board members toured all towns and cities in the Wide Bay to assist in preparing the WBHHS Strategic Plan 2014/17. This document was publicly launched on May 2014.

The consultation process, entitled Your Hospital Your Say, engaged Wide Bay residents and let the Board and the health service better understand what the community expected. It was the most comprehensive project of its type ever undertaken by a HHS in Queensland.

The Board has also continued to provide governance and oversight to the health service.

Financially, the health service reported a $95,000 surplus. This is evidence of continued rigour around spending and delivering value for money.

Strong performances were recorded in delivery of National Emergency Access Target (77.7% seen within four hours on a target of 83%) and the National Elective Surgery Targets (NEST).

Outstanding results have been achieved in elective surgery with all patients in Categories 1 and 3 seen within clinically recommended times and only 4 patients out of 454 Category two patients waiting longer than the recommended 90 days for surgery.

Innovation in our approach to service delivery was highlighted by the success of a $2m endoscopy blitz. In a five month period, 2620 patients were seen resulting in waiting times from GP referral to surgery dropping from 36 months to six weeks.

I would like to acknowledge former Board members, Dr Denise Powell and Ms Debbie Carroll who resigned during the year due to work commitments and Mr Adrian Daniel and Mr Bob Evans who were not reappointed.

It is also important to acknowledge my fellow Board members for their hard work during the year and the diligence of Board secretary John Clerke.

Thanks also to the Chief Executive Adrian Pennington and his executive team who have done an excellent job in realigning the service to deliver first class hospital and health services.

Dominic Devine
Chair, Wide Bay Hospital and Health Board

Wide Bay Hospital & Health Service

Chief Executive's overview

The success of the 2013/14 financial year was built on our achievements in 2012/13. Our performance in 2013/14 had to inspire confidence in Queensland Health, the State Government and the wider community, and it did. This was necessary for the WBHHS to be able to argue for substantial growth in resourcing and the repatriation of services. These negotiations were successful as in 2013/14 we could point to a significant range of achievements across our services.

Emergency department performance continued to improve in both Bundaberg and Maryborough but Hervey Bay had difficulties due to patient demand. Hervey Bay needs significant expansion of our emergency department and support facilities to meet four hour targets on a sustained basis. We are currently preparing a funding bid for a substantial development in emergency services at Hervey Bay Hospital. An interim measure has been to expand the Clinical Decision Unit.

Minimising oral health waiting lists was challenging but rewarding. Oral health waiting times have reduced from 12 years to no more than 16 months anywhere in the Wide Bay. Our aim is a maximum eight week wait.

Our approach to waiting list management has been to link the three stages of the clinical pathway - those being outpatients, diagnostics, and procedural phases. In September 2012, our longest clinical pathway within Wide Bay was 16 years and 9 months. I am proud to say that our longest clinical pathway waiting time is now two years. Of this we can be extremely proud.

During the past 12 months we have embarked on setting a vision and strategy for the WBHHS through to 2017. This involved an extensive community and staff consultation process. The WBHHS Strategic Plan was launched in May 2014 and 127 projects have been launched across the organisation to ensure delivery of its content. These projects will be co-ordinated through a project management office which will report direct to me as chief executive.

Since the launch of the WBHHS Strategic Plan 2014/17, we have announced development of medical and radiation oncology services for Wide Bay. The development of a palliative care unit at Maryborough Hospital is underway. In addition, we have established orthopaedic lists at Maryborough Hospital which will permit patients to better utilise that state-of-the-art Rehabilitation Unit at the facility. We have reduced our endoscopy waiting times to the lowest in Australia.

I have approved the development of urology services to deliver a sustainable eight week pathway as part of a wider strategy in our fight against cancer. We have submitted bids to Queensland Health to repatriate cardiac angiography, and pacemakers. We have submitted a substantial paper aimed at developing a public private partnership for ophthalmology services. In June 2014, we also announced an expansion of ear, nose and throat services in Bundaberg which will include emergency services, to support the elective work undertaken in the private sector.

I would like to take this opportunity to thank each and every one of you for the excellent contribution you have made to the quality of our health services in Wide Bay. I look forward to working with you in the years to come.

Adrian Pennington
Chief Executive, WBHHS

Key achievements 2013/14

- Undertook a six month community and staff consultation process entitled 'Your Hospital Your Say' including 11 public meetings, online survey and extensive media campaign to gather strategic planning information.
- Used more than 1000 submissions to produce and launch the 4-year WBHHS Strategic Plan, the most ambitious and thorough strategic plan ever produced within Queensland Health.
- Dental waiting times reduced from 12 years to no more than 16 months anywhere in the Wide Bay, with the number of patients waiting more than two years reduced from 9378 to zero.
- A dedicated 22-bed rehabilitation ward opened in Maryborough Hospital and linked to a dedicated orthopaedic service.
- A 12-bed Clinical Decision Unit opened at Hervey Bay Hospital to improve emergency services and reduce ambulance ramping.
- Construction underway on a new 20-bed Community Care Unit for mental health consumers and Cancer Care/Oral Health Centres in both Hervey Bay and Bundaberg worth $35 million.
- Cardiac and pulmonary community rehabilitation programs developed in partnership with local NGOs to better manage chronic disease and prevent readmissions.
- New public-private partnerships agreed with Oceania Oncology to provide radiation oncology services locally and extended public private agreements for cardiac investigation services, ENT and urology services.
- Reduced outpatient waiting lists across the WBHHS by more than 60% including a 49% reduction in outpatient waiting times exceeding the clinically recommended time.
- $2 million WBHHS wide blitz on endoscopy waiting lists whereby 2620 patients were seen over a 5-month period resulting in waiting times from GP referral to surgery dropping from 36 months to six weeks.
- Reduced elective surgery waiting lists by 32% and the number of patients exceeding clinically recommended waiting times by 94%.

In 2013/14, there were...

71,134

people admitted to hospital

119,741

people presented to our emergency departments

305,873

outpatient occasions of services were performed

5,033

elective surgery procedures were performed

Wide Bay Hospital & Health Service

Our organisation

WBHHS is a provider of public health services and health education in the Wide Bay region which covers Bundaberg, Hervey Bay, Maryborough, North Burnett and surrounds.

Role and functions of the WBHHS

The WBHHS is an independent statutory body responsible for the delivery of public hospital and health services to the 210,660 residents of the Wide Bay. It is accountable through the Hospital and Health Board Chair to the Minister of Health for local performance, delivering local priorities and meeting national standards.

The WBHHS is subject to the *Financial Accountability Act 2009* and the *Statutory Bodies Financial Arrangements Act 1982*. It is also legally bound by health service directives issued by the Chief Executive of the Department of Health and also by Ministerial directives.

The WBHHS's main function is to deliver hospital and other health services, teaching, and research as agreed in the Service Agreement with the System Manager (Department of Health).

Other key functions of the WBHHS include:

- Ensuring the operations of the WBHHS are carried out efficiently, effectively and economically
- Contributing to and implementing state-wide service plans that apply to the WBHHS, including the implementation of national clinical standards
- Co-operating with other providers of health services, including other HHSs, the Department of Health and providers of primary health care in planning for and delivering health services
- Co-operating with local primary health care organisations including Medicare Local
- Consulting with health professionals working in the WBHHS, health consumers, and members of the community about the provision of health services
- Other functions approved by the Health Minister.

Strategic overview

In alignment with the government's objective to Getting Queensland Back on Track and it's Blueprint for Better Healthcare in Queensland, the declared vision of the WBHHS is: Improving health, together.

> *The WBHHS's purpose is to deliver quality health services focused on patients and families that reflect the needs of the Wide Bay community. We will do this by investing in our workforce and encouraging innovation in future plans that maximise the value of resources and infrastructure.*

Our five pledges as outlined in the WBHHS Strategic Plan 2014/17 are:

1. Delivering **sustainable, patient centred, quality health services**
2. Engaging with **our communities and partners**
3. Developing and empowering **our workforce**
4. Encouraging **innovation and excellence**
5. Delivering **value for money**

Operating environment

Demographics

The WBHHS incorporates the North Burnett, Bundaberg and Fraser Coast local government areas and part of Gladstone Regional Council (Miriam Vale) covering a geographical area of 37,000 square kilometres. Demographically it is a high needs area given its low socio-economic status and high elderly population. Over the last 10 years, the population of Fraser Coast has increased by 39 per cent while Bundaberg has grown by 24 per cent, placing significant demands on local health services.

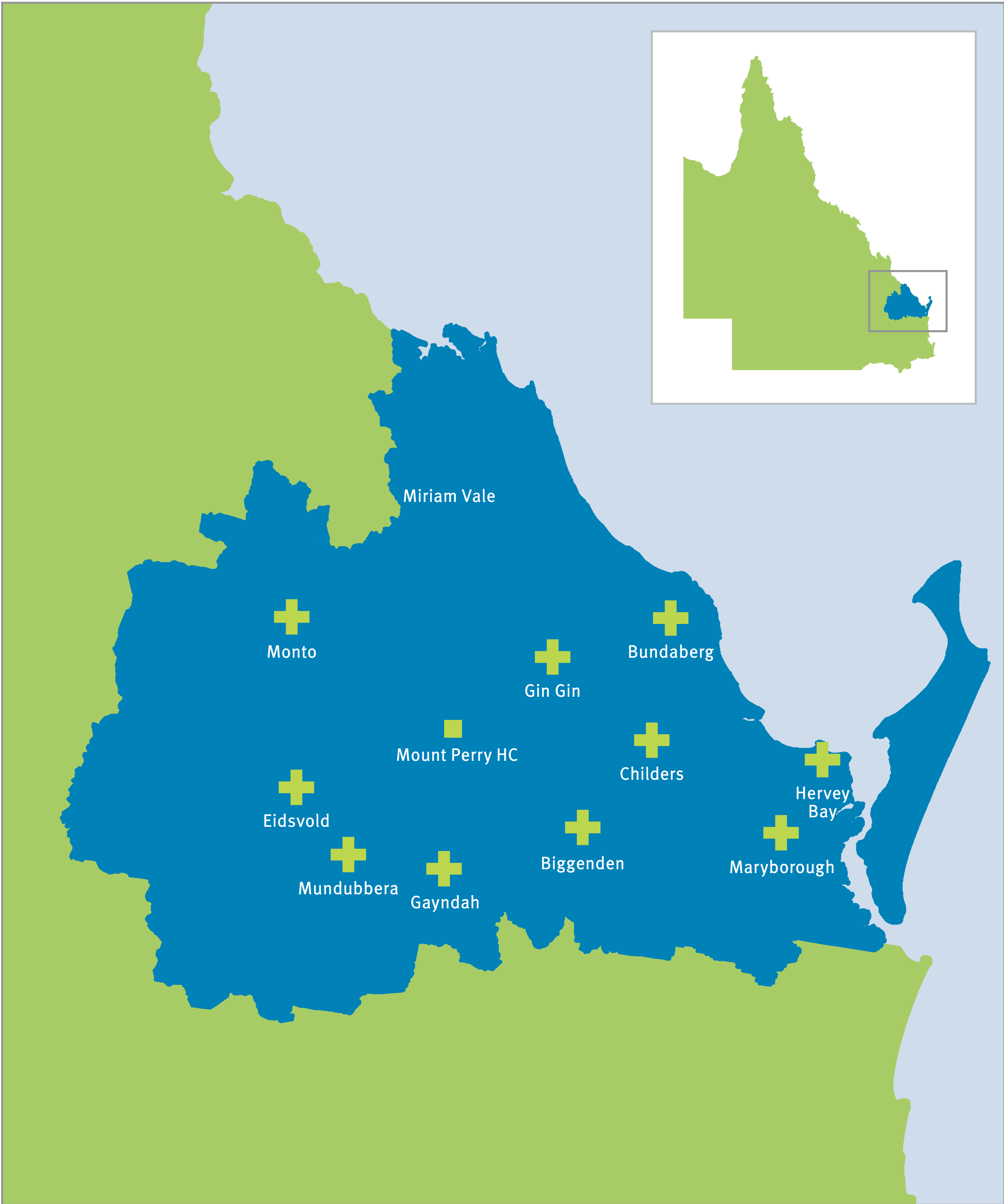
Key demographic features of the Wide Bay population are:

- population of the Wide Bay projected to increase from 210,660 to reach 300,000 within the next 25 years
- high numbers of elderly residents – 21 per cent of our total population are over 65 years of age (13 per cent for Queensland[1] and highest for a HHS in Queensland)
- low number of people aged between 20 and 44 years (lowest in Australia)
- 83 per cent of our residents fall in the most disadvantaged socioeconomic quintiles (second highest HHS in Queensland)
- 3.6 per cent of the population is Indigenous (3.6 per cent for Queensland)
- 8 per cent of the population is in 'need of assistance' with a core activity as a result of a profound or severe disability (4 per cent for Queensland)
- 38 per cent of the population are Centrelink concession card holders (21 per cent for Queensland) with Wide Bay having the highest health uptake in Australia
- 45 per cent of residents aged 15 years and over received a weekly income of less than $400 (defined as below the poverty line)
- 32 per cent of the population has private health insurance (42 per cent for Queensland[2]).

[1] Australian Bureau of Statistics, estimated resident population by age and sex as at 30 June 2013.

[2] Social Health Atlas of Australia Public Health Information Development Unit, May 2013.

Wide Bay Hospital and Health Service map



Service profile

The WBHHS provides health care services to a growing regional area of 210,660[3] residents (5 per cent of state population) in South East Queensland. The WBHHS provides acute inpatient and specialist services, mental health services, oral health services and a range of community and outreach services. Services are provided from major hospitals in Bundaberg, Hervey Bay and Maryborough as well as the eight rural facilities in Biggenden, Childers, Eidsvold, Gayndah, Gin Gin, Monto, Munduberra and Mount Perry.

Acute hospital, specialist (general surgery, gynaecology, orthopaedics, obstetrics, urology, paediatrics, rehabilitation, oral health, oncology/ palliative care, coronary care) services and 24-hour emergency department (ED) services are provided from three major facilities: Bundaberg Hospital (263 including bed alternatives), Hervey Bay Hospital (166) and Maryborough Hospital (102).

The eight rural WBHHS facilities surrounding Bundaberg provide acute and sub-acute medical inpatient services, palliative care, long stay and respite care as well as emergency services, outpatient clinics and a wide range of community and allied health services located in: Biggenden (18 beds), Childers (20 beds), Eidsvold (11 beds), Gayndah (12 beds), Gin Gin (six beds), Monto (14 beds), Munduberra (18 beds) and Mount Perry Health Centre.

Mental Health Services

The Wide Bay Mental Health Alcohol and Other Drug Service provides acute inpatient services at Bundaberg and Maryborough, and a range of recovery focused community mental health services for adults, children and youth in Hervey Bay, Maryborough, Childers, Gayndah and associated rural facilities. The Alcohol and Other Drug Service offers a range of treatment and preventative services including the Opiate Treatment Program and Needle Syringe Program across the Wide Bay.

Community and Allied Health

A wide range of multi-disciplinary community health, allied health and clinical support services are provided at all WBHHS facilities. These services span the continuum of care, including early intervention, assessment and treatment, palliative care and rehabilitation services.

[3] Australian Bureau of Statistics, estimated resident population as at 30 June 2012.

Risk profile (SWOT analysis)

Strengths

- Waiting list management
- Clinical pathway development
- Strong financial management
- Improved clinical performance and engagement
- Four year strategic planning completed
- Disaster management capability
- Innovation and service improvement
- Consumer engagement structures in place.

Weaknesses

- Integration of three major hospitals and eight smaller health facilities
- Delivering services within national efficient price
- Recruitment and retention including locum costs
- Infrastructure inhibiting service expansion.

Opportunities

- Telemedicine
- Clinical redesign and service reconfiguration
- Population-based funding
- Upskilled health workforce
- Manage demand in primary care/aged care sector
- Public-private partnerships for new service delivery.

Threats

- Ageing, low socio-economic population
- Increasing demand for health services
- Community expectations re ongoing access to full range of free health services
- Increasing demand for health services
- Natural disasters
- High and increasing prevalence of chronic disease
- Fragmented primary care/community care sector
- Barriers to greater uptake of primary care including low bulk billing rates among GPs, few NGO services and patient charges for medication.

Challenges & Opportunities

Key Challenges	Strategic Risk	Opportunities
Increasing demand for services We continue to experience greater demand for our health services as our population ages and our lifestyles choices impact our health	Impact of population growth, demographics, increased life expectancy and growing burden of disease	Clinical redesign, service reconfiguration, technology and demand management strategies jointly developed with the primary care and aged care sectors
Community expectations Improve community understanding of the safest and most sustainable way to provide health services in regional and rural communities	Ongoing access to a full range of free hospital and health services 24 hrs a day and 7 days a week throughout the HHS	Create a more inclusive environment using the Wide Bay Community Engagement Strategy and the local Consumer Advisory Networks
Financial pressures Health services across Australia are having to responsibly manage services within finite resources	Ability to maintain budget integrity, increase revenue and deliver services within a national efficient price	Delivery of a balanced financial position to surplus by implementing the Wide Bay Resource Management Framework
Workforce The capacity, capability and culture of our workforce helps determine the quality of the services we offer	Ability to build capacity and capability through the recruitment and retention of suitably skilled staff	Development and implementation of an innovative Workforce Plan
Infrastructure Well maintained and designed infrastructure in accessible locations which meets service demands	Limited capacity and location of existing buildings, equipment and ICT systems and their impact on ability to introduce new and advanced technologies/services	Manage structural inefficiencies through service reconfiguration, relocation, public/ private partnerships and other strategies outlined in the WBHHS Asset Management Plan
Natural disasters Our ability to react to and manage the impact of natural disasters and emergency events is crucial to our sustainability	High exposure and vulnerability of hospital and health services to natural disasters and their impact on service delivery	Active participation in the Implementation of the Wide Bay Disaster Management Strategy

Wide Bay Hospital & Health Service

Our governance

The WBHHS was established in July 2012, bringing local control and accountability for health services back to the community.

Machinery of government changes

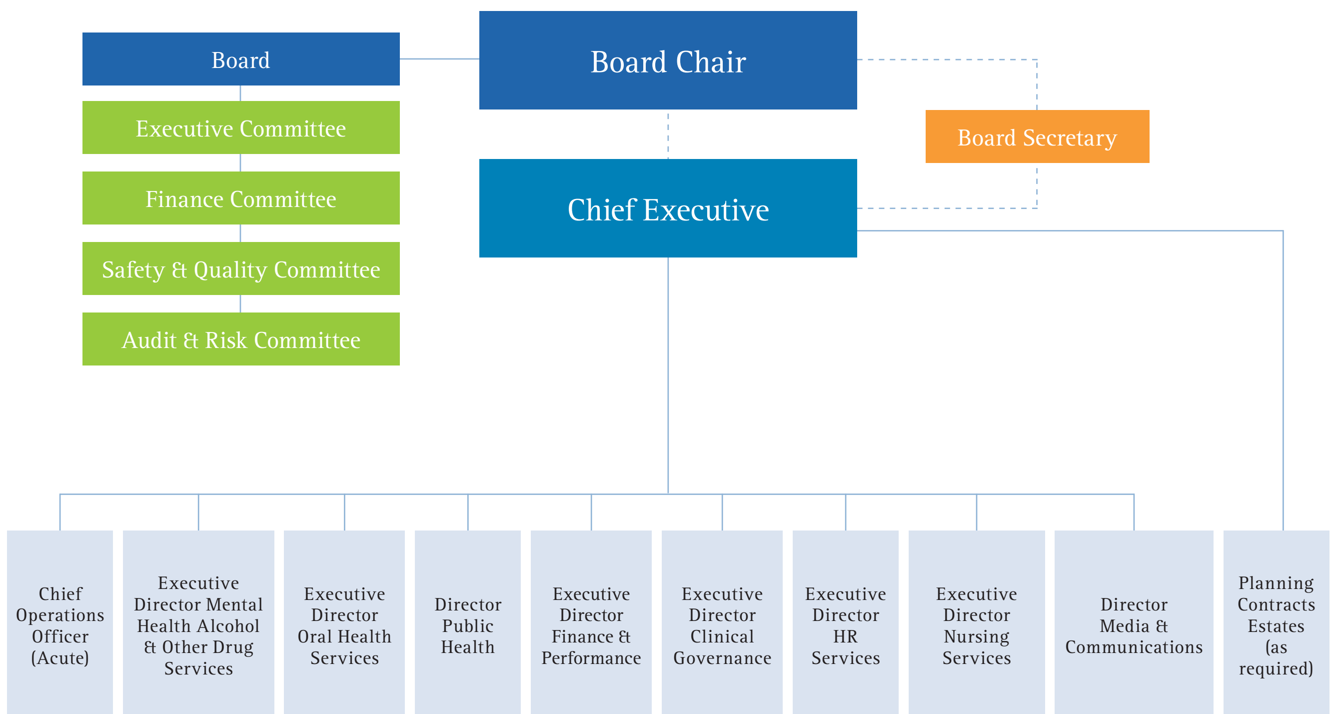
The WBHHS was established in July 2012 as an independent statutory body, overseen by a local hospital and health board, responsible for providing public hospital and health services to the residents of Wide Bay.

Under the National Health Reform Agreement, Queensland Health was restructured, effective 1 July 2012, to facilitate the devolution of management in the healthcare setting to more localised models of decision making including moving to a purchaser-provider model with health service delivery to be purchased from legally independent HHSs.

Queensland Health's reform agenda was driven by the belief that the best health service outcomes are achieved by devolving management, responsibility and accountability for the delivery of services to local decision-makers. Queensland Health had become confused, with corporate office both overseeing the total system and intervening in the delivery of health services. The lack of role separation (between system manager and health services provider) departed from industry best practice, which recognised the disparate capabilities in performing true strategic direction-setting and frontline service delivery roles. It also disempowered local staff and communities who were unable to influence decisions in relation to local healthcare arrangements. The devolution of functions empowers local communities to respond swiftly and decisively in relation to any local healthcare issues.

Under the new arrangement, the Department of Health, Queensland purchases services from HHSs under service level agreements negotiated with each HHS. Service delivery to the community is expected to be enhanced by placing accountability and responsibility for decision making as close to the frontline as possible, thereby reducing costly delays and optimising health service outcomes.

WBHHS organisational structure



The Wide Bay Hospital and Health Board

The new Wide Bay Hospital and Health Board was announced on 17 May 2013. The Chair was announced on 13 June. The members were appointed by the Minister of Health for 12 months, effective from 18 May 2013 to 17 May 2014.

Wide Bay Hospital and Health Board

Nominee	Position	Term of Appointment
Mr Dominic Devine	Chairman	18/05/2014 to 17/05/2018
Mrs Barbara Hovard	Deputy Chairman	18/05/2014 to 17/05/2017
Mr Paul Dare	Member	18/05/2014 to 17/05/2017
Mr Christopher Hyne	Member	18/05/2014 to 17/05/2017
Ms Joy Jensen	Member	18/05/2014 to 17/05/2017
Mr Gary Kirk	Member	18/05/2014 to 17/05/2017
Mr Rowan Bond	Member	18/05/2014 to 17/05/2015
Mr Ralph Coles	Member	18/05/2014 to 17/05/2015
Mr George Plint	Member	18/05/2014 to 17/05/2015
Professor Bryan Burmeister	Member	18/05/2014 to 17/05/2015

The Board meets monthly and has four sub-committees:

- Executive Committee
- Audit and Risk Committee
- Finance Committee
- Safety and Quality Committee

Board members

Mr Dominic Devine

Chairman
Wide Bay Hospital and Health Board

Dominic is a Bundaberg-based businessman who has had significant experience on numerous business, community and industry boards.

Dominic is married to Tracey and has two daughters and their family lives in the Bundaberg region. Dominic spent his childhood and school years in Bundaberg. Prior to moving back home to Bundaberg in 2010 he spent almost twenty years living in Charleville developing his business. Dominic is a qualified valuer and is the senior partner at Devine Agribusiness, a firm he established in 1993 in Charleville with his wife. Devine Agribusiness is a specialised agricultural advisory and accounting practice with offices in Brisbane, Charleville, Roma and Mackay.

During the last 20 years Dominic has served on numerous business, community and industry boards and has been a member of the Australian Institute of Company Directors since 2006. Dominic has always been passionate about being involved in important community issues such as health, education and regional development.

Mrs Barbara Hovard

Deputy Chair and Board Member
Wide Bay Hospital and Health Board

Barbara has local and state government experience in the Wide Bay region. She has served as Mayor and councillor on the Maryborough City Council and was previously employed as manager of organisational services at Maryborough Hospital.

Barbara recently held the position of councillor on the Fraser Coast Regional Council. Prior to this, she served as Mayor of the Maryborough City Council between 2004 and 2008 following seven years as a councillor. Before beginning a career in local government, Barbara spent more than 20 years providing aged, community and hospital-based care to the people of Maryborough and Wide Bay including periods with the Blue Nurses and managing the Fair Haven Retirement Village.

Barbara was awarded a Bachelor of Business in 1996 while employed by Queensland Health as manager of organisational services at Maryborough Hospital.

Mr Gary Kirk

Board Member
Wide Bay Hospital and Health Board

Gary has almost 40 years experience in the public education system in Queensland as a school teacher and later as principal until his retirement in 2010. He has contributed to the community for nearly two decades, and for the past two years he has operated a small business in the tourism sector.

Gary has dedicated 40 years to teaching students and guiding teachers in the Queensland public education system in both country and city settings including Bundaberg and Surat. As a member of the Queensland Association of State School Principals (QASSP) for 20 years, Gary held the positions of branch president, secretary and treasurer as well as supporting the organisation's aims to support, develop and strengthen educational leadership capabilities to improve educational outcomes for state school students in Queensland.

Gary, along with his wife Elaine, are involved in the local tourism industry. They opened the Baffle Retreat Bed and Breakfast located in Winfield (between Bundaberg and the town of 1770) in 2011. Gary has contributed to the community through his membership of Rotary International. He was involved in Rotary Club of Bundaberg Sunrise for seventeen years firstly as a member, then service director and president. Gary was appointed an Ambassadorial Speaker by the Prostate Cancer Foundation of Australia and has travelled throughout rural Queensland educating men about prostate cancer.

Mr Christopher Hyne

Board Member
Wide Bay Hospital and Health Board

Christoper is semi-retired from an executive position with Hyne Timber. Christopher was born in Maryborough in 1945 and has lived in Ferney (15 km south of Maryborough) since 1980.

His current positions include: Director - Hyne and Son Pty. Limited; Chair Remuneration Committee - Hyne and Son Pty Ltd; Audit Committee - Hyne and Son Pty Ltd; Director - Australian Forest Products Association; member– Wide Bay Hospital and Health Board

Previous positions include: Chairman - Bassett Barks Pty. Ltd; Director - Charles Porter and Sons Pty. Ltd; Chair Audit Committee - Hyne and Son Pty. Limited; Director - Nanum Tawap Ltd (Weipa); Chairman of Pine and Hardwood Divisions of the Queensland Timber Board; Deputy Chairman Queensland Timber Board; Chairman Timber Research and Development Advisory Council (TRADAC); Executive in Hyne Timber holding a number of positions including Branch Mills Manager, Marketing Manager and Business Development Manager.

Christopher's tertiary education and qualifications include: MAICD, Diploma of Marketing (University of Singapore); Bachelor of Science (UQ)

Secondary school: Church of England Grammar School (Brisbane)

Rowan Bond

Board Member
Wide Bay Hospital and Health Board

Rowan recently retired as the Superintendent, District Officer, Bundaberg District. He was born and educated in Rockhampton.

Rowan joined the Queensland Police Service and completed a three year cadetship. He served in most uniform positions including 12 years in operational traffic duty including enforcement on police motorcycles, and crash investigation. He was also involved in training staff in the Rockhampton District. This function led to Rowan being appointed to co-ordinate the implementation of the Fitzgerald Royal Commission reforms in the Rockhampton District from May 1990. He was promoted to Inspector in 1997 as the first Regional Traffic Co-ordinator in Central Region. In September 2004, Rowan was appointed District Officer, Gladstone and then promoted to Superintendent in Charge of Mackay District in May 2007. Rowan was transferred to Bundaberg in December 2010. In those positions, significant skills and experience was gained in executive leadership, HR management and financial responsibility.

It is in thc role of District Officer that he has considerable experience in crisis management including managing major incidents and disasters. Some interesting highlights include command of the Rescue 9 Helicopter Crash in Rockhampton in 2000, the Tilt Train crash in 2004, co-ordinating the response to the devastating floods in Mackay in 2008 and Cyclone Ilii in 2010, and response to the floods in Bundaberg in 2010 and 2013.

Rowan holds an Associate Diploma of Business (Justice Administration), a Graduate Certificate in Applied Management, and a Diploma of Public Safety (Policing). He is a recipient of the Australian Police Medal and the Commissioner's Award for Meritorious Service.

Mr Ralph Coles

Board Member
Wide Bay Hospital and Health Board

Originally from Sydney where he worked for the Wormald International Group for 17 years Ralph and his wife, Jill, were early seachangers, moving to Hervey Bay in 1975 where they established a marine retail business and sailing school.

Eleven years later, adventure once again beckoned and the couple and their five children moved to tropical north Queensland where Ralph took on the position of Chief Accountant at the Northern Iron and Brass Foundry in Innisfail for 10 years.

With their older children moving to Brisbane for university and work, Ralph and Jill made the decision to follow in 1997, with Ralph taking on the challenge as Financial Controller at Uniting Church Qld Synod and upgrading the reporting and budgeting process for the organisation.

He subsequently brought stability to the accounting function at Canterbury College and retired from the position of Director of Finance/Company Secretary to return to Hervey Bay where Ralph has finally found the time to indulge his love of oil painting, while applying past experience to serving on the Audit Committee of Fraser Coast Regional Council.

A qualified accountant whose specialty has been management accounting and budgeting, Ralph is a Fellow of CPA Australia, Fellow of Chartered Institute of Secretaries, and Fellow of Governance Institute of Australia.

Mr George Plint

Board Member
Wide Bay Hospital and Health Board

George prior to his current position was the Executive Director of the Integrated Mental Health, Alcohol and Other Drugs Service for the WBHHS.

George completed his Psychiatric Nurse training at Baillie Henderson Hospital, Toowoomba in 1982 and his General Nursing training at Gold Coast Hospital in 1986.

He later completed his Bachelor of Nursing Degree from University of Southern Queensland, Graduate Diploma in Community Mental Health from the University of Queensland and Graduate Certificate in Health Service Management from the Queensland University of Technology.

He has worked across a range of health settings associated with general and psychiatric nursing as well as extensive experience in aged care nursing,Red-cross Blood Bank and community mental health case-management prior to establishing and managing the Fraser Coast Mental Health Service in 1999.

Areas of interest include service development and health promotion.

Pastor Paul Dare

Board Member
Wide Bay Hospital and Health Board

Paul has had a successful career in the military and business world, and is currently pastoring a rural church in Mundubbera.

Paul spent his childhood in rural Tasmania and has two adult children. He spent 20 years in the Australian Army during which time he completed a trade in electronics. In 1989, Paul attended the Royal Military College Duntroon. On graduation in 1990 Paul went on to serve in army aviation as an aerospace engineer and logistics manager. Paul left the army after 20 years to pursue a career in the aviation field.

Paul spent six years working for Sikorsky Australia (Sikorsky is the manufacturer of the Blackhawk and Sea Hawk helicopters) as the ADF Customer Service Manager and Engineering Manager. In 2007, a change of direction was made and studies undertaken to allow Paul to become a pastor within Queensland Baptists. As a result of this Paul is now pastoring the Mundubbera Baptist Church.

Paul has a passion for people and desires the best to be brought out in all he meets as well as the best for the Wide Bay Burnett as a whole. Paul has the following formal qualifications: MBA (Technology Management), MDiv, GradDip Ministry and BEng (Aerospace).

Professor Bryan Burmeister

Board Member
Wide Bay Hospital and Health Board

Bryan is currently the Director of Radiation Oncology at Princess Alexandra Hospital in Brisbane, Australia. Since 1997 he has been on the staff of the Faculty of Health Sciences, University of Queensland where he is involved in the teaching medical students and supervising clinical research.

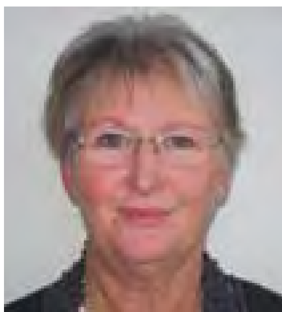
He is frequently invited to speak at both national and international meetings and has a major interest in clinical trials involving new radiation technologies, melanoma and oesophageal cancer. His research achievements in the last six years include being a principal or co-investigator on over 20 clinical trials/projects, a number of which have been awarded funding by the Australian National Health and Medical Research Council.

He has over 25 proffered papers at learned society meetings and has published over 100 papers in peer reviewed journals. He completed his degree of Doctor of Medicine at the University of Queensland in 2008. He also has a strong involvement in serving the professional community.

He was the President of the Trans-Tasman Radiation Oncology Group from 2007 – 2012 and is deputy chair of the Medical and Scientific Advisory Committee of Queensland Cancer Council. He is currently also President of the Australian and New Zealand Melanoma Trials Group. He has sat on a number of grant review panels and is a frequent manuscript reviewer for prestigious oncology journals. He resides part time at Maaroom on the Fraser Coast and has an interest in cancer care in the Wide Bay community.

Mrs Joy Jensen

Board Member
Wide Bay Hospital and Health Board



Joy has the unique distinction of having been the last mayor of the Perry Shire and the first mayor of the North Burnett Regional Council. Her background is in rural industry namely cattle and horses, and rural communities.

Joy lives west of Mt Perry on Elliotts Creek where she is partner in a family owned and operated beef cattle and horse breeding enterprise. Over many years, she has contributed in an executive role to a variety of community groups from P and C and sporting clubs to care service providers. Joy is currently secretary of Mt Perry Race Club and a member of Agforce. Notable representation in past years has been on the Board of the RM Williams Australian Bush Learning Centre, Wide Bay Burnett Area Consultative Committee, Burnett Mary Regional Group, Wide Bay Burnett Regional Organisation of Councils, Wide Bay Burnett Regional Roads Group, Bundaberg District Health Council and Trustee of Narayen (Australian Agricultural College Campus).

Elected to local government in 2000, Joy followed on from her husband who also contributed 12 years as an elected member of local government. In her first term, she was appointed Deputy Mayor of Perry Shire which was a good grounding for her next term when she was elected unopposed as mayor. It was a testing time for the community as they reluctantly relinquished their small shire council during the Queensland Local Government Reform process. As mayor of a newly amalgamated regional council, the challenges were many with the North Burnett being one of six Queensland councils categorised by Queensland Treasury from inception as under financial watch and rated as being financially weak. Joy demonstrated her ability to work and lead a team through this testing time noting the improved rating to moderate within their first term as a major achievement for council.

Joy believes an individual's access to a professional and safe health service is an entitlement of every Queenslander and is a keen participant in ensuring health services in the Wide Bay are appropriate and effective.

Executive team

Professor Adrian Pennington

WBHHS Chief Executive

- Adrian has over 30 years health care experience of which some 15-20 years has been at executive and senior management levels both within acute hospitals and leading national programs within the National Health Service, United Kingdom
- During Adrian's career he has managed every department within a hospital including support services
- Adrian's previous employment includes Chief Executive Officer, James Paget University Hospitals NHS Foundation Trust, Chief Executive NHS Heart Improvement
- Chief executive of national heart disease programme for seven years reducing mortality figures from 130,000 to 68,000 per annum. Led clinical redesign work including introduction of clinical Microsystems lean and six sigma
- Adrian has acted an advisor to the Minister of Health British Columbia to develop a strategy for Health re-design within British Columbia
- Adrian has over sixty published documents recognised internationally and has presented in many countries including the United States, Canada, Czech, Finland, Australia and New Zealand
- Whilst Chief Executive Officer at the James Paget University Hospitals, Adrian raised the profile of the Trust to that commensurate with University Hospital status, delivered the first six week one stop pathway across all specialities from GP referral to surgical event, delivered a surplus financial position performance exceeding 15% annual turnover, achieved highest possible quality recognition from the HCC rated at excellent / excellent, published "How to avoid a CDiff outbreak in healthcare" which became a national guide reference for all hospitals in England, and also won cleanest hospital of the year award in 2008
- Adrian has lectured for Harvard and Stamford Universities in regard to process improvement activity and developing a strategy for a country-wide service improvement service.

Ms Deborah Carroll

WBHHS A/Chief Operations Officer

- Deborah has worked across a number of health facilities throughout Queensland. She has undertaken significant postgraduate studies including a Masters of Health Administration and Information Systems and a Graduate Certificate in Health Service Planning
- Deborah completed her general nurse training at the Mackay Base Hospital in 1981 where she was acknowledged for both outstanding theoretical knowledge and nursing care
- She later gained a Bachelor of Health Science (Nursing) with Distinction from Central Queensland University in 1995 and a Graduate Diploma in Emergency Nursing
- Deborah has worked in the Wide Bay Hospital and Health Service since 2006 following periods in Rockhampton, Sarina and Mackay
- In 2008, she was awarded Recipient Queensland Health Australia Day Award for exceptional leadership and restoring community confidence.

Mr Geoff Evans

Executive Director, Finance and Performance
Chief Financial Officer

- Geoff has five years banking, five years small business, and over 30 years of health care experience
- During Geoff's health care career he has worked in rural health, integrated health services, acute hospitals, mental health, and regional health services
- Geoff's previous employment includes Director Finance & Corporate Services Southern Adelaide Health Services, Director Financial Services Royal Brisbane & Women's Hospital, Strategic Director Financial Planning & Performance, Adelaide Health Service
- He has worked at executive level on significant health and information systems reforms, lead corporate governance restructures, and redesigned financial and performance management systems achieving quality outcomes and a high level of stewardship
- Geoff has a Business Certificate Accounting qualification, is a Graduate of the Health Industry Development Council Management Program, and is a Fellow of the Australian Institute of Company Directors.

Mrs Fiona Sewell

WBHHS A/Executive Director of Nursing and Midwifery Services

- Fiona spent her childhood in Maryborough and completed her general nurse training at the Maryborough Base Hospital in 1990
- Following gaining further experience in other Queensland public and private healthcare facilities, Fiona and her husband Robert moved back to the Wide Bay area in 1994
- Fiona immediately gained a nursing position at the Bundaberg Hospital and since then has worked in multiple units within the Wide Bay Hospital and Health Service, as a Registered Nurse, Clinical Nurse, Clinical Nurse Consultant, Nurse Unit Manager, Nursing Director and now Executive Director of Nursing and Midwifery Services. Fiona has also acted in the Chief Operating Officer Role. Somewhere in amongst all of this, Fiona and Robert have raised 2 children who are now young adults, and her family is totally immersed in the community life
- Fiona has successfully completed studies in the areas of Orthopaedic Nursing, Emergency Nursing, Investigations Management and Report Writing, and most recently, a Post Graduate Certificate in Health Leadership, Management and Quality. Fiona is currently working towards completing her Masters
- Fiona was awarded a Queensland Health Australia Day Award for exceptional leadership during the 2013 floods.

Dr Malcolm Donaldson

Executive Director Oral Health

- Malcolm is the Executive Director of Education, Training, Research and Oral Health for the WBHHS
- Malcolm is the Adjunct Associate Professor Griffith University School of Medicine and Dentistry
- Malcolm is a qualified dental surgeon with 30 years experience
- Malcolm owned a large NHS practice in Scotland for 16 years
- Malcolm has worked as a Business Manager and Clinical Director for the largest Dental Corporate in the UK
- After moving to Australia in 2005, Malcolm worked as senior for Quality and Education in Cairns
- In 2008, Malcolm took up the position of Director for Oral Health on the Gold Coast which included managing the student, placement and treatment contracts with Griffith University Dental School
- In 2011, Malcolm took up the position of Clinical Director with the WBHHS
- Malcolm is both an experienced open disclosure consultant and facilitator for disclosure training.

Ms Robyn Bradley

A/Executive Director, Integrated Mental Health, Alcohol and Other Drugs Service

- Robyn achieved her degree in Occupational Therapy from Curtin Univeristy, Western Australia and has engaged in additonal studies in Health Management
- Robyn has worked in health management roles for the past 18 years and has held managment and executive leadership positions at the WBHHS and previoulsy under the Regional Health Authority in South West Queensland
- Has presented papers at both mental health and allied health national and international conferences on rural models of mental health service delivery
- Is passionate about driving access and equity and developing a community that acknowledges and supports the pathway to recovery for mental health consumers
- Robyn settled in the Wide Bay approximately nine years ago and enjoys the outdoor adventure lifestyle the area offers.

Mr Peter Heinz

A/Executive Director, Human Resource Services

- Mr Peter Heinz has worked within the public sector, both at the federal and state level, for over 27 years, having held a number of posts across both sectors, with the most recent being the position of Acting Executive Director, Human Resource Services, Wide Bay Hospital & Health Service. Peter was appointed to this role in February 2014, having previously held the position of Human Resources Manager for Bundaberg and North Burnett since June 2010
- Prior to joining the Wide Bay Hospital & Health Service, Peter was employed as the Principal HR Advisor with the Department of Employment, Economic Development and Innovation (DEEDI), located in Brisbane. DEEDI had been created in 2009 by the previous government through the amalgamation of several government departments, one of which was the Department of Tourism, Regional Development & Industry (DTRDI), which Mr Heinz had joined in January 2008. Prior to this, Peter had served in a number of Senior and Principal Human Resource roles within the Environmental Protection Agency from 2001 to 2007
- Peter's other roles in the public sector have been with the Department of Defence, based in Canberra and other locations, where Mr Heinz held positions in the Defence Signals Directorate, Defence Intelligence Organisation and with the Royal Australian Navy, where he was initially trained as a linguist analyst.

Dr Margaret Young

Director and Public Health Physician

- Dr Margaret Young is the Director and Public Health Physician at the Wide Bay Public Health Unit
- Dr Young is a medically trained doctor with specialist qualifications in Public Health Medicine which is concerned with the promotion of health and prevention of disease and illness at the population level
- The Public Health Unit provides multi-disciplinary community-oriented communicable disease control and environmental health services, complementing health protection functions of government and non-government agencies
- Dr Young worked in hospital-based medicine and general practice in Australia before working as a volunteer in Cambodia in the early to mid 1990s. There she began to more fully understand the contribution to health outcomes of the environment, socio-economic circumstances, literacy and education, in addition to personal behaviours
- Since completing public health medicine training, she has worked at the Communicable Disease Unit in Brisbane and the Gold Coast Public Health Unit before moving to the Wide Bay eight years ago.

Mr Pieter Pike

Executive Director of Clinical Governance and Education and Training

- Dr Pieter Pike is the Executive Director of Clinical Governance for the WBHHS
- Pieter has over 30 years of health care experience and has clinical and managerial specialist qualifications.
- He worked internationally in primary, secondary and tertiary healthcare, in both the private and public sector.
- Pieter was appointed as external medical advisor to the New Zealand Health and Disability Commissioner and act as an auditor for urgent care medical centres
- He was invited by Massey University to teach Strategic Health Management as part of the Business Management Faculty and acted as external examiner for Auckland University.
- Pieter has a keen interest in Clinical Governance and Systems Thinking and sees that as key to providing safe and sustainable healthcare services.

Mr Mathew Nott

Director, Media and Communications

- Mr Mathew Nott is the Director of Media and Communications for WBHHS.
- He is a former print and broadcast journalist who has worked for news organisations in Australia and internationally.
- He was most recently editor of the Fraser Coast Chronicle.
- He holds a Diploma in Law and a BA.Comm (Journalism) degree.

Boards and Committees

Role and responsibilities of the Board

The primary role of the Board is to provide effective governance over the delivery of hospital services, other health services, teaching, research and other services stated in the WBHHS service agreement.

The Board's responsibilities include, but are not limited to, the matters listed below. The Board may refer some or all of these matters to one or more Committees of the Board. In such cases, the Board will oversee the work of these committees and attend to matters referred to it by those committees.

To contribute to the effective management and delivery of health services, and in accordance with the Act, the Board undertakes the following:

- to ensure the operations of the service are carried out efficiently, effectively and economically
- to enter into a service agreement with the chief executive
- to comply with the health service directives that apply to the service
- to contribute to, and implement, state-wide service plans that apply to the service and undertake further service planning that aligns with state-wide plans
- to monitor and improve the quality of health services delivered by the service, including, for example, by implementing national clinical standards for the service
- to develop local clinical governance arrangements for the service
- to undertake minor capital works, and major capital works approved by the chief executive, in the service area
- to maintain assets owned by the network or the state in the service area
- to co-operate with other providers of health services, the department and providers of primary healthcare, in planning for, and delivering, health services
- to co-operate with local primary healthcare organisations
- to arrange for the provision of health services to public patients in private health facilities
- to manage the performance of the service against the performance measures stated in the service agreement
- to provide performance data and other data to the chief executive
- to consult with health professionals working in the network, health consumers and members of the community about the provision of health services
- other functions approved by the Minister
- other functions necessary or incidental to the above functions.

Membership of the Board

The Board consists of ten members appointed by the Governor in Council, by gazette notice, on recommendation of the Minister (refer to earlier section profiling current members). The Minister will recommend persons considered to have the skills, knowledge and experience required for a network to perform its functions effectively and efficiently.

The tenure of the members of the Board is stated in the member's instrument of appointment and is not more than four years.

The Governor in Council may, on recommendation of the Minister, appoint a member of the Board to be Chair of the Board; and another member to be Deputy Chair of the Board.

For terms of current Board Members refer to page 16.

Authority of the Board

The Board functions under the authority of the *Hospital and Health Boards Act 2011 (the Act)*. The Board may delegate its functions under the Act and the *Financial Accountability Act 2009* to a committee of the Board if all of the members of the committee are board members or to the WBHHS Chief Executive.

The Board has the authority to create relevant committees prescribed by legislation or regulation, or others as deemed necessary to assist the Board in discharging its responsibilities. The Board may only delegate decision making authority to a committee where its members are Board members. Non-Board members may participate in any such committees only as non-voting members.

To assist the Board in discharging its responsibilities, the Board oversees the following Committees:

- Executive Committee
- Audit and Risk Committee
- Finance Committee
- Safety and Quality Committee

Each Committee has a charter, and membership is determined by the Board. The Board will review its committee membership in 2015.

Guiding principles

The *Hospital and Health Boards Act 2011* provides the following principles intended to guide achievement of the Act's objectives. These principles guide all deliberations of the Board.

Hospital and Health Boards Act 2011

- the best interests of users of public sector health services should be the main consideration in all decisions and actions under this Act
- there should be a commitment to ensuring quality and safety in the delivery of public sector health services
- providers of public sector health services should work with providers of private sector health services to achieve coordinated, integrated health service delivery across both sectors
- there should be responsiveness to the needs of users of public sector health services about the delivery of public sector health services
- information about the delivery of public sector health services should be provided to the community in an open and transparent way
- there should be commitment to ensuring that places at which public sector health services are delivered are places at which –
    - employees are free from bullying, harassment and discrimination
    - employees are respected and diversity is embraced
    - there is a positive workplace culture based on mutual trust and respect
- there should be openness to complaints from users of public sector health services and a focus on dealing with the complaints quickly and transparently
- there should be engagement with clinicians, consumers and community members and local primary healthcare organisations in planning, developing and delivering public sector health services
- opportunities for research and development relevant to the delivery of public sector health services should be promoted
- opportunities for training and education relevant to the delivery of public sector health services should be promoted.

Remuneration

The Governor in Council approves the remuneration arrangements for Hospital and Health Board Chairs, Deputy Chairs and Members. Chairs, Deputy Chairs and Members will be paid an annual salary consistent with the Government policy titled: Remuneration procedures for part-time chairs and members of Queensland government bodies.

For Board remuneration see Section 5 Financial Statements page 86.

Achievements of the Board in 2013/14

Governance

- Board meets on the last Monday of each month
- Each committee reviews it's charter annually
- Board has held additional meetings for induction of Board Members, strategic planning days and community engagement workshops
- Invited a number of the WBHHS Executive Team to present information/reports at Board meetings
- Specific performance reports being presented at monthly Board meetings by HSCE:
  - Budget
  - FTE (MOHRI target)
  - NEAT
  - NEST
  - Quality and Safety
- Minutes of the Board are available on the WBHHS external website at www.health.qld.gov.au/widebay

Planning

- WBHHS Strategic Plan 2014/17 was adopted and publicly launched in May 2014
- As part of an extensive community consulation process in November 2013 entitled Your Hospital Your Say, Board members conducted public meetings in the following centres to better understand community health service needs:
  - Bundaberg
  - Maryborough
  - Hervey Bay
  - Childers
  - Biggenden
  - Gayndah
  - Mundubbera
  - Eidsvold
  - Monto
  - Mt Perry
  - Gin Gin

The information obtained through these meetings and a co-ordinated media campaign informed the strategic planning process.

- Consumer and community engagement strategy commenced and workshop held
- WBHHS and Medicare Local protocol ratified and enhanced to align planning and service delivery
- WBHHS and Wide Bay Medicare Local jointly commissioned a detailed heath needs atlas which can be viewed at www.health.qld.gov.au/widebay/documents/PH-WideBay-Atlas13.pdf
- WBHH Board Work Plan completed.

Community Engagement

- Meetings with key media identities
- Civic reception with Bundaberg Regional Council councillors
- Meetings with Fraser Coast Regional Council councillors
- Visits by Board members to Gayndah, Biggenden, Maryborough, Hervey Bay, Monto, Mt Perry, Mundubbera, Bundaberg, Gin Gin, Childers and Eidsvold
- Attendance at Bundaberg Nurse Oration - 5 November, 2013
- Visit by Premier and Health Minister to Bundaberg and Maryborough Hospitals - 16 Jan, 2014
- Meeting with Integrated Wellbeing centre (IWC)
- Health Minister officially opens Maryborough Dental Clinics - 7 March, 2014
- Health Minister, Board Chair, board members attend Maryborough community health forum - 7 March, 2014
- Deputy Premier Jeff Seeney attends official opening Biggenden Multi-Purpose Health Service - 28 March, 2014
- Health Minister visited Hervey Bay Hospital and Maryborough Hospital - 13 May, 2014
- Chair attends HHS Chairs meeting quarterly
- Community Consultative Committee meetings attended by Board members at eight rural facilities
- Consumer and Community Advisory Networks (CANs) operational in Bundaberg and Fraser Coast
- Meetings with local MPs
- Responded proactively to media enquiries with potential to impact negatively on WBHHS
- Increased number of positive hospital and health features in the local media.

Capital Works

- Expanded/enhanced facilities to meet the needs of the Wide Bay community
- Confirmation of Cancer Clinic for Bundaberg
- Confirmation of Oral Health Projects in Maryborough Hospital
- Aged care wing constructed at Childers Multi-purpose Health Service
- Development of $35m co-located cancer and dental health capital works in Bundeberg and Hervey Bay progressed.

Health Services

- After hours emergency services closure at a private hospital averted
- Doctors contracts
- Maryborough Hospital specialist endoscopy centre
- Improvements in waiting lists
- OHS audit
- Sale of Yaralla Nursing Home to Prescare
- Patient transporters based in Bundaberg and Hervey Bay operating well.

Related entities

Schedule of statutory bodies, acts and subordinate legislation

Crime and Misconduct Act 2001	*Hospitals Foundations Regulation 2005*
Dental Technicians Registration Act 2001	*Medical Radiation Technologist Registration Act 2001*
Dental Technicians Registration Regulation 2002	*Medical Radiation Technologists Registration Regulation 2002*
Financial Accountability Act 2009	*Mental Health Act 2000*
Health Act 1937	*Mental Health Regulation 2002*
Health Regulation 1996	*Mental Health Review Tribunal Rule 2009*
Health (Drugs and Poisons) Regulation 1996	*Occupational Therapists Registration Act 2001*
Health Practitioner Registration Boards (Administration) Act 1999	*Occupational Therapists Registration Regulation 2001*
Health Practitioner Regulation National Law Act 2009	*Public Health Act 2005*
Health Practitioner Regulation National Law Regulation	*Public Health Regulation 2005*
Health Practitioner Regulation National Law (Transitional) Regulation 2010	*Radiation Safety Act 1999*
Health Practitioners (Professional Standards) Act 1999	*Radiation Safety Regulation 2010*
Health Practitioners (Professional Standards) Regulation 2010	*Radiation Safety (Radiation Safety Standards) Notice 2010*
Health Quality and Complaints Commission Act 2006	*Speech Pathologists Registration Act 2001*
Hospital and Health Boards Act 2011	*Speech Pathologists Registration Regulation 2001*
Hospital and Health Boards Regulation 2012	*Statutory Bodies Financial Arrangements Act 1982*
Hospitals Foundations Act 1982	

Public Sector Ethics Act 1994

WBHHS is committed to upholding the values and standards of conduct outlined in the Code of Conduct for the Queensland Public Service which came into effect 1 January 2011. The code of conduct applies to all employees of WBHHS and was developed under the Public Sector Ethics Act 1994 consisting of four core aspirational principles consisting of:

- Integrity and impartiality
- Promoting the public good
- Commitment to the system of government
- Accountability and transparency.

As of 1 July 2012, following the devolution of functions from the Department of Health, the Executive Director, Human Resource Services became the central point within WBHHS to receive, assess and refer allegations of suspected official misconduct to the Crime and Misconduct Commission. This role enabled the WBHHS Chief Executive to fulfil his obligation to report allegations of suspected official under the Crime and Misconduct Act 2001.

The WBHHS delivers mandatory training to all staff which includes Code of Conduct and public sector ethics.

The WBHHS abides by the Department of Health HR policies that relate to the application of the Code of Conduct and the reporting of suspected official misconduct.

Risk management

Overview of committee role, responsibilities and membership

The WBHHS Clinical Governance Executive Committee is the designated risk management committee for the WBHHS. Its key role and responsibilities are to ensure that:

- Safety and quality risks are actively managed through the WBHHS integrated systems of governance
- Care provided by the WBHHS clinical workforce is guided by current best practice
- The provision of safe, high quality health care is provided by qualified and skilled managers and clinical workforce
- Patient safety and quality incidents are recognised, reported and analysed to inform improved safety systems for the WBHHS
- Patients of the WBHHS will have their rights respected and be supported to participate in their care
- Strategic and operational planning ensures the delivery of high quality and safe health care and services
- Safety management systems ensure the safety and wellbeing of patients, staff, visitors and contractors
- Governance is supported through formal structures and appropriate delegation across the Health Service.

The committee meets monthly and reports directly to the Chief Executive. It is chaired by the executive Director of Clinical Governance and its membership comprises:

Members
Executive Director Clinical Governance Support Unit (Chair)
Chief Operations Officer
District Director Medical Services
Deputy District Director Medical Services
Executive Director Mental Health
Director Public Health
Director Oral Health
Director of Education
Executive Director Finance and Performance
Executive Director HR Services
District Director of Nursing & Midwifery Services
Director Medical Services Rural
Director Nursing & Midwifery Services – South
Director Community & Allied Health – North
Director Community & Allied Health – South
Clinical Director Paediatrics – South
Director ATODS
Nursing Director – South
Nursing Director – North
Manager Clinical Governance
Accreditation Compliance & Risk Manager
Data and Audit Coordinator
Manager Operational & Support Services – North
Manager Operational & Support Services – South
Manager OH&S
Integrated Risk and Policy Coordinator Coordinator

Standing agenda items include:

CLINICAL GOVERNANCE BOARD REPORT

Patient Safety

- 5.1.1.1 Clinical Incident
- 5.1.1.2 Death Reviews
- 5.1.1.3 Safety Alert Broadcasts

Quality

- 5.1.2.1 Accreditation Plan
- 5.1.2.2 Clinical Audit
- 5.1.2.3 VLAD
- 5.1.2.4 Credentialing
- 5.1.2.5 Infection Control
- 5.1.2.6 Medication Safety
- 5.1.2.7 Specific Quality Management Programs

Clinical Indicators

Consumer Engagement

- 5.4.1 Compliments
- 5.4.2 Complaints
- Performance Agreement Specific KPI's

OHS

Risk Management

Items for Escalation to Clinical Governance Executive Committee from the Divisions

- 5.4.1 Clinical Governance Issues
- 5.4.2 Corporate Governance Issues

Items for Escalation to the ELT

- 5.5.1 Clinical Governance Issues
- 5.5.2 Corporate Governance Issues

The key achievements of this risk management committee over the past 12 months include:

- Development and introduction of WBHHS Integrated Risk Management Procedure
- Development of 10 Quality and Safety Subcommittees to oversee operational risk and continuous improvement programs based on EQuIPNational Standards
- Revised Terms of Reference to ensure broader stakeholder involvement and accountability
- Revised agenda which ensures consistency of reporting "from the ward to the Board".

Corporate risk management

All accountability areas within the WBHHS structure are responsible for developing a risk register and implementing the Integrated Risk Management Policy. The financial and management accountabilities control risks within each position.

The corporate risk management strategy maintains the Wide Bay and Hospital Health Service risk management policy framework and promotes risk management training and education. The risk management strategy reinforces engagement with risk advisory services and supports the administration of the WBHHS risk management information system.

Mechanisms to strengthen corporate accountability include integrating risk management into executive committee business and development of a department risk/profile register.

A roll out of a process across executive committees plans to enable the identification and documentation of risk and to facilitate mapping of an organisational risk profile. Important principles are that the process should be simple to apply and flexible in its structure so it is relevant to all executive committees.

The process should support information sharing across committees to enable effective decision making and resource allocation. Each executive committee is to identify high level (strategic) risks. An owner of the risk will be identified and risk management/ mitigation strategies will be agreed and recorded.

Each executive committee will use a standard template to document risks and these risk registers will be consolidated to provide organisation-wide oversight that will be set down in a centralised strategic risk register for the WBHHS.

Audit and Risk Committee

The Audit and Risk Committee is a committee of the Wide Bay Hospital and Health Service Board and operates under a charter to provide independent assurance and assistance to the Board on:

- risk, control and compliance frameworks
- external accountability responsibilities as prescribed in the *Financial Accountability Act 2009*, the *Auditor-General Act 2009*, the *Financial Accountability Regulation 2009* and the *Financial and Performance Management Standard 2009*

Broadly, the committee's responsibilities are aligned to the functions prescribed in the *Hospital and Health Boards Regulation 2012* which covers:

- assessing the adequacy of the service's financial statements, having regard to the following:
  - the appropriateness of the accounting practices used
  - compliance with prescribed accounting standards under the *Financial Accountability Act 2009*
  - external audits of the service's financial statements
  - information provided by the service about the accuracy and completeness of the financial statements
- monitoring the service's compliance with its obligation to establish and maintain an internal control structure and systems of risk management under the *Financial Accountability Act 2009*, including:
  - whether the service has appropriate policies and procedures in place
  - whether the service is complying with the policies and procedures
- if an internal audit function is established for the Service under the *Financial and Performance Management Standard 2009*, part 2, division 5 – monitoring and advising the service's board about its internal audit function
- overseeing the service's liaison with the Queensland Audit Office in relation to the service's proposed audit strategies and plans; *Financial Accountability Act 2009*; assessing external audit reports for the service and the adequacy of actions taken by the service as a result of the reports, and how the service is managing the risks or concerns
- monitoring the adequacy of the service's management of legal and compliance risks and internal compliance systems, including the effectiveness of the systems in monitoring compliance by the service with relevant laws and government policies
- assessing the service's complex or unusual transactions or series of transactions, or any material deviation from the service's budget
- any other function given to the committee by the service's board, if the function is not inconsistent with a function mentioned above.

The committee reports to the Board and takes a proactive approach to risk management and escalation of concerns to the Board.

The committee met four times and undertook an annual self assessment of its performance.

Name	Membership	Dates
Gary Kirk	Chair	July 2013 – June 2014
Dominic Devine	Member	July 2013 – June 2014
Paul Dare	Member	July 2013 – June 2014

Internal audit

Internal audit is an integrated component of corporate and clinical governance, promoting efficient management, ensuring patient safety and informing appropriate risk management.

The WBHHS is part of an Internal Audit Hub in conjunction with Central Queensland and Sunshine Coast HHS's which commenced in late 2013. There is an Internal Audit (IA) Charter, IA Strategic Plan and IA Annual Work Plan approved by the WBHHS Board Audit & Risk Committee.

The 2013/14 internal audit program incorporated the following:

- Review and monitoring outcomes from the Queensland Audit Office (QAO) Reports to Parliament and open items from Internal and External Audit reports
- Conducting a continuous monitoring program to provide financial management assurance and integrity checks
- Implementing the fraud assurance strategy
- Commissioning the annual internal audit program 1 March 2014 to September 2014.

Internal audit also liaised extensively with the external auditors in actioning recommendations from the Interim Audit and the Final Audit related to the certification of the Annual Financial Statements.

The Internal Audit function operated with due regard to Queensland Treasury and Trade's *Audit Committee Guidelines and Section 29 of the Financial and Performance Management Standard 2009*.

Information systems and recordkeeping

The WBHHS is committed to improving record keeping practices to comply with the *Public Records Act 2002*, Information Standard 40: Recordkeeping and Information Standard 31: Retention and Disposal of Public Records.

Under Machinery-of-Government (MoG) changes, permanent transfer of administrative and functional records (with the exception of personnel, workplace health and safety, and capital works and infrastructure files) from the Department of Health to the WBHSS occurred.

The WBHHS uses the RecFind recordkeeping program for record management and classifies records under the BCS (Business Classification Scheme).

3 Our performance

Government objectives for the community

The Queensland Government is committed to ensuring better healthcare outcomes for Queenslanders. In February 2013, the Queensland Government released its Blueprint for Better Healthcare in Queensland which sets the scene for structural and cultural improvements across the health system. The Blueprint has four principal themes:

1. Health services focused on patients and people
2. Empowering the community and our health workforce
3. Providing Queenslanders with value in health services
4. Investing, innovating and planning for the future.

In addition, the Queensland Government has applied six key values, outlined in Getting Queensland Back on Track and its subsequent Statement of Health Priorities to guide the Government's policies and actions to improve health outcomes for Queenslanders. These values include:

- Better services for patients
- Better healthcare in the community
- Valuing our employees and empowering frontline staff
- Empowering local communities with a greater say over their hospital and local health services
- Value for money for taxpayers, and
- Openness

The WBHHS and Board developed the Strategic Plan 2014/17 after a full consultation process with staff, other health providers and the wider community.

The WBHHS Strategic Plan 2014/17 aligns with these earlier government and reflects the priorities and directions outlined in the Queensland Government's Blueprint for Better Healthcare in Queensland.

Whole of government plans

Overview – National Health Reform Agreement and National Partnership Agreement on Improving Public Hospital Services

National Partnership Agreement on Treating More Public Dental Patients

The objective of the National Partnership Agreement on Treating More Public Dental Patients (NPA) is to alleviate pressure on public dental waiting lists with a particular focus on Indigenous patients, patients at high risk of, or from, major oral health problems, and those from rural areas.

WBHHS had one of the longest dental waiting lists in Queensland with an average 12 year wait. NPA funds have been used to establish seven additional dental teams and fund outsourcing to the private sector.

During 2013/14, waiting times were reduced to a maximum of 16 months. Activity targets were exceeded by 29.4 per cent while spending remained within budget.

WBHHS strategic objectives and performance indicators

Strategic Plan Objectives	Performance Indicators 2013/17	Result / Status as at 30 June 2014
Revitalise frontline services within the WBHHS in line with the Government's objective to Getting Queensland Back on Track	100% National Elective Surgery Target (NEST) for patients treated within the clinically recommended timeframes	Cat 1 95% Cat 2 92% Cat 3 98%
	83% National Emergency Access Target (NEAT) for patients seen in ED within agreed timeframes	77.7%
	Clinical service capability framework (CSCF) that meets acute health needs of local population	Reviewed CSCF WBHHS
	8% reduction in the cost per Weighted Activity Unit (WAU) for the WBHHS	22% reduction achieved 2013 v 2014
	90% occupancy rates in Hervey Bay and Maryborough Hospitals at all times	94% occupancy for Fraser Coast hospitals as at 30 June 2013
Improve health services and health outcomes for the Wide Bay community in alignment with the Blueprint for better healthcare in Queensland	Reduction in average length of stay (ALOS) for medical patients	ALOS 1.98 days in Fraser Coast from 2.09 days in 12/13; Bundaberg 1.9 to 1.7 ALOS
	Reduction in readmissions to hospital for chronic conditions	Ongoing
	Improved access to self-management and group based therapies	Ongoing discussions with Medicare Local and key specialities eg COPD, heart disease
	Reduced obesity rates in the Wide Bay and Bundaberg in particular	Joint needs assessment and planning undertaken with Medicare Local
Ensure services are focused on patients and people, and are delivered in the right setting	Formal protocols established with Wide Bay Medicare Local, aged care and disability sectors	Enhanced protocol with Wide Bay Medicare Local
	Increased use of home therapies and hospital in the home programs	Proportion of renal home dialysis increased from 24% June 2013 to 39% June 2014
	Seamless transition of care from GP to hospital to aged care facility/community based provider	GP referral guidelines implemented for 18 specialties
	100% achievement of all national Closing the Gap Key Performance Indicators (KPIs)	ATSI follow-up within 7 days post MH discharge %; ATSI discharges against medical advice 3%
Restore accountability and confidence in the WBHHS	Effective Consumer Advisory Networks (CANs) operating in both Bundaberg and Hervey Bay	2 CANs established – bi-monthly meetings
	Well informed and engaged clinical staff as reflected in positive clinician feedback	Instigated direct feedback of ideas to CE + open planning days
	QIP embedded in the culture of the organisation	Ongoing process - QIP features in all service plans
	100% of WBHHS services are accredited at all times	Achieved
	Improved clinical governance and robust clinical processes/practices across all service streams	New clinical governance framework and structure implemented
	20% sustained improvement in performance in key clinical safety indicators	1 Never Events and 0 Deaths in Low Mortality DRGs recorded in 2013/14
	Reduced staff turnover and reliance on locums and agency clinical staff	Locum usage 35 FTEs in 2012/13 to 43 in 2013/14; Agency nursing 9.5 FTEs 2012/13 to 25 FTEs 2013/14
Ensure financial viability of the WBHHS to provide value for money health services	Financial integrity is maintained at all times	Achieved balanced budget 2013/14
	Alignment of WBHHS activities with budgets, workforce and performance	Implemented new annual planning template and budget setting process
	Alignment of WBHHS service priorities to Government policies and priorities	Blueprint priorities reflected in all Strategic/Operational plans
	Development of consultative 7-year Strategic Plan with detailed service plans	Process commenced - 3 planning forums held
	Achievement of own source revenue targets and all financial targets as per Service Agreement	Achieved 2013/14
	Highly skilled, high performing and resilient workforce	Ongoing

WBHHS Service Delivery Performance Statement 2013/14

Wide Bay Hospital and Health Service	Notes	2013/14 Target/Est.	2013/14 Actual	2014/15 Target/Est.
Percentage of patients attending emergency departments seen within recommended timeframes:				
• Category 1 (within 2 minutes)		100%	100%	100%
• Category 2 (within 10 minutes)		80%	85%	80%
• Category 3 (within 30 minutes)		75%	81%	75%
• Category 4 (within 60 minutes)		70%	76%	70%
• Category 5 (within 120 minutes)		70%	90%	70%
Percentage of emergency department attendances who depart within four hours of their arrival in the department		83%	77.7%	83%
Median wait time for treatment in emergency departments (minutes)		20	21	20
Median wait time for elective surgery (days)		25	33	25
Percentage of elective surgery patients treated within clinically recommended times:				
• Category 1 (30 days)		100%	95%	100%
• Category 2 (90 days)		94%	83%	94%
• Category 3 (365 days)		97%	92%	97%
Percentage of specialist outpatients waiting within clinically recommended timeframes:				
• Category 1 (within 30 days)		95%	62%	90%
• Category 2 (within 90 days)		90%	64%	90%
• Category 3 (within 365 days)		90%	84%	90%
Total weighted activity units:		Q16	Q16	Q17
• Interventions & Proceedures		7,298	6,371	6,171
• Emergency		12,876	12,810	14,136
• SNAP		6,218	5,781	5,902
• Mental Health		2,041	2,143	2,938
• Inpatients		37,355	30,213	40,977
• Outpatients		6,999	7,456	10,103
Average cost per weighted activity unit for Activity Based Funding facilities		$4,660	$4,712	$4,676
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	1	2	Dec 2013 1.04	1.1
Postnatal in-home visiting	2	85%	70%	85%
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit		60%	75.38%	>80%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	3	12%	10.1%	<12%
Ambulatory mental health activity	4, 5	95%	90%	95%

Notes:

1. 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 WBHHS level.

2. The number of women with newborns that we supported by a home visit program in the first month following birth as a % of total births of the Mums and Bubs commitment.

3. The 2013/14 Target/Est. has been revised to <12%. This is in line with the national target and aligns with WBHHS Service Agreement.

4. 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. This is a measure of community mental health services provided by HHSs, which represent more than 50 per cent of the total expenditure on clinical mental health services in Queensland.

5. 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 2014/15.

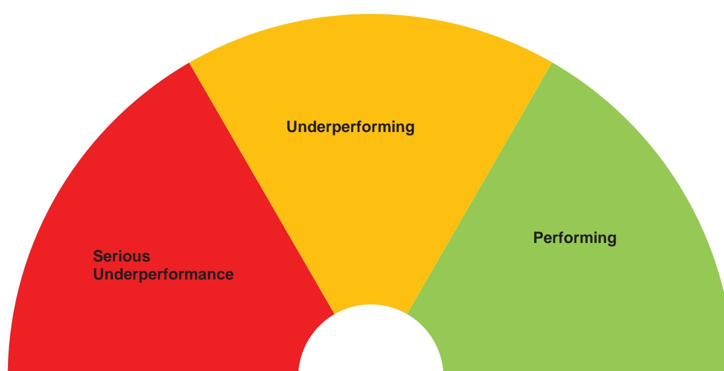
WBHHS Service Agreement Performance Indicators 2013/14

PERFORMANCE DOMAIN - KEY PERFORMANCE INDICATORS - SUMMARY PERFORMANCE

TIER1			REPORTED	TARGET	DATA AS AT	YTD Result / Latest Result			
EFFECTIVENESS – SAFETY AND QUALITY									
1.1	NSQHS Standards Compliance		Quarterly	green	December	green			
EFFICIENCY – EFFICIENCY AND FINANCIAL PERFORMANCE							$ Surplus / - Deficit		
1.6	Full-year Forecast Operating Position		Monthly	Balanced-$0.0	June		$0.095 M		
1.7	Purchased activity variance		Monthly	+/- 2%	June		985 1.4%		
		ABF/non-ABF split							
		ABF	Monthly	+/- 2%	June	1,021 1.5%			
		Non-ABF	Monthly	+/- 2%	June	-36 -0.01%			
EQUITY AND EFFECTIVENESS - ACCESS									
1.2	Shorter stays in emergency departments * (NEAT)		Monthly	83%	June			77.7%	↓
1.3	Shorter waits for elective surgery * (NEST)								
		Category 1: within 30 days	Monthly	100%	June			94.7%	▫
		Category 2: within 90 days	Monthly	94%	June			83.1%	↑
		Category 3: within 365 days	Monthly	97%	June		92.1% ↑		
1.4	Maintain surgical activity *	Full year target (2010 baseline + 5%) = 4,372	Monthly	2,186	June	2,551			
1.5	Fewer long waiting patients - Category 1								
		# waiting > 60 days	Monthly	0	June	0			
		# waiting > 30 & <= 60 days	Monthly	0	June	0			
		% waiting > 30 days	Monthly	2%	June	0.0%			

* denotes calendar year result

Performance Management Framework: Performance category rating - *not yet determined*



WBHHS Key Performance Indicators 2013/14

Data source: Decision Support System (DSS) 14 July 2014

TIER 2		REPORTED	TARGET	DATA AS AT	YTD Result / Latest Result	
EFFECTIVENESS – SAFETY AND QUALITY						
2.1	Healthcare–associated Infections (rate per 10,000 bed days)	6 Monthly		June	0.97	
2.2	28 day mental health readmission rate	Monthly	12%	June	10.1%	▫
2.3	Home based renal dialysis	Monthly	50%	June	39.6%	
EFFICIENCY – EFFICIENCY AND FINANCIAL PERFORMANCE					$ Surplus / - Deficit	
2.18	Year to Date Operating Position	Monthly	Balanced-$0.0	June	$ 0.095 M	↑
2.19	External labour - 20% decrease of 2011-12 YTD expenditure	Monthly	n/a	n/a		
2.20	*Average QWAU cost ------- published 2012-13 $4668	Monthly	$4,660	May	$ 4,712	
2.21	YTD average FTE (MOHRI FTE)	Monthly	2,669	June	2,593	
2.22	WorkCover Absenteeism (average hours lost)	Quarterly	0.40	June	0.44	
EQUITY AND EFFECTIVENESS - ACCESS						
2.4	Shorter waits for emergency departments					
	Category 1: within 2 minutes	Monthly	100%	June	100.0%	▫
	Category 2: within 10 minutes	Monthly	80%	June	84.7%	▫
	Category 3: within 30 minutes	Monthly	75%	June	81.2%	↓
	Category 4: within 60 minutes	Monthly	70%	June	75.6%	↓
	Category 5: within 120 minutes	Monthly	70%	June	89.6%	↓
2.5	Treating elective surgery patients in turn	Monthly	60%	June	59.6%	↑
2.6	Shorter maximum wait for elective surgery (days)					
	Cardiothoracic	Monthly	365	June	-	
	ENT	Monthly	365	June	141	↓
	General	Monthly	365	June	328	↓
	Gynaecology	Monthly	365	June	332	↑
	Ophthalmology	Monthly	365	June	-	
	Orthopaedics	Monthly	365	June	353	↓
	Neurosurgery	Monthly	365	June	-	
	Plastic & Reconstructive	Monthly	365	June	-	
	Urology	Monthly	365	June	264	↓
	Vascular	Monthly	365	June	-	
2.7	Fewer long waiting patients					
	Category 2: % waiting > 90 days	Monthly	2%	June	0.8%	↑
	Category 3: % waiting > 365 days	Monthly	2%	June	0.0%	▫
2.8	Shorter waits for specialist outpatient clinics					
	Category 1: % within 30 days	Monthly	95%	June	78.2%	↑
	Category 2: % within 90 days	Monthly	90%	June	74.4%	↑
	Category 3: % within 365 days	Monthly	90%	June	90.5%	↑
2.9	Postnatal in-home visiting	Quarterly	85%	June	70.4%	
2.10	Aboriginal and Torres Strait Islander PPH	Quarterly	17.7%	June	15.9%	
2.11	Potentially Preventable Hospitalisations Chronic conditions	Quarterly	4.9%	June	6.16%	
2.12	Aboriginal and Torres Strait Islander DAMA	Quarterly	1.7%	June	3.3%	
2.13	Aboriginal and Torres Strait Islander Low birthweight babies	Annual	n/a	n/a		
2.14	Rate of post discharge community contact - Mental Health	Monthly	60%	June	75.4%	
2.15	Ambulatory mental health activity	Monthly	95%	June	89.9%	
2.16	BreastScreen Queensland Screening Activity	Monthly	13,050	June	13,080	
2.17	Dental waiting lists	Monthly	0%	June	0.0%	
EFFECTIVENESS – PATIENT EXPERIENCE						
2.23	Emergency Department patient experience	Annual		December	red	

Legend: **n/a** not applicable to this HHS or data not yet available.
Latest /YTD Result compared to previous reporting period: Favourable ↑ Stable ▫ Unfavourable ↓

*** Note:** Costs for Enteral Nutrition are yet to be excluded from this indicator. Results may be slightly inflated for some HHSs this month.

2013/14- 2015/16 Service Agreement - Key Performance Indicators

KPI No.	Level	Key Performance Indicator (KPI)	Target	Strategic Link	Reporting Frequency
EFFECTIVENESS – SAFETY AND QUALITY					
1.1	**Tier 1**	National Safety and Quality Health Service Standards Compliance	All actions met	National Safety and Quality Health Service (NSQHS) Standards, Australian Commission on Safety and Quality in Healthcare Blueprint for Better Healthcare in Queensland Queensland Health Strategic Plan 2012-2016	**Quarterly**
2.1	Tier 2	Healthcare–associated infections Healthcare associated staphylococcus aureus (Including MRSA) bacteraemia	Rate is less than or equal to 2.0 per 10,000 occupied bed days	National Performance and Accountability Framework National Healthcare Agreement Blueprint for Better Healthcare in Queensland	**6 monthly**
2.2	Tier 2	28 day mental health readmission rate Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	Less than or equal to 12%		**Monthly**
2.3	Tier 2	Home based renal dialysis	40% YTD (Cairns & Hinterland, Townsville, Mackay, Central Queensland) 50% YTD (Darling Downs, Gold Coast, Metro North, Metro South, Sunshine Coast, Wide Bay)	Queensland Statewide Renal Services Plan (2008 – 2017)	**Monthly**
EQUITY AND EFFECTIVENESS - ACCESS					
1.2	**Tier 1**	Shorter stays in emergency departments National Emergency Access Target (NEAT): % of patients who attended an emergency department (ED) who depart within 4 hours of arrival	**2013** 77% **2014** 83%	National Performance and Accountability Framework National Partnership Agreement on Improving Public Hospital Services Schedule C – National Emergency Access Target Blueprint for Better Healthcare in Queensland	**Monthly**
2.4	Tier 2	Shorter waits for emergency departments Emergency department patients seen within the clinically recommended time: · Category 1: within 2 minutes · Category 2: within 10 minutes · Category 3: within 30 minutes · Category 4: within 60 minutes · Category 5: within 120 minutes	Category 1: 100% Category 2: 80% Category 3: 75% Category 4: 70% Category 5: 70%	National Performance and Accountability Framework National Partnership Agreement on Improving Public Hospital Services Schedule C – National Emergency Access Target	**Monthly**
1.3	**Tier 1**	Shorter waits for elective surgery National Elective Surgery Target (NEST): % of patients receiving elective surgery who were treated within the clinically recommended timeframe for their urgency category: · Category 1: within 30 days · Category 2: within 90 days · Category 3: within 365 days	**2013** Category 1: 100% Category 2: 87% Category 3: 94% **2014** Category 1: 100% Category 2: 94% Category 3: 97%	National Performance and Accountability Framework National Partnership Agreement on Improving Public Hospital Services Schedule A – National Elective Surgery Target Blueprint for Better Healthcare in Queensland	**Monthly**
1.4	**Tier 1**	Maintain surgical activity Elective Surgery Volume	≥5% more than 2010 volume	National Partnership Agreement on Improving Public Hospital Services Schedule A – National Elective Surgery Target	**Monthly**
1.5	**Tier 1**	Fewer long waiting patients Number of category 1 elective surgery patients waiting more than the clinically recommended timeframe for their category: · Category 1: within 30 days	Category 1: 0 to ≤ 2% with no patients waiting longer than 60 days	National Partnership Agreement on Improving Public Hospital Services Schedule A – National Elective Surgery Target Blueprint for Better Healthcare in Queensland	**Monthly**
2.5	Tier 2	Treating elective surgery patients in turn % of elective surgery patients who were treated in turn	60%	Blueprint for Better Healthcare in Queensland National Partnership Agreement on Improving Public Hospital Services Schedule A – National Elective Surgery Target	**Monthly**
2.6	Tier 2	Shorter maximum wait for elective surgery Maximum waiting time of elective surgery patients waiting · Cardiothoracic · ENT · General Surgery · Gynaecology · Ophthalmology · Orthopaedics · Neurosurgery · Plastic & Reconstructive Surgery · Urology · Vascular Surgery	365 days	Blueprint for Better Healthcare in Queensland National Partnership Agreement on Improving Public Hospital Services Schedule A – National Elective Surgery Target	**Monthly**

2013/14- 2015/16 Service Agreement - Key Performance Indicators

KPI No.	Level	Key Performance Indicator (KPI)	Target	Strategic Link	Reporting Frequency
2.7	Tier 2	Fewer long waiting patients Number of category 2 and 3 elective surgery patients waiting more than the clinically recommended timeframe for their category: · Category 2: within 90 days · Category 3: within 365 days	Category 2: 0 to ≤ 2% Category 3: 0 to ≤ 2%	National Partnership Agreement on Improving Public Hospital Services Schedule A – National Elective Surgery Target Blueprint for Better Healthcare in Queensland	**Monthly**
2.8	Tier 2	Shorter waits for specialist outpatient clinics Specialist outpatients waiting within the clinically recommended time: · Category 1: within 30 days · Category 2: within 90 days · Category 3: within 365 days	Category 1: 95% Category 2: 90% Category 3: 90%	Blueprint for Better Healthcare in Queensland	**Monthly**
2.9	Tier 2	Postnatal in-home visiting Enhanced maternal and child health service – post natal in-home visiting	HHS specific target	Blueprint for Better Healthcare in Queensland	**Quarterly**
2.1	Tier 2	Aboriginal and Torres Strait Islander potentially preventable hospitalisations	≤ 17.7%	Making Tracks: toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 Policy and Accountability Framework National Healthcare Agreement	
2.11	Tier 2	Potentially preventable hospitalisations – chronic conditions	≤ state average	National Performance and Accountability Framework	**Quarterly**
2.12	Tier 2	Aboriginal and Torres Strait Islander discharge against medical advice Aboriginal and Torres Strait Islander patients who discharged themselves against medical advice (DAMA)	≤ HHS quarterly target	Aboriginal and Torres Strait Islander Health Performance Framework Chronic Disease Indigenous Health (Queensland Health Indigenous Health Funding Package) National Partnership Agreement Closing the Gap in Indigenous Health Outcomes Making Tracks: towards closing the gap in health outcomes for Indigenous Queenslanders by 2033 – Policy and Accountability Framework	**Quarterly**
2.13	Tier 2	Aboriginal and Torres Strait Islander Low birthweight babies Low birthweight babies (weighing less than 2500g at birth) born to Aboriginal and Torres Strait Islander women	≤ HHS quarterly target	National Indigenous Reform Agreement National Partnership Agreement Early Childhood Development Agreement National Healthcare Agreement	**Annual**
2.14	Tier 2	Rate of post discharge community contact Rate of community follow up within 1 to 7 days following discharge from an acute mental health inpatient unit	60%	National Performance and Accountability Framework	**Monthly**
2.15	Tier 2	Ambulatory mental health activity Progress towards duration of ambulatory mental health service contacts annual target	100%		
2.16	Tier 2	BreastScreen Queensland screening activity Proportion of the annual breast screening target achieved	98%		**Monthly**
2.17	Tier 2	Dental waiting lists Number of patients waiting more than the clinically recommended maximum time on the general care dental waiting list	0	National Partnership Agreement on Treating More Public Dental Patients	**Monthly**
EFFICIENCY – EFFICIENCY AND FINANCIAL PERFORMANCE					
1.6	**Tier 1**	Full Year Forecast Operating Position (agreed position between Department of Health and HHS)	Balanced or surplus	Financial Accountability Act 2009 Financial and Performance Management Standard 2009 National Performance and Accountability Framework	**Monthly**
2.18	Tier 2	Year to Date Operating Position	Balanced	Financial Accountability Act 2009 Financial and Performance Management Standard 2009 National Performance and Accountability Framework	**Monthly**
2.19	Tier 2	External Labour Expenditure on locum and agency staff	20% reduction on prior year		**Monthly**
1.7	**Tier 1**	Purchased activity monitoring Variance between YTD purchased activity and actual activity	Metro North: 0% to +/-1% Metro South: 0% to +/-1% All other HHSs: 0% to +/-2%		**Monthly**
2.2	Tier 2	Average QWAU cost Average cost per Queensland weighted activity unit (QWAU)	At or below the Queensland ABF price	National Performance and Accountability Framework	**Monthly**
2.21	Tier 2	YTD MOHRI FTE MOHRI FTE – number of MOHRI year to date	HHS specific target		**Monthly**
2.22	Tier 2	WorkCover absenteeism Hours lost (WorkCover) vs Occupied FTE	0.4		**Quarterly**
EFFECTIVENESS – PATIENT EXPERIENCE					
2.23	Tier 2	Emergency department patient experience Emergency Department patient experience survey (EDPES)	Question 1: 40% Question 2: 40% Question 3: 60% Question 4: 90%	National Performance and Accountability Framework	**Annual**

Summary of financial performance

WBHHS is committed to delivering further efficiencies to provide the maximum value for money from its funding in order to deliver safe, high quality and timely services to its community.

A balanced budget was achieved for the 2013/14 financial year which is a significant achievement given the continued increase in activity. Key non financial performance targets such as waiting times in the Emergency Department and waiting lists for Elective Surgery and Dental treatment were achieved within the available funding. Weighted (funded) activity exceeded the previous year by 6%. This is the 5th consecutive year that weighted activity has exceeded the prior year in the region of 5-7%.

Plans are in place over the next financial year to continue the reinvestment of savings into service initiatives specifically targeted to reduce waiting times at a pace never experienced in Queensland.

Comparison of actual financial results with budget

Statement of Comprehensive Income for the year ended 30 June 2014

	Notes	2013-14 Actual $'000	2013-14 Budget $'000	Variance %
Income from Continuing Operations				
User charges	1	31,651	27,286	16%
Government funding	2	432,657	432,657	
Grants and other contributions	3	7,968	7,052	13%
Other revenue	4	5,800	6,685	(13%)
Gains		6	-	
Reversal of impairment losses on receivables		13	-	
Total Income from Continuing Operations		478,095	473,680	1%
Expenses from Continuing Operations				
Employee expenses	5	(884)	(870)	(2%)
Health Service labour expenses	6	(321,679)	(316,607)	(2%)
Supplies and services		(136,011)	(137,132)	1%
Grants and subsidies				
Depreciation and amortisation		(12,163)	(12,471)	
Impairment losses	7	(164)	-	
Other expenses	8	(6,986)	(6,600)	(6%)
Impairment of assets	9	(113)	-	
Total Expenses from Continuing Operations		(478,000)	(473,680)	(1%)
Total Operating Results from Continuing Operations		95	-	

Notes:

1. User charges predominantly comprise of hospital fees (eg. patient fees) and reimbursements for pharmaceuticals under the PBS (Pharmaceutical Benefit Scheme). The variance against budget is due to improved revenue generation for private patients, outpatients and diagnostic services.
2. Government funding is provided by the Australian and State Governments for activity based funding, block grants and other contributions. In the prior year this income was included under grants and contributions.
3. Grants and Contributions are predominantly received from the Australian and State Governments to fund operations.
4. Other revenue is predominantly cost recoveries for employee expenses, flood mitigation works and minor building projects.
5. Employee expenses are represented by expenses for Board Members, the Health Service Chief Executive and the Chief Financial Officer who are directly employed by the HHS.
6. Health Service labour expenses are represented by employee expenses of the Department of Health staff who are contracted to the HHS as the HHS is not a prescribed service. Under this arrangement, the Department provides employees to perform work for the HHS and accepts its obligations as the employer of the Department employees. The HHS is responsible for the day-to-day management of these departmental employees and reimburses the Department for the costs of these employees. The variance against budget is due to expenses for new service initiatives funded internally by the HHS and increased WorkerCover premiums.
7. Impairment losses were incurred in the write-off of bad debts and losses on disposal of assets.
8. Other expense is predominantly the insurance premium for the HHS.
9. A revaluation of land assets resulted in a revaluation decrement which under accounting standard AASB136 Impairment of Assets is expensed.

Statement of Financial Position as at 30 June 2014

	Notes	2014 $'000	2013 $'000
Assets			
Current Assets			
Cash and cash equivalents	17	13,852	8,496
Trade and other receivables	18	11,719	18,533
Inventories	19	3,388	2,945
Other	20	208	361
Total Current Assets		29,167	30,335
Non-current Assets			
Property, plant and equipment	21	177,969	197,756
Total Non-Current Assets		177,969	197,756
Total Assets		207,136	228,091
Liabilities			
Current Liabilities			
Trade and other payables	22	28,392	27,918
Accrued employee benefits	23	17	32
Unearned revenue	24	132	49
Total Current Liabilities		28,541	27,999
Total Liabilities		28,541	27,999
Net Assets		178,595	200,092
Equity			
Contributed equity	25	177,694	199,828
Asset revaluation surplus	26	791	249
Retained surplus	27	110	15
Total Equity		178,595	200,092

Notes:

For note references refer to the Financial Statements – 30 June 2014

4

Human resources

Our people

Workforce planning, attraction, retention and performance

Overview of plan, strategies and performance, use of MOHRI FTE

Following the significant reform that was undertaken during 2012/13, which saw the WBHHS review all departments and realign a number of programs, reform was continued during the 2013/14 year. This reform, which also comprised a second round of voluntary redundancies that finalised in September 2013, allowed the WBHHS to focus on workforce planning, establishment management and remaining fiscally responsible for its workforce structure.

With the release of the WBHHS Strategic Plan 2014/17, the WBHHS has clearly set its strategic workforce planning objectives for the next three years. These objectives include clinical ownership, accountability and leadership, succession planning, and the creation of an environment where the WBHHS is the preferred career and destination for high performing health professionals. With the focus on WBHHS meeting its responsibilities to workforce planning and establishment management, the Human Resources team has undergone structural reform to embed these business objectives HR Services team. This reform will also further bed down the WBHHS's responsibilities for compliance with FTE, MOHRI and other metrics as placed upon the WBHHS for audit and reporting.

As set out in the strategic plan, the WBHHS will continue to seek to create a workplace culture that supports positive and respectful behaviours, high performance employees, recognises and utilises the skills of staff as advisers and solution managers, while addressing poor performance when required. The WBHHS will seek to continue the development of a localised leadership and development framework that will support supervisors and managers in being responsive and equipped to meet clinical activity and financial targets and while developing effective staff management skills and abilities.

To support the commitment to staff development, the WBHHS has available a comprehensive and diverse range of training programs and courses, to enhance employee performance and capability. Areas included are:

- EquIP/Quality Improvement
- Recruitment & Selection
- Safety Essentials for Managers
- Managing Performance
- Managing Conflict & Grievances
- Aggressive Behaviour Management
- Cultural Diversity
- Cost Centre Management
- Driver Safety
- Fire Safety
- Warden Training
- Healthcare Ergonomics
- Code of Conduct
- Public Interest Disclosures
- Workplace equity & harassment

The WBHHS, which currently holds non-prescribed employer status, is supported by Department of Health in the application of employment policies that assist managers and employees in undertaking day to day business activities. These include flexible working arrangements such as purchased leave, parental leave, telecommuting, special leave, conference leave arrangements, job sharing opportunities and study and research assistance. These policies are promoted to staff through formal performance appraisal and development plans, orientation and induction programs, role descriptions, staff forums and other meetings and committees.

Performance management and development of staff is undertaken at a workplace level with assistance by HR Services when required. This includes Performance and Development plans, which are applied using generic and specialist provisions depending on the stream of the employee.

The WBHHS also participates in a number of consultative forums in which the executive and senior managers meet and share information with union representative enabling information sharing on industrial relations matters affecting our staff. Additionally the Chief Executive holds a monthly combined meeting with lead union officials, which is an open forum for officials and the Chief Executive to raise any issue deemed relevant.

Prescribed Employer

During the 2014/15 year, the WBHHS will commence activities to become a prescribed employer.

The Hospital and Health Boards Act 2011 (the Act) provides for Wide Bay Hospital and Health Services (WBHHS) to be prescribed by regulation to be the employer of all employees working in and for the WBHHS. WBHHS may be prescribed to be the employer based on mutual confidence of WBHHS capacity and capability to administer the employment related processes for employees. Currently, under the Act the WBHHS has the power to employ chief executives and other health executive service employees, but not other employees as the departmental chief executive (Director-General) is the employer of all other WBHHS health service employees.

To that end, the WBHHS already delivers and performs a wide range of human resource activities and authorities (hire to retire), achieved through the sub-delegation of these functions by the Director-General. Therefore, on becoming prescribed as the employer, the WBHHS should not experience a significant increase in HR function work activities or in the performance of these functions.

The Director-General will remain responsible for establishing and setting terms and conditions of employment, including remuneration and classification structures, and will retain the authority to provide more favourable terms and conditions if required by the HHS. The Director-General will also remain responsible for negotiating Enterprise Agreements and other state-wide employment matters. All departmental staff working for the WBHHS, at the time of the WBHHS being prescribed as an employer, and any future staff, will become employees of the WBHHS on the same employment terms and conditions on the date prescribed.

WBHHS are required to submit for consideration of the Director General, evidence that they are able to assume the responsibilities of prescribed employer by March 2015, with an aim of achieving prescribed employer status by 1 July 2015.

Early retirement, redundancy and retrenchment

Overview of the 2013/14 year

The structural reform of the WBHHS during the 2012/13 year continued into the 2013/14 year, with significant changes continuing to take place. These changes continued to be based on sound business reasoning, the first and foremost being the ongoing maintenance of the high level of clinical care being provided for our patients and support for our employees.

The most significant milestone in this reform was the transition of the Yaralla Aged Care Facility to the private provider, Prescare, and the provision of redundancies to eligible staff employed in the facility. This process was led by a transition team who undertook a comprehensive communications strategy with staff and residents, using face to face on-site meetings, written and web based communication and full engagement with union representatives. The outcome of this was a seamless transmission of business to the new provider.

Further minor reforms took place following applications from staff for voluntary redundancy, which were in turn evaluated on a case by case basis, which allowed the WBHHS to further refine its MOHRI target and position the WBHHS in an excellent MOHRI position going forward.

It should be further noted that by keeping open strong lines of communication to staff and employees through frequent meetings and updates, the provision of FAQ's, free onsite counselling, financial and superannuation advice, worked very well to support the WBHHS's position going forward. This communication, combined with consultative forums and regular one on one updates to union officials from the Chief Executive, resulted in no industrial or other court action against the WBHHS.

For the 2013/14 year, 87 redundancies packages were received by employees at a cost of $4,689,319.13, which was funded by Treasury. Employees who did not accept an offer of redundancy were offered case management for a set period while reasonable attempts were made to find them alternative placements. Following this period, if no placement was found and further efforts to obtain a placement weren't appropriate, the employees were terminated and paid a retrenchment package. During the 2013/14 year, three employees received retrenchment packages.

MOHRI FTE Fiscal by Paypoint, Employ Status

		2011 June 2011	2012 July 2012	2013 June 2013	2013 June 2013	2014 June 2014
Managerial and Clerical	Total	417.78	421.30	353.86	361.84	422.32
	Casual	23.94	24.49	8.33	12.47	8.35
	Permanent	325.10	337.30	295.83	297.74	334.95
	Temporary	68.74	59.51	49.70	51.63	79.02
Medical incl VMOs	Total	237.63	278.34	323.62	330.89	309.96
	Casual	0.08	0.08	0.13	0.10	0.42
	Permanent	100.55	107.01	107.71	110.51	109.89
	Temporary	137.00	171.25	215.78	220.28	199.65
Nursing	Total	1,148.83	1,224.02	1,218.96	1,213.81	1,143.12
	Casual	80.53	71.40	34.38	39.49	38.30
	Permanent	929.78	1,051.40	1,088.46	1,073.29	1,003.70
	Temporary	138.52	101.22	96.12	101.03	101.12
Operational	Total	505.72	529.69	437.90	431.48	433.12
	Casual	55.42	69.61	20.54	20.97	31.16
	Permanent	409.65	418.88	361.49	356.40	342.88
	Temporary	40.65	41.20	55.87	54.11	59.08
Trade and Artisans	Total	18.00	19.00	13.00	13.00	14.00
	Permanent	16.00	17.00	12.00	12.00	14.00
	Temporary	2.00	2.00	1.00	1.00	0.00
Professional and Technical	Total	258.77	286.11	278.80	280.54	303.08
	Casual	0.51	1.28	0.21	0.11	0.40
	Permanent	209.35	244.96	248.33	250.37	259.70
	Temporary	48.91	39.87	30.26	30.06	42.98
All Paypoints	Total	2,586.73	2,758.46	2,626.14	2,631.56	2,625.60
	Casual	160.48	166.86	63.59	73.14	78.63
	Permanent	1,990.43	2176.55	2113.82	2100.31	2065.12
	Temporary	435.82	415.05	448.73	458.11	481.85

- The permanent retention rate is 98.89%
- The permanent separation rate is 1.11%

Open Data: Expenditure on consultancy and overseas travel will be published on the Queensland government's open data website, available via: www.data.qld.gov.au

Wide Bay Hospital and Health Service

ABN 67 558 031 153

Financial statements

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General information

Wide Bay 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 Wide Bay Hospital and Health Service.

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

The head office and principal place of business of Wide Bay Hospital and Health Service is:

c/- Bundaberg Hospital
PO Box 34, BUNDABERG QLD 4670

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

These financial statements cover the Wide Bay Hospital and Health Service (WBHHS, Wide Bay HHS or Hospital and Health Service).

For information in relation to Wide Bay Hospital and Health Service's financial statements, please call 07 4150 2020, email Board-Widebay@health.qld.gov.au or visit the website http://www.health.qld.gov.au/widebay.

Amounts shown in these financial statements may not add to the correct sub-totals or totals due to rounding.

Wide Bay Hospital & Health Service
Statement of Comprehensive Income
For the year ended 30 June 2014

	Note	2014 $'000	2013 $'000
Income from Continuing Operations			
User charges	5	31,651	24,393
Government funding*	6	432,657	425,880
Grants and other contributions	7	7,968	15,726
Other revenue	8	5,800	3,467
Gains	9	6	153
Reversal of impairment losses on receivables	18	13	937
Total Income from Continuing Operations		478,095	470,556
Expenses from Continuing Operations			
Employee expenses	10	(884)	(701)
Health Services labour expenses	11	(321,679)	(329,189)
Supplies and services	12	(136,011)	(120,940)
Grants and subsidies		-	(85)
Depreciation and amortisation	13	(12,163)	(12,826)
Impairment losses	14	(164)	(129)
Other expenses	15	(6,986)	(6,298)
Impairment of assets	16	(113)	(373)
Total Expenses from Continuing Operations		(478,000)	(470,541)
Operating Results from Continuing Operations	27	95	15
Other Comprehensive Income			
Items that will not be reclassified subsequently to operating result			
Gain on the revaluation of land and buildings		542	249
Other comprehensive income for the year		542	249
Total comprehensive income for the year		637	264

* Comparatives have been adjusted to enhance disclosures of government funding previously included in receipt of grants and other contributions. Refer Note 6.

The above statement of comprehensive income should be read in conjunction with the accompanying notes

Wide Bay Hospital & Health Service
Statement of Financial Position
As at 30 June 2014

	Note	2014 $'000	2013 $'000
Assets			
Current Assets			
Cash and cash equivalents	17	13,852	8,496
Trade and other receivables	18	11,719	18,533
Inventories	19	3,388	2,945
Other	20	208	361
Total Current Assets		29,167	30,335
Non-current Assets			
Property, plant and equipment	21	177,969	197,756
Total Non-current Assets		177,969	197,756
Total Assets		207,136	228,091
Liabilities			
Current Liabilities			
Trade and other payables	22	28,392	27,918
Accrued employee benefits	23	17	32
Unearned revenue	24	132	49
Total Current Liabilities		28,541	27,999
Total Liabilities		28,541	27,999
Net Assets		178,595	200,092
Equity			
Contributed	25	177,694	199,828
Asset Revaluation Surplus	26	791	249
Retained surpluses	27	110	15
Total equity		178,595	200,092

The above statement of financial position should be read in conjunction with the accompanying notes

Wide Bay Hospital & Health Service
Statement of Changes in Equity
For the year ended 30 June 2014

	Contributed Equity $'000	Asset Revaluation Surplus $'000	Retained Surplus $'000	Total Equity $'000
Balance at 1 July 2012	-	-	-	-
Operating Result from Continuing Operations	-	-	15	15
Other comprehensive income for the year	-	249	-	249
Total comprehensive income for the year	-	249	15	264
Transactions with owners in their capacity as owners:				
Net asset received (transferred under Administrative Arrangement as at 1 July 2012)	202,135	-	-	202,135
Contributions of equity, net of transaction costs (minor capital works)	5,585	-	-	5,585
Non-appropriated equity withdrawals (depreciation funding)	(12,755)	-	-	(12,755)
Non-appropriated equity injections (transfer of assets on practical completion)	4,863	-	-	4,863
Balance at 30 June 2013	199,828	249	15	200,092

	Contributed Equity $'000	Asset Revaluation Reserves $'000	Retained Surplus $'000	Total Equity $'000
Balance at 1 July 2013	199,828	249	15	200,092
Operating Result from Continuing Operations	-	-	95	95
Other comprehensive income for the year	-	542	-	542
Total comprehensive income for the year	-	542	95	637
Transactions with owners in their capacity as owners:				
Net asset received (transferred under Administrative Arrangement as at 1 July 2012)	-	-	-	-
Contributions of equity, net of transaction costs (minor capital works)	3,933	-	-	3,933
Non-appropriated equity withdrawals (transfer of assets to Department)	(14,001)	-	-	(14,001)
Non-appropriated equity withdrawals (depreciation funding)	(12,105)	-	-	(12,105)
Non-appropriated equity injections (transfer of assets on practical completion)	39	-	-	39
Balance at 30 June 2014	177,694	791	110	178,595

The above statement of changes in equity should be read in conjunction with the accompanying notes

Wide Bay Hospital & Health Service
Statement of Cash Flows
For the year ended 30 June 2014

	Note	2014 $'000	2013 $'000
Cash flows from operating activities			
Government funding		428,425	416,784
User charges		30,601	31,547
Grants and other contributions		7,968	-
Other revenue		5,813	3,467
Employee expenses		11,374	(732)
Supplies and services		(147,688)	(108,336)
Grants and subsidies		-	(85)
Other expenses		(6,629)	-
Net GST remitted		(89)	(711)
Contract Labour		(322,093)	(335,477)
Net cash from operating activities	35	7,682	6,457
Cash flows from investing activities			
Payments for property, plant and equipment		(6,589)	(5,574)
Proceeds from sale of property, plant and equipment		330	392
Net cash used in investing activities		(6,259)	(5,182)
Cash flows from financing activities			
Proceeds from equity injections		3,933	5,585
Cash transferred in under administrative arrangement		-	1,636
Net cash used in financing activities		3,933	7,221
Net increase in cash and cash equivalents		5,356	8,496
Cash and cash equivalents at the beginning of the financial year		8,496	-
Cash and cash equivalents at the end of the financial year	17	13,852	8,496

The above statement of cash flows should be read in conjunction with the accompanying notes

Wide Bay Hospital & Health Service

WIDE BAY HOSPITAL AND HEALTH SERVICE
Notes to and Forming Part of the Financial Statements 2013-14

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Wide Bay Hospital & Health Service
Notes to the financial statements
30 June 2014

Note 1. Objectives and principle activities

Wide Bay Hospital and Health Services (WBHHS) was established on 1 July 2012, as a not-for-profit statutory body under the Hospital and Health Boards Act 2011, as part of the National Health Reform Agreement. It is responsible for providing services for an assigned regional area from Maryborough to Miriam Vale in the east and Mundubbera to Monto in the west.

The WBHHS provides health care for more than 200,000 residents of the Wide Bay region and the many visitors to the region each year. Population growth across the WBHHS region is expected to increase by 19% to reach over 267,000 in 2021. Of the current resident population, 3% are Indigenous Australians.

WBHHS is serviced by two acute care hospitals and one acute/sub-acute hospital located in the main regional centres of Bundaberg, Hervey Bay and Maryborough respectively. Additionally, there are seven rural facilities, a rural health centre and a residential aged care facility (facility sold 27 October 2013). WBHHS provides primary health care services, ambulatory services, acute and non-acute care, aged care, mental health and oral health care services.

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

Facilities

The WBHHS is responsible for operating three main hospital sites, being:

- Bundaberg Base Hospital
- Hervey Bay Hospital
- Maryborough Hospital

Inpatient services are also provided at the following rural facilities:

- Biggenden Multi Purpose Health Service
- Childers Multi Purpose Health Service
- Eidsvold Multi Purpose Health Service
- Gayndah Hospital
- Gin Gin Hospital
- Monto Hospital
- Mundubbera Multi Purpose Health Service

Services provided

The WBHHS will continue to provide the following services through the facilities listed above:

- Inpatient services
- Outpatient and ambulatory services
- Interventions and procedures
- State funded outreach services
- Telehealth services
- Organ and tissue donation
- Public health services
- Cancer screening, Oral Health and Mental Health services
- Closing the Gap services for Indigenous Queenslanders
- Teaching, training and research

A Service Agreement exists between WBHHS and the Department of Health which gives detailed prescription of the services to be provided, objectives and funding sources. A copy of this Service Agreement is available to the public from the Queensland Health website.

Note 2. Significant accounting policies

The principal accounting policies adopted in the preparation of the financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated.

Wide Bay Hospital & Health Service
Notes to the financial statements
30 June 2014

(a) Statement of compliance

Wide Bay Hospital and Health Service has prepared these financial statements in compliance with Section 62(1) of the *Financial Accountability Act 2009* and Section 43 of the *Financial and Performance Management Standard 2009*.

These financial statements are general purpose financial statements and have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations. In addition, the financial statements comply with Queensland Treasury and Trade's *Minimum Reporting Requirements* for the year ending 30 June 2014, and other authoritative pronouncements.

With respect to compliance with Australian Accounting Standards and Interpretations, as WBHHS is a not-for-profit statutory body it has applied those requirements applicable to not-for-profit entities.

Historical cost convention
The financial statements have been prepared under the historical cost convention, except for, where applicable, the revaluation of financial assets at fair value through profit or loss, investment properties and certain classes of property, plant and equipment.

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 WBHHS'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.

(b) The Reporting Entity

The financial statements include the value of all revenues, expenses, assets, liabilities and equity of Wide Bay Hospital and Health Service.

(c) Fiduciary Trust transactions and balances

The Wide Bay Hospital and Health Service acts in a fiduciary trust capacity in relation to patient trust accounts. As WBHHS acts only in a custodial role in respect of these transactions and balances, they are not recognised in the financial statements. Although patient funds are not controlled by WBHHS, trust activities are included in the audit performed annually by the Auditor-General of Queensland. Note 33 provides additional information on the balances held in patient trust accounts.

(d) User charges, fees and fines

User charges and fees are controlled by Wide Bay HHS when they can be deployed for the achievement of the WBHHS's objectives. User charges and fees are recognised as revenues when earned and can be measured reliably with sufficient degree of certainty. This involves either invoicing for related goods or services, and/or the recognition of accrued revenue.

Wide Bay HHS predominantly obtains its funding from the Department of Health which is recognised as revenue when earned. The funds are governed and determined by a Service Agreement between the Department of Health and Wide Bay HHS. This agreement is reviewed periodically in line with Queensland Treasury's budget timetable and updated for changes in activities and prices of services delivered by Wide Bay HHS. Wide Bay HHS's ability to continue viable operations is dependent on this funding. At the date of this report management has no reason to believe that this income will not continue.

Wide Bay Hospital & Health Service
Notes to the financial statements
30 June 2014

User charges and fees controlled by WBHHS consist of funding from the Department of Health, hospital fees, sales of goods and services and rental income. Hospital fees mainly consist of private patient hospital fees, interstate patient revenue and Department of Veterans' Affairs revenue. Private patient hospital fees revenue is recognised when invoices are raised. Interstate patient revenue and Department of Veterans' Affairs revenue are recognised based on estimates.

Pharmaceutical benefits scheme

A weekly claim for services provided to patients under the pharmaceutical benefits scheme is submitted electronically with funds transmitted to Wide Bay BHHS account every Friday. The revenue is recognised and entered to Wide Bay HHS's financial system as and when it is received in the bank account.

(e) Government funding – National Health Reform

Funding revenue is received in accordance with Service Agreements with the Department of Health. The Department purchases delivery of health services based on nationally set funding and efficient pricing models determined by the Independent Hospital Pricing Authority (IHPA). The majority of services are funded on an activity unit basis. State funding is also provided for depreciation and minor capital works.

IHPA was established to develop and specify national classifications for activity in public hospitals for the purposes of Activity Based Funding. It determines the national efficient price for services provided, on an activity basis, in public hospitals and develops data and coding standards to support uniform provision of data. In addition to this, IHPA determines block funded criteria and what other public hospital services are eligible for Commonwealth funding.

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

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 is an independent statutory office holder, distinct from Commonwealth and State departments.

A review of the nature of service payments made to third parties and their subsequent disclosure was undertaken during 2013-14. As a consequence of this review, and to ensure consistency in classification between the Department of Health and Wide Bay HHS, funding received from the Department has been reclassified from grant review to government funding revenue. Comparatives have been restated to improve transparency across the years.

Depreciation funding

Wide Bay HHS receives funding from the Department of Health to cover depreciation costs. However as depreciation is a non-cash expenditure item, the Health Minister has approved a withdrawal of equity by the State for the same amount, resulting in a non-cash revenue and non-cash equity withdrawal.

Minor capital works

Purchases of clinical equipment, furniture and fittings associated with capital works projects are managed by Wide Bay HHS. Theses outlays are funded by the State through the Department of Health as equity injections throughout the year.

(f) 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. Where grants are received that are reciprocal in nature, revenue is progressively recognised as it is earned, according to the terms of the funding arrangements.

Contributed assets are recognised at their fair value. Contributions of services are recognised only when a fair value can be determined reliably and the services would be purchased if they had not been donated.

Wide Bay Hospital & Health Service
Notes to the financial statements
30 June 2014

(g) Other revenue

Other revenue primarily reflects recoveries of payments for contracted staff from third parties such as universities and other government agencies.

(h) Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with financial institutions, other short-term, highly liquid investments with original maturities of three months or less that are readily convertible to known amounts of cash and which are subject to an insignificant risk of changes in value.

WBHHS operational bank accounts form part of the Whole-of-Government banking arrangement with the Commonwealth Bank of Australia.

Debit Facility

WBHHS has access to the Whole-of-Government debit facility with limits approved by Queensland Treasury and Trade.

(i) Trade and other receivables

Trade receivables are recognised at their carrying value less any impairment. The recoverability of trade receivables is reviewed on an on-going basis. Trade receivables are generally due for settlement within 120 days.

Collectability of trade receivables is reviewed on an on-going basis. Debts which are known to be uncollectable are written off by reducing the carrying amount directly. A provision for impairment of trade receivables is raised when there is objective evidence that WBHHS will not be able to collect all amounts due according to the original terms of the receivables. Significant financial difficulties of the debtor, probability that the debtor will enter bankruptcy or financial reorganisation and default or delinquency in payments are considered indicators that the trade receivable may be impaired. The amount of the impairment allowance is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the original effective interest rate. Cash flows relating to short-term receivables are not discounted if the effect of discounting is immaterial.

(j) Inventories

Inventories consist mainly of medical supplies held for distribution in hospitals and are provided to public admitted patients free of charge except for pharmaceuticals which are provided at a subsidised rate. Inventories are measured at weighted average cost, adjusted for obsolescence.

(k) Other non-financial assets

Other non-financial assets primarily represent prepayments by WBHHS. These include payments for rental and maintenance agreements, deposits and other payments of a general nature made in advance.

(l) Investments and other financial assets

Investments and other financial assets are initially measured at fair value. Transaction costs are included as part of the initial measurement, except for financial assets at fair value through profit or loss. They are subsequently measured at either amortised cost or fair value depending on their classification. Classification is determined based on the purpose of the acquisition and subsequent reclassification to other categories is restricted. The fair values of quoted investments are based on current bid prices. For unlisted investments, WBHHS establishes fair value by using valuation techniques. These include the use of recent arm's length transactions, reference to other instruments that are substantially the same, discounted cash flow analysis, and option pricing models.

Financial assets are derecognised when the rights to receive cash flows from the financial assets have expired or have been transferred and WBHHS has transferred substantially all the risks and rewards of ownership.

Wide Bay Hospital & Health Service
Notes to the financial statements
30 June 2014

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are carried at amortised cost using the effective interest rate method. Gains and losses are recognised in profit or loss when the asset is derecognised or impaired.

Impairment of financial assets

Wide Bay HHS assesses at the end of each reporting period whether there is any objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes significant financial difficulty of the issuer or obligor; a breach of contract such as default or delinquency in payments; the lender granting to a borrower concessions due to economic or legal reasons that the lender would not otherwise do; it becomes probable that the borrower will enter bankruptcy or other financial reorganisation; the disappearance of an active market for the financial asset; or observable data indicating that there is a measurable decrease in estimated future cash flows.

The amount of the impairment allowance for loans and receivables carried at amortised cost is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the original effective interest rate. If there is a reversal of impairment, the reversal cannot exceed the amortised cost that would have been recognised had the impairment not been made and is reversed to profit or loss.

(m) Property, plant and equipment

On 1 July 2012, the Minister for Health approved the transfer of land and buildings via a three year concurrent lease (representing its right to use the assets) to the Wide Bay Hospital and Health Service from the Department of Health. Under the terms of the lease no consideration in the form of a lease or residual payment by the HHS is required. While the Department of Health retains legal ownership, effective control of these assets was transferred to WBHHS. Under the terms of the lease WBHHS has full exposure to the risks and rewards of asset ownership. WBHHS has the full right of use, managerial control of the assets and is responsible for maintenance. The Department generates no economic benefits from these assets. Therefore, in accordance with the definition of control under Australian Accounting Standards, WBHHS must recognise the value of these assets on its Statement of Financial Position.

Land and buildings are shown at fair value in accordance with AASB 116 *Property, Plant & Equipment*, AASB 13 *Fair Value Measurement* and Queensland Treasury and Trade's *Non-current Asset Policies for the Queensland Public Sector*, based on periodic valuations by external independent valuers, less subsequent depreciation and impairment for buildings. The valuations are undertaken more frequently if there is a material change in the fair value relative to the carrying amount. Increases in the carrying amounts arising on revaluation of land and buildings are credited in other comprehensive income through to the revaluation surplus reserve in equity. Any revaluation decrements are initially taken in other comprehensive income through to the revaluation surplus reserve to the extent of any previous revaluation surplus of the same asset. Thereafter, the decrements are taken to profit or loss.

Property, plant and equipment acquired during the financial year are initially recorded at consideration plus any other costs directly incurred in bringing the asset ready for use. Items or components that form an integral part of an asset are recognised as a single (functional) asset. The cost of items acquired during the financial year has been judged by management to materially represent the fair value at the end of the financial reporting period. Items of property, plant and equipment with a cost or other value equal to or greater than the following thresholds and with a useful life of more than one year are recognised at acquisition :

Buildings	$10,000
Land	$1
Plant and equipment	$5,000

Items below these values are expensed on acquisition.

An item of property, plant and equipment is de-recognised upon disposal or when there is no future economic benefit to WBHHS. Gains and losses between the carrying amount and the disposal proceeds are taken to profit or loss. Any revaluation surplus reserve relating to the item disposed of is transferred directly to retained profits.

Wide Bay Hospital & Health Service
Notes to the financial statements
30 June 2014

Valuations

In 2013-14 WBHHS engaged the State Valuation Service to provide indices for all land holdings as at 30 June 2014. Indices are based on actual market movements for each local government area issued by the Valuer-General. An individual factor change per property has been developed from review of market transactions, having regard to the review of land values undertaken for each local government area and has been endorsed by the Queensland Audit Office. 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 an asset to current standards.
Buildings are measured at fair value by applying either, revised estimates of individual asset's depreciated replacement cost, or interim indices which approximates movement in price and design standards as at reporting date. These estimates are developed by independent quantity surveyors. In 2013-14, WBHHS engaged independent quantity surveyors, Davis Langdon Australia Pty Ltd (Davis Langdon) to comprehensively revalue all buildings exceeding a predetermined materiality threshold and that had not been comprehensively revalued in the last five years. They were also requested to calculate relevant indices for all other assets. Buildings valuation date was as at 30 June 2014.

In determining the replacement cost of each building, the estimated replacement cost of the asset, or the likely cost of construction including fees and on costs if tendered on the valuation date is assessed. This is based on historical and current construction contracts. Assets are priced using Brisbane rates with published industry benchmark location indices applied. Revaluations are then compared and assessed against current construction contracts for reasonableness. The valuation assumes a replacement building will provide the same service function and form (shape and size) as the original building but built consistent with current building standards.

In determining the asset to be revalued the measurement of key inputs include:
- Gross floor area
- Number of floors
- Girth of the building
- Height of the building
- Number of lifts and staircases

Area estimates were compiled by measuring floor areas of Project Services e-plan room or drawings obtained from the Department of Health. Refurbishment costs were derived from specific projects and are therefore indicative of actual costs.

The 'cost to bring to current standards' is the estimated cost of refurbishing the asset to bring it to current design standards and in an "as" new condition. This estimated cost is linked to the condition factor of the building assessed by the quantity surveyor. It is also representative of the deemed remaining useful life of the building. The condition of the building is based on visual inspection, asset condition data, guidance from asset managers and previous reports.

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In assessing the condition of a building the following ratings (International Infrastructure Management Manual) were applied:

1 - Very good condition - only normal maintenance required. Generally newly constructed assets that have no backlog maintenance issues.

2 - Minor defects only - minor maintenance required or the asset is not built to the same standard as equivalent new assets (such as IT cabling, complying with new regulations such as the Disability Discrimination Act). Refurbishment is approximately 5% of replacement cost.

3 - Largely still in good operational state however maintenance required to return to acceptable level of service - Significant maintenance required up to 50% of capital replacement cost.

4 - Requires renewal - complete renewal of internal fit out and engineering services required (up to 70% of capital replacement cost).

5 - Asset unserviceable - complete asset replacement required. Asset's value is nil.

Valuations assume a nil residual value. Significant capital works, such as a refurbishment across multiple floors of a building, will result in an improved condition assessment and higher depreciated replacement values. This increase is typically less than the original capitalised cost of the refurbishment, resulting in a small write down. Presently all major refurbishments are funded by the Department of Health.

The balance of assets (previously comprehensively revalued by the Department of Health) have had indices applied, approximating movement in market prices for labour and other key resource inputs, as well as changes in design standards as at reporting date. These estimates were developed by Davis Langdon.

Revaluation increments are credited to the asset revaluation surplus of the appropriate class, and decrements charged as an expense. The 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 valuers/quantity surveyors. The proportionate method has been applied to those assets that have been revalued by way of indexation.

Assets under construction are not revalued until they are ready for use.

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.

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Depreciation

Property, plant and equipment are depreciated on a straight-line basis. Annual depreciation is based on fair values and WBHHS's assessments of the useful remaining life of individual assets. Land is not depreciated.

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

In accordance with Queensland Treasury and Trade's Non-current Asset Policy Guideline 2, Wide Bay HHS has determined through sampling and testing of material specialised health service building that, whilst complex in nature, there are no components of sufficiently significant value or with sufficiently different useful life such that a material difference in depreciation expense for the asset would result from depreciated those components at a differential depreciation rate.

Any expenditure that increases the capacity or service potential of an asset is capitalised and depreciated over the remaining useful life of the asset. Major spares purchased specifically for particular assets are capitalised and depreciated on the same basis as the asset to which they relate. The depreciable amount of improvements to or on leasehold land is allocated progressively over the shorter of the estimated useful lives of the improvements or the unexpired period of the lease. The unexpired period of leases includes any option period where exercise of the option is probable.

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

Buildings	2.5% - 3.33%
Plant and Equipment	5.0% - 20.0%

The residual values, useful lives and depreciation methods are reviewed and adjusted if appropriate, at each reporting date.

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. AASB 117 Leased Assets is not applicable to land and buildings, currently under a Deed of Lease with the Department of Health, as no consideration in the form of lease payments are required under the agreement.

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, WBHHS determines the asset's recoverable amount by taking the 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.

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(n) Financial instruments

Recognition

Financial assets and financial liabilities are recognised in the Statement of Financial Position when WBHHS becomes party to the contractual provisions of the financial instrument.
C*lassification*

Financial instruments are classified and measured as follows:
- Cash and cash equivalents - held at fair value through profit or loss
- Receivables - held at amortised cost
- Payables - held at amortised cost

WBHHS does not enter into transactions for speculative purposes, or for hedging. Apart from cash and cash equivalents, WBHHS holds no financial assets classified at fair value through profit and loss. All other disclosures relating to the measurement and financial risk management of financial instruments held by WBHHS are included in note 28.

(o) Employee benefits and Health Service employee expense

Health Service labour expenses

Under Section 20 of the Hospital and Health Boards Act 2011, a Hospital and Health Service (HHS) can employ health executives and, where regulation has been passed for the HHS to become a "prescribed service", a person employed previously in the department as a health service employee. Where an HHS has not received the status of a "prescribed service", non-executive staff working in that HHS remain legally employees of the Department of Health.

In 2013/14, Wide Bay Hospital and Health Service was not a prescribed service and accordingly all non-executive staff were employed by the Department of Health. Under this arrangement, the Department provides employees to perform work for WBHHS and accepts its obligations as the employer of the Department employees. As for WBHHS, it is responsible for the day-to-day management of these departmental employees and reimburses the Department for the salaries and on-costs of these employees. As a result, WBHHS treats the reimbursements to the Department of Health for departmental employees in these financial statements as health service labour expenses and these are detailed in note 11. In addition to the employees contracted from the Department of Health, WBHHS has engaged employees directly. The information detailed below relates specifically to the directly engaged employees.

WBHHS's directly engaged employees

WBHHS classifies salaries and wages, rostered days-off, sick leave, annual leave levies, long service leave levies and employer superannuation contributions as employee benefits in accordance with AASB119 Employee Benefits. Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at current salary rates. 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 engaging 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.

Annual Leave

The Queensland Government's Annual Leave Central Scheme (ALCS) became operational on 30 June 2008 for departments, commercial business units, shared service providers and selected not-for-profit statutory bodies. WBHHS was admitted into this arrangement effective 1 July 2012. Under this scheme, a levy is made on WBHHS to cover the cost of employee's annual leave (including leave loading and on-costs).

The levies are expensed in the period in which they are payable. Amounts paid to employees for annual leave are claimed from the scheme quarterly in arrears. The Department of Health centrally manages the levy and reimbursement process on behalf of WBHHS. No provision for annual leave is recognised in WBHHS's financial statements as the liability is held on a whole-of-government basis and reported in those financial statements pursuant to AASB1049 *Whole of Government and General Government Sector Financial Reporting*.

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Long Service Leave

Under the Queensland Government's Long Service Leave Scheme, a levy is made on WBHHS to cover the cost of employees' long service leave. Amounts paid to employees for long service leave are claimed from the scheme quarterly in arrears. The Department of Health centrally manages the levy and reimbursements process on behalf of WBHHS. No provision for long service leave is recognised in the WBHHS financial statements as the liability is held on a whole-of-government basis and reported in those financial statements pursuant to AASB1049 *Whole of Government and General Government Sector Financial Reporting*.

Superannuation

Employer superannuation contributions are paid to QSuper, the superannuation scheme for Queensland Government employees, at rates determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are paid or payable and WBHHS'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 AASB1049 *Whole of Government and General Government Sector Financial Reporting*.

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

Key management personnel and remuneration

Key management personnel and remuneration disclosures are made in accordance with Section 5 of the Financial Reporting Requirements for Queensland Government Agencies issued by Queensland Treasury and Trade. Refer to Note 29 for the disclosure on key executive management personnel and remuneration.

(p) Insurance

Property and general losses above a $10,000 threshold are insured through the Queensland Government Insurance Fund (QGIF). Health litigation payments above a $20,000 threshold and associated legal fees are also insured through QGIF. Premiums are calculated by QGIF on a risk assessed basis.

The Insurance Arrangements for Public Health Entities Health Service Directive (directive number QH-HSD-011:2012) enables Hospital and Health Services to be named insured parties under the department's policy. For the 2013-14 policy year, the premium was allocated to each HHS according to the underlying risk of an individual insured party. The Hospital and Health Service premiums cover claims from 1 July 2012, pre 1 July 2012 claims remain the responsibility of the department, however WBHHS must pay the $20,000 excess payment on these claims.

Queensland Health pays premiums to WorkCover Queensland on behalf of all Hospital and Health Services in respect of its obligations for employee compensation. These costs are reimbursed on a monthly basis to the department.

(q) Contributed equity

Non-reciprocal transfers of assets and liabilities between wholly-owned Queensland State Public Sector entities as a result of machinery-of-Government changes are adjusted to contributed equity in accordance with Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities'. Appropriations for equity adjustments are similarly designated.

(r) Goods and Services Tax ('GST') and other similar taxes

Revenues, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the tax authority. In this case it is recognised as part of the cost of the acquisition of the asset or as part of the expense.

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Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the tax authority is included in other receivables or other payables in the statement of financial position.

Cash flows are presented on a gross basis. The GST components of cash flows arising from investing or financing activities which are recoverable from, or payable to the tax authority, are presented as operating cash flows.

Commitments and contingencies are disclosed net of the amount of GST recoverable from, or payable to, the tax authority.

(s) Federal taxation charges

WBHHS is a State body as defined under the Income Tax Assessment Act 1936 and is exempt from Commonwealth taxation with the exemption of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). The Australian Taxation Office has recognised the Department of Health and the seventeen Hospital and Health Services as a single taxation entity for reporting purposes. All FBT and GST reporting to the Commonwealth is managed centrally by the department, with payments/ receipts made on behalf of the HHS reimbursed to/from the department on a monthly basis. GST credits receivable from, and GST payable to the ATO, are recognised on this basis.

(t) Issuance of financial statements

The financial statements are authorised for issue by the Chairman of the Wide Bay Hospital and Health Service, the Chief Executive and the Chief Financial Officer at the date of signing the Management Certificate.

(u) Rounding of amounts

Amounts in this report have been rounded off to the nearest $1,000 or, where that amount is $500 or less, to zero, unless disclosure of the full amount is specifically required.

(v) Comparatives

As of 1 July 2013, Wide Bay HHS has changed the classification of State Government funding received from the Department of Health from 'Grants and contributions' to Government funding'. This is in keeping with Queensland Treasury and Trade's guideline Distinction between Grants and Service Procurement Payments, issued in January 2014. This re-classification of revenue will also ensure consistency in classification between the Department of Health and Wide Bay HHS in regards to the purchase of health services.

The comparative information has been restated where necessary to be consistent with disclosures in the current reporting period and to improve transparency across the years. This revision does not affect the timing of revenue recognition and has no impact on the treatment of GST. Refer to Note 2 (x) for further commentary on the voluntary change in accounting policy.

(w) New and revised accounting standards

WBHHS is not permitted to early adopt a new or amended accounting standard ahead of the specified commencement date unless approval is obtained from Queensland Treasury and Trade. Consequently, the WBHHS has not applied any Australian Accounting Standards and Interpretations that have been issued but are not yet effective. WBHHS applies standards and interpretations in accordance with their respective commencement dates.

At the date of authorisation of the financial report, the following new or amended Australian Accounting Standards are expected to impact on the Wide Bay Hospital and Health Service in the current period:

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• *AASB 13 Fair Value Measurement and AASB 2011-8 Amendments to Australian Accounting Standards arising from AASB 13*

AASB 13 Fair Value Measurement became effective from reporting periods beginning on or after 1 January 2013. AASB 13 sets out a new definition of 'fair value' as well as new principles to be applied when determining the fair value of assets and liabilities. The new requirements apply to all of the HHS's assets and liabilities (excluding leases) that are measured and/or disclosed at fair value or another measurement based on fair value. The impacts of AASB 13 relate to the fair value measurement methodologies used and financial statement disclosures made in respect of such assets and liabilities.

Wide Bay HHS reviewed its fair value methodologies (including instructions to valuers, data used and assumptions made) for land and buildings measured as fair value to assess whether those methodologies comply with AASB13. To the extent that the methodologies didn't comply, changes were made and applied to the valuations. None of the changes to valuation methodologies resulted in material differences from the previous methodologies. AASB13 has required an increased amount of information to be disclosed in relation to fair value measurements for both assets and liabilities. For those fair value measurements of assets or liabilities that substantially are based on data that is not 'observable' (i.e. accessible outside the HHS), the amount of information disclosed has significantly increased.

• *AASB 119 Employee Benefits (September 2011) and AASB 2011-10 Amendments to Australian Accounting Standards arising from AASB 119 (September 2011)*

This revised standard and its consequential amendments are applicable to annual reporting periods beginning on or after 1 January 2013. The amendments make changes to the accounting for defined benefit plans and the definition of short-term employee benefits, from 'due to' to 'expected to' be settled within 12 months. The latter will require annual leave that is not expected to be wholly settled within 12 months to be discounted allowing for expected salary levels in the future period when the leave is expected to be taken. However, as WBHHS is a member of the Whole of Government Annual Leave Scheme, the impact of these changes is expected to be minimal. The only implication for WBHHS is the clarification of the 'concept of termination benefits', with the recognition criteria for these liabilities differing. If termination benefits meet the timeframe criterion for 'short-term employee benefits' they will be measured according to the AASB119 requirements for ‘short-term employee benefits', otherwise these benefits will need to be accounted for according to most of the requirements for defined benefit plans.

• *AASB 1053 Application of Tiers of Australian Accounting Standards*

This is intended to apply to periods beginning on or after 1 July 2013. Essentially this standard allows for differential reporting frameworks, however Queensland Treasury and Trade has advised that it is its policy decision to require full disclosure and adoption of Tier 1 reporting by all Queensland government entities consolidated into the whole-of-Government financial statements. Therefore, there is no change from the current reporting requirements applicable to WBHHS.

Standards effective for annual periods beginning on or after 1 July 2014:

• *AASB 1055 Budgetary Reporting*

AASB 1055 applies to reporting periods beginning on or after 1 July 2014. Wide Bay HHS will need to include in its 2014-15 financial statements the original budgeted figures from the Income Statement, Balance Sheet, Statement of Changes in Equity, and Cash Flow Statement as published in the 2014-15 Queensland Government's Service Delivery Statements. The budgeted figures will need to be presented consistently with the corresponding (actual) financial statements, and will be accompanied by explanations of major variances between the actual amounts and the corresponding original budgeted figures.

The following new and revised standards apply as from reporting periods beginning on or after 1 January 2013:

• *AASB 10 Consolidated Financial Statements*

AASB 10 redefines and clarifies the concept of control of another entity, and is the basis for determining which entities should be consolidated into an entity's financial statements. AASB 2013-8 applies the various principles in AASB 10 for determining whether a not-for-profit entity controls another entity. On the basis on those accounting standards, Wide Bay HHS has reviewed the nature of its relationships with entities that the HHS is connected with to determine the impact of AASB 2013-8. Currently, Wide Bay HHS does not have control over any other entities.

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- *AASB 11 Joint Arrangements & AASB 128 (revised) Investments in Associates and Joint Ventures*

AASB 11 deals with the concept of joint control and sets out new principles for determining the type of joint arrangements that exist, which in turn dictates the accounting treatment. The new categories of joint arrangements under AASB 11 are more aligned to the actual rights and obligations of the parties to the arrangement. Wide Bay HHS has assessed its arrangements with other entities to determine whether a joint arrangement exists in terms of AASB 11. Based on present arrangements, no joint arrangements exist. However, if a joint arrangement does arise in the future, Wide Bay HHS will need to follow the relevant accounting treatment specified in either AASB 11 or the revised AASB 128, depending on the nature of the joint arrangement.

- *AASB 9 Financial Instruments and AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010)[AASB 1,3,4,5,7,101,108,112,118,120,121,127,128,131,132,136,137,139,1023 & 1038 and Interpretations 2,3,10,12,19 & 127]*

Effective for reporting periods beginning on or after 1 January 2017, the main impacts of these standards on Wide Bay HHS are that they will change the requirements for the classification, measurement and disclosures associated with Wide Bay HHS's financial assets. Under the new requirements, financial assets will be more simply classified according to whether they are measured at amortised cost or fair value. Pursuant to AABS 9, financial assets can only be measured at amortised cost if two conditions are met. One of these conditions is that the asset must be held within a business model whose objective is to hold assets in order to collect contractual cash flows. The other condition is that the contractual terms of the asset give rise to cash flows that are solely payments of principal and interest on the principal amount outstanding. The only financial asset currently disclosed at amortised cost is receivables and as they are short term in nature, the carrying amount is expected to be a reasonable approximation of fair value to the impact of this standard is minimal. 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.

(x) Voluntary change in accounting policy

Wide Bay HHS has made a voluntary change in accounting policy for the recognition of funding provided by the Department of Health under a service agreement. The service agreement specifies those public health services purchased by the Department from Wide Bay HHS.

In 2012-13 the Department of Health provided this funding as grant payments but for 2013-14 has determined that the payment is not of a grants nature but rather is procurement of public health services. Specific public health services are received by the Department under a service agreement and the Department has determined that it receives approximately equal value for the payment provided, and directly receives an intended benefit.

To align with this basis of funding provided by the Department of Health, Wide Bay HHS now recognises $428 million as Government funding revenue for 2013-14 rather than as grants revenue which occurred in 2012-13. The main effect is that the revenue is now recognised under the criteria detailed in AASB118 *Revenue* for 2013-14, rather than under AASB 1004 *Contributions* in 2012-13,

This change in accounting policy has been applied retrospectively with the effect that grants and other contributions revenue for 2012-13 has reduced by $425 million and Government funding has increased by the same amount.

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, management believes to be reasonable under the circumstances. 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 sales experience, the ageing of receivables, historical collection rates and specific knowledge of the individual debtors financial position.

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Provision for impairment of inventories
The provision for impairment of inventories assessment requires a degree of estimation and judgement. The level of the provision is assessed by taking into account the ageing of inventories and other factors that affect inventory obsolescence.

Estimation of useful lives of assets
Wide Bay HHS determines the estimated useful lives and related depreciation and amortisation charges for its property, plant and equipment and finite life intangible assets. The useful lives could change significantly as a result of technical innovations or some other event. The depreciation and amortisation 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.

Impairment of non-financial assets other than goodwill and other indefinite life intangible assets
Wide Bay HHS assesses impairment of non-financial assets other than goodwill and other indefinite life intangible assets at each reporting date by evaluating conditions specific to WBHHS and to the particular asset that may lead to impairment. If an impairment trigger exists, the recoverable amount of the asset is determined. This involves fair value less costs of disposal or value-in-use calculations, which incorporate a number of key estimates and assumptions.

Note 4. Administrative arrangements under the National Health Reform

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 Service (HHSs) in Queensland);
- Introducing national funding models and a national efficient price for services, with the majority of services to be funded on an activity unit basis into the future;
- Defining a refocused role for state governments in managing the health system, including:
  i. The use of purchasing arrangements and other levers to drive access and clinical service improvements within and across the HHSs;
  ii. A responsibility to intervene to remediate poor performance, either at the state's initiative or in response to prompting by the National Health Performance Authority, which will publicly report on performance of the HHSs and healthcare facilities.

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

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Opening Balances

On 1 July 2012, certain balances were transferred from the Department of Health to Hospital and Health Services. This was effected via a transfer notice signed by the Minister for Health, designating that the transfer be recognised as a contribution by owners through equity.

The transfer notices were approved by the Director-General of the Department of Health and the Chairman and Chief Executive Officer of each Hospital and Health Board.

Balances transferred to HHSs materially reflected the closing balances of Health Service District's as at 30 June 2012 and these balances became the opening balances of HHSs. The cash balance transferred to individual HHSs was the amount required to ensure entities commenced operations with a balanced working capital position.

The value of assets and liabilities transferred to the Wide Bay Hospital and Health Service were as follows:

	$'000
Cash and cash equivalents	1,636
Receivables	10,777
Inventories	2,934
Other	301
Property, plant and equipment*	200,508
Payables	(14,013)
Other financial liabilities	(8)
Contributed equity	202,135

*Legal title to land and buildings has not been transferred as at 30 June 2014. The Department of Health retains legal ownership, however control of these assets was transferred to WBHHS, via a concurrent lease representing its right to use the assets. Under the Deeds of Lease, WBHHS has full exposure to the risks and rewards of asset ownership. However, proceeds from the sale of major infrastructure assets cannot be retained by WBHHS, with funds to be returned to the Consolidated Fund (the State).

WBHHS has the full right of use, managerial control of land and building assets and is responsible for maintenance. The Department generates no economic benefits from these assets. In accordance with the definition of control under Australian Accounting Standards, each Hospital and Health Service must recognise the value of these assets on their Statement of Financial Position.

Transfer of assets on practical completion

Construction of major health infrastructure continues to be managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department to WBHHS by the Minister of Health as a contribution by the State through equity.

Note 5. User charges

	2014 $'000	2013 $'000
Pharmaceutical Benefit Scheme Reimbursement	8,240	4,552
Hospital fees	20,858	17,016
Sale of goods and services	2,553	2,825
	31,651	24,393

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Note 6. Government funding

	2014 $'000	2013 $'000
Activity Based Funding - State	217,097	190,625
Activity Based Funding - Commonwealth	112,044	98,300
Block funding - State	20,190	39,356
Block funding - Commonwealth	11,792	17,118
Teacher Training funding - State	1,662	6,642
Teacher Training funding - Commonwealth	989	2,889
General Purpose funding - State	68,883	70,950
	432,657	425,880

Note 7. Grants and other contributions

	2014 $'000	2013 $'000
Australian Government - nursing home grants	1,714	5,504
Australian Government - Home and community care	-	2,855
Australian Government - Transition care program	3,239	2,968
Australian Government - other specific purpose recurrent grants	2,026	2,042
Other grants	892	1,648
Donations other	97	709
	7,968	15,726

Note 8. Other revenue

	2014 $'000	2013 $'000
Contract staff recoveries	3,304	2,494
Recoveries	2,116	709
Interest	75	92
Rental income	150	18
Sale proceeds of non-capitalised assets	3	4
Licences and registration charges	2	4
Other	150	146
	5,800	3,467

Note 9. Gains

	2014 $'000	2013 $'000
Gain on sale of property, plant and equipment	6	153

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Note 10. Employee expenses

	2014 $'000	2013 $'000
Wages and salaries	767	589
Employer superannuation contributions	51	57
Annual leave expense	41	33
Long service leave levy	9	9
Payroll tax	16	13
	884	701

These figures include only those employees directly employed by WBHHS. This includes 13 board members (both current and prior incumbents) who received wages during the year and 2 executive positions.

Details of Key Management Personnel and Board Members and their associated remuneration can be found in note 29.

Note 11. Health Services labour expenses

	2014 $'000	2013 $'000
Health Services labour expenses	321,679	329,189

Health service employee expenses represent the cost of Department of Health employees contracted to the HHS to provide public health services. As established under the Hospital and Health Boards Act 2011, the department is the employer for all health service employees (excluding persons appointed as a Health Executive) and recovers all employee expenses and associated on-costs from HHSs.

The number of employees as at 30 June 2014, includes both full-time employees and part-time employees, measured on a full-time equivalent basis (reflecting Minimum Obligatory Human Resource Information (MOHRI)) is 2,622.

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Note 12. Supplies and services

	2014 $'000	2013 $'000
Clinical supplies and services	34,339	28,777
Consultants and contractors	19,273	17,357
Drugs	14,324	13,680
Pathology and lab supplies	9,998	10,626
Repairs and maintenance	8,652	6,535
Catering and domestic supplies	5,872	5,620
Queensland Ambulance service agreement	5,556	5,615
Patient travel	8,445	5,584
Aeromedical service agreements	4,289	5,299
Electricity and other energy	4,259	3,711
Operating lease rentals	3,177	3,429
Expenses relating to capital works	766	1,273
Other travel	2,288	1,166
Motor vehicles	1,118	728
Communications	837	713
Building services	790	697
Water	342	378
Computer services	256	362
Other	11,430	9,390
	136,011	120,940

Note 13. Depreciation and amortisation

	2014 $'000	2013 $'000
Buildings and land improvements	8,061	8,517
Plant and equipment	4,102	4,309
	12,163	12,826

Note 14. Impairment losses

	2014 $'000	2013 $'000
Impairment loss on trade receivables	164	129

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Note 15. Other expenses

	2014 $'000	2013 $'000
External audit fees*	437	100
Bank fees	11	10
Insurance**	5,312	4,994
Inventory written off	64	43
Losses from the disposal of non-current assets	190	199
Special payments - donations/gifts	-	11
Special payments - ex-gratia payments	109	149
Sponsorships	5	-
Other legal costs	553	578
Journals and subscriptions	72	53
Advertising	150	61
Interpreter fees	23	29
Other	60	71
	6,986	6,298

* External audit fees includes fees for a number of external audits conducted through the year, including the audit of Financial Statements conducted by the Queensland Audit Office. Total audit fees paid or payable to the Queensland Audit Office relating to the 2013-14 financial year are estimated to be $180,000. There are no non-audit services included in this amount.

** Includes payments to Department of Health representing share of the departments QGIF premium. Certain losses of public property and health litigation costs are insured with the Queensland Government Insurance Fund (refer note 2(p)).

Note 16. Impairment of assets

	2014 $'000	2013 $'000
Revaluation decrement - Land	113	373

In 2013-14 WBHHS engaged the State Valuation Service to provide indices for all land holdings at 30 June 2014, for the purpose of valuing the land assets. As a result of those indices provided, a devaluation or impairment of the land assets was recorded.

The asset revaluation surplus represents the net effect of upwards and downwards revaluations of assets to fair value. The decrement, not being a reversal of a previous revaluation increment in respect of the same class of assets, has been recognised as an expense in the Statement of Comprehensive Income.

Note 17. Current assets - cash and cash equivalents

	2014 $'000	2013 $'000
Cash on hand	10	11
Cash at bank and on hand	12,107	6,354
24 hour call deposits	1,735	2,131
	13,852	8,496

Cash on hand represents petty cash floats held at various locations throughout the WBHHS to provide for small cash purchases needed. Petty cash is reconciled monthly and random cash counts are performed through the year.

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WBHHS's operating bank accounts are grouped as part of a Whole-of-Government (WoG) banking arrangement with Queensland Treasury Corporation, and does not earn interest on surplus funds nor is charged interest or fees for accessing its approved cash debit facility.

WBHHS's 24 hour call deposits are held with Queensland Treasury Corporation. This account earns interest, calculated on a daily basis reflecting market movements in cash funds. Rates achieved throughout the year range between 3.3% and 4.2%, compared to rates in the prior year of between 3.5% and 5%.

Note 18. Current assets - trade and other receivables

	2014 $'000	2013 $'000
Trade receivables	6,496	5,932
Less: Provision for impairment of receivables	(227)	(240)
	6,269	5,692
Payroll receivables	65	63
GST input tax credits receivable	875	769
GST Payable	(75)	(58)
	800	711
Grants receivable from Queensland Health	4,585	12,067
	11,719	18,533

Reversal of impairment losses on receivables

WBHHS has recognised a gain of $13,204 in profit or loss in respect of impairment of receivables for the year ended 30 June 2014.

Movements in the provision for impairment of receivables are as follows:

	2014 $'000	2013 $'000
Opening balance	240	1,177
Unused amounts reversed	(13)	(937)
Closing balance	227	240

Note 19. Current assets – inventories

	2014 $'000	2013 $'000
Inventories held for distribution – at weighted average cost		
Medical supplies and equipment	3,344	2,890
Catering and domestic	17	17
Other	27	38
	3,388	2,945

Wide Bay Hospital & Health Service
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Note 20. Current assets - other

	2014 $'000	2013 $'000
Prepayments	208	361

Note 21. Non-current assets - property, plant and equipment

	2014 $'000	2013 $'000
Land - at independent valuation	16,373	17,378
Buildings - at independent valuation	307,871	320,775
Less: Accumulated depreciation	(170,523)	(165,405)
	137,348	155,370
Plant and equipment - at cost	49,428	45,623
Less: Accumulated depreciation	(26,087)	(24,039)
	23,341	21,584
Capital works in progress - at cost	907	3,424
	177,969	197,756

Reconciliations

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

	Land $'000	Buildings $'000	Plant & equipment $'000	Work in progress $'000	Total $'000
Balance as at 1 July 2012	-	-	-	-	-
Acquisitions through restructuring (note 2 h)	17,031	159,706	21,048	2,723	200,508
Acquisition major infrastructure transfers	720	2,638	1,504	-	4,862
Acquisitions	-	142	3,000	2,446	5,588
Disposals	-	-	(242)	-	(242)
Transfers between classes	-	1,151	583	(1,745)	(11)
Revaluations (Increment/decrement)	(373)	249	-	-	(124)
Depreciation	-	(8,516)	(4,309)	-	(12,825)
Balance as at 30 June 2013	17,378	155,370	21,584	3,424	197,756

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	Land $'000	Buildings $'000	Plant & equipment $'000	Work in progress $'000	Total $'000
Balance as at 1 July 2013	17,378	155,370	21,584	3,424	197,756
Acquisitions through restructuring (note 2 h)	-	-	-	-	-
Acquisition major infrastructure transfers	-	1,637	-	-	1,637
Acquisitions	251	384	4,972	907	6,304
Disposals	-	-	(324)	-	(324)
Machinery of Government transfer - sale of Yaralla Place Aged Care	(1,143)	(12,524)	(334)	-	(14,001)
Transfers between classes	-	-	75	-	285
Inter District Transfers in/(out)	-	-	1,469	(3,424)	(1,955)
Revaluations (Increment/decrement)	(113)	542	-	-	429
Depreciation	-	(8,061)	(4,101)	-	(12,162)
Balance as at 30 June 2014	16,373	137,348	23,341	907	177,969

Valuations of land and buildings

The basis of the valuation of land and buildings is fair value, being the amounts for which the assets could be exchanged between willing parties in an arm's length transaction, based on current prices in an active market for similar properties in the same location and condition. Details of valuations performed in 2014 are contained in Note 2 (m). The directors do not believe that there has been a material movement in fair value since the revaluation date.

Categorisation of fair values recognised as at 30 June 2014

The following table details the WBHHS assets, measured or disclosed at fair value, using a three level hierarchy, based on the lowest level of input that is significant to the entire fair value measurement, being:

- Level 1: Quoted prices (unadjusted) in active markets for identical assets that the entity can access at the measurement date.
- Level 2: Inputs other than quoted prices included within Level 1 that are observable for the assets, either directly or indirectly.
- Level 3: Unobservable inputs for the assets.

2014	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Assets				
Land	-	16,373	-	16,373
Buildings	-	3,609	133,739	137,348
Total assets	-	19,982	133,739	153,721

There were no transfers between levels during the financial year.

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Level 3 significant inputs and relationship to fair value

The fair value of health service site buildings is computed by quantity surveyors. The methodology is known as the Depreciated Replacement Cost valuation technique. The following table highlights the key unobservable (Level 3) inputs for those assets subject to comprehensive valuation in the current year and the relationship to the estimated fair value.

Description	Significant unobservable inputs	Unobservable inputs quantitative measures Ranges used in valuations	Unobservable inputs - general effect on fair value measurement
Buildings - health service sites ($134m)	Replacement cost estimates	Hospitals $1,185,134 to $5,907,181 Other buildings $865,668 to $2,025,181	Replacement cost is based on tender pricing and historical building cost data. An increase in the estimated replacement cost would increase the fair value of the assets. A decrease in the estimated replacement cost would reduce the fair value of the assets.
	Remaining lives estimates	8 year to 36 years	The remaining useful lives are based on industry benchmarks. An increase in the estimated remaining useful lives would increase the fair value of the assets. A decrease in the estimated remaining useful lives would reduce the fair value of the assets.
	Costs to bring to current standards	Hospitals $363,110 to $3,238,244 Other buildings $20,622 to $535,675	Costs to bring to current standards are based on tender pricing and historical building cost data. An increase in the estimated costs to bring to current standards would reduce the fair value of the assets. A decrease in the estimated remaining useful lives would reduce the fair value of the assets.
	Condition rating	1 to 4	The condition rating is based on the physical state of the assets. An improvement in the condition rating (possible high of 1) would increase the fair value of the assets. A decline in the condition rating (possible low of 5) would reduce the fair value of the assets.

For further information on Condition Ratings refer to Note 2 (m).

Usage of alternative quantitative values (higher or lower) for each unobservable input that are reasonable in the circumstances as at the revaluation date would not result in material changes in the reported fair value.

The condition rating of an asset is used as a mechanism to determine the cost to bring to current standards and also to estimate the remaining life.

There are no other direct or significant relationships between the unobservable inputs which materially impact fair values.

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Note 22. Current liabilities - trade and other payables

	2014 $'000	2013 $'000
Trade payables	8,624	10,432
DoH Payables	19,768	17,485
Other payables	-	1
	28,392	27,918

Refer to note 28 for further information on financial instruments.

Note 23. Current liabilities - accrued employee benefits

	2014 $'000	2013 $'000
Salaries and wages accrued	17	32

Note 24. Current liabilities - unearned revenue

	2014 $'000	2013 $'000
Unearned other revenue	132	49

The unearned revenue balance is composed entirely of patient fees received in advance.

Note 25. Equity - contributed

	2014 $'000	2013 $'000
Contributed equity	177,694	199,828

Note 26. Equity - Asset Revaluation Surplus

	2014 $'000	2013 $'000
Asset revaluation surplus - buildings	791	249

Movements in reserves
Movements in each class of reserve during the current and previous financial year are set out below:

	Asset Revaluation surplus - Buildings $'000
Balance at 1 July 2012	-
Revaluation - gross	249
Balance at 30 June 2013	249
Revaluation - gross	542
Balance at 30 June 2014	791

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Note 27. Equity - retained surpluses/(accumulated deficits)

	2014 $'000	2013 $'000
Retained surpluses at the beginning of the financial year	15	-
Surplus/(deficit) for the year	95	15
Retained surpluses/(accumulated deficits) at the end of the financial year	110	15

Note 28. Financial instruments

Financial risk management objectives

WBHHS's activities expose it to a variety of financial risks - credit risk, liquidity risk and market risk. Financial risk management is implemented pursuant to Government and WBHHS's policy. These policies focus on the unpredictability of financial markets and seek to minimise potential adverse effects on the financial performance of WBHHS.

WBHHS measures risk exposure using a variety of methods as follows:

Risk Exposure	*Measurement method*
Credit risk	Ageing analysis, cash inflows at risk
Liquidity risk	Monitoring of cash flows by active management of accrual accounts
Market risk	Interest rate sensitivity analysis

Market risk

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

Wide Bay HHS has interest rate exposure on the 24 hour call deposits, however there is no risk on its cash deposits. The HHS does not undertake any hedging in relation to the interest rate risk.

Price risk

Wide Bay HHS is not exposed to any significant price risk.

Interest rate risk

Changes in interest rate have a minimal effect on the operating result of WBHHS. This is demonstrated in the interest rate sensitivity analysis below showing the effect of an interest rate movement on interest earnings on the cash and cash equivalents balance.

	Basis points increase			Basis points decrease		
2014	**Basis points change**	**Effect on profit before tax $'000**	**Effect on equity $'000**	**Basis points change**	**Effect on profit before tax $'000**	**Effect on equity $'000**
Cash and cash equivalents	1	139	139	(1)	(139)	(139)

	Basis points increase			Basis points decrease		
2013	**Basis points change %**	**Effect on profit before tax**	**Effect on equity**	**Basis points change %**	**Effect on profit before tax**	**Effect on equity**
Cash and cash equivalents	1	85	85	(1)	(85)	(85)

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Credit risk

Credit risk refers to the risk that a counterparty will default on its contractual obligations resulting in financial loss to Wide Bay HHS. WBHHS has a strict code of credit, including obtaining credit agency information, confirming references and setting appropriate credit limits. Wide Bay HHS obtains guarantees where appropriate to mitigate credit risk. The maximum exposure to credit risk at the reporting date to recognised financial assets is the carrying amount, net of any provisions for impairment of those assets, as disclosed in the statement of financial position and notes to the financial statements. Wide Bay HHS does not hold any collateral.

No financial assets have had their terms renegotiated as to prevent them from being past due or impaired and are stated at carrying amount as indicated. No financial assets and financial liabilities have been offset and presented net in the Statement of Financial Position.

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

The allowance for impairment reflects the occurrence of loss events. If no loss events have arisen in respect of a particular debtor, or group of debtors, no allowance for impairment is made in respect of that debtor or group of debtors.

	2014 $'000	2013 $'000
Financial Assets past due but not impaired		
Not overdue	8,601	14,387
Less than 30 days	720	950
30-60 days	725	590
61-90 days	538	440
More than 90 days	1,135	948
	11,719	17,315

Liquidity risk

Vigilant liquidity risk management requires the Wide Bay HHS to maintain sufficient liquid assets (mainly cash and cash equivalents) and available borrowing facilities to be able to pay debts as and when they become due and payable.

Wide Bay HHS manages liquidity risk by maintaining adequate cash reserves and continuously monitoring actual and forecast cash flows to ensure that sufficient funds are available to meet the employee and supplier obligations at all times. Additionally, an approved debt facility of $3 million under Whole-of-Government arrangements has been established to manage any short term cash shortfalls.

Fair value of financial instruments

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

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Note 29. Key management personnel disclosures

The following details for key management personnel include those positions that had the authority and responsibility for planning, directing and controlling the major activities of the entity, directly or indirectly, during the financial year.

Name and position of current incumbents	Responsibilities	Contract classification and appointment authority	Appointment date
Adrian Pennington - Health Service Chief Executive	Overall leadership and management of WBHHS to ensure achievement of strategic and operational objectives.	S24/S70 - Appointed by Board under Hospital and Health Board Act 2011 (Section 7(3)).	10/09/12
Geoff Evans - Executive Director Finance & Performance Management	Management and oversight of the WBHHS finance framework.	HES2 - Previously Queensland Health employee transferred to WBHHS.	19/09/11
Debbie Carroll - Acting Chief Operating Officer	Strategic direction and operational management for WBHHS northern and southern region.	NRG12-1 - Permanent substantive Queensland Health employee contracted to WBHHS	26/04/14
Fiona Sewell - Acting Executive Director of Nursing & Midwifery Service	Strategic and professional leadership of nursing and midwifery workforce.	Nse QPH-DON - Permanent substantive Queensland Health employee contracted to WBHHS	29/04/14
George Plint - Director Integrated Mental Health Services	Strategic and professional leadership of WBHHS Mental Health services department and staff.	HP7-2 - Permanent substantive Queensland Health employee contracted to WBHHS	14/02/94 to 07/03/14
Robyn Bradley - Acting Executive Director Mental Health, Alcohol & Other Drug Services	Strategic and professional leadership of WBHHS Mental Health services department and staff.	DHSEA-HP - Permanent substantive Queensland Health employee contracted to WBHHS	03/03/14
Josephine Leveritt - Executive Director Human Resources	Strategic and operational management of the Human Resources function within WBHHS.	HES2 - Permanent substantive Queensland Health employee contracted to WBHHS	03/12/12
Peter Heinz - Acting Executive Director Human Resource	Strategic and operational management of the Human Resources function within WBHHS.	C-HES - Permanent substantive Queensland Health employee contracted to WBHHS	17/02/14
Malcolm Donaldson - Director Oral Health Services	Strategic and professional leadership of WBHHS Oral Health Services workforce.	DO46 - Permanent substantive Queensland Health employee contracted to WBHHS	29/08/11
Dr Pieter Pike - Executive Director Clinical Governance	Strategic and professional leadership of WBHHS Clinical Governance workforce.	DHS-SMO - Permanent substantive Queensland Health employee contracted to WBHHS	05/08/13
Stephen Bell - Acting Chief Operating Officer South	Strategic and operational management of the WBHHS southern region	C-HES – Permanent substantive Queensland Health employee contracted to WBHHS	08/07/13 to 25/04/14

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Name and position of current incumbents	Responsibilities	Contract classification and appointment authority	Appointment date
Dr Margaret Young – Director of Public Health	Strategic and professional leadership of WBHHS Public Health workforce.	DHS-SMO – Permanent substantive Queensland Health employee contracted to WBHHS	28/01/13

The Hospital and Health Service is independently and locally controlled by the Hospital and Health Service Board (the Board). The Board appoints the Health Service Chief Executive and exercises significant responsibilities at a local level, including controlling the financial management of the Service and the management of the Service's land and buildings (Section 7, Hospital and Health Board Act 2011).

WIDE BAY HOSPITAL AND HEALTH SERVICE BOARD

Name & position of incumbents	Responsibilities	Appointment date
Dominic Devine	Chair	14/06/13
Gary Kirk	Board Member	01/06/12
Barbara Hovard	Deputy Chair	29/06/12
Joy Jensen	Board Member	18/05/13
Paul Dare	Board Member	18/05/13
Christopher Hyne	Board Member	18/05/13
George Plint	Board Member	18/05/14
Bryan Burmeister	Board Member	18/05/14
Rowan Bond	Board Member	18/05/14
Ralph Coles	Board Member	18/05/14
Adrian Daniel	Board Member	29/06/12-17/05/14
Robert Evans	Board Member	18/05/13-17/05/14
Denis Powell	Board Member (resigned)	18/05/13 - 13/12/13
Debbie Carroll	Board Member (resigned)	29/06/13 - 31/03/14

Remuneration

Section 74 of the Hospital and Health Board Act 2011 provides that the contract of employment for health executive staff must state the term of employment, the person's functions and any performance criteria, as well as the person's classification and remuneration package. Section 76 of the Act provides the Chief Executive authority to fix the remuneration packages for health executives, classification levels and terms and conditions having regard to remuneration packages for public sector employees in Queensland or other States and remuneration arrangements for employees employed privately in Queensland.

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Remuneration policy for WBHHS's key executive management personnel is set by direct engagement common law employment contracts. The remuneration and other terms of employment for the key executive management personnel are also addressed by these common law employment contracts. The contracts provide for other benefits including motor vehicles.

Remuneration packages for key management personnel comprise the following components:

- Short term employee benefits which include:
  - Base - consisting of base salary, allowances and leave entitlements expensed for the entire year or for that part of the year during which the employee occupied the specified position.
  - Non-monetary benefits - consisting of provision of vehicle together with fringe benefits tax applicable to the benefit.
- Long term employee benefits include amounts expensed in respect of long service leave.
- 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.
- Performance bonuses are not paid under the contracts in place.
- 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.

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Key management personnel remuneration 2014:

Name and position	Short-term benefits		Post-employment benefits	Long-term benefits	Termination benefits	Total
	Base $'000	Non-monetary $'000	$'000	$'000	$'000	$'000
Adrian Pennington - Health Service Chief Executive	334	-	34	7	-	375
Geoff Evans - Chief Financial Officer	190	18	19	4	-	231
Debbie Carroll - Director Midwifery & Nursing, Acting Chief Operating Officer North	206	18	23	5	-	252
George Plint - Director Integrated Mental Health Services	111	-	12	2	-	125
Malcolm Donaldson - Director Oral Health Services	171	-	19	4	-	194
Josephine Leveritt - Executive Director Human Resources	183	-	18	3	-	204
Robyn Bradley - Acting Executive Director Mental Health Alcohol & Other Drugs	46	17	5	1	-	69
Peter Heinz - Acting Executive Director Human Resources	62	17	6	1	-	86
Dr Pieter Pike - Executive Director Clinical Governance	434	15	30	4	-	483
Fiona Sewell - Acting Executive Director of Nursing & Midwifery Service	27	16	3	1	-	47
Stephen Bell - Acting Chief Operating Officer (South)	142	17	11	3	-	173
Dr Margaret Young - Director of Public Health	423	19	31	5	-	478

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Board remuneration 2014:

2014	Short-term benefits		Post-employment benefits	Long-term benefits	Termination benefits	Total
Name and position	Base $'000	Non-monetary $'000	$'000	$'000	$'000	$'000
Dominic Devine - Chair	68	-	-	-	-	68
Gary Kirk - Board Member	40	-	3	-	-	43
Barbara Hovard - Board Member	37	-	-	-	-	37
Joy Jensen - Board Member	39	-	-	-	-	39
Paul Dare - Board Member	37	-	-	-	-	37
Christopher Hyne - Board Member	36	-	-	-	-	36
George Plint - Board Member	6	-	-	-	-	6
Bryan Burmeister - Board Member	6	-	-	-	-	6
Rowan Bond - Board Member	6	-	-	-	-	6
Adrian Daniel - Board Member	28	-	-	-	-	28
Robert Evans - Board Member	29	-	3	-	-	32
Denise Powell - Board Member	14	1	1	-	-	16
Debbie Carroll - Board Member	21	-	3	-	-	24

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Key management personnel remuneration 2013:

2013	Short-term benefits		Post-employment	Long-term	Termination	
Name and position	**Base $'000**	**Non-monetary $'000**	**benefits $'000**	**benefits $'000**	**benefits $'000**	**Total $'000**
Kieran Keyes - Acting Health Service Chief Executive	39	-	-	1	-	40
Adrian Pennington - Health Service Chief Executive	229	10	25	4	-	268
Geoff Evans - Chief Financial Officer	146	17	17	3	-	183
Tim Smart - Executive Director medical Services	402	31	30	4	-	467
Debbie Carroll - Director Midwifery & Nursing, Acting Chief Operating Officer North	206	17	20	4	-	247
George Plint - Director Integrated Mental Health Services	128	17	16	3	-	164
Malcolm Donaldson - Director Oral Health Services	153	-	16	3	-	172
Josephine Leveritt - Executive Director Human Resources	81	16	-	2	-	99
Phillipa Blakey - Chief Operating Officer South (contract)	141	-	-	-	-	141

Board remuneration 2013:

2013	Short-term benefits		Post-employment	Long-term	Termination	
Name and position	**Base $'000**	**Non-monetary $'000**	**benefits $'000**	**benefits $'000**	**benefits $'000**	**Total $'000**
Gary Kirk - Chair, Board Member	66	-	6	-	-	72
Barbara Hovard - Deputy Chair	36	-	-	-	-	36
Deborah Carroll - Board Member	31	-	6	-	-	37
Adrian Daniel - Board Member	29	-	-	-	-	29
Professor Bradley Murphy - Board Member	27	-	-	-	-	27

Wide Bay Hospital & Health Service
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Note 30. Contingencies

Litigation in Progress

As of 30 June 2014 there were 2 claims being managed by the Queensland Government Insurance Fund (QGIF) on behalf of Wide Bay HHS which were in the process of litigation. 1 case has been filed with the Supreme Court and 1 case (which also names Metro North HHS) has been filed with the District Court. The maximum exposure to Wide Bay HHS under the QGIF policy is $20,000 for each insurable event.

Native Title

The National Title Tribunal reported 0 native title claims in respect of Wide Bay HHS in 2013-14.

Note 31. Commitments

	2014 $'000	2013 $'000
Lease commitments - operating		
Committed at the reporting date but not recognised as liabilities, payable:		
Not later than one year	927	695
Later than one year and not later than five years	3,160	3,067
Later than five years	395	1,279
	4,482	5,041

WBHHS has non-cancellable operating leases relating to office accommodation. No lease arrangements contain restrictions on financing or other leasing activities.

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Note 32. Restricted assets

Under the Right of Private Practice scheme, Senior Medical Officers (SMOs) employed in the public health system are permitted to treat individuals who elect to be treated as private patients. In order to do so, the SMOs receive a private practice allowance and in return assign any private practice revenue to the Hospital (Option A). A variation of this model allows the SMOs to pay a facility charge and administration fee to the Hospital and to retain a proportion of the private practice revenue (Option B). The remaining revenue is deposited into a trust account to fund research and education of all staff. Receipts and payments relating to right of private practice (Option A & B) during the financial year were as follows:

	2014 $'000	2013 $'000
*Receipts**		
Billings - (Doctors and Visiting Medical Officers)	9,114	5,801
Total receipts	9,114	5,801
*Payments**		
Payments to Doctors	10,754	10,134
HHS recoverable administrative costs	125	102
HHS education/travel fund	37	100
Total payments	10,916	10,336
Right of Private Practice trust assets		
Current assets		
Opening cash at bank and on hand	478	453
Receipts	157	116
Payments	(58)	(91)
Closing cash at bank and on hand	577	478

Note 33. Fiduciary trust transaction and balances

WBHHS acts in a custodial role in respect of these transactions and balances. As such, they are not recognised in the financial statements, but are disclosed below for information purposes.

	2014 $'000	2013 $'000
Trust receipts and payments		
Receipts		
Yaralla Place Aged Care Patient Trust receipts	262	820
Bundaberg Health Service District Patient Trust receipts	80	130
Total receipts	342	950
Payments		
Yaralla Place Aged Care Patient Trust payments	396	838
Bundaberg Health Service District Patient Trust payments	101	137
Total payments	497	975
Trust assets and liabilities		
Assets		
Yaralla Place Aged Care Patient Trust cash at bank	-	134
Bundaberg HSD Patient Trust cash at bank	20	41
Total assets	20	175

Wide Bay Hospital & Health Service
Notes to the financial statements
30 June 2014

Note 34. Events after the reporting period

Transfer of employee housing

As part of a whole-of-Government initiative, management of all non-operational housing transitioned to the Department of Housing and Public Works (DHPW) on 1 January 2014. Legal ownership of housing assets will transfer to the DHPW on 1 July 2014.

As at 30 June 2014, Wide Bay HHS held non-operational housing assets with a total net book value of $3.6 million under a Deed of Lease arrangement with the Department of Health. Effective 1 July 2014, the Deed of Lease arrangement in respect of these assets will cease, and the assets will be transferred to the Department of Health at their net book value, prior to their transfer to the DHPW.

As this transfer will be designated as a Contribution by Owners, the transfer will be undertaken through WBHHS's Equity account. Therefore, this transaction will have no impact on the Statement of Comprehensive Income in the 2014-15 Financial Year.

Prescribed Employer Status

Currently, all staff, except Health Service Chief Executives and health executive service (HES) employees (working in a HHS), are employed by the Director-General, Department of Health.

In June 2012, amendments were made to the Hospital and Health Boards Act 2011, giving Hospital and Health Boards mor autonomy by allowing them to become the employer of staff working for their HHS. HHSs will become prescribed employer by regulation.

Once an HHS becomes prescribed to be the employer, all existing and future staff working for the HHS become its employees The HHS, not the department, will recognise employee expenses in respect of these staff. The Director-General, Departmer of Health, will continue to be responsible for setting terms and conditions of employment, including remuneration an classification structures, and for negotiating enterprise agreements.

Wide Bay HHS is expected to become a prescribed employer on 1 July 2015.

Medical Contracts

Effective 4 August 2014, Senior Medical Officers and Visiting medical Officers will transition to individual employmer contracts.

Individual contracts mean senior doctors will have a direct employment relationship with their HHS and employment terms an conditions tailored to individual or medical specialty circumstances (within a consistent state-wide framework).

As a direct employment relationship will be established between contracted medical officers and their HHS, employee-relate costs for contracted Senior Medical Officers and Visiting Medical Officers will be recognised by the employing HHS (not th department) from the date the contracts are effective.

Non-contracted Senior Medical Officers and Visiting Medical Officers will remain employed under current award arrangements Where their HHS is not a prescribed employer, they will continue to be employed by the department.

Wide Bay Hospital & Health Service
Notes to the financial statements
30 June 2014

Land and Buildings legal title transfer

The control of health services land and buildings transferred to each Hospital and Health Service (HHS) at no cost to the HH through deed of lease arrangements when HHSs were established on 1 July 2012. The Department of Health retained lega ownership of the health services land and buildings, however the intention was for legal title of the assets to eventually transfe to each HHS.

Due to effective control of the assets transferring to HHSs, these assets are recognised within the financial statements of eac HHSs and not within the Department of Health's financial statements.

On 23 June 2014, the Minister for Health announced that the Queensland government had approved the transfer of lega ownership of health services land and buildings to HHSs in a staged process over the next 12 months.

The transfer of legal ownership of land and buildings to Wide Bay HHS will occur from 1 July 2015. There is no material impac for the financial statements as these assets are already controlled and recognised by the HHS.

No other matter or circumstance has arisen since 30 June 2014 that has significantly affected, or may significantly affect Wide Bay HHS's operations, the results of those operations, or its state of affairs in future financial years.

Note 35. Reconciliation of surplus/(deficit) to net cash from operating activities

	2014 $'000	2013 $'000
Surplus/(deficit) for the year	95	15
Adjustments for:		
Depreciation and amortisation	12,163	12,826
Depreciation grant funding	(12,106)	(12,755)
Impairment of non-current assets	113	373
Net gain on disposal of non-current assets	(6)	(153)
Change in operating assets and liabilities:		
Decrease/(increase) in trade and other receivables	6,814	(6,536)
Increase in inventories	(443)	(12)
Decrease/(increase) in prepayments	40	(172)
Decrease in other operating assets	113	112
Increase in trade and other payables	831	12,686
Increase/(decrease) in other employee benefits	(15)	32
Increase in other operating liabilities	83	41
Net cash from operating activities	7,682	6,457

Wide Bay Hospital & Health Service
Management certificate
30 June 2014

CERTIFICATE OF WIDE BAY HOSPITAL AND HEALTH SERVICE

These general purpose financial statements have been prepared pursuant to s.62(1) of the *Financial Accountability Act 2009* (the Act), s.43 of the *Financial and Performance Management Standard 2009* and other prescribed requirements. In accordance with s.62(1)(b) of the Act we certify that in our opinion:

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

b) the statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of the Wide Bay Hospital and Health Service for the financial year ended 30 June 2014 and of the financial position of the entity at the end of that year; and

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

Mr Dominic Devine
AD,Bus,MIMC,AICD
Chairman of WBHHS Board
25 / 8 /2014

Mr Adrian Pennington
AFCHSM,CIPFA(BFM),APSA,AAT
Chief Executive Officer
25 / 8 /2014

Mr Geoff Evans
BCertA,GradHIDCM,MAICD
Chief Finance Officer
25 / 8 /2014

QAO
certified statements

INDEPENDENT AUDITOR'S REPORT

To the Board of Wide Bay Hospital and Health Service

Report on the Financial Report

I have audited the accompanying financial report of Wide Bay Hospital and Health Service, which comprises the statement of financial position as at 30 June 2014, 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 Chairman, Chief Executive Officer and Chief Finance Officer.

The Board's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

Independence

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

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

Opinion

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

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

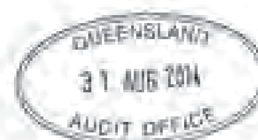
(b) in my opinion –

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

(ii) the financial report presents a true and fair view, in accordance with the prescribed accounting standards, of the transactions of the Wide Bay Hospital and Health Service for the financial year 1 July 2013 to 30 June 2014 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.



B.R Steel CPA
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane

Annual report 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	p. 5
Accessibility	• Table of contents • Glossary	ARRs – section 10.1	p. 4 p. 98
	• Public availability	ARRs – section 10.2	p. 2
	• Interpreter service statement	Queensland Government Language Services Policy ARRs – section 10.3	p. 2
	• Copyright notice	Copyright Act 1968 ARRs – section 10.4	p. 2
	• Information licensing	Queensland Government Enterprise Architecture – Information licensing ARRs – section 10.5	p. 2
General information	• Introductory Information	ARRs – section 11.1	p. 6
	• Agency role and main functions	ARRs – section 11.2	p. 9
	• Operating environment	ARRs – section 11.3	p. 10
	• Machinery of Government changes	ARRs – section 11.4	p. 14
Non-financial performance	• Government objectives for the community	ARRs – section 12.1	p. 37
	• Other whole-of-government plans / specific initiatives	ARRs – section 12.2	p. 37
	• Agency objectives and performance indicators	ARRs – section 12.3	p. 38
	• Agency service areas, service standards and other measures	ARRs – section 12.4	p. 39
Financial performance	• Summary of financial performance	ARRs – section 13.1	p. 45
Governance – management and structure	• Organisational structure	ARRs – section 14.1	p. 15
	• Executive management	ARRs – section 14.2	p. 22
	• Related entities	ARRs – section 14.3	N/A
	• Boards and committees	ARRs – section 14.4	p. 27
	• *Public Sector Ethics Act 1994*	*Public Sector Ethics Act 1994* (section 23 and Schedule) ARRs – section 14.5	p. 32

Governance – risk management and accountability	• Risk management	ARRs – section 15.1	p. 33
	• External Scrutiny	ARRs – section 15.2	p. 36
	• Audit committee	ARRs – section 15.3	p. 35
	• Internal Audit	ARRs – section 15.4	p. 36
	• Public Sector Renewal Program	ARRs – section 15.5	p. 7
	• Information systems and recordkeeping	ARRs – section 15.7	p. 36
Governance – human resources	• Workforce planning, attraction and retention and performance	ARRs – section 16.1	p. 48
	• Early retirement, redundancy and retrenchment	Directive No.11/12 Early Retirement, Redundancy and Retrenchment ARRs – section 16.2	p. 49
Open Data	• Open Data	ARRs – section 17	p. 50
Financial statements	• Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	p. 93
	• Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	p. 94
	• Remuneration disclosures	Financial Reporting Requirements for Queensland Government Agencies ARRs – section 18.3	p. 83

Glossary of terms & acronyms

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: generally a recognised hospital that provides acute care and excludes dental and psychiatric hospitals.

Admission: process whereby a hospital accepts responsibility for a patient's care and/or treatment. It follows a clinical decision, based on specified criteria, that a patient requires same-day or overnight care or treatment, which can occur in hospital and/or in the patient's home (for hospital-in-the-home patients).

Admitted patient: a patient who undergoes a hospital's formal admission process as an overnight-stay patient or a same-day patient. Also may be referred to as 'inpatient'.

Allied Health staff: professional staff who meet mandatory qualifications and regulatory requirements in the following areas – audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; leisure therapy; medical imaging; music therapy; nuclear medicine technology; occupational therapy; orthoptics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work.

Average length of stay (ALOS): the average number of patient days for admitted patient episodes.

Beddays: the number of full or partial days of stay for patients who were admitted for an episode of care and who underwent separation during the reporting period.

Benchmarking: involves collecting performance information to undertake comparisons of performance with similar organisations.

Best practice: cooperative way in which organisations and their employees undertake business activities in all key processes, and use benchmarking that can be expected to lead to sustainable world class positive outcomes.

Burden of disease: burden of disease is a measure of population health that aims to quantify the gap between the ideal of living to old age in good health, and the current situation where healthy life is shortened by illness, injury, disability and premature death.

Case mix: a tool that provides funding framework for clinical activity.

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 Services Capability Framework (CSCF): CSCF has been designed to guide a coordinated and integrated approach to health service planning and delivery in Queensland. It applies to both public and licensed private health facilities and enhances the provision of safe, quality services by providing service planners and service providers with a standard set of minimum capability criteria.

Clinical workforce: staff who are or who support health professionals working in clinical practice, have healthcare specific knowledge/experience, and provide clinical services to health consumers, either directly and/or indirectly, through services that have a direct impact on clinical outcomes.

Decision support system (DSS): consolidates data suitable for finance, human resources, pharmacy and pathology related information for decision support purposes.

Demand: demand is the health service activity that a catchment population can generate. Where the current and projected incidence and prevalence of diseases and conditions are known (using evidence from epidemiological studies), this data can be used to estimate demand in the catchment population. However, in most institutional planning, demand is measured by analysing expressed need or the amount of healthcare that the catchment population actually utilises. Because utilisation is influenced by other factors (such as existing service availability, access, cost and so-called 'supplier-induced demand'), the resultant estimates of demand inherently incorporate elements of supply.

Emergency Department waiting time: time elapsed for each patient from presentation to the emergency department to start of services by the treating clinician. It is calculated by deducting the date and time the patient presents from the date and time of the service event.

Full-time equivalent (FTE): refers to full-time equivalent staff currently working in a position.

Health outcome: change in the health of an individual, group of people or population attributable to an intervention or series of interventions.

Health reform: response to the National Health and Hospitals Reform Commission Report (2009) that outlined recommendations for transforming the Australian health system

Health status: an individual's or population's overall level of health, taking into account various aspects such as life expectancy, amount of disability, levels of disease risk factors and so on.

Hospital: healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.

Hospital and Health Boards: 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. 17 HHSs replaced existing health service districts from 1 July 2012.

Hospital-in-the-home: provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.

Incidence: number of new cases of a condition occurring within a given population, over a certain period of time.

Inpatient: a patient who undergoes a hospital's formal admission proves to received treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

Life expectancy: an indication of how long a person can expect to live. Technically it is the number of years of life remaining to a person at a particular age if death rates do not change.

Long wait: a 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for a category 1 patient, more than 90 days for a category 2 patient and more than 365 days for a category 3 patient.

Medicare Locals: established by the Commonwealth to coordinate primary health care services across all providers in a geographic area. Will work closely with HHSs to identify and address local health needs. Selected and funded by the Commonwealth and rolled out progressively from 1 July 2011.

Medical practitioner: a person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.

Models of care: a model of care outlines best practice patient care delivery through the application of a set of service principles across identified clinical streams and patient flow continuums. An overarching design or description of how care is managed and organised within the system.

Never events: inexcusable actions in a health care setting.

Non-admitted patient: a patient who does not undergo a hospital's formal admission process.

Non-admitted patient services: an examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service facility.

Nurse practitioner: a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessing and managing clients using nursing knowledge and skills and may include, but is not limited to, direct referral of clients to other healthcare professionals, prescribing medications, and ordering diagnostic investigations.

Outpatient: a non-admitted health service provided or accessed by an individual at a hospital or health service facility.

Outpatient service: examination, consultation, treatment or other service provided to non-admitted non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.

Overnight-stay patient: a patient who is admitted to, and separated from, the hospital on different dates (not same-day patients).

Patient flow: optimal patient flow means the patient's journey through the hospital system, be it planned or unplanned, happens in the safest, most streamlined and timely way to deliver good patient care.

Performance indicator: a measure that provides an 'indication' of progress towards achieving the organisation's objectives usually has targets that define the level of performance expected against the performance indicator.

Population health: promotion of healthy lifestyles, prevention or early detection of illness or disease, prevention of injury and protection of health through organised population-based programs and strategies.

Private hospital: a private hospital or free-standing day hospital, and either a hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients or insurers patients admitted to private hospitals are treated by a doctor of their choice.

Public patient: a public patient is one who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.

Public hospital: public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.

Registered nurse: an individual registered under national law to practice in the nursing profession as a nurse, other than as a student.

Separation: term used to refer to an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). A separation also includes the process by which an admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital or changing type of care.

Service delivery model: service delivery models are an adaptation of an organisation's Model of Care and describes 'where' and 'how' work is carried out. Service delivery models suit the local environment and resources to best meet the overarching organisational requirements.

Statutory bodies: a non-departmental government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.

Sustainable: a health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs, for example, research and monitoring within available resources.

Telehealth: delivery of health-related services and information via telecommunication technologies, including:

- live, audio and or/video inter-active links for clinical consultations and educational purposes
- store-and-forward Telehealth, including digital images, video, audio and clinical (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists
- teleradiology for remote reporting and clinical advice for diagnostic images
- telehealth services and equipment to monitor people's health in their home.

Triage category: urgency of a patient's need for medical and nursing care.

List of acronyms

AASB Australian Accounting Standards Board

ABF activity based funding

ALOS average length of stay

CALD culturally and linguistically diverse communities

CAN community advisory network

CSFC Clinical Service Capability Framework

ED emergency department

FTE full time equivalent

GP general practitioner

GST Goods and Services Tax

HACC Home and Community Care

HITH Hospital in the Home

HHS hospital and health service

HR human resources

HSCE health service chief executive

KPI key performance indicator

MATES Maryborough Access Targeted Evaluation Service

MCDU Medical clinical decision unit

MOHRI Minimum Obligatory Human Resource Information

MRSA Methicillin-resistant *Staphylococcus aureus*'

NEAT National Emergency Access Target

NEST National Elective Surgery Target

NGO non government organisation

NPA National Partnership Agreement

PIP performance improvement plan

QHEPS Queensland Health Electronic Publishing Site

QIP quality improvement program

SAP business management software

SWOT strengths, weaknesses, opportunities, strengths

VMO visiting medical officer

WAU weighted activity unit

WBHHS Wide Bay Hospital and Health Service

Wide Bay Hospital and Health Service
2013/14 Annual Report
www.health.qld.gov.au/widebay/annual-report