Annual Report 2013–2014

Great state. Great opportunity.

Queensland Government

Communication Objective

This annual report aims to:

- Describe our performance by communicating our achievements and performance for 2013–2014
- Be accountable and transparent by enabling the Minister for Health and the Queensland Parliament to assess our efficiency and effectiveness.

Public Availability Statement

Copies of this publication can be obtained at **www.health.qld.gov.au/southwest/** or by phoning (07) 4505 1544.

Additional information to accompany this annual report can be accessed at **http://publications.qld.gov.au**

Interpreter Service Statement

South West Hospital and Health Service Annual Report 2013–2014

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty understanding the annual report, you can contact us on (07) 4505 1544 and we will arrange an interpreter to effectively communicate this report to you.

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Letter of compliance

The Honourable Lawrence Springborg MP
Minister for Health
Member for Southern Downs

Level 19, 147–163 Charlotte Street
Brisbane Qld 4000

26 August 2014

Dear Minister

I am pleased to present the annual report 2013–2014 for the South West 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 on pages 66–67 of this annual report or accessed at **www.health.qld.gov.au/southwest/**

Yours sincerely

Lindsay Godfrey
Board Chair
South West Hospital and Health Service

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Welcome

Welcome to the *South West Hospital and Health Service Annual Report for 2013–2014*. Our annual report describes our achievements, performance, outlook and financial position for the reporting year. It is a key accountability document reporting on non-financial and financial performance. It is designed to strive for continuous improvement and to build confidence and trust in the delivery of our services.

The South West Hospital and Health Service (South West HHS) is one of 17 Hospital and Health Services (HHSs) that was established and assumed accountability for the delivery of public hospital and health services on 1 July 2012. We deliver health services across a vast area of South West Queensland and are committed to providing quality and safe outcomes for our communities.

We value the input of our consumers, community and all stakeholders to support continuous improvement in the delivery of health services and welcome any feedback on this report. A feedback survey form is provided at the end of the report.

Our annual report is prepared in accordance with Section 63 of the *Financial Accountability Act 2009* (FAA) for tabling in the Legislative Assembly, and Section 49(5) of the *Financial and Performance Management Standard 2009* (FPMS).

Lindsay Godfrey
Board Chair

Glynis Schultz
Acting Health Service Chief Executive

Key highlights 2013–2014

- The Charleville midwifery model was implemented, including outreach to Cunnamulla
- The Flying Specialist Service was restructured and flight schedules revised to provide an increase in flying time and clinician-patient contact time
- The Injune Multipurpose Health Service officially opened in August 2013
- The Mitchell Multipurpose Health Service expansion officially opened in September 2013
- Service planning was completed and a number of areas of opportunity were identified to explore service gaps
- A revised model of care was implemented at the Morven Community Clinic with a transition to a Tier 1 clinical service delivery and 24/7 on-call service
- The Productive Ward program was introduced across a number of facilities
- Two dentists commenced work under Queensland Health's Rural Scholarship Program
- Roma Hospital's maternity services scored "Best Hospital in Queensland" in seven out of 26 rate indicators in a 2012 maternity survey
- The Telehealth Emergency Management Support Unit (TEMSU) was rolled out across all South West HHS facilities
- Injune, Cunnamulla and Quilpie Medical Practices were recognised for their commitment to quality and safety with an award of accreditation from the Australian General Practice Accreditation Limited (AGPAL)
- A user-friendly practice guide for nurses and midwives was launched
- The Allied Health Capability Development Framework was implemented
- Rural and Remote Infrastructure Works at Roma Hospital were completed
- Capital Infrastructure Planning Studies (master planning) for Roma and Charleville were progressed in conjunction with the Health Infrastructure Branch
- Accreditation status was achieved against the Commonwealth Home and Community Care Program Standards
- Accreditation status was achieved against the 10 National Safety and Quality Health Service Standards
- The oral health general care waiting list for longer than two years was reduced to zero
- Four advanced rural proceduralists were appointed to Roma Hospital
- New appointments were made to the South West Hospital and Health Board
- Lindsay Godfrey was appointed as Board Chair in May 2014
- The graduate nurse program achieved a 77 per cent retention rate of nurses staying in the South West after their first year
- Key performance indicators for telehealth usage were exceeded
- Key plans were reviewed and released for formal consultation with key stakeholders to influence the direction of the South West HHS, including the Strategic Plan 2014–2018, Clinician Engagement Strategy, Consumer and Community Engagement Strategy, Operational Plan and Communication Plan
- The Strategic Plan was reviewed and Strategic Plan 2014–2018 published
- The South West HHS delivered an operating surplus for 2013–2014
- The South West Sub-acute Rehabilitation Service was introduced at Roma Hospital and officially opened in June 2014
- An internal audit was undertaken by KPMG on contract management, asset management, legislative compliance, budget management and credentialing
- Contestability for radiology services was completed
- New medical models of service delivery have been explored
- Development began on an Integrated Paediatric Service
- The Ontario Telehealth Review Team visited the South West HHS
- The Telehealth Management Plan was approved
- The South West HHS delivered on Minimum Obligatory Human Resource Information (MOHRI) targets
- Successful Community Advisory Network forums were held in Mitchell in September 2013 and St George in June 2014
- Business Planning Frameworks (BPFs) were implemented for nursing
- The community and allied health team participated in a highly successful Roma Health Expo.

At a glance

During the year...

52,474
outpatients attended our facilities

1,289
surgical procedures were performed

31,402
patients attended an emergency department

265
babies were welcomed into the South West

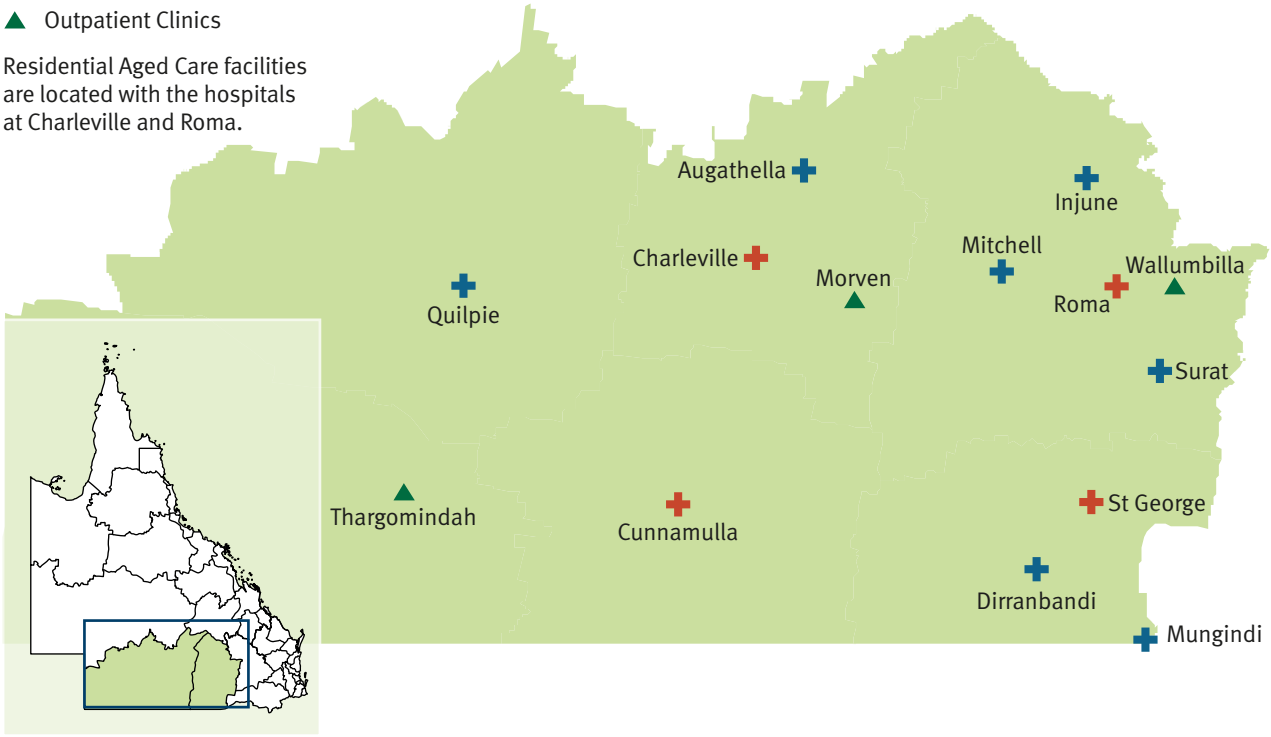
24,376
Oral Health Weighted Occasions of Service (WOOS) – a 39.4% increase since the 2012–2013 Financial Year

7,393
patients were admitted into our facilities, who stayed a total of 31,056 bed days, with an average length of stay of 4.2 days

South West Hospital and Health Service

- Hospitals
- Multipurpose Health Services
- Outpatient Clinics

Residential Aged Care facilities are located with the hospitals at Charleville and Roma.



Board Chair Report

I am proud of the achievements we have seen within the South West Hospital and Health Service during 2013–2014. We have come a long way this year and I have seen good improvements in our relationships with the community and in our health service delivery.

We have opened new services during the year, including the aged care wing at the Injune MPHS; an expansion at the Mitchell MPHS; and the opening of the South West Sub-acute Rehabilitation Service, based at Roma Hospital. These services will increase the breadth of health services available to people in communities across the South West. There has also been a lot of preparation work to bring the Bollon Bush Nursing Centre into the South West Hospital and Health Service. From July 1 2014, we assume responsibility for health services in Bollon and I look forward to working with the Bollon community to make it the best health service possible.

Significant advances with telehealth, including wireless telehealth machines, are also increasing access to specialist services across the region. One of our aims is to reduce the need for local residents to travel for healthcare, when possible, and we are achieving this by developing strong links with specialists at metropolitan hospitals that our local patients can regularly link with via telehealth.

It was heartening to see positive results from the three-yearly accreditation completed in April. I applaud the efforts of staff to prepare for the independent certification by the Institute for Healthy Communities Australia Certification. It was great to hear a lot of positive feedback about our service, especially with clinical care.

There are challenges that we continue to face. It is not easy to attract permanent doctors to rural and remote areas, but we are making inroads. This year we recruited four rural generalist doctors, who are specially trained to deliver healthcare in the bush. We have also engaged the Queensland Country Practice to actively plan for a new medical model that will be sustainable in our region. Our graduate nursing program has also been a success with about 77 per cent of graduate nurses choosing to stay in the South West after their graduate year.

In the coming year, we will face the challenge of taking ownership of our own land and buildings and the South West Hospital and Health Service will also become the prescribed employer to its staff.

The infrastructure upgrade works at Roma Hospital and Charleville Hospital are almost complete. The works have provided significant challenges for the staff at these locations who have continued to deliver quality and safe health services amidst the building works. I would like to pay tribute to the staff that have done a tremendous job with this.

The board and executive team have worked hard this year to forge strong bonds with our Community Advisory Networks (CANs) and our broader community. At our face-to-face CAN forum in St George in June 2014, it was great to see staff and community representatives communicating effectively to work through issues and ideas that were brought to the table. We welcomed new board members, Fiona Gaske and Dr John Scott to our board in May and they contribute great expertise to the board.

During the year, I have encouraged our executive team and the board to get out into the community and speak with our health clients in the local environment. I have been proud to watch the team connect with community members and establish a meaningful rapport.

Our goal is to be the best health service that we can be and it is satisfying to look back on the progress that we have made. There is still plenty of work to be done and I look forward to working with the board, the executive team and the communities to make sure we offer the best services possible.

Finally, I would like to pay tribute to all of the staff within the South West Hospital and Health Service who have provided dedicated service to the people in the South West, it is greatly appreciated by the board and by our local communities.

Lindsay Godfrey
Board Chair

Health Service Chief Executive Report

It is a great privilege to contribute to the 2013–2014 South West Hospital and Health Service Annual Report as Acting Chief Executive since November 2013.

The 2013–2014 financial year has been a period of consolidation, as the South West Hospital and Health Service builds on the good work that has already been completed as a statutory body and takes on an increasing number of functions that have previously been the responsibility of the Department of Health.

Our board and executive are actively focused on quality and safety, as well as engaging with the community and staff. Our strategic health service planning focuses on delivering services that provide the best value for money and improve access to services closer to people's homes.

The South West Hospital and Health Service's performance against targets is sound and it has been wonderful to see this continue to improve. Significant highlights include the decrease in waiting lists for people waiting more than two years for general dental care; the increase in elective surgery sessions provided by the expanded Flying Specialist Service; and the opening of the new South West Sub-acute Rehabilitation Service.

During the year, we had the privilege of working with the Morven community to implement a new service model under the *Queensland Rural and Remote Health Service Framework*. We were also able to welcome the community of Bollon as the South West will assume responsibility for health services in the town from 1 July 2014.

The most important attribute of a health service is that safe, quality care is provided with compassion and respect. In the 2013–2014 year, the South West Hospital and Health Service undertook a rigorous audit and was awarded another three years of accreditation against the AS/ANZ ISO 9001:2008 standard, by the Institute for Healthy Communities Australia Certification.

This year has not been without its challenges and I thank the staff for their professionalism in responding to those challenges with passion and commitment that has ensured that our services remain patient focused.

I would like to thank the South West Hospital and Health Board and our local Community Advisory Networks for their support and their role in ensuring that the communities we serve see the benefit and value in the health services we provide.

Glynis Schultz
Acting Health Service Chief Executive

Our organisation
About us

About us

Who we are

On 1 July 2012, in accordance with the *National Health Reform Agreement* and Queensland's subsequent *Hospital and Health Boards Act 2011*, the former South West Health Service District became one of 17 Hospital and Health Services (HHSs) with a Hospital and Health Board assuming accountability for the delivery of public hospital and health services. Our purpose is to provide sustainable healthcare services to meet the needs of the communities within our service.

The service is an independent statutory body, overseen by a local Hospital and Health Board, with responsibility for providing public hospital and health services and aged care services to a population of just over 26,000. The area covers over 319,000 square kilometres, including the three main centres Roma, Charleville and St George and surrounding areas of Augathella, Cunnamulla, Dirranbandi, Injune, Mitchell, Morven, Mungindi, Quilpie, Surat, Thargomindah and Wallumbilla. The service provides public health services and achieves health system outcomes as defined in the service agreement with Department of Health, as manager of the public hospital system.

What we do

The service was established under the *Hospital and Health Boards Act 2011* which prescribes the functions and powers of the Hospital and Health Service. As a statutory body, the board is accountable through the Hospital and Health Board Chair to the Minister for Health for local performance, delivering local priorities and meeting national standards. Our main function is to deliver health services as agreed in the service agreement with the Department of Health. Other key functions include:

- 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 statewide service plans that apply to the service and undertake further service planning that aligns with the statewide plans
- To monitor and improve the quality of health services delivered by the service, including, for example, by implementing national clinical standards
- 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 health service area
- To maintain land, buildings and other assets owned by the service
- To cooperate with other providers of health services, including the Department of Health and other providers of primary healthcare, in planning for and delivering health services
- To cooperate 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 service, health consumers and members of the community about the provision of health services.

The service is:

- Subject to the *Financial Accountability Act 2009, Statutory Bodies Financial Arrangements Act 1982* and Public *Service Act 2008*
- A unit of public administration under the *Crime and Corruption Act 2001*
- A body representing the State and with the privileges and immunities of the State
- A legal entity that can sue and be sued in its corporate name.

The service is responsible for the direct management of facilities and services including hospitals, multipurpose health services (MPHS), residential aged care services and outpatients clinics (OPC):

- Augathella MPHS
- Charleville Hospital
- Cunnamulla Hospital
- Dirranbandi MPHS
- Injune MPHS
- Mitchell MPHS
- Morven OPC
- Mungindi MPHS
- Quilpie MPHS
- Roma Hospital
- St George Hospital
- Surat MPHS
- Thargomindah OPC
- Wallumbilla OPC
- Waroona Aged Care Facility
- Westhaven Aged Care Facility

A range of services and programs are provided through the facilities listed above. Not all facilities provide all services and some services may be provided only in a limited capacity, during emergencies. Some outpatient services are provided by visiting clinicians and/or through telehealth.

The service operates a number of community and allied health service and outpatient clinics, which provide a comprehensive range of community and primary health services, including aged care assessment; Aboriginal and Torres Strait Islander health programs; child and maternal health services; alcohol, tobacco and other drug services; home care services; community health nursing: sexual health service; allied health services; oral health; health promotion programs; and sub-acute rehabilitation services.

Our vision

To be a respected leader and partner organisation to improve and maintain the health and wellbeing of patients, staff and our communities.

Our purpose

The South West Hospital and Health Service is responsible for the development and provision of sustainable healthcare services to meet the needs of the communities within our service.

Our values

Customers first

- Know your customers
- Deliver what matters
- Make decisions with empathy

Ideas in action

- Challenge the norm and suggest solutions
- Encourage and embrace new ideas
- Work across boundaries

Unleash potential

- Expect greatness
- Lead and set clear expectations
- Seek, provide and act on feedback

Be courageous

- Own your actions, successes and mistakes
- Take calculated risks
- Act with transparency

Empower people

- Lead, empower and trust
- Play to everyone's strengths
- Develop yourself and those around you

Our organisation

About us

Our operating environment

Statutory obligations

As an independent statutory body governed by the South West Hospital and Health Board, we are responsible to the Minister for Health and local community. Our obligations and responsibilities are set out in the *Hospital and Health Boards Act 2011* and the *Financial Accountability Act 2009* and subordinate legislation. The service is responsible for specific statutory functions in accordance with Section 19 of the *Hospital and Health Boards Act 2011*.

We operate according to a service agreement with the Department of Health, which identifies the services to be provided, the funding arrangements for our services, the defined performance indicators and targets to ensure outcomes are achieved, and how the Department of Health will manage our performance and reporting requirements.

Our service agreement establishes the funding arrangements. The main sources of funding that contribute to our service agreement budget are:

- State funding
- Commonwealth funding
- Grants and contributions
- Own source revenue.

An integrated strategic planning framework has been implemented to ensure we are responsive to our communities and deliver sustainable services. The integrated framework consists of our strategic plan and service plan, which enable the development of operational and individual plans which are closely aligned to whole-of-government strategic directions that are outlined in the:

- *National Healthcare Agreement*
- *Queensland Government Statement of Objectives for the Community*
- *Queensland Health Strategic Plan 2012–2016*
- *Blueprint for Better Healthcare in Queensland, February 2013*
- *Statement of Government Health Priorities 2012*
- *Better Health for the Bush Plan,* June 2014
- *Queensland Rural and Remote Health Service Framework*, June 2014.

Nature and range of operations

The service is a rural and remote public health service committed to providing quality, dependable, safe and sustainable healthcare.

The service encompasses a vast area and is bordered by three states. Services are provided to 16 individual facilities across a vast geographical area, which covers 21 per cent of Queensland. Roma is the primary clinical hub with St George and Charleville as secondary clinical hubs that provide services to the communities and surrounding areas of Augathella, Cunnamulla, Dirranbandi, Injune, Mungindi, Mitchell, Morven, Quilpie, Surat, Thargomindah and Wallumbilla. Given the vast geographical area, the communities of the South West are unique and diverse with varying needs and issues. The local government areas within the service area are Balonne Shire, Bulloo Shire, Maranoa Regional Council, Murweh Shire, Paroo Shire and Quilpie Shire.

We employ 685.28 full time equivalent (FTE) staff with a head count of 842.8 across the administrative, operational and clinical fields, who contribute to our rich diversity of skills, knowledge and experience. Our operating budget for 2013–2014 was $117.7million. As servants of the public and the custodians of the healthcare system for our communities, we recognise our responsibility and accountability to ensure funds are utilised appropriately for the delivery of health services.

This year 52,474 outpatients attended our facilities, 31,402 patients attended an emergency department, 7,393 patients were admitted into our facilities and 265 babies were welcomed into the South West at our facilities.

The service contains four hospitals (in Charleville, Cunnamulla, Roma and St George); seven multipurpose health services (Augathella, Dirranbandi, Injune, Mitchell, Mungindi, Quilpie and Surat) and three outpatient clinics (Morven, Thargomindah and Wallumbilla). The larger hospitals in Roma, Charleville and St George provide outreach services to the smaller centres. Under the *Queensland Rural and Remote Health Service Framework*, the outpatient clinics are now known as community clinics. The service is also responsible for two residential aged care facilities; Waroona in Charleville and Westhaven in Roma. The South West HHS has undertaken work to transition the Bollon Bush Nursing Centre to the Bollon Community Clinic. It will become a Queensland Health facility, managed by the South West HHS from 1 July, 2014, bringing the number of community clinics to four.

The services span a continuum of care, including promotion, protection and prevention; primary healthcare; ambulatory care; acute care; emergency care; general surgery; community and allied health; dental services; maternity services; rehabilitation and extended care; and integrated mental health.

A number of specialist services are provided through visiting specialists in areas including dermatology; endocrinology; gastroenterology; ear, nose and throat; ophthalmology; cardiology; paediatrics; orthopaedics and urology.

Planning for a new sub-acute rehabilitation service was completed during the year and the service was officially opened in June 2014. This new service will provide geriatric evaluation and management, as well as rehabilitation services for the whole of the South West region. The service aims to give local people the best chance to improve their health, physically and mentally, so that they can look after themselves and live healthy, independent lives.

The sub-acute service includes a brand new therapy room, as well as seven dedicated inpatient beds within the main acute ward at Roma Hospital. It is the first time this integrated service has been available to patients locally. It is anticipated that the service will allow people to undergo rehabilitation closer to their homes and support networks. The service also aims to reduce the reliance on institutionalised care in meeting the needs of the ageing population in the South West.

Flying Specialist Services (FSS), consisting of a surgeon, an obstetrician and gynaecologist and an anaesthetist, are based at Roma and provide services to rural and remote locations in the South West, the western part of the Darling Downs, Central Queensland and Central West Queensland. This service was restructured during the year, which saw the implementation of a revised flight schedule for the Flying Obstetrician and Gynaecologist that has allowed for increased patient contact time. The Flying Obstetrician and Gynaecologist has also started to deliver urodynamics clinics at the sub-acute service in Roma for women with continence issues.

Telehealth services are provided across the region. Considerable effort and resources, including a dedicated clinical nurse consultant, have been directed towards expanding telehealth services throughout 2013–2014. There is significant potential for this service to support healthcare delivery in rural and remote locations by removing the physical and social distances between health professionals and patients. The Telehealth Emergency Management Support Unit (TEMSU) was introduced during the year, which coordinates support for health practitioners in rural settings who are dealing with complex non-acute cases. At Roma Hospital, a wireless telehealth device has been introduced, which allows specialists to speak to patients at the bedside. Several relationships between specialists in metropolitan hospitals have been developed throughout the year, which has created a greater opportunity for continuity of specialist care via telehealth.

Multipurpose health service model

The MPHS model is a health and aged care service model providing flexible and sustainable service options for small rural and remote communities. It combines a range of services from acute hospital care to residential aged care, community health and home and community care. The benefits of the MPHS model include greater service choices which are tailored to the specific needs of the community; a focus on health education and illness prevention programs; the encouragement of innovative service delivery through participatory consultation processes; and more flexible use of public funding.

Outpatients clinics

Thargomindah, Morven and Wallumbilla are primary health care outpatient centres. Services are delivered to non-admitted, non-emergency patients. These centres provide a range of health services, although not all services are provided by the South West HHS. The services provided include pharmacy and some pathology services; diabetes education; mobile women's health nurse; dietetics; home and community care services; Blue Care nursing services; mental health; oral health; Royal Flying Doctor Services (including emergency services); physiotherapy; social work; child health services; and Queensland Ambulance Services.

Residential aged care facilities

The service is responsible for two residential aged care facilities, Waroona in Charleville and Westhaven in Roma. Waroona provides accommodation for 45 permanent residents with respite services offered to people of the South West, however this depends on permanent residency numbers. Westhaven provides for 39 permanent residents and one respite bed. Residents at both facilities are encouraged to be actively involved and to contribute to the community to share their lifetime of skills and knowledge within a supportive environment.

Community and allied health services

Community health centres are located at Charleville, Roma and St George. Primary and community health services are provided by a range of healthcare professionals in socially appropriate and accessible ways and are supported by integrated referral systems. Services focus on promoting healthy lifestyles to reduce the burden of disease. Services provided include Aboriginal and Torres Strait Islander health; child and family health; community health nursing; mobile women's health nurse; mental health (adult and child); sexual health; chronic disease management; aged care assessment team; home and community care; oral health services; antenatal and postnatal services;

young people's support program; and alcohol, tobacco and other drugs services. BreastScreen Queensland is provided through outreach by the Darling Downs HHS.

Allied health services include physiotherapy; speech and occupational therapy; optometry; radiography; dietetics; podiatry; social work; speech pathology; oral health; and pharmacy. Allied health services are located at Charleville, Roma and St George and provide outreach visiting services to surrounding areas.

Outreach services

Outreach services refer to a range of visiting services provided to smaller centres from the hub centres of Charleville, Roma and St George.

Ambulance

The South West HHS works collaboratively with the Queensland Ambulance Service to support a number of ambulance models, including hospital-based ambulances at Augathella and Quilpie, as well as a volunteer-driver model in Thargomindah and Morven where clinical services are provided by the nursing staff from the local clinics.

Our strategic risks, opportunities and challenges

Strategic risks

The service identified a number of strategic risks at the beginning of the 2013–2014 financial year which have the potential to impact on the ability of the service to achieve its purpose. These include:

- *Financial viability* – A service plan will be developed, which will provide evidence for discussions with the Department of Health in relation to financial sustainability, appropriateness of service and models of service delivery to be implemented against the background of budgetary constraints
- *Recruitment and retention* – A human resource plan will be developed to ensure strategies are in place to address recruitment and retention of permanent staff, impacts on accommodation and building capacity and capability
- *Infrastructure* – Infrastructure planning will be closely monitored to ensure resources are provided to address ageing building assets, information and communication technology and to cater for population need, service demand and emerging trends in service delivery
- *Culture* – The service is committed to a culture that recognises the contribution of our highly valued workforce, promotes continuous learning and improvement in all that we do, and fosters feelings of pride and workplace satisfaction
- *Contemporary relevance* – Innovation and contemporary practice in service delivery models will be explored and implemented
- *Access and tyranny of distance* – Evidence-based service delivery models will be established to meet local health needs and changing environmental factors such as population, burden of disease, economy and medical advances
- *Political* – We commit to working in partnership with federal, state and local governments to gain support for the delivery of health services to our communities.

Opportunities

Opportunities include:

- Enhancement of consumer and community engagement to achieve improved health outcomes
- Implementation of recommendations from the service plan
- Development of robust partnerships with stakeholders to reduce duplication of services
- Implementation of a person-centred healthcare approach
- Development of workforce capacity and capability to meet the demands of contemporary practices
- Development of innovative models of care
- Enhancing cost and time effective access to specialist services
- Improve the integration of services through primary healthcare networks.

Challenges

Challenges include:

- Managing the complex process of healthcare delivery by ensuring the right services are provided in the right places for patients within a safe environment
- Building public confidence in the healthcare system and responding to rising public expectations
- Providing a seamless transition for patients as they move across healthcare providers and settings
- Attracting and retaining a skilled workforce, especially for specialist services in regional and rural areas
- An ageing workforce
- Ageing buildings and information and communication technology infrastructure which impacts on information security, accessibility and ability to provide contemporary care
- Establishing meaningful and measurable outcome indicators for complex health and community services

- Managing the growing demand for services within tight economic and financial environments
- Improving the health literacy of communities
- Responding to advances in treatment and developing technologies
- Changing the focus of community and health workers to the prevention of illness and maintenance of good health
- Implementing evidenced-based service delivery models to address the demand for health services
- Partnering with other health service providers to reduce duplication and provide a seamless continuum of care approach
- Achieving a collective and coordinated response across multiple levels and complexities of government
- Becoming a prescriber employer from 1 July 2015
- Transfer of land and buildings assets to the service from 1 July 2015
- Harnessing resources through primary healthcare networks to improve efficiencies and reduce duplication of services.

Environmental factors

The service delivers health services across a vast geographical area of approximately 319,000 square kilometres in South West Queensland. A population of just over 26,000 people is served, which is forecast to increase only marginally by 2021. At June 2011, 11.8 per cent of the service's population were Aboriginal and Torres Strait Islanders, 4 per cent of the population were born overseas and 1.3 per cent of the population spoke a language other than English at home. The large geographical spread means the various communities in the region are unique and have their own individual health needs. The tyranny of distance creates significant challenges for the population to access services.

Within this demographic, some areas of the South West are experiencing unprecedented growth with the coal seam gas development and a significant transient population of fly-in fly-out staff who utilise local health services.

System and stakeholder engagement

National and State partnerships

The service works within a legislative framework of broader State and Commonwealth Government policies. At a Commonwealth and State level, a range of intergovernmental forums exist. The State Government works with the Commonwealth Government and other states and territories through the Council of Australian Governments (COAG) to achieve the implementation of strategic health priorities and objectives. Recent health initiatives include chronic disease prevention; improving access to elective surgery and emergency departments; improving health outcomes for Aboriginal and Torres Strait Islanders; supporting immunisation to protect the population's health; developing and implementing eHealth and supporting information systems; and delivering new and improved infrastructure.

Under COAG, the Standing Council on Health (SCoH) is focusing on a number of key priorities including improving health outcomes for all Australians and ensuring the sustainability of the health system; mental health reform; ensuring a high quality and sustainable workforce; closing the gap in health outcomes between Indigenous and non-Indigenous Australians; and providing a robust health and safety framework.

Through the service agreement with the Department of Health, the service is responsible for ensuring State and Commonwealth Government priorities, services, outputs and outcomes are achieved.

Community partnerships

As part of the service's commitment to providing enhanced health outcomes for its patients, a number of arrangements are in place with other primary care providers, including Aboriginal medical services, the Royal Flying Doctor Service and a number of private allied health service providers. The service has also been actively involved in the South West Health Partnership which is facilitated by the Darling Downs South West Queensland Medicare Local (DDSWQML) where primary healthcare partners work together to improve service delivery coordination and develop opportunities.

Medicare Local

Partnering continued throughout the year between the service and the DDSWQML to promote the fostering of improved service delivery and outcomes across government providers, non-government providers, private providers and the community.

Our organisation

About us

Local government

Linkages are also maintained with local government representatives within the region. There are six local government areas within the service. The service values these partnerships as they help to understand and respond to local needs and provide a platform for improved integration of services across the service. The Board Chair and Acting Health Service Chief Executive met with local government representatives on a number of occasions to receive and provide feedback to key local government representatives. This occurred during facility visits and at regional local government meetings.

Other government departments and agencies

The service interfaces with a number of government departments and agencies to provide services to the community. The Home and Community Care Program, jointly funded by the Queensland and Australian Governments, provides basic maintenance and support services to help frail older people and younger people with disabilities. The Department of Communities provides funding for the Charleville and District Healthy Ageing Program, which supports older people to develop and manage healthy ageing programs in their communities. Community Aged Care Packages (CACPs) are individually planned and coordinated packages of care tailored to help older community members to continue living in their own homes.

Our stakeholders

The service engages with a range of consumer and community stakeholders. We work with our stakeholders through service provider partnerships, community groups, local, state and commonwealth governments, community organisations, regional development organisations, education and research providers, Aboriginal and Torres Strait Islander groups, special interest groups, individuals and our staff.

The South West HHS is supported by three Aboriginal medical services in the South West: Goondir Health Services, Cunnamulla Aboriginal Corporation for Health and Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health (CWAATSICH), who provide a broad range of services including medical; dental; chronic disease management; substance use; and counselling services.

The Royal Flying Doctor Service (RFDS) plays a vital role in the provision of emergency retrievals, while Retrieval Services Queensland provide clinical coordination for the aeromedical retrieval and transfer of patients to tertiary centres. The Queensland Ambulance Service plays a key role in providing emergency and non-emergency transport and paramedical services.

The South West HHS is also supported by tertiary facilities such as the Princess Alexandra Hospital to provide expertise and advice, plus a range of specialists conduct clinics in the region under the CheckUp Program.

Community engagement

The service is committed to providing high quality, safe and sustainable health services and recognises that in order to do this, genuine partnerships between patients, consumers and providers will help to achieve the best possible outcome. Under the provisions of the *Hospital and Health Boards Act 2011*, the service is required to consult with its communities to ensure services are relevant and meet the needs of patients and communities. The establishment of the South West HHS as an independent body provided increased opportunity for engagement with local communities. The South West HHS has numerous established engagement mechanisms through local hospital auxiliaries, support groups, community meetings, workshops, volunteer involvement, partnerships and advisory networks.

The Consumer and Community Engagement Strategy is our guiding document to assist in planning meaningful and transparent engagement with our stakeholders. The service recognises the immense value in consulting with our communities to obtain and provide feedback on services, strategic and planning initiatives and models of care and needs that are specific to each community.

Community Advisory Network (CAN) groups have been established across all sites. Individual CANs meet on a quarterly basis with the chair of each group meeting as a collective with the board on a quarterly basis. The board hosted an inaugural face-to-face CAN forum in September, 2013 at Mitchell. This inaugural meeting set the scene for the development of good working relationships between community members and board members. A second forum was held in St George in June, 2014, which built on the success of the previous forum. These face-to-face forums are essential to forge relationships and allow for networking across different communities that may face similar issues. The forums are also an opportunity to meet with the executive team and foster a collegial approach to healthcare. The relationship between the CANs and the board has matured since the groups were first established. The CANs provide valuable feedback to local facilities at an operational level and provide strategic feedback to the board. The board is also able to tap into local knowledge through the CANs.

The board visited Injune in August, 2013 and Mitchell in September, 2013 for the official opening of Multipurpose Health Services and took the opportunity to meet with community members and facility staff. On occasions, board members attend individual facility CAN meetings to complement their involvement through regular board meetings.

Our organisation

Key priorities 2014–2015

The South West HHS's key priorities for 2014–2015 include:

- Providing person centred care that links patients to the services they require
- Addressing service gaps to concentrate on the burden of disease through partnerships with other health service providers that will increase health awareness and reduce the rates of chronic disease
- Improving systems and processes and reporting against performance measures while working to a sustainable budget
- Undertaking master planning for Roma and Charleville Hospitals
- Reviewing models of service delivery to improve local access to services
- Achieving expectations outlined in the *Blueprint for better healthcare in Queensland* and working in synergy with the Department of Health strategic objectives
- Enhancing engagement and developing closer working relationships with patients, families, community groups, GPs and other primary health providers
- Increasing the use of telehealth services
- Developing an information technology strategic direction for the health service
- Ensuring that services have the necessary activity levels, workforce, infrastructure and resources to make them sustainable.

The six strategic objectives of the South West HHS are:

- **Person centred** – South West HHS will, in all it says and does, put the 'person' in the centre of our planning and delivery of services
- **Quality and safety outcomes in service delivery** – South West HHS will, through continuous improvement, improve our systems and processes to provide safe and high quality health service delivery
- **Governance and leadership** – South West HHS will deliver effective governance, visioning and leadership
- **Financial viability and sustainability** – South West HHS is committed to efficient management of resources to provide and maintain high quality health service delivery through a robust financial management framework
- **Excellence in processes, systems and data** – South West HHS will, through accountability, monitoring, evaluating and actioning continuous improvement in processes, systems and data, achieve improved health outcomes
- **Stakeholder engagement and communication** – South West HHS will engage our stakeholders in partnerships to achieve improved health outcomes through a well planned and executed communication framework.

Our financial performance

Chief Finance Officer's statement

South West Hospital and Health Service (HHS) total revenue for 2013–2014 was $117.7M with the final total expenditure of $115.8M providing a community dividend (or surplus) of $1.9M. This dividend is expected to be invested in capital projects for 2014–2015.

The South West HHS finances performed largely as per expected, which was a strong result.

Cost pressures on the South West HHS continue to be providing a health service in a large remote region of Queensland. Specific issues include specialist recruitment, medical specialist placements and other costs associated with remoteness, including staff and patient travel, support service staff and minimum staffing models in outlying areas of the South West HHS. These areas continue to provide budgetary challenges to the service. A business focus as a component of the decision making process will see continued success in the management of these costs.

Our Financial Position	2014 $'000	2013 $'000
Income from Continuing Operations		
User charges	6,306	6,162
Government funding	100,059	101,994
Grants and other contributions	10,874	9,298
Interest	19	23
Other revenue	451	789
Total revenue	117,709	118,267
Gains on sale of assets	–	33
Total Income from Continuing Operations	**117,709**	**118,300**
Expenses from Continuing Operations		
Employee expenses	1,025	662
Health service labour expenses	66,517	69,087
Supplies and services	41,327	36,426
Grants and subsidies	18	9
Depreciation and amortisation	5,196	4,529
Impairment losses	84	41
Other expenses	1,613	1,526
Total Expenses from Continuing Operations	**115,780**	**112,280**
Operating Results from Continuing Operations	**1,929**	**6,019**

Revenue

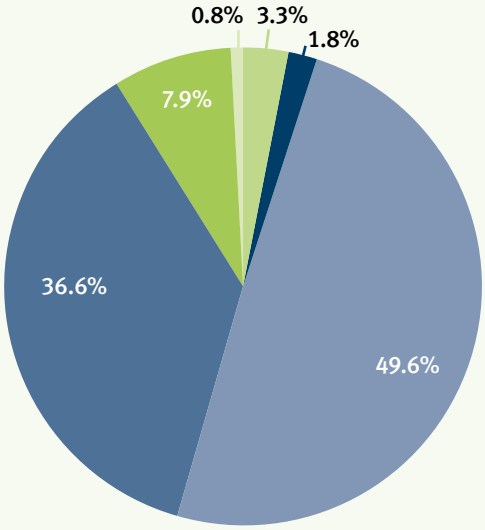
Total Government funding has remained consistent from the prior year to the current year, this included General Purpose and Block funding moving downward of 3%.

The HHS is committed to continuously driving its strategies to increase revenues and further improve and develop its financial strengths.

Block and General Purpose funding increases were due to new services introduced in 2013–2014 including:

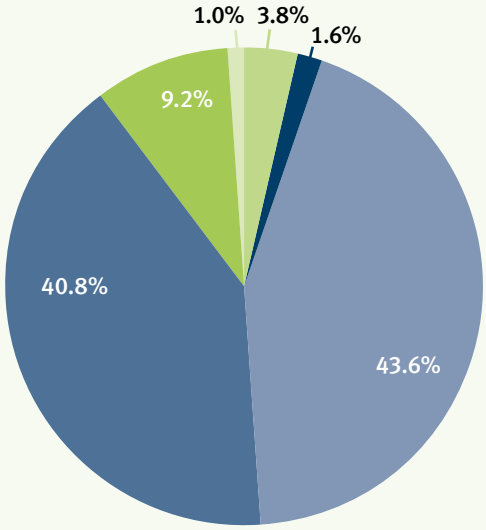
- New Sub-Acute Service at Roma Hospital
- Revitalisation funding to address services at St George and Charleville Hospitals, including increased telehealth services and midwifery
- Increase in Flying Specialist Services
- Backlog Maintenance for four years.

2012–2013 Revenue Stream



- Hospital Fees
- Sale of goods and services
- Block Funding
- General Purpose Funding
- Grants and other contributions
- Other revenue

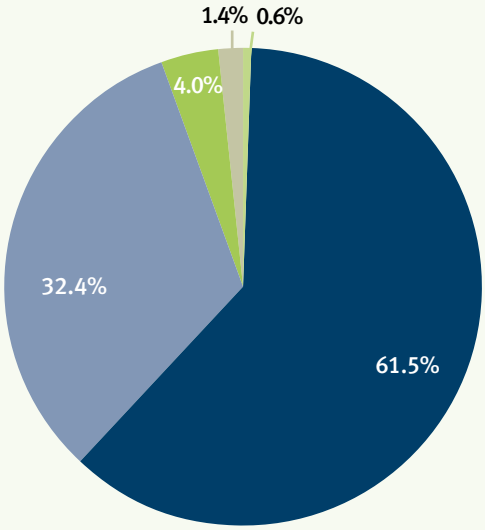
2013–2014 Revenue Stream



- Hospital Fees
- Sale of goods and services
- Block Funding
- General Purpose Funding
- Grants and other contributions
- Other revenue

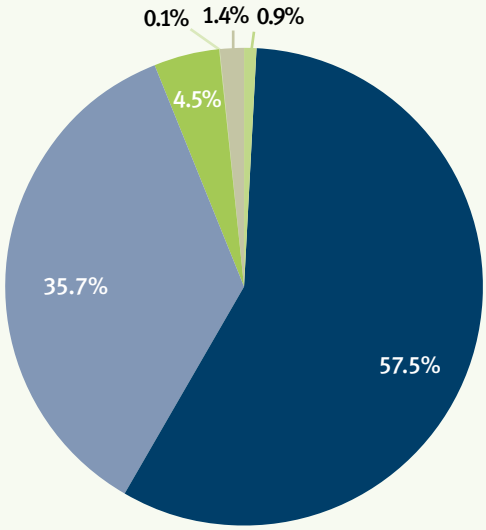
Expenditure

2012–2013 Expenditure Stream



- SWHHS Employee expenses
- Health service labour expenses
- Supplies and services
- Grants and subsidies
- Depreciation and amortisation
- Impairment losses
- Other expenses

2013–2014 Expenditure Stream



- SWHHS Employee expenses
- Health service labour expenses
- Supplies and services
- Grants and subsidies
- Depreciation and amortisation
- Impairment losses
- Other expenses

Our financial performance

Chief Finance Officer's statement

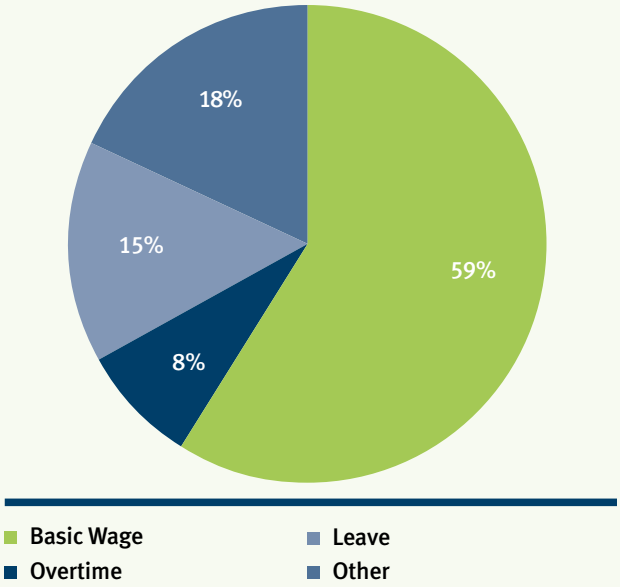
Expenditure remained consistent with 2012–2013, with slight increases in Health Service Labour to accommodate new introduced services.

Labour expenses

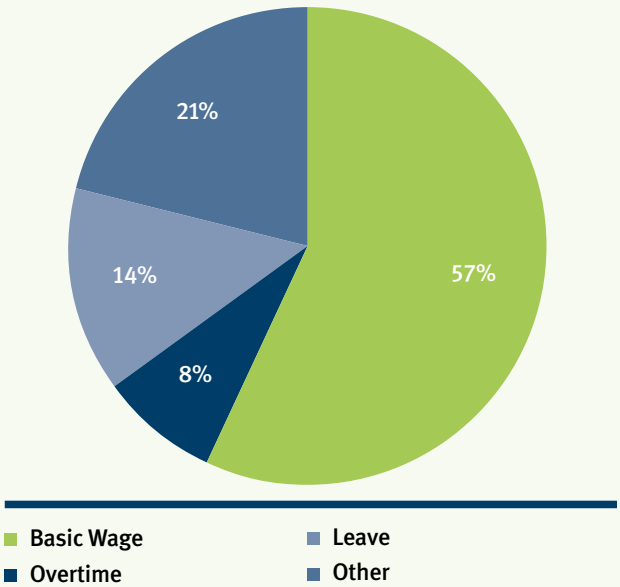
Total employee expenses compared to the prior year are set out below. Overtime, leave and superannuation costs remained relatively constant as a percentage of the total costs.

Through our service agreement arrangements with the Department of Health, South West HHS increased its workforce from 662 (as reported in 2012–2013) to 685 full-time equivalent persons. This increase is due to the new services for sub-acute, Flying Specialist Services, midwifery and telehealth services.

FY14 Health Service Employee Expenses (%)



FY13 Health Service Employee Expenses (%)



Non-labour expenses

Major Components of Supplies and Services

Supply and Services	FY14 (000's)	FY13 (000's)	% Change
Consultants and contractors	14,306	12,276	17%
Patient Travel	6,507	6,297	3%
Repairs and maintenance	4,146	3,199	30%
Clinical Supplies and Services	2,589	2,103	23%
Drugs	1,752	1,006	74%

- Consultants and contractors have increased due to increase in locums, in particular medical staff
- Patient Travel has increased in line with increased allowances approved earlier in the year
- Repairs and maintenance increase is due to new funding for backlog maintenance
- Clinical supplies have been impacted by an increase in purchasing and logistics costs charged
- Drugs have been impacted by increase in pricing and ordering practices. This will settle in 2014–2015.

Financial Controls

Based on the results of my assessment of the South West financial controls and processes for the financial year ended 30 June 2014, it is my opinion that a reasonable assurance can be given that:

- The financial records of South West HHS have been properly maintained throughout the year
- The financial statements for the year are fairly stated.

Significant events after end-of-year

As part of a whole-of-Government initiative, management of employee housing assets transitioned to the Department of Housing and Public Works (DPHW) on 1 July 2014. Legal ownership of housing assets will transfer to the DHPW on 1 July 2014. As at 30 June 2014 South West HHS held assets with a total net book value of $6.4 million under a Deed of Lease arrangement with the Department of Health. These housing assets initially transferred to South West HHS at no cost to South West HHS. Effective 1 July 2014, the Deed of Lease arrangement in respect of these assets will cease, and the assets will be transferred for no consideration to the Department of Health at their net book value as at 30 June 2014, prior to their transfer to the DHPW.

Veronica Chung
A/Chief Finance Officer, South West Hospital and Health Service
29 August 2014

Our performance

Government objectives for the community

The South West HHS is committed to working closely with the Queensland Government to implement the priorities for the Queensland public sector health system as defined in the *Queensland Health Strategic Plan 2012–2016*, the *Blueprint for better healthcare in Queensland* and in the *Statement of Government Health Priorities*.

The *Blueprint for better healthcare in Queensland* sets out four principle themes for the provision of health services in Queensland:

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

The South West HHS has contributed to the government objectives for Getting Queensland Back on Track and has supported the government objectives for the community to:

- Grow a four-pillar economy based on tourism, agriculture, resources and construction
- Lower the cost of living for families by cutting waste
- Revitalise frontline services
- Restore government accountability in government.

As part of Getting Queensland Back on Track, a number of priority actions were identified in the public health sector to meet these objectives. These priorities were:

- Revitalising services for patients
- Reforming Queensland's health system
- Focusing resources on frontline services
- Restoring accountability and confidence in the health system.

The government also established a number of values to guide these outcomes:

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

Other whole-of-government plans/ specific initiatives

The South West HHS has a number of obligations in relation to agreements between the Commonwealth and Queensland Governments. These obligations relate to residential aged care facilities and Aboriginal and Torres Strait Islander health. The Queensland Government has articulated its long-term strategy to eliminate the health gap and to sustain health status improvement for Indigenous Queenslanders in *"Making tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033"*. The South West HHS continues to work to improve health outcomes for Aboriginal and Torres Strait Islander Queenslanders. The South West HHS maintains a number of partnerships with Aboriginal medical services to help improve health service coordination for Indigenous communities. It is also important that culturally responsible health services are delivered. An Aboriginal and Torres Strait Islander Cultural Practice Program is mandatory for all staff to instil them with the knowledge and skills to support culturally capable care.

Mental health and alcohol and other drug treatment services are provided by the South West HHS and these services align with the principles, priorities and outcomes in the *Fourth National Mental Health Plan, Queensland Plan for Mental Health 2007–2017, 2011–2012 Queensland Drug Action Plan and the National Drug Strategy 2010–2015*. The South West HHS, in accordance with the Queensland Government's commitment to building safe and healthy communities, provides numerous programs to minimise alcohol, tobacco and other drug-related health, social and economic harm.

The South West HHS operates within the Health and Hospital Services Performance Framework which is consistent with the National Performance and Accountability Framework, the National Performance Standards, Indicators and Targets for Health and Hospital Services and National Performance Reporting which are designed to improve accountability of services and reporting of performance.

Our Strategic Plan 2013–2017

In line with the Government objectives and priorities, the strategic plan provided a road map for improved performance and enhanced services. The plan included a framework for planning, monitoring and accountability to our communities.

The South West HHS Board developed a four year strategic plan that focused on the whole-of-government's statewide plans, policies and actions to improve health outcomes.

The South West Hospital and Health Service's key priorities for 2013–2014 included:

- Providing person centred care
- Improving systems and processes and reporting against performance measures while working to a sustainable budget
- Undertaking master planning for Roma and Charleville Hospitals
- Reviewing models of service delivery to improve local access to services
- Achieving expectations outlined in the *Blueprint for better healthcare in Queensland* and working in synergy with the Department of Health's strategic objectives
- Enhancing engagement and developing closer working relationships with patients, families, community groups, GPs and other primary health providers
- Telehealth expansion
- Developing an information technology strategic direction for the health service.

Our strategic priorities

A review of the strategic plan was undertaken in early 2013 for the ensuing four-year period. The strategic plan 2013–2017 was developed and aligned to the principal themes contained in the *Blueprint for better healthcare in Queensland*. The core areas for the strategic plan 2013–2017 were: person centred approach; quality and safety outcomes in service delivery; governance and leadership; financial viability and sustainability; excellence in processes, systems and data; and stakeholder engagement and communication. The table below explains the strategies and outcomes:

Strategy	Outcome
Objective 1 – Person centred The South West Hospital and Health Service will, in all it says and does, put the 'person' in the centre of our planning and delivery of services.	
Customer focus Partnering, networking and collaborating with stakeholders to provide effective integrated patient centred care.	• Strategic plan was reviewed and approved by the board at the June 2014 meeting.
Quality human resources Management of strategic requirements through a comprehensive Human Resources Plan.	• Strategic planning well underway for the 2015 transition to a prescribed employer. Supporting models developed. • Human resources key performance indicators were met – Minimum Obligatory Human Response Information (MOHRI) target for 2013–2014. • Improvement in medical recruitment and allied health which includes meeting dental and recruitment targets.
Feedback Engagement in positive dialogue with our patients, staff and partners to produce enhanced health outcomes.	• Quarterly inpatient feedback surveys completed with a 37 per cent return rate. • Alternative electronic measures under consideration on how to assess inpatient feedback. • Successful CAN forums held in Mitchell in September 2013 and in St George in June 2014. • CAN representatives on director of nursing recruitment panels. • Consumer feedback email established.
Planning Delivery of sustainable models of service delivery through planning to ensure a smooth transition through the patient journey.	• Service plan 2014–2018 endorsed by board.

Our performance

Strategy	Outcome
A positive workplace and environment Attraction, retention, development and redesign of a quality, responsive and skilled professional workforce.	• Workforce models reviewed and change-implementation plans initiated. • Working for Queensland Survey undertaken with individual developmental plans initiated and workforce development planning completed for 2014–2015. • Successful workplace awards held in October 2013.
Accessibility of services Safe, timely and appropriate care based on local health needs and changing environments.	• Commencement of the sub-acute service in Roma with visits by specialists from the Princess Alexandra Hospital. Service includes a weekly scheduled telehealth service, as well as physical visits. Extensive publicity about the service has been circulated to providers. • The radiology service review was completed with a new a model of public/private provider partnership fully developed. • Trial underway to develop medical services in rural general practices. • Queensland Country Practice has been engaged to provide a detailed analysis of the community health needs in the South West as part of the program of primary care development. • Funding has also been secured for the development of a primary/community healthcare IT system to allow better planning and delivery of care.
Objective 2 – Quality and safety outcomes in service delivery The South West Hospital and Health Service will, through continuous improvement, improve our systems and processes to provide safe and high quality health service delivery.	
Actioning the Quality and Safety Plan Provision of quality health services through continuous improvement in processes, practices, policies, culture, research, training and development.	• Most applicable tier 1 KPIs achieved. • Statewide bedside safety audit was undertaken with the majority of indicators performing more favourably than statewide results by more than 10 per cent. • Use of telehealth services continued to increase. • Telehealth Emergency Management Support Unit (TEMSU) rollout and use. • Quality and safety scorecard used to provide feedback on internal audit recommendation progress and external audit action plan progress. • Quality meetings with Executive Management Team (EMT) held on a regular basis.
Actioning facility/unit operational plans Provision of safe, timely and appropriate care.	• Progress against plans tracked through performance management meetings between directors of nursing and the executive.
Meeting key performance indicators (KPIs) Achievement of continuing accreditation of all services and meeting key performance indicators.	• South West HHS is achieving most applicable tier 1 KPIs. KPIs not met since becoming a statutory body are advertising and consultancies 20% savings. These KPIs cannot be met due to imposed audits and attraction and retention of staff.
Objective 3 – Governance and leadership The South West Hospital and Health Service will deliver effective governance, visioning and leadership.	
Board composition skills and development Execution of best practice governance to demonstrate accountability and transparency.	• Compliance achieved for occupational health and safety audit and food safety audits. • Internal audits commissioned on priority areas, including: credentialing and clinical privileges; contract management; asset management; budget management; legislative compliance framework; and development of a structured Chief Financial Officer Assurance Statement.

Strategy	Outcome
Continued education and skill development Providing training and educational opportunities to enhance the skills of our staff.	• Improved workforce development planning processes combined with training needs analysis feedback has resulted in a comprehensive district-wide training calendar being produced.
Risk management Identification, management and evaluation of risks.	• Risk Management Coordinator position approved on a temporary basis within the office of the chief executive. • Significant progress with development of risk reports to the board.
Performance management Management of services and activities in accordance with the performance management framework.	• Establishment of 3-on-3 meetings with all facilities every quarter. • Localised KPIs and reference to some KPIs from the service agreement have been implemented.
Compliance Ensuring systems and processes are in place to meet all regulatory requirements.	• Business capability review completed. • Compliance framework, policies and procedures under review. • Service agreement entered into with the Department of Health as a requirement of the *National Health Reform Agreement (NHRA)*. • Compliance with the *Financial Accountability Act 2009*.
Innovation Supporting and encouraging innovation, leadership and collaboration.	• Collaboration by EMT on areas that cross traditional boundaries, such as medical, nursing and allied health, to develop an integrated paediatric service and a sub-acute rehabilitation service. • A maternity review is scheduled to commence.
Workplace culture Promotion and encouragement of a workplace culture based on organisational values.	• Queensland Health workplace survey recently conducted and closed on 30 May, 2014.
Good industrial relations Building positive relationships with stakeholders and partners, such as unions, to develop a flexible, productive and sustainable workforce.	• Industrial disputes trending down and reports provided to EMT and board.
Objective 4 – Financial viability and sustainability The South West Hospital and Health Service is committed to the efficient management of resources to provide and maintain high quality health service delivery through a robust financial management framework.	
Effective business planning Delivery of cost-effective and sustainable services through the development of evidence-based practice and procedures.	• Financial and workforce performance reporting is distributed to facility/program/service managers on a monthly basis for analysis and review. • Formal monitoring of performance is by exception via performance management meetings held quarterly or more regularly, dependent on performance.
Ongoing financial skills development and literacy Providing training opportunities to enhance the skills of our staff.	• Training plans have been updated and will be circulated for consultation in the first quarter of 2014–2015.
Asset management Advocating for infrastructure needs and undertaking measures that meet organisation needs for effective and efficient use and maintenance of assets.	• 2014–2015 Annual Maintenance Plan developed, submitted to, and approved by Health Infrastructure Branch prior to 30 June 2014.
Purchase management Ensuring value for money.	• Health Information Manager employed and a review of clinical data integrity is being conducted. There are some favourable and unfavourable activity variances and these are being investigated to realign activity targets in the service agreement.

Strategy	Outcome
Inventory and stock Ensuring appropriate stock controls.	• Limited inventory levels are held, with the exception of drugs and clinical supplies. • In 2013–2014, minimum quarterly drug inventory stocktakes were conducted across all facilities to ensure appropriate review and monitoring of inventory management controls.
External reporting Providing statutory and non-statutory reporting of government and non-government bodies in accordance with required timeframes.	• 2012–2013 annual report completed and published in accordance with legislative requirements. • 2012–2013 annual financial statements – unqualified opinion.
Internal reporting Ensuring robust internal reporting arrangements are in place to support timely and accurate decision making.	• Governance processes in place to ensure that reports are submitted to and monitored by the relevant committee.
Service agreement Ensuring services are delivered and targets are achieved in accordance with the service agreement.	• Quarterly meetings with the Department of Health to discuss performance against KPIs reported in the dashboard. • Performance on track.
Benchmarking Establishment of meaningful and measurable benchmarks for services and the development of capacity, experience and knowledge to meet best practice benchmarks.	• Monthly dashboard reports received from the Department of Health are tabled with the board for review.
Balanced budget Development of a financially sustainable organisation and a culture of accountability.	• Achievement of a balanced budget for 2013–2014. • Late allocation of funding for revitalisation, backlog maintenance, telehealth, dental, and clinical redesign has created some challenges in being able to complete projects.
Objective 5 – Excellence in processes, systems and data The South West Hospital and Health Service will, through accountability, monitoring, evaluating and actioning continuous improvement in processes, systems and data, achieve improved health outcomes.	
Processes and systems Developing and refining processes and systems to obtain accurate and quality data.	• Quality and safety scorecard has been in use for both 3-on-3 performance meetings and reporting to the board. • Utilisation of QIS2 by the service improvement team and quality and safety. Education in QIS2 provided to other staff for tracking procedures, work instructions, internal audits and external audit action plans.
Reporting Providing timely and meaningful reports to support decision making and monitoring and evaluating performance.	• Governance processes in place to ensure that reports are submitted to and monitored by the relevant committee.
Records Maintaining effective record-keeping processes.	• Review of records management procedures undertaken to incorporate both administration and clinical records.

Strategy	Outcome
Information technology Monitoring progress of approved information technology systems, upgrades and enhancements through the development of an Information Technology Plan and advocate for funding to implement new information technology systems.	• Development of an ICT strategic plan commenced and will be finalised in the 2014–2015 financial year.
Objective 6 – Stakeholder engagement and communication The South West Hospital and Health Service will engage our stakeholders in partnerships to achieve improved health outcomes through a well planned and executed communication framework.	
Sound communication with our consumers Development of sound communication networks to engage and work with all stakeholders in a respectful and open way to produce better health care outcomes.	• Communication plan developed and will be finalised in the 2014–2015 financial year.
Improving health literacy Improving the levels of community health literacy to enable consumers to be engaged in enhancing health outcomes.	• A number of collaborative initiatives aimed at increasing health literacy have been implemented by the Community and Allied Health Team. • Collaborative partnerships with the Department of Communities e.g Healthy Ageing Charleville and the Darling Downs and South West Queensland Medicare Local to deliver programs e.g. healthy living, diabetes awareness and neonatal nutrition. • Other health literacy initiatives included: child health, immunisation and new parent café. • 'Waist Watchers' support group established and committed to informing people about the value of reducing weight and its impact on reducing cardiovascular and type 2 diabetes risk. Healthy hearts promoted by the Heart Foundation Walking Group and clients educated on the need for exercise and dietary programs to reduce health risks.
Cultivating partnerships with our community Cultivating partnerships through positive engagement to make better decisions and result in enhanced health outcomes.	• Consumer and Community Engagement Strategy reviewed and will be finalised in the 2014–2015 financial year. • Community Advisory Networks (CANs) established for all facilities across the South West. • Successful CAN forums held in Mitchell in September 2013 and St George in June, 2014.
Engagement of our staff Engaging and empowering our workforce in the South West Hospital and Health Service.	• Workforce models reviewed and change implementation plans initiated. • Working for Queensland Survey undertaken with individual developmental plans initiated and workforce development planning completed for 2014–2015. • Successful workplace awards held in October 2013.
Utilising the media, publications, signage and web Improving dissemination of public information.	• Media officer appointed and increases in media releases. • Signage review undertaken and work commenced on the upgrading of facility signage. • Intranet enhanced.

Our performance

Performance management

The South West HHS operates within the Performance Management Framework for Queensland Hospitals and Health Services. This is a robust system for the reporting and monitoring of performance information and ensures the service is locally accountable for the delivery of the services and obligations outlined in their service agreement with the Department of Health. The framework aligns expectations and key performance indicators to statewide and Commonwealth plans. The framework is a supporting document to the service agreement between the South West HHS and the Department of Health, and sets out how performance will be managed. Meetings are regularly held with the Department of Health to discuss progress and a regular report is produced demonstrating performance against the indicators and targets set out in the service agreement.

As a commitment to continue to drive performance, the service developed a Performance Management Framework relating to activity performance, budget performance and quality of patient care and outcomes. This framework involves a system of reporting performance against specified key performance indicators (KPIs) tailored to programs and facilities. The framework provides linkages between clinical, quality, financial performance, workforce management and effective governance.

Performance domains

The service agreement is underpinned by a legislative framework between the Department of Health and the South West HHS. It is the primary vehicle through which the Department of Health manages the performance of the service and holds it to account.

This service agreement defines the extent of public hospital and other services to be provided; the funding to be provided to the service for the provision of services; and it establishes the performance indicators and benchmarks that will be measured to ensure outcomes are achieved. It also provides a platform for greater public accountability and ensures State and Commonwealth priorities, services, outputs and outcomes are achieved.

The key performance indicators used to monitor the extent to which the service is delivering the objectives set out in the service agreement are identified under the following performance domains:

- Safety and quality
- Access
- Efficiency and financial performance.

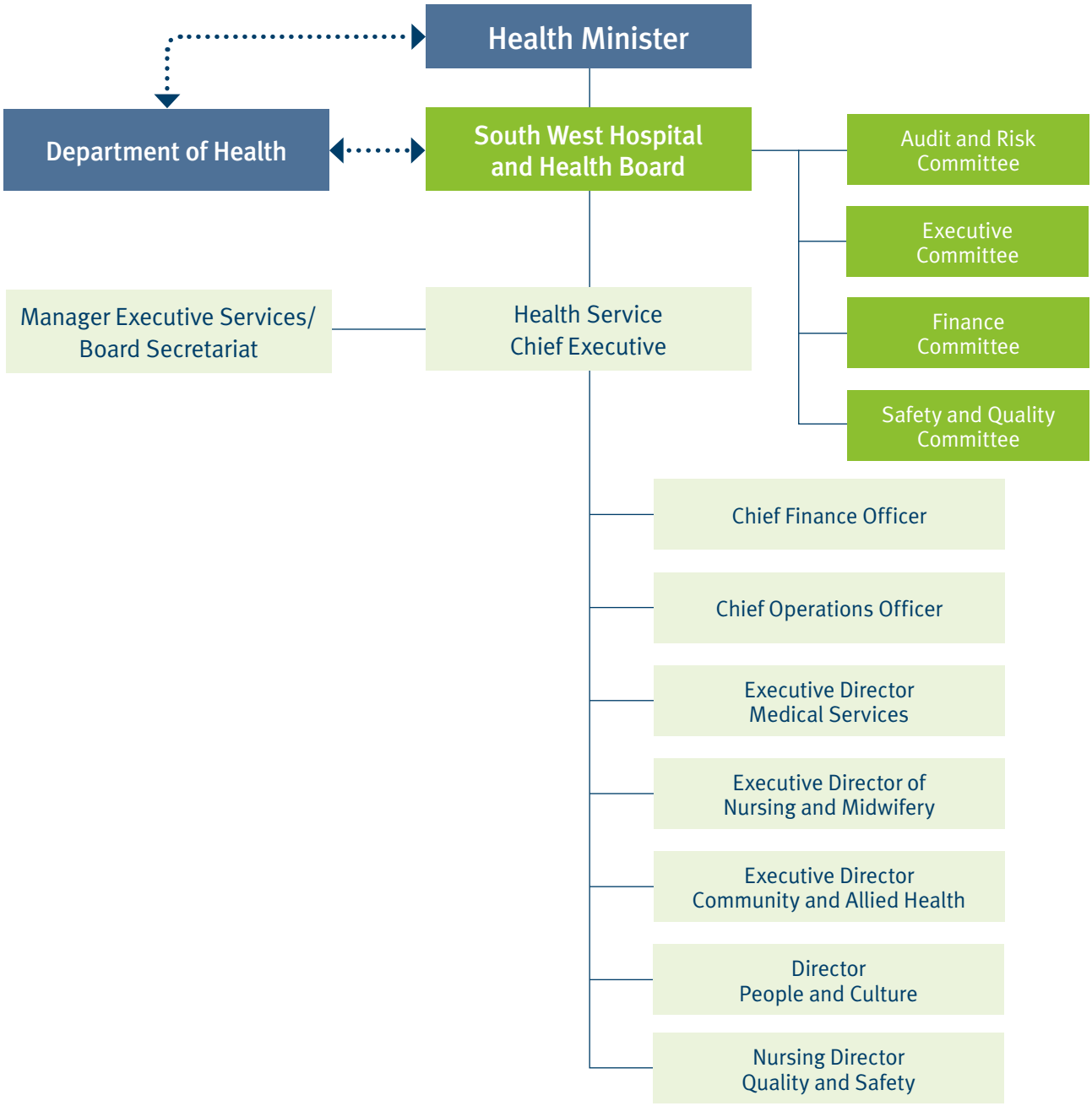
KPI	Key Performance Indicator (KPI)	Target	Result	Comments
Effectiveness – safety and quality				
1.1	National Safety and Quality Health Service (NSQHS) Standard Compliance	All actions met	On target	Re-accredited in 2014 against NSQHS and ISO Standards
2.1	Healthcare associated infections Healthcare associated staphylococcus aureus (including MRSA) bacteraemia	Rate is ≤ 2.0 per 10,000 occupied bed days	Nil reported	Based on information available
Equity and effectiveness – access				
2.9	Postnatal in-home visiting Enhanced maternal and child health service with postnatal in-home visiting	≥ 85% of HHS specific target of 402 visits	249% average	Based on information available
2.10	Aboriginal and Torres Strait Islander potentially preventable hospitalisations	≤ 17.7 (Queensland average for Aboriginal and Torres Strait Islander potentially preventable hospitalisations for the period July 2012 – March 2013)	20.8 average	Leading conditions: cellulitis and diabetes complications

KPI	Key Performance Indicator (KPI)	Target	Result	Comments
2.11	Potentially preventable hospitalisations – chronic conditions	≤ 4.9 (Queensland average for the period July 2012 – March 2013)	5.1% average	Based on information available
2.12	Aboriginal and Torres Strait Islander discharge against medical advice Aboriginal and Torres Strait Islander patients who discharge themselves against medical advice (DAMA)	Jul to Sep 2013 ≤ 4.6% Oct to Dec 2013 ≤ 3.6% Jan to Mar 2014 ≤ 2.6% Apr to Jun 2014 ≤ 1.6%	2.9% 5.7% 2.7% 8.3%	Work is progressing with communities and staff to improve in this area
2.13	Aboriginal and Torres Strait Islander low birth weight babies Low birth weight babies (weighing less than 2500g at birth) born to Aboriginal and Torres Strait Islander women	≤ 8.4%	5.4% average	Based on information available the South West HHS has the second lowest rate across Queensland of babies born of low birth weight to Aboriginal and Torres Strait Islander women
2.14	Rate of post-discharge community contact Rate of community follow up within one to seven days following discharge from an acute mental health inpatient unit	≥ 60%	63.4% average	Based on information available
2.15	Ambulatory mental health activity Progress towards duration of ambulatory mental health services contracts annual target	≥ 95%	104% average	Based on information available
Efficiency – efficiency and financial performance				
1.6	Full year forecast operating position (agreed position between the Department of Health and the South West HHS)	Balanced or surplus	Small surplus	Based on information available
2.19	External labour Expenditure on locum and agency staff	20% reduction on 2011–2012	6.7% increase	Medical locum use is a contributing factor
1.7	Purchased activity monitoring Variance between year to date (YTD) purchased activity and actual activity	0% to +/-2%	-2.5%	Work is progressing to improve data collection and reporting
2.21	YTD Minimum Obligatory Human Resource Information (MOHRI) full time equivalent (FTE) MOHRI FTE – number of MOHRI YTD	HHS specific target of 700 as identified in schedule two	685 at June 2014	Locums are filling a number of vacant medical positions
2.22	WorkCover absenteeism Hours lost (WorkCover) vs occupied FTE	0.40	0.44 as at June 2014	

* Information based on available data, averaged over the 12 months between July 2013 and June 2014.

Corporate governance

Good governance is fundamental to achieving outcomes by setting up effective mechanisms and moving beyond compliance to focus on the achievement of objectives. Governance encompasses the framework of processes, policies and systems by which we are directed, controlled and held to account. Governance occurs through various mechanisms, including the organisational structure and culture, policies, processes for delegating authority, and governance committees and their respective responsibilities and authority.



Our board of management

The South West HHS Board is an independent statutory body appointed by the Governor-in-Council with a significant role in providing astute leadership, strategic direction, a client focus, financial accountability, ethical behaviour and effective planning. The board is a professional skills-based board with members that possess skills and expertise in health management, primary health care, clinical areas, business management, financial management, compliance, legal, and knowledge of consumer and community issues.

The board is responsible for setting the strategic direction for the service and, with the Chief Executive, will be accountable for its performance. The Chief Executive is appointed by the board and reports to the board. The board has responsibility for the delivery of hospital and health services in accordance with the terms of the service agreement.

The board is legally accountable for the South West HHS's operations and sets the policies to guide the service to achieve objectives. Advice and recommendations are provided by the Chief Executive on key strategic issues. The Chief Executive has a number of core responsibilities, including service planning and delivery, governance, risk management and compliance and performance and reporting. The board has judicious monitoring systems in place to monitor performance. The board operates in accordance with its terms of reference and business rules and is accountable to the Minister for Health.

The term of the board appointed on 18 May, 2013 ended on 17 May, 2014. The same members, with the exception of Dr Julia Leeds and Sheryl Lawton, were reappointed and two new members, Dr John Scott and Fiona Gaske, joined the board from 18 May 2014.

Name	Office	Number of monthly meetings attended	Percentage attendance (since appointment commenced)	Previous term of appointment	Current term of appointment
Michael Cowley	Member	11	92%	18.05.2013 – 17.05.2014	18.05.2014 – 17.05.2015
Fiona Gaske	Member	2	100%		18.05.2014 – 17.05.2015
Lindsay Godfrey	Chair	12	100%	18.05.2013 – 17.05.2014	18.05.2014 – 17.05.2017
Heather Hall	Member	11	92%	18.05.2013 – 17.05.2014	18.05.2013 – 17.05.2017
James Hetherington	Member	11	92%	18.05.2013 – 17.05.2014	18.05.2014 – 17.05.2017
Lyn Kajewski	Member	12	100%	18.05.2013 – 17.05.2014	18.05.2014 – 17.05.2015
Dr Julia Leeds *(Leave of absence from 11.11.2013 – 17.05.2014)*	Chair	4	40%	18.05.2013 – 17.05.2014	
Sheryl Lawton	Member	6	60%	18.05.2013 – 17.05.2014	
Richard Moore	Member	11	92%	18.05.2013 – 17.05.2014	18.05.2014 – 17.05.2017
Karen Prentis	Member	12	100%	18.05.2013 – 17.05.2014	18.05.2014 – 17.05.2017
Dr John Scott	Member	1	50%		18.05.2014 – 17.05.2015

Corporate governance

The board meets on a monthly basis and its usual place of meeting is Roma. During the 2013–2014 year there were 12 board meetings. A number of extra-ordinary meetings were also held to discuss specific issues. Board decision making is supported by board briefing papers and a number of standing items are on board agendas, such as risk, compliance and community engagement. The Chief Executive along with the Chief Operations Officer (COO) and Chief Finance Officer (CFO) attend all board meetings. On occasions, executive members are invited to be present to provide further explanation and clarification to the board on matters specific to their portfolios.

During the year, the board also invited guests from the Department of Health to provide presentations. This included Nick Steele, Executive Director Healthcare Purchasing and Funding; Colleen Jen, Senior Director Policy and Planning, who addressed the board on funding and activity, the Performance Management Framework and the Rural and Remote Health Service Framework; and Mark Davey, Executive Director, Contestability Branch, who provided a presentation on contestability matters.

The Minister for Health, the Honourable Lawrence Springborg met with the board when the Mitchell Multipurpose Health Service extension was opened on 24 September 2013.

During the year, the board approved a Board Education and Training Development Policy. The board recognises that it is important that education and training is provided to support board members in their roles. It is acknowledged that board members bring a wide range of knowledge, experience and valuable skills when they are appointed to the board and these skills can be enhanced with additional knowledge that is specific to their roles and responsibilities. This aims to assist them in making decisions in the best interests of users of the public health service and to achieve strategic and corporate governance objectives.

Above (from left to right): Richard Moore, James Hetherington, Karen Prentis, Dr John Scott, Lyn Kajewski, Lindsay Godfrey, Fiona Gaske, Michael Cowley and Heather Hall.

Corporate governance

Board member profiles

Lindsay Godfrey

Board Chair

Mr Lindsay Godfrey is the Mayor of the Paroo Shire Council and an experienced South West Queensland grazier. Mr Godfrey is a dedicated and committed community member, serving on many industry and local groups and committees.

Mr Godfrey is a wool and beef producer from Tinnenburra, 100km south of Cunnamulla. Mr Godfrey and his wife Carol have been trading as Tinnenburra Pastoral Company since 1980. Their family company currently operates a diverse range of property and farm related assets over a wide area. He was awarded the Diligent and Ethics Service Medal in 2014.

Over the past years, Mr Godfrey has participated in a large number of industry, commercial and club positions, including Mayor of the Paroo Shire Council (2013 – current); Chair of South West Regional Economic Development Board (2013 – current); Board of Wideland Insurance (1999 – 2005); Ministerial appointment to Wool Working Party to manage Woolpoll 2000 (1999 – 2000); Ministerial appointment to Woolgrower Advisory Group to restructure A WRAP/ The Woolmark Co (2000); Agforce Executive (1999 – 2000); Founding President of Agforce Sheep and Wool Ltd (1999 – 2000); Wool Council of Australia Executive (1999 – 2000); Final Senior Vice President of the UGA (1998 – 1999); South West Strategy Representative (1996 – 1999); Inaugural Chairman of South West Strategy Natural Resource Management Group (1998 – 1999); Fire Warden Kungie Fire Brigade (1990 – current); President Cunnamulla Polocrosse Club (late 1980s); and Regional Economic Development Officer Paroo Shire Council (early 1990s).

Mr Godfrey has a Bachelor of Business (Economics and Ethics) from the University of Southern Queensland and has attended the Australian Rural Leadership Program (Course 4), and is a member of the Australian Institute of Company Directors.

Michael Cowley

Board member

Mr Michael Cowley is a St George local and Director of Fox and Thomas Business Lawyers. He has spent more than 15 years advising individuals, business and the rural sector on legal issues. Mr Cowley understands and appreciates the legal issues which affect rural communities and businesses, and particularly agribusiness sectors. He is a recognised leader in western Queensland on legal issues around water rights and entitlements.

Mr Cowley is one of three directors of Fox and Thomas and is the director in charge of the St George office.

His practice covers a wide range of legal issues, with particular expertise in the areas of rural property and water entitlements, business structuring and succession and estate planning.

He has served on the South West HHS Board for two years and is a member of the Queensland Law Society, New South Wales Law Society, Downs and South West Queensland Law Association and Law Australia.

Mr Cowley has a Bachelor of Commerce and Bachelor of Laws (BCom/LLB).

Corporate governance

Board member profiles

Fiona Gaske

Board member

Ms Fiona Gaske is a councillor for Balonne Shire Council and an active member of the St George community. She is a passionate advocate for public health services and the arts in rural areas. Ms Gaske served as the chair of the St George Community Advisory Network (CAN) for two years from its inception in 2012.

She was elected as a councillor in 2012 and maintains a diverse range of portfolios including: public health; arts and culture; information technology and libraries; and parks and gardens. Ms Gaske also chairs the local Regional Arts Development Fund committee as part of her responsibilities as a councillor.

From 2008 until 2013, Ms Gaske worked as a speech pathologist in the St George Primary Health Care Unit. She has also worked as an allied health coordinator in a rural setting and as a speech pathologist at the Royal Brisbane and Women's Hospital.

Ms Gaske holds a Master of Speech Pathology Studies and a Bachelor of Music. She received a Merit-based Postgraduate Equity Scholarship and a Dean's Commendation for High Achievement while at university.

Heather Hall

Board member

Ms Heather Hall has extensive experience working in the healthcare sector for community and government organisations in the South West. During her career, Ms Hall has been recognised for her outstanding service to outback communities and for excellence and innovation in her field.

Ms Hall has over twenty years' experience working in community healthcare. She is currently the Community Services Manager for Anglicare South Queensland Rural and Remote — a position she has held for 12 years. Previously, she worked as Clinical Nurse and Acting Clinical Nurse Coordinator at Roma Hospital, and as a Community Nurse for Blue Care in Roma.

Ms Hall has extensive experience in high level advisory and board positions. She is also a board member for the South West Partnership Council and a member of the Surat Basin Workforce Council. Ms Hall has held the positions of South West Board member for Connecting Health Care in the Community, a non-GP board member for R Health, and board member for Enable Care Services. Ms Hall has received the Anglicare Australia Excellence and Innovation Award for Outstanding Service in the Outback in 2002 and was a finalist in the Management Excellence Awards for Rural and Remote Manager of the Year in 2010.

Ms Hall holds a Bachelor of Health Science in Nursing, Certificate in Chemotherapy Nursing, Diploma of Business Management, Certificate of Palliative Care and a General Nursing Certificate. She recently completed a Graduate Diploma in Business Management.

Ms Hall has performed various roles in Zonta from general membership to President of the Roma Club and Area 4 Director. She was recently nominated to chair the Amelia Earhart Zonta International Scholarship Award Committee for District 22 and is currently the secretary of the Roma Rednecks Mud Racing Club.

James Hetherington
Board member

Mr James Hetherington is a highly respected and experienced South West Queensland grazier. He is also a dedicated and committed community member, serving on many local Dirranbandi and district advisory groups and committees.

Mr Hetherington began his career after completing a Bachelor of Commerce degree at the University of Queensland in 1979. He worked at the Australian Tax Office for the following two years, first as a provisional taxation clerk before being promoted to taxation assessor in 1980.

In 1981, Mr Hetherington was appointed property manager of Nindi-Thana, one of his family's properties, and assisted with the finance, accounting and wool marketing responsibilities for the family group.

The family's agricultural business is involved in wool, fat lamb, cattle and broad acre dry land winter crop production over an aggregated 73,000 acres within the Balonne Shire. Mr Hetherington was appointed director of the business in July, 1999 and officially assumed the finance director and secretary positions, with full responsibility for its finance, accounting and wool marketing.

Mr Hetherington is currently Finance Director and Secretary of J W Hetherington Pty Ltd. As well as running his family's business venture, Mr Hetherington is also heavily involved in his local community and health services and is an active member of many organisations in the South West.

Lyn Kajewski
Board member

Ms Lyn Kajewski has played a strong community role in Roma, South West Queensland. She is an experienced local councillor and previously held the position of Deputy Mayor of Roma Town Council.

Between 2000 and 2004, Ms Kajewski served on Roma Town Council as a Councillor responsible for ambulance, tourism and the Murray-Darling Basin. She served as Deputy Mayor between 2005 and 2008, when the town of Roma was merged with the shires of Bendemere, Booringa, Bungil and Warroo to become the Roma Regional Council. From 2009, the new council became known as the Maranoa Regional Council.

Ms Kajewski's commitment to rural Queensland is demonstrated by the key role she has played in many community projects, including as Chairperson of Church Council (Maranoa Uniting Church, Australia); Chairperson of Easter in the Country Inc; Chairperson of Roma Tourism; Chairperson of the Sustainable Cypress Management Group; member of St John's Parents and Friends; Treasurer of Play Group (Roma); member of Local Ambulance Committee; member of the Roma Day Surgery Centre Committee; member of the Maranoa Combined Christian Churches Flood Appeal (2012); Student Coordinator of the World Education Program (Roma); member of the Mitchell Early Childhood Education Centre; and member of the Maranoa Regional Council Airports Advisory Committee.

Ms Kajewski's contribution to the rural community and industry was formally recognised when she received the Roma Community Award for Contributions to Rural Industry. She was a state winner and national finalist in the Timber Communities of Australia, and was Roma's 2010 Citizen of the Year.

Corporate governance

Board member profiles

Richard Moore
Board member

Mr Richard Moore is a well-regarded expert in the areas of strategic planning, governance, marketing and promotion, and stakeholder engagement. He is a skilled professional with strong analytical, conceptual and implementation skills that have been applied across his wide networks and relationships at all levels of government and industry.

Richard Moore is the Queensland and Pacific Manager at the Australian Institute of Company Directors, the peak body for directors which offers education and professional development, director specific information services, and representation of directors' interests to government and the regulators. He has held this position since 2004.

Mr Moore started his career as a Geological Data Engineer in the oil and gas industry. He has more than 25 years experience in general management in Australia and overseas, including over 20 years in senior management positions.

Mr Moore is a graduate of the AICD Company Directors Course and the Harvard University Corporate Governance program. In addition to his executive role, he is currently a non-Executive director of the Townsville-Mackay Medicare Local Board.

Directorships previously held include: GP Partners – Brisbane North Division of General Practice; Cystic Fibrosis Queensland; Queensland Private Enterprise Centre Inc.; and Defence Reserves Support Council.

Karen Prentis
Board member

Ms Karen Prentis has over 30 years of experience in the financial services industry, including senior executive roles in commercial banking, corporate services and funds management. Ms Prentis' breadth of experience has spanned the private and public sectors, with a strong emphasis on corporate governance and the development and monitoring of compliance structures for organisations.

After early career appointments in the banking sector and Queensland Treasury, her focus and expertise developed predominantly in the area of corporate governance, compliance and risk management. She gained significant industry experience in senior executive positions with listed entities in the financial services industry. Her motivation and commitment to strengthening the framework of corporate governance in Australia is evidenced by her leadership in establishing the Independent Compliance Committee Members Forum (ICCMF) in Brisbane to help guide and facilitate issues that affect the financial services industry.

Ms Prentis is an executive and external director with extensive experience in providing leadership in the development of strong corporate governance and risk management and developing and monitoring compliance structures for public and private organisations, including companies with financial services registered with ASIC.

Prior to her appointment with the South West Hospital and Health Service Board, her cross-sector expertise saw her appointed to a number of positions including her current appointments as Chair of the Independent Compliance Committees for the Australian Property Growth Fund Ltd and Cromwell Property Securities Ltd (and subsidiaries). In addition, she is also an independent member of Department of Education, Training and Employment's Audit and Risk Committee.

Ms Prentis' previous appointments include Chair of the Funds Management Committee for the Queensland Trust for Nature and Compliance Committee Member for QInvest.

Ms Prentis has a Bachelor of Economics from James Cook University and a Master of Administration from Griffith University Brisbane, where she was awarded the Griffith University Postgraduate HECS Award.

Dr John Scott
Board member

Dr John Scott is a Brisbane-based doctor who has worked extensively as a general practitioner, in managerial roles in the public health service, and for a short time as a tertiary educator. He brings a wealth of medical, managerial and fiscal skills and experience to the South West Hospital and Health Service Board.

Dr John Scott graduated from the University of Queensland with a Bachelor of Medicine, Bachelor of Surgery in 1976. He holds a Bachelor of Economics, which he received from the University of New England in 1994. In 1994, he also graduated from the Australian National University with a Master of Applied Epidemiology. Dr Scott also holds Fellowships of the College of General Practitioners and the Faculty of Public Health Medicine of the Royal Australasian College of Physicians.

In the years from January 2008 to the present, Dr Scott has worked in general practice and as a locum doctor at various health services across Queensland and New South Wales, including Bamaga, Brewarrina, Fortitude Valley, Clermont, Cunnamulla, Surat and in the Brisbane CBD.

Dr Scott was responsible for establishing a Centre for Young People's Health while he was an Associate Professor at the Health Sciences Faculty at the University of Queensland during 2006 and 2007.

From 1995 to 2005, Dr Scott held senior roles with Queensland Health, including Deputy Director-General, Senior Executive Director of Health Services, State Manager of Public Health Services and Director of the Communicable Diseases Branch, among other positions.

Prior to these roles, Dr Scott worked in general practice at Ingham in North Queensland, and for a short time with the Royal Flying Doctor Service in Cairns. He completed his training as a General Practice Registrar at Toowoomba Hospital in 1979 and 1980 and during that time was awarded the Diploma of Obstetrics from the Royal Australian College of Obstetrics and Gynaecology.

In 2004–2005 Dr Scott was awarded the Sidney Sax Medal of the Public Health Association of Australia.

Dr Scott is passionate about public health medicine, health administration, rural and remote general practice and community health.

Board remuneration

The Governor-in-Council approves the remuneration arrangements for board chairs, deputy chairs and members. Chairs, deputy chairs and members are paid an annual salary consistent with the government policy titled: *Remuneration of Part-time Chairs and Members of Government Boards, Committees and Statutory Authorities*. The South West HHS is classified as a C1, which is the rural basis. It takes into consideration operational budget, diversity of operations, communities served, complexity of services provided, volume of business, bed numbers and workforce numbers. Details on remuneration for the reporting period for each individual board member can be found in the notes to the financial statements on Page 5-42.

Board governance committees

The Hospital and Health Boards Act 2011 and supporting *Hospital and Health Regulation 2012* requires the board to establish a range of committees to assist in carrying out its responsibilities. The board has established four committees to assist it in carrying out its responsibilities.

The committees are:

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

The board committees make recommendations to the board. Each committee operates within its terms of references, including applicable business rules approved by the board. Minutes of all committee meetings are provided to the board and recommendations are submitted for board consideration, endorsement and approval. Evaluation of committee performance was undertaken in November, 2013.

Corporate governance

Audit and Risk Committee (01.07.2013 – 27.10.2013)

Committee purpose: Independent assurance and assistance on risk, control and compliance frameworks; and external accountability requirements

Number of board members 2	*Number of non-board external members* 1
Board members: • Karen Prentis (Chair) • Richard Moore	**Non-board members:** • Lesley Lalley
Frequency of meetings *Quarterly** 1	*Number of meetings held 2013–2014* 2

Audit and Risk Committee (28.10.2013 – 17.05.2014)

Committee purpose: Independent assurance and assistance on risk, control and compliance frameworks; and external accountability requirements

Number of board members 6	*Number of non-board external members* 1
Board members: • Karen Prentis (Chair) • Michael Cowley • James Hetherington • Lyn Kajewski • Sheryl Lawton • Richard Moore	**Non-board members:** • Lesley Lalley
Frequency of meetings *Quarterly** 1	*Number of meetings held 2013–2014* 3

Audit and Risk Committee (18.05.2014 –current)

Committee purpose: Independent assurance and assistance on risk, control and compliance frameworks; and external accountability requirements

Number of board members 5	*Number of non-board external members* 1
Board members: • Karen Prentis (Chair) • Michael Cowley • James Hetherington • Lyn Kajewski • Richard Moore	**Non-board members:** • Lesley Lalley
Frequency of meetings *Quarterly** 1	*Number of meetings held 2013–2014* *1*

Executive Committee

Committee purpose: Governance responsibilities, strategic planning, service agreement and engagement strategies

Number of board members 9	*Number of non-board external members* 0
Board members: Full Board	**Non-board members:**
Frequency of meetings *Quarterly** 2	*Number of meetings held 2013–2014* 12

Finance Committee (01.07.2013 – 17.05.2014)

Committee purpose: Financial position

Number of board members 4	*Number of non-board external members* 1
Board members: • James Hetherington (Chair) • Michael Cowley • Sheryl Lawton • Lyn Kajewski	**Non-board members:** • Lesley Lalley
Frequency of meetings **Quarterly**	*Number of meetings held 2013–2014* 3

Finance Committee (18.05.2014–current)

Committee purpose: Financial position

Number of board members 5	*Number of non-board external members* 1
Board members: • James Hetherington (Chair) • Michael Cowley • Lyn Kajewski • Richard Moore • Karen Prentis	**Non-board members:** • Lesley Lalley (non-board member)
Frequency of meetings **Quarterly**	*Number of meetings held 2013–2014* 1

Safety and Quality Committee (01.07.2013 – 17.05.2014)

Committee purpose: Clinical governance; patient safety; workplace health and safety; continuous quality improvement; clinical incident; consumer feedback; clinical risks and compliance with relevant legislation; and policies and standards

Number of board members 3	*Number of non-board external members* 0
Board members: • Heather Hall (Chair) • Dr Julia Leeds • Lindsay Godfrey	**Non-board members:**
Frequency of meetings **Quarterly**	*Number of meetings held 2013–2014* 2

Safety and Quality Committee (18.05.2014 – current)

Committee purpose: Clinical governance; patient safety; workplace health and safety; continuous quality improvement; clinical incident; consumer feedback; clinical risks and compliance with relevant legislation; and policies and standards

Number of board members 4	*Number of non-board external members* 0
Board members: • Heather Hall (Chair) • Fiona Gaske • Lindsay Godfrey • Dr John Scott	**Non-board members:**
Frequency of meetings **Quarterly**	*Number of meetings held 2013–2014* 1

*1 – Special meetings may be called if required

*2 – Executive committee business is dealt with as a segment to the board meeting

Corporate governance

External appointments to board committees

Ms Lesley Lalley is an external non-board member on both the Audit and Risk Committee and Finance Committee. Ms Lalley has extensive experience across audit, risk and finance areas. She is a Certified Practising Accountant (CPA) with postgraduate qualifications who has enjoyed wide-ranging experience at a senior level in the private and public sectors, both in Australia and overseas.

Executive members attend board committee meetings

Executive members have been nominated to attend prescribed committees. The Health Service Chief Executive, Chief Operating Officer and Chief Finance Officer attend Audit and Risk and Finance Committee meetings; and the Executive Director Medical Services, Executive Director of Nursing and Midwifery, the Executive Director Community and Allied Health and the Nursing Director Quality and Safety attend the Safety and Quality Committee meetings.

Public Sector Ethics Act 1994

The South West HHS is committed to upholding the values and standards of conduct outlined in the Code of Conduct for the Queensland Public Service which came into effect on 1 January, 2011. The Code of Conduct for the Queensland Public Service applies to all Queensland Health employees.

The Code of Conduct was developed under the *Public Sector Ethics Act 1994* and consists of four principles:

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

Each principle is strengthened by a set of values and standards of conduct which describe the behaviour that will demonstrate that principle. Administration procedures and management practices have due regard to the ethical principles and values espoused in the Code of Conduct. As well as ensuring the principles of the Code of Conduct are embedded, the South West HHS has adopted the whole-of-government public service values. These include: customers first; ideas into action; unleash potential; be courageous; and empower people. Compliance with the Code of Conduct and South West HHS principles are included as part of staff review under the performance and appraisal development process.

All Queensland Health employees are required to undertake training in the Code of Conduct for Queensland Public Services during their induction and reacquaint themselves with the code annually. Ethical decision-making training is also provided. This training forms part of the mandatory training requirement each year.

Our Executive Management Team

The Executive Management Team (EMT) is the peak hospital and health service forum for leadership and management of the South West HHS and is responsible for championing the vision, values and strategic direction of the service.

The committee ensures significant issues of shared or common interest relevant to the service's delivery of safe, cost effective and quality services are considered and addressed in a collaborative way with all relevant stakeholders. Policy and practice requirements which are fundamental to ensuring the effective delivery of health services are also identified and addressed by the EMT.

The EMT is committed to influencing the organisation through a culture of accountability, service, safety, operational excellence and organisational learning. It operates in an environment of collective leadership, professional respect and courtesy, mutual support, innovation and teamwork.

The EMT meets on a monthly basis and also holds a planning meeting once a month. Three governance committees – finance, corporate governance and clinical governance – report to the EMT. These committees also hold monthly meetings.

Executive member profiles

Name	Position	Dates
Glynis Schultz	Acting Health Service Chief Executive	11.11.2013–30.06.2014
Meryl Brumpton	Chief Operations Officer	01.07.2013–30.06.2014
Josh Carey	Chief Finance Officer	01.07.2013–10.02.2014
Veronica Chung	Acting Chief Finance Officer	02.02.2014–30.06.2014
Dr Tom Gibson	Executive Director Medical Services	01.07.2013–30.06.2014
Chris Small	Executive Director of Nursing and Midwifery	01.07.2013–30.06.2014
Josh Freeman	Acting Executive Director Community and Allied Health	19.08.2013 – 30.06.2014
Wendy Jensen	Director People and Culture	01.07.2013 – 30.06.2014
Robyn Brumpton	Nursing Director Quality and Safety	01.07.2013 – 30.06.2014

Corporate governance

Executive member profiles

Glynis Schultz

Acting Health Service Chief Executive

Ms Glynis Schultz has a strong history and affinity with rural and remote Queensland which began with her childhood in Cloncurry in North West Queensland.

She has a clinical background working as a registered nurse, midwife and across many specialist areas in rural and regional locations and as Director of Nursing at Kilcoy Hospital.

Her clinical background is complemented by her academic studies in nursing science, health management, education and training and policy analysis.

Ms Schultz has worked in the Department of Health in leadership, managerial and director roles, including workforce planning and development and as the Senior Director of the Office of Rural and Remote Health. In 2011, she was awarded an Australia Day Certificate of Achievement Award for her role in piloting a new workforce role.

She joined the South West Hospital and Health Service in November, 2013 as Acting Health Service Chief Executive and she feels privileged to be able to work and travel in the South West. She has met some amazing, resilient and courageous people. Alongside the people, she has a strong appreciation for the bush, for the sunrises and sunsets that fill the sky and, the smell of rain on parched earth.

Meryl Brumpton

Chief Operations Officer

Mrs Meryl Brumpton was appointed as Chief Operations Officer in November 2008. Mrs Brumpton has acted as Chief Executive Officer for more than a 12 month period, on a number of occasions. She has worked in South West Queensland in senior state government positions for nearly 30 years, with 15 years at Queensland Health, including three years as Manager of Queensland Health's Office of Rural Health, plus roles at TAFE Queensland and the Department of Child Safety.

Mrs Brumpton has extensive experience in health, governance and managing change and is a passionate advocate for rural health services. She is a graduate of the Australian Institute of Company Directors, Associate Fellow of the Australian College of Health Service Executives and a Justice of the Peace (Qualified).

Veronica Chung

Acting Chief Finance Officer

Ms Veronica Chung is a trained accountant with a Bachelor of Commerce (accounting major) and holds inactive registrations with the CPA, and CA qualifications. Ms Chung has held senior positions with Queensland Health for 17 years, with roles including Finance Manager, Senior Director Business Development, Director of Finance, Chief Finance Officer, Senior Director Business Services and with the South West HHS as Acting Chief Operations Officer for six months and Chief Finance Officer in 2013.

For 15 years Ms Chung worked with Pathology and Scientific Service, which has been known as Clinical and Statewide Services since 2005. Some of Ms Chung's achievements include the introduction of AUSLAB statewide private practice central billing system, including the Rural and Remote Medical Benefits Scheme (RRMBS) changes; implementation of the Pathology and Biomedical Technical Service Fee for service billing for public hospitals from 1999; and development and implementation of the pathology costing and reporting module of the Decision Support System (DSS).

Ms Chung has extensive experience in health where she has gained an understanding of governance structures in large complex organisations and this has enabled her to manage complex financial implementations.

Ms Chung has a passion for supporting quality, safe and sustainable healthcare by ensuring robust processes and adherence to Australian financial legislation and guidelines.

Corporate governance

Executive member profiles

Christopher Small

Executive Director of Nursing and Midwifery

Mr Small was appointed as the South West District Director of Nursing in August, 2009. Prior to this he was the Director of Nursing of Mitchell Hospital.

Mr Small completed his training at the Princess Alexandra Hospital in 1992. Since this time he has completed his Bachelor of Nursing, Rural and Isolated Practice and Immunisation Endorsement, and post graduate studies in management. He has a passion for delivering innovative rural health care that focuses on advanced clinical skill development to ensure evidence-based acute and emergency care is given. He also focuses on creative health promotion and chronic disease programs to address the broadening burden of disease in rural communities.

Mr Small has a strong interest in healthcare quality, patient safety and clinical governance. He has worked in a range of positions in the public and private sectors, including roles as quality manager across a group of hospitals, clinical nurse in anaesthetics and recovery and nurse unit manager of a medical/high dependency unit ward.

He sits on a number of state committees that work towards ensuring the sustainability of nursing as a profession and to ensure that rural and remote issues are on relevant agendas. Mr Small has acted in the District Chief Executive Officer position on a number of occasions.

Josh Freeman

Acting Executive Director Community and Allied Health

Mr Freeman has a background in public and not-for-profit leadership roles. He trained as a pharmacist and holds a Bachelor of Pharmacy and Post Graduate Certificate in Medicines Management, both from the University of Otago (New Zealand). He has held leadership positions in pharmacy and allied health in New Zealand and Australia.

Mr Freeman has an understanding of governance structures in large organisations, after serving as a member of the University of Otago Senate and Health Sciences Divisional Board. He also provided leadership as board chair of a regional sporting authority in New Zealand.

Mr Freeman is passionate about transformational leadership and has interests in organisational culture. He is currently halfway through the completion of a Master of Business Administration degree through the University of South Australia. Mr Freeman has completed the Australian Institute of Company Directors Course, is a member of the Australian Institute of Management and has recently completed the Queensland Health Emerging Clinical Leaders Program.

Dr Tom Gibson

Executive Director Medical Services

Dr Tom Gibson was appointed as the Executive Director Medical Services in January 2013. For the past 30 years, Dr Gibson has worked as a rural general practitioner, surgeon, obstetrician and teacher in New Zealand, as a volunteer surgeon for two years in Tanzania and most recently in the Kimberley, enjoying rural Australia.

Throughout his career, Dr Gibson has been involved in rural health reform and has a strong interest in how rural communities can continue to maintain the best and most appropriate health services in a time of medical, political and financial change. Throughout his career, Dr Gibson has held numerous leadership and board positions, including chairperson and founding member of the board that built and managed a rural hospital in Dannevirke, New Zealand.

Dr Gibson is a fellow of the Royal Australian College of General Practitioners, the Royal College of Surgeons of Edinburgh and the Royal New Zealand College of General Practitioners. He spent 10 years as a general practice teacher with the Royal New Zealand College of GPs and two years teaching clinical officers in Tanzania, among other teaching positions.

Wendy Jensen
Director People and Culture

Ms Wendy Jensen has been in the role of Director People and Culture since November 2012. She has over 30 years experience with the Department of Health in a variety of management and senior leadership roles in human resources, corporate services and quality and safety management.

Ms Jensen was a recipient of an Australia Day award in 2004 and has been recognised for her partnership work on workforce strategies through the 2003 Ministers Award for Excellence in State/Local Government partnership programs

She was a finalist for the Rural Award for Innovation at the 2002 Health Services and Aged Care National Awards for Local Government.

Ms Jensen holds a Bachelor of Business in Human Resource Management and Management and Leadership, plus a Diploma of Occupational Health and Safety and is a graduate member of the Australian Institute of Company Directors and an associate member of the Australian Safety Institute.

Robyn Brumpton
Nursing Director Quality and Safety

As Nursing Director Quality and Safety, Mrs Robyn Brumpton provides leadership in clinical governance, including accreditation, risk management frameworks, research programs, medico-legal process, mortality review processes and clinical performance reporting for the South West HHS. Mrs Brumpton leads the Quality and Safety Unit in the South West to ensure a culture of safety and continuous quality improvement, which includes achieving ongoing accreditation status; clinical practice standardisation; implementation and sustainability of the National Safety and Quality Healthcare Standards; and internal and external audit programs.

Mrs Brumpton has been nursing for over 25 years and has worked in rural, metropolitan and corporate settings as a nurse, an infection control practitioner, state project officer, patient safety officer, director of nursing and district director of nursing.

Mrs Brumpton has a Masters of Health Science (Infection Control), is an endorsed nurse immuniser and has qualifications in sterilising services.

Service governance committees

Three service-wide governance committees have been established to assist the South West HHS to carry out its responsibilities. The committees are:

- Finance and Performance Committee
- Clinical Governance Committee
- Corporate Governance Committee.

Executive Member Report

Chief Operations Officer

Scope

Leadership of infrastructure, including the delivery of the South West HHS Capital Infrastructure Program; accommodation and asset management; contract management; operational services, including water quality, food safety, cleaning, grounds maintenance, porterage; support services, including staff and patient travel, administrative records, disaster response and business continuity matters; and executive sponsor of the Corporate Governance Committee.

Achievements and outcomes

Infrastructure works

Critical infrastructure projects at Roma Hospital were completed in February 2014, including fire and electrical safety upgrades. These works were funded under the statewide Rural and Remote Infrastructure Renewal project. Additional building work was undertaken at the same time to incorporate facilities for the new sub-acute service. The infrastructure work associated with the Telecommunications Infrastructure Replacement (TIR) Program was also undertaken during this time. The associated information technology (IT) enhancements at Roma campus were completed in June.

The Charleville critical infrastructure project is still underway. This involves a new lift, fire compliance, electrical upgrades and associated works. We have seen additional planning committed to this to allow the replacement of ageing plumbing systems. Construction is expected to be completed in mid 2015.

Capital Infrastructure Planning studies (master planning) for Roma and Charleville sites occurred with recommendations to government that outlined the on-going and critical need for full hospital replacements or further major refurbishments to these two hospitals. These proposals have been submitted to government as part of their budget planning process and we hope to hear the outcome early in the new financial year.

All Roma-based health service executives and service-wide support staff were consolidated into the one location at the executive and support service building in Bungil Street, Roma. This move has allowed for efficiencies in ongoing building costs and workflows.

The 2013–2014 year was the first of four years of our Backlog Maintenance Remediation Program and we saw a number of projects undertaken, including refurbishment of bathrooms at Injune; replacement of roofing in some Charleville Hospital ancillary buildings; replacement of flooring at the Mitchell Multipurpose Health Service (MPHS); and the renewal of external pathways at Surat MPHS. There are still a couple of this year's projects underway, including replacement of the disability access ramp and kitchen ceiling at Roma Hospital.

Major items in the repairs and maintenance program for the year saw our bathroom refurbishment program continue. This included selected floor covering replacements at a number of facilities, including Roma Hospital and the Waroona Aged Care Facility. We undertook a laundry refurbishment at Injune; replaced roof awnings at Augathella; refurbished the administration area at Dirranbandi; and the replacement of the underfloor plumbing at Charleville Hospital, which was a major task.

Our capital program saw a number of new major clinical and non-clinical items provided to assist our staff and patients across the HHS. In the non-clinical area, we saw new ride-on lawns mowers at some sites; and a range of new equipment for our operational services staff including cleaning, kitchen and laundry equipment. In the clinical area, new spirometers were purchased across the HHS; and St George theatre saw a range of new equipment, including a new steriliser, colonovideoscope, washer/disinfector, drying cabinet and instrument cabinet. A number of new defibrillators were provided across the HHS, along with pressure ulcer prevention mattresses and enhanced low-low beds for our patients in a number of sites. We also purchased a new incubator and shuttle for the Roma maternity unit.

Our new position of Coordinator of Operational Services was recruited, and has been reviewing and strengthening our compliance with food services and cleaning standards, including coordinating the purchase and training of new equipment. We have been critically analysing long standing processes in our operational services workforce and introducing improved efficiencies and better work practices.

Future directions – looking ahead

- We have appointed a temporary project officer to oversee the implementation of an action plan to introduce a more robust contract management framework, contract lifecycle management and processes across the health service.
- From 1 July 2015, the South West HHS will take on ownership of all our fixed assets (land and buildings) and we are preparing for this increased responsibility. We are also preparing to be assessed by the Department of Health against the International Standards Organisation (ISO) 55000 Asset Management Capability Model. There will be a large body of work undertaken over the next 12 months for us to develop systems, processes, capability and capacity to take on this responsibility.
- In late 2013, the board committed funds to a major capital project to provide new staff accommodation units at Surat, Injune and Dirranbandi; two new clinical houses at Roma; and major refurbishments of the emergency departments at Injune and St George. Schematic designs have been approved for these projects and the construction was released for tender in May 2014. We expect to award the tenders in July 2014, and these construction projects should be completed by October 2014.
- Backlog Maintenance Remediation projects will continue, including the disability ramp upgrade and kitchen ceiling at Roma Hospital.

Executive Member Report

Executive Director Medical Services

Scope

Service-wide medical services; the position of Director of Medical Services for Roma Hospital; credentialing and recruitment of medical staff; the Flying Specialist Services, including surgical services and the Flying Obstetrician and Gynaecologist service; general practice; joint chair of the Clinical Governance Committee in conjunction with the Executive Director of Nursing and Midwifery.

Achievements and outcomes

Medical staffing

There has been an intense focus on medical recruitment, which has paid off with four new rural generalist doctors appointed to the staff of Roma Hospital. A fifth is due to join in August 2014. These doctors have trained specifically to work in rural hospitals, with advanced skills in obstetrics, anaesthetics and surgery. Their recruitment provides stability for the medical workforce in Roma.

St George Hospital maintains its current stable staffing situation and in the coming year the rural generalist doctor will be replaced with an obstetrics-trained colleague. At present Charleville does not have a permanent Director of Medical Services (DMS) and recruitment advertising for this position continues. The appointment of a full-time DMS, even on a job-share basis, is crucial to the development of Charleville Hospital because the appointment of rural generalist trained doctors requires supervision. Considerable work has been undertaken in the search for a suitable candidate.

Two of our communities have bid farewell to two iconic doctors. Dr Chester Wilson left Charleville after 35 years of committed and steadfast service. Dr Wilson was very much the last of his kind, the rural doctor who set up his shingle and committed his life to the wellbeing of his community. The stories at his farewell reflected more than anything the high regard and affection the staff and community had for Dr Wilson. Dr Robert Burke from Surat also announced his decision to retire at the end of July after many years of service in the South West, both in Roma and Surat. Dr Bourke has been an outstanding rural physician and has provided great service over the years to the patients and communities of the South West.

The departures of Dr Wilson and Dr Bourke reflect the difficulty the South West HHS and other HHSs are having in placing permanent staff in small rural and remote communities. There are significant challenges in attracting doctors to the communities that need them and it is unlikely that medical models that have worked in the past will continue to be delivered in the same manner. Experience has shown that doctors will choose to work in a supported team environment where the workload is shared and there is a work/lifestyle balance.

The South West HHS has placed considerable effort into developing different models of medical care that may be more sustainable heading into the future. In this regard, the South West HHS is delighted to announce a partnership with Queensland Country Practice (QCP) who is undertaking a review of all our facilities, with a view to working with us to prepare options for how we develop sustainable services in the future. This is exciting strategic work and we look forward to some positive outcomes.

Flying services

At the beginning of 2014 a rigorous selection process yielded appointments to positions within the Flying Specialist Services. The clinicians appointed have settled well into the new service and the flying roster has been updated to increase the frequency of visits to each site from every four weeks to every three weeks. This has been achieved by holding the Roma outpatient clinics on a Saturday, and as a result, additional services have been offered, including surgical services to Longreach and Biloela. The plan for 2015 is to include orthopaedic services in the flying service schedule.

Radiology

The South West HHS has participated in the major radiology review through the contestability unit of Queensland Health, whose aim is to establish CT scanning in rural hospitals in Queensland. The outcome of this review is currently being implemented and it is anticipated that CT scanning will be available at Roma Hospital soon.

Other services

Pharmacy services continued to operate effectively throughout the year, keeping well within budget, with minimal write downs and full staffing quarters. General practice has become part of the South West HHS's core business in some small communities. A new project is currently underway to provide a uniform IT service throughout these practices and allied health primary community care services. In addition to this, the Queensland Country Practice review is anticipated to be the next step towards the development of sustainable general practice services.

Future directions – looking ahead

- Developing sustainable medical workforce models
- Establishing a stable medical workforce
- Inclusion of orthopaedic services in the flying services schedule
- Enhancing the model for child health and paediatrics
- Establishment of a stroke service
- Provision of chemotherapy for a target cohort of patients
- Continuing to expand the range of surgical services provided locally.

Executive Member Report

Executive Director of Nursing and Midwifery

Scope

Management and oversight of the nursing profession and the clinical nursing standards across the health service; executive manager of four hospitals (Charleville, Cunnamulla, Roma and St George), seven multipurpose health services (Augathella, Dirranbandi, Injune, Mitchell, Mungindi, Quilpie and Surat), three community clinics (Morven, Thargomindah and Wallumbilla), and two residential aged care facilities (Westhaven and Waroona); and joint sponsor of the Clinical Governance Committee in conjunction with the Executive Director Medical Services.

Achievements and outcomes

Graduate Nursing Program

The Graduate Nursing Program has had another successful year with 24 first-year registered nurses employed. With the support of the Department of Health's Nursing and Midwifery Office, we have successfully transitioned our graduates onto further university studies after their graduate year. We provided support to undertake tertiary studies in rural and remote health, which, when completed, will allow them to apply for the Rural and Isolated Practice Registered Nurse endorsement. The reputation of the South West HHS graduate program is growing among university graduates with a record 90 graduates applying for the 24 positions we had available for the June 2014 intake.

The retention rate of our first year graduate registered nurses is increasing. At present, 77 per cent of graduates are electing to stay with the South West HHS.

Business Planning Framework

For the first time, the nursing division has had full implementation of service profiles across all facilities. These are in line with budget processes and ensure that appropriate resources are available at all our facilities. These profiles will be further refined and developed to ensure that we are using the framework to deliver nursing resources to match each facility's needs.

Nursing and Midwifery Clinical Practice Framework

A major accomplishment for the nursing division has been the development and launch of the *Nursing and Midwifery Practice Framework* and *weCare* customer service standards. These documents set a detailed framework of care expectations and programs which will drive person-centred care and clinical practice, enhance staff culture and drive innovation in nursing. They ensure everyone in the nursing division is working along the same journey of practice and our patients are receiving best practice and empathetic health care.

Models of care

Throughout the year, work has continued to develop responsive changes to the way that we operate our services. This includes the increased use of nursing staff in our general practices to increase chronic disease case management, assessments and planning.

Monitoring of our clinical incident data has led to the introduction of changes in the way we deliver aged care services in our multipurpose health services and residential aged care facilities.

Increased focus and confidence within our midwifery models has seen an increase in antenatal and postnatal services and an increase in home visit rates under the Mums and Bubs Program.

Sub-acute care

The South West Sub-acute Rehabilitation Service was established within the financial year and began accepting patients in April 2014. The service was officially launched on 23 June 2014. The service is the first of its kind to be established in a rural and remote region and will provide intensive allied health, nursing and specialist services for South West residents whose needs include rehabilitation, aged care maintenance and management of continence, dementia and falls.

The service will allow patients that would normally have to receive treatment and therapy in larger metropolitan facilities to receive treatment in Roma, so that they are closer to their families and support networks. Once fully established, the service has the potential to be expanded to Charleville and St George.

Future directions – looking ahead

Our nursing division workforce data indicates the potential for 25 per cent of our workforce to retire in the next five years. This is a significant risk for the South West HHS. In that regard, some of the future directions for the nursing division includes:

- Developing a graduate enrolled nurse program
- Succession planning for senior nursing management positions
- Leadership and development programs
- Perioperative education
- Midwifery education
- Developing of a women's and children's health division.

Executive Member Report

Executive Director Community and Allied Health

Scope

Management of program areas: mental health and other drugs; oral health; healthy ageing; child and family; and chronic disease.

The Community and Allied Health Division is a collaborative, multidisciplinary team united by a shared understanding of the patient journey. The team has adopted a "no wrong door" ethos, which has helped to provide a clear communication link that allows clients and clinicians to be partners in healthcare planning and decision-making. The team have delivered on objectives under the *Blueprint for better health in Queensland* as well as planning for safe, applicable healthcare in rural and remote Queensland as described in *Better Health for the Bush*.

Achievements and outcomes

Mums and Bubs Program

Our Child and Family Team has expanded its home visiting services to new mums before, during and after the birth of their child. This program is committed to offering greater levels of support for parents of newborns with home visits in the first month after the birth. All families are able to access two home visits, and these are augmented with clinic consultations with an experienced maternal and child health professional during their baby's first year of life. This program provides a seamless transition through the antenatal, perinatal and postnatal phases of childbirth and is aligned to the *Blueprint for better health in Queensland* objective of providing increased support for families.

Hearing Health Program

The South West Hospital and Health Service has worked in partnership with stakeholders in the South West Paediatric Hearing Health Reference Group. This partnership has seen improvements in education and training of staff and the purchase of clinical resources to provide ear, nose and throat (ENT) specialist telehealth services in St George, Roma, Charleville and outreach services to Cunnamulla. The partnership was the recipient of the *Leadership and Partnership award* at the 2013 National Aboriginal Community Controlled Health Organisation (NACCHO) National Hearing Symposium.

The South West Paediatric Hearing Health Reference Group is evidence of the community and allied health's commitment to engagement and shows that opportunities are strengthened through solid relationships with our partners.

Aboriginal and Torres Strait Islander – continuous quality improvement

The Chronic Disease Multidisciplinary Care Team (CDMD) has delivered clinically and culturally effective primary healthcare services to Aboriginal and Torres Strait Islander people. Activity to improve health outcomes in Aboriginal and Torres Strait Islander people is emphasised in the *Blueprint for better health in Queensland*. The aim of the CDMD has been to improve the early detection, treatment and management of chronic diseases. The team has focused on reducing the rate of potentially preventable hospitalisations and discharges against medical advice.

The development of the South West HHS Aboriginal and Torres Strait Islander Cultural Capability Framework has been used to improve the cultural competence of our health workforce. This framework has also been utilised to implement strategies to improve the cultural security of health services delivered in South West HHS facilities.

Oral health services

Delivery of oral health services across the South West region is challenging due to geographic barriers and the recruitment and retention of staff. Our service has worked hard to improve client access through the use of the outsourcing voucher initiative as well as building capacity with targeted demand-based outreach delivery. These two strategies have been instrumental in reducing the number of clients waiting over two years on the general care waiting list to zero. The number of people waiting on the general care waiting list has been reduced by 52 per cent.

The dental outsourcing voucher initiative further demonstrates the community and allied heath's commitment to partnering with the private healthcare sector, which is in line with the *Blueprint for better health in Queensland*.

Sub-acute services

The new South West Sub-acute Rehabilitation Service, based at Roma Hospital, is the first such unit to be established within a rural and remote Hospital and Health Service. The sub-acute service is a multi-disciplinary unit focused on evaluating and improving the health outcomes of its clients. The model of care provides scope for the clients' healthcare journey to be shared between the community and allied health team and other disciplines.

Allied health services have been instrumental in the service delivery model of care for this unit. Physiotherapy, occupational therapy and social work are integrated into the service with speech pathology and dietetic support coming from existing program areas. These allied health services are fortified with continence and falls and mobility expertise from within the division.

Executive Member Report

Executive Director Community and Allied Health

Revitalisation of rural and remote Queensland

The Revitalisation of Regional, Rural and Remote Health Services funding has been used to provide much-needed social and emotional support in St George and Charleville during the drought. To address the clinical need, two social workers have been employed to assist these communities. This funding has been provided on a recurrent basis and is aligned to the objectives of adaptable and accessible services in rural and remote Queensland, as outlined in *Better Health for the Bush*.

Mental Health

The Mental Health Team has worked on assessing the environmental and social impact of drought in the South West region. Drought recovery information has been developed and sent to local stakeholders for distribution. Our mental health team has been active in working with non-government organisations across the region to build inclusive relationships that support drought affected people in the South West.

Allied Health Capability Development Framework

A new framework that describes the capabilities and work expectations has been introduced to support our allied health practitioners. The framework aims to build capacity for a well-supported allied health team. It promotes consistency and ease of staff movement around the South West HHS and supports self-reflection, career progression and selection of appropriate professional development.

Future directions – looking ahead

- Enhancing the paediatric development model of care
- Augmenting stakeholder relationships, plus strengthening important relationships with Aboriginal medical services across the South West
- Continue to develop and enhance clinical care models
- Improving client access to care through increased use of telehealth
- Focus on seamless patient journeys from acute to community settings
- Development of a ‘centre of excellence’ for community and allied healthcare
- Developing a workforce planning framework.

Compliance, risk and accountability

Risk management

We take a proactive approach to monitoring and improving risk management practices across the service. Risk management is an integral part of the South West HHS corporate governance framework. The service operates within the Queensland Health Integrated Risk Management Policy Framework based upon the Australian / New Zealand (AS/NZ) ISO Standard 31000:2009 for risk management.

Our risk management procedure is embedded and provides a framework for identifying, managing and elevating risk. All staff are required to apply risk management practices. The framework provides for the identification of risks regardless of location; and a process for raising the risk rating for local site assessment and mitigation and escalation if the risk is unable to be managed, based on whether the risk is clinical, occupational health and safety related or is a finance or business risk. All risks, including clinical and non-clinical, are captured and provide a total risk profile.

The board holds ultimate responsibility for risk oversight and risk management with the aim of meeting the organisation's strategic objectives. The chief executive is accountable for the effective implementation of the risk management framework in the organisation. A service level risk register is maintained and risk control measures are implemented and evaluated. Managers are responsible for reporting and managing risks within their area of responsibility.

Strategic risks have been identified, assessed and captured in the board risk register for regular review, monitoring and reporting. The assessment and treatment of operational risk is monitored through executive governance committees and escalated to the board if the risk is considered strategic, very high or extreme and is unable to be treated.

The Audit and Risk Committee reviews strategic risks on a quarterly basis and a monthly risk report is provided to the board. Reports on executive and operational risks are also provided. During 2013–2014 there has been a focus on enhancing risk reporting and this will continue into the 2014–2015 year. An integrated risk coordinator position will be created on a temporary basis to ensure risk is fully embedded across all areas of the service and to provide education and training.

External scrutiny

Auditor-General reports

The South West HHS is an independent statutory body with probity and propriety obligations. It is accountable and responsible for achieving its goals and discharging its statutory obligations. The service is subject to external scrutiny through an external audit undertaken of operations including annual financial statements by the Queensland Audit Office on behalf of the Auditor-General.

The 2013–2014 year was the second year of operation for the board and the Queensland Audit Office audited and certified the annual financial statements without qualification.

Audit and Risk Committee

The Audit and Risk Committee comes within the ambit of an 'audit committee' under the *Financial and Performance Management Standard 2009*. The board approved the terms of reference for the committee and has given due regard to Queensland Treasury's *Audit Committee Guidelines*. The Audit and Risk Committee meets quarterly, however extraordinary meetings are scheduled as required.

During the year the membership of the Audit and Risk Committee was expanded. Details of committee membership are detailed below:

Name	Appointment	Office	Remuneration
Karen Prentis	01.07.2013 – 30.06.2014	Chair	See note 29C to financial statements
Michael Cowley	28.10.2013 – 30.06.2014	Committee member	See note 29C to financial statements
James Hetherington	28.10.2013 – 30.06.2014	Committee member	See note 29C to financial statements
Lyn Kajewski	28.10.2013 – 30.06.2014	Committee member	See note 29C to financial statements
Sheryl Lawton	28.10.2013 – 17.05.2014	Committee member	See note 29C to financial statements
Richard Moore	01.07.2013 – 30.06.2014	Committee member	See note 29C to financial statements

Compliance, risk and accountability

The board appointed an external non-board member to the committee on 22 April, 2013 on a pro bono basis to provide expert financial and accounting advice. Other non-voting members of the committee are members of staff: the Health Service Chief Executive, Chief Operations Officer and Chief Finance Officer who attend all Audit and Risk Committee meetings.

The committee is responsible for providing independent assurance and assistance to the board on risk, control and compliance frameworks; and external accountability responsibilities as prescribed in the *Financial Accountability Act 2009, Auditor-General Act 2009, Financial Accountability Regulation 2009* and *Financial and Performance Management Standard 2009*.

The committee has an oversight role in relation to financial statements; internal control; internal audit; external audit; and compliance.

Financial statements

The committee assesses the adequacy of the service's financial statements, with regard to 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; and information provided by the service about the accuracy and completeness of the financial statements.

Internal control

The committee monitors 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; and whether the service is complying with the policies and procedures.

Internal audit

The committee monitors and advises the board about its internal audit function and oversees the liaison with the Queensland Audit Office in relation to the service's proposed audit strategies and plans.

External audit

The committee assesses external audit reports for the service and the adequacy of actions taken by the service as a result of the reports.

Compliance

The committee monitors 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.

During the year, matters addressed by the Audit and Risk Committee included internal audit planning; external audit activities; annual financial statements; risk management; and monitoring action plans.

Internal audit

The board has an Internal Audit Charter that provides the functional and organisational framework within which the internal audit function operates. The charter sets out the nature, role, status, authority and responsibility of internal audits and was developed considering the *Financial Accountability Act 2009, Financial and Performance Management Standard 2009, Queensland Treasury's Audit Committee Guidelines: Improving Accountability and Performance, December 2009 and International Professional Practices Framework, Institute of Internal Auditors, January 2009*.

The internal audit's primary objective is to provide an independent and objective assurance to the board, via the Audit and Risk Committee, on the state of risks, internal controls, organisational governance and to provide the Executive Management Team with recommendations to enhance current systems, processes and practices. The internal audit process also assists management and staff to effectively discharge their responsibilities through a process of systematic and independent audits.

During 2013–2014, the board engaged an accounting firm with specialised experience in internal audit to undertake an internal audit on a number of identified priority areas. These areas included contract management, clinical credentialing, asset management, budget management and compliance framework and the Chief Finance Officer Assurance Statement. These audits were designed to add value and enhance the South West HHS operations. Following completion of the audit and delivery of findings, action plans were developed to address identified areas for improvements. The Audit and Risk Committee monitors progress against the action plans. A review was also undertaken of the internal audit strategic program over the next three years with annual audit plans identified for each year.

Multicultural activities

We acknowledge the special position of the Aboriginal and Torres Strait Islanders as the first people of the land and recognise their rich diversity in cultures and languages and contribution to Queensland.

We are committed to multiculturalism, including social justice and equity for disadvantaged, non-English speaking communities, women and young people of culturally and linguistically diverse backgrounds and newly arrived refugees and migrants. We offer translation and interpreter services at all facilities.

The Queensland Cultural Diversity Policy applies and the South West HHS will work towards delivering on the four outcomes: language independence; education participation; economic independence and participation; and community participation of the whole-of-government action plan, once it is developed.

Information systems and record keeping

The South West HHS has a commitment to improving record keeping practices and complying with the *Public Records Act 2002* – Information Standard 40: Record keeping and Information Standard 31: Retention and Disposal of Public Records. The South West HHS has a wide range of documents and records held in electronic and hard copy format including plans, reports, minutes, general correspondence, publications, financial records and policy and procedure documents.

Records management training is part of our mandatory training program and is delivered through two online training modules: Introduction to Record Keeping and Records Management Basics. Information is categorised in accordance with the Department of Health's Business Classification Scheme.

The records management procedure is currently under review to ensure all legislative, administrative and business requirements are met. The procedure has been redeveloped to ensure that both clinical and corporate record management, and archiving and scheduling are addressed. Investigations are underway to research the effective storage of non-active clinical and corporate records.

Our people

The South West Hospital and Health Service is committed to a sustainable, effective workforce that is reflective of the capacity and capability to deliver the highest standards of safe, accessible and sustainable evidence-based healthcare. Our workforce is highly skilled and valued.

The People and Culture Unit provides services to support our staff to be safe and well at work; work under fair and equitable conditions; identify and access learning and development opportunities; and to be engaged with their work and colleagues. We value, respect and invest in our staff and understand the importance of ensuring work tasks are strategically aligned with the goals of the service. The unit brings together a number of services, including human resources, safety and wellbeing and our workforce development team to provide quality services to our staff.

Listening to our staff

South West Hospital and Health Service staff are invited to participate in regular workplace culture surveys. The Working for Queensland Employee Opinion Survey (replacing the previous Better Workplace Staff Opinion Survey) is a whole-of-government survey of employees that measures key aspects of workplace culture, staff engagement levels and identifies potential areas for improvement in the professional environment.

The South West HHS participated in the Working for Queensland Employee Opinion Survey in March 2013 and again in April 2014. The results of these surveys assist us to monitor our leadership capability and performance as part of the Queensland Public Service, and help us to build on the positive work and outcomes achieved to date.

Staff exiting our service are surveyed for feedback on their employment experience and this often results in improvement initiatives.

Engagement with our staff

The South West HHS clinician engagement strategies aim to provide flexible ways for clinicians to contribute to the development of the health service's programs and future projects. It allows staff to have their say and build strong, mutually-supportive relationships.

Profile

The workforce profile at 30 June 2014 was:

Full-time equivalent (FTE) staff establishment	685.28
Head count	842.80
Permanent separation rate	12.33%

	MOHRI occupied FTE	MOHRI occupied headcount
All paypoints		
All employ types	685.28	842.80
Casual	23.76	69.00
Permanent	555.12	648.80
Temporary	106.40	125.00
Managerial and clerical		
All employ types	126.83	147.26
Casual	2.70	7.50
Permanent	94.04	104.76
Temporary	30.09	35.00
Medical including VMOs		
All employ types	19.20	20.00
Permanent	13.20	14.00
Temporary	6.00	6.00
Nursing		
All employ types	318.99	395.18
Casual	6.69	22.00
Permanent	270.51	324.18
Temporary	41.79	49.00
Operational		
All employ types	163.21	214.36
Casual	14.18	37.50
Permanent	130.40	153.86
Temporary	18.63	23.00
Trade and artisans		
All employ types	4.00	4.00
Permanent	4.00	4.00
Professional and technical		
All employ types	53.05	62.00
Casual	0.19	2.00
Permanent	42.97	48.00
Temporary	9.89	12.00

The separation rate describes the number of permanent employees who separated during the year as a percentage of permanent employees.

Human resource management

Throughout the year, 31 complex case management files were managed. This included providing advice to line managers and employees on cases related to employee performance, harassment, bullying, official misconduct and other workplace matters, plus providing reporting as required.

Attraction and retention

Maintaining our workforce continues to challenge us in areas which include:

- Competition for skilled employees
- Finite budget and the impact of turnover costs
- Capacity and commitment to implement succession planning
- Residential accommodation availability.

	2012–2013		2013–2014	
Turnover	**%**	**Number**	**%**	**Number**
Management and clerical	23.78	31	27.84	41
Medical	40.65	9	10	2
Nursing	25.43	95	16.20	64
Operational	29.57	68	34.52	74
Trade and artisans	41.67	2	0	0
Professional and technical	28.72	18	19.35	12
Total		**223**		**193**

During the financial year ending 30 June 2014, two (2) employees received redundancy packages at a cost of $64,663.22. Both employees accepted the offer of a redundancy. No retrenchment packages were paid during this period.

During the 2013–2014 year, 374 recruitment processes were undertaken

Performance management

The South West HHS has a performance and appraisal system in place to identify, evaluate and develop the performance of employees in the organisation. It is a valuable process to document key performance and developmental objectives in regards to needs and targets. This mechanism also provides an opportunity for staff to be recognised, receive feedback and discuss career planning. All employees participate in an annual appraisal, plus six-monthly reviews to discuss progress.

Industrial relations

The South West HHS is committed to open communication and appropriate consultation with employees through management-union forums. The District Consultative Forum meets ten times per annum and is a shared table between the South West HHS management and the trade unions.

Three local consultative forums provide a more local forum for facility managers and the unions and their workplace representatives to discuss local industrial relations matters. These forums are conducted in the western, eastern and southern sectors. Meetings are often poorly attended as staff may be absent or busy in their roles.

Work-life balance

The South West HHS understands the importance of ensuring staff balance their personal and working lives. This is fundamental to our culture and we recognise the contribution of staff with family responsibilities. Flexible working arrangements and conditions can be negotiated to balance working and family responsibilities. Part-time arrangements are available to staff returning to work following maternity leave.

Workplace culture

The South West HHS participated in the Working for Queensland Employee Opinion Survey during the year. The outcomes of the survey will assist the South West HHS executive and management teams to better understand the views and opinions of the workforce and identify and address priorities for improvement. Employee surveys are a best practice strategy for engaging our workforce, and have proven links with improved performance and improved patient outcomes.

Our people

Staff recognition

Our staff continue to demonstrate an outstanding commitment to our vision and our values and we would like to congratulate all those who have achieved recognition from our South West HHS awards or in the community.

The South West Hospital and Health Service 2013 Annual Awards were presented to members of staff that were nominated by their colleagues for their contribution to the health service in their chosen field.

The recipients of our annual staff awards were:

- Vicki Rhodes, St George – Jim and Jill Baker Award
- Ruth Moore, Roma – Health Service Executive Award for Excellence
- Tracey Ferguson, Roma – Improvement Initiative Award
- Alison Bebbington and Rosie Mohr, Roma – Prevention and Promotion Award
- Katie Castles, Roma – Leadership and Culture Award
- Carolyn Farndon, Roma – Clinical Excellence Award
- Dianne Marshall, Injune – Improved Access and Partnering Improvement Award

Safety and wellbeing

Our management system continues to evolve with the changing needs of the organisation. An external audit was conducted in November 2013 to review our performance of our Occupational Health and Safety Management System in accordance with standards in AS/NZ 4801:2001. The recommendations from this audit were comparative to previous audits and confirmed our conformance status.

Fire and emergency evacuation training and drills continued through the year in partnership with local fire and rescue personnel. Testing and tagging requirements changed as a result of updated risk assessments and this process continues to ensure the electrical safety of our facilities.

The South West HHS continues to review its performance and procedures for the disposal of waste and other environmental hazards, as required by environmental legislation. The South West HHS has taken significant steps forward in the management of confined spaces by implementing a permit to entry protocol.

Health and safety representatives have undertaken comprehensive training to enhance the monitoring of our compliance against legislation, policy and procedures. The training program has been complemented by the re-establishment of the South West HHS Health and Safety Network. To further support facility representatives, the safety and wellbeing team has undertaken 332 audits to identify hazards, monitor risk controls and gauge compliance.

The training of employees and managers has continued to be a priority for the safety and wellbeing team with 107 education sessions delivered during the year.

Workers' compensation and injury management

The overall number of workers' compensation claims remains lower than previous years, however the average days lost and cost of claims has risen. The staff wellness team has focused on injury prevention and fostering an early return to work for employees after an incident.

Workplace incidents and injuries	2010–2011	2011–2012	2012–2013	2013–2014
Number of incidents/near misses reported	286	190	188	170
Number of injury workers' compensation claims	19	24	24	22
Total days lost from work	209	251	535	520
Average days lost	20.90	13.21	21.40	27.37 *
Total claims cost	$143,224	$165,647	$253,615	$302,037^
Average monthly payment to WorkCover	$3,581	$2180	$2588	$2560
Average days to first return to work	9.25	17.47	25.88	15.69

Source : Incident Management System and WorkCover Queensland

* Three long term cases, workers being rehabilitated to their substantive positions

^ Claim costs related to three long term rehabilitation cases

Workforce development unit

The South West HHS provides educational leadership and support for the workforce by fostering a culture of learning that is focused on a person-centered approach that encourages and empowers the 'teacher' within each employee. We want our healthcare teams to adopt a 'high challenge, high support' attitude and this is supported with evidence from clinical practice and patient experiences.

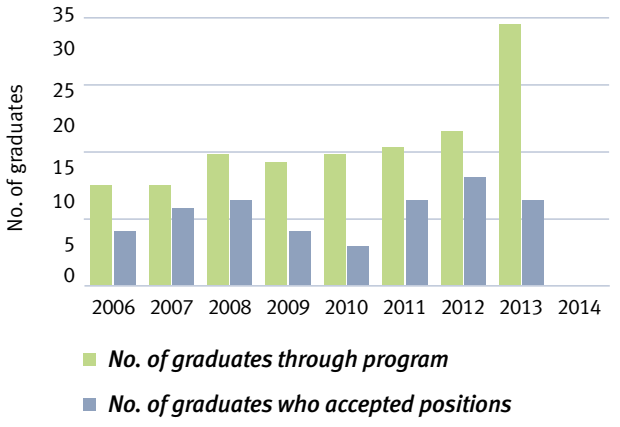
A robust orientation and mandatory training program is in place for newly appointed staff and for the continuing education and development of staff. This framework recognises the importance of welcoming new staff members, ensuring they have a clear understanding of their role, safe practices, expected behaviours and responsibilities. Staff are also given an overview of the organisation and the environment in which they will operate. Mandatory training is mandated by the relevant Commonwealth or State legislation, administrative policy, code of practice or directives. As well as face-to-face training, training in various modules is provided on-line and by videoconference. Mandatory training is continually monitored to ensure all employees maintain up-to-date skills and knowledge that is relevant to their area.

The service supports students and staff through a variety of programs that require significant resources, including undergraduate, graduate and postgraduate programs, plus general up-skilling. The workforce development unit utilises external partnerships with universities and TAFE to support students to gain rural and remote experience in all of our facilities. This training uses the preceptorship framework for support.

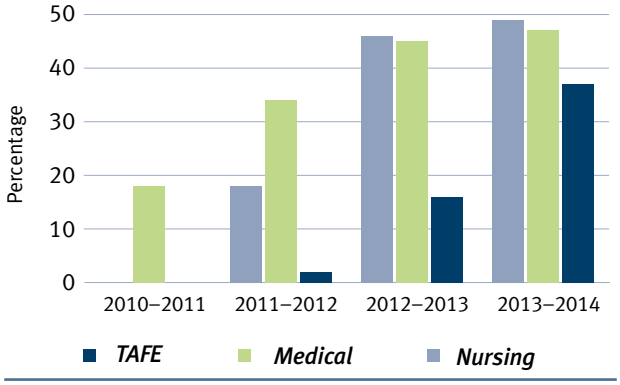
Graduate Nursing Program

The workforce development unit has provided many nurses with a unique experience of rural nursing through the 12-month graduate nurse program. The program allows nurses the flexibility to rotate through larger hub facilities and smaller multipurpose health service facilities, which exposes the nurses to a variety of clinical experiences. The program supports nurses to undertake advanced clinical training to learn skills such as cannulation, venipuncture and triage, which are critical skills in rural nursing.

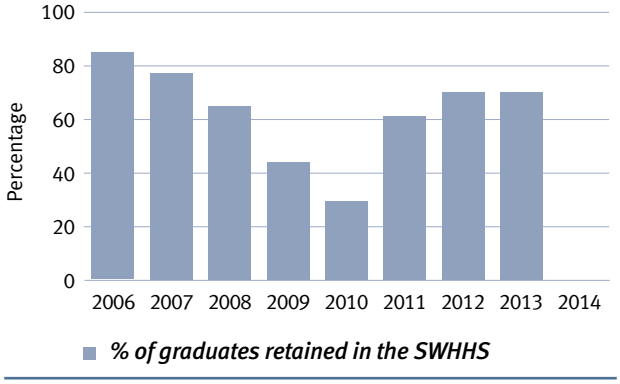
Graduate nurses who accept permanent positions with SWHHS



Nursing, Medical and TAFE Students support by SWHHS



Percentage of graduate nurses who are retained in the SWHHS



Celebrating our staff successes

Annual staff awards celebrate our successes

A highlight of the South West HHS calendar is the annual staff awards. The staff awards provide an excellent opportunity to recognise the outstanding contributions of our staff across the service. Projects promoting leadership, improving health, closing the gap and improving health service delivery are acknowledged and recognised annually at the staff awards. It is also a time for teams across the region to come together and celebrate individual and team achievements.

The awards ceremony was held at Roma on 28 October, 2013. These awards are a great way to celebrate and acknowledge the hard work that occurs every day to achieve our ultimate goal of excellence in patient care. The awards celebrate the dedication, commitment and vision of staff who work tirelessly to deliver high quality healthcare programs to their local communities.

Recipients of individual staff awards – 2013

Improvement Access and Partnering Improvement Award

Recognises employees/teams that have improved health care through partnering with an external source, community or other organisations.

Recipient: **Dianne Marshall, Healthy Ageing Recreation Officer, Injune**

Dianne does an outstanding job with flexible care clients at the Injune Multipurpose Health Service (MPHS). Partnering with Blue Care and Anglicare, she established weekly morning activities for all clients and any other older people in the community. Her proactive and creative approach to recreational activities creates a non-institutional environment where clients' recreational needs are met.

Leadership and Culture Award

Recognises any employee who contributes to developing a leadership culture in relation to Department of Health core values.

Recipient: **Katie Castles, Human Resources Manager**

Katie showed exceptional leadership during the stage one and stage two organisation restructure of the South West HHS. During this change, Katie demonstrated personal and professional integrity. She applied ethical decision-making and established robust and independent processes.

Clinical Practice Excellence Award

For an employee/team that demonstrates excellence in clinical practice through a process to improve patient care, or ease of work for staff.

Recipient: **Carolyn Farndon, Enrolled Nurse Advanced Practice and Bachelor of Midwifery Student, Roma Maternity Unit, Roma Hospital**

Carolyn provides exceptional clinical service to the maternity unit, including antenatal clinics and supporting the Flying Obstetrician and Gynaecology service during clinics in Roma. Carolyn recently secured a position as a Bachelor of Midwifery student that will see Roma Hospital benefit from a highly qualified, competent and dedicated midwife when she graduates.

Prevention and Promotion Award

For the employee/team who promotes wellbeing strategies to the community that result in chronic disease education/prevention.

Recipients: **Alison Bebbington, Support Officer, Health Promotion, Community and Allied Health, Roma, and Rosie Mohr, Community Nutritionist, Community and Allied Health, Roma**

Alison and Rosie worked jointly on "The Battle of the Bulge", a three-month program to promote better health and wellbeing for the Roma community. Rosie utilised her knowledge as a nutritionist to design the healthy eating sessions and provide nutritional support while Alison utilised her skills from her Certificate III in Fitness to design exercise sessions.

Improvement Initiative Award

This is awarded to the employee who delivers excellence in improvement in an administrative/professional/operational stream through innovation or team work.

Recipient: **Tracey Ferguson, Manager Strategic Revenue**

Tracey has driven change in increasing the number of private patients opting to use their private hospital cover as well as capturing revenue for medical consultations. She always consults with key staff and engages with the multidisciplinary team to plan the implementation of new systems and processes. Tracey provides relevant education to key staff including administrative, medical and nursing to ensure engagement with new processes.

Health Service Executive Award for Excellence

For the employee/team who demonstrates excellence in their chosen field.

Recipient: **Ruth Moore, Maintenance Planner, Roma**

Ruth's broad knowledge of medical and non-medical equipment, along with building industry standards allows her to carry out tasks beyond expectations. Local staff, contractors and employees from the Health Infrastructure Branch in Brisbane often comment on the excellent job Ruth performs.

Jim and Jill Baker Award

This is awarded to the employee/team who demonstrates excellence in their chosen field.

Recipient: **Vicki Rhodes, Administration Officer, St George Hospital**

Vicki has been recognised for her values, innovation and teamwork. She demonstrated strong leadership during the implementation of new software programs and contributed a significant amount of her personal time into learning the new program.

Roma midwife joins the National Rural Health Alliance

Roma Hospital's Midwifery Unit Nurse Manager Anne Bousfield was appointed as the first stand-alone midwifery representative on the National Rural Health Alliance (NRHA) Council in early 2014.

Ms Bousfield has been a midwife for 28 years and is a member of the Australian College of Midwives Rural and Remote Advisory Council.

She said her top priorities on the national council were to promote continuity of midwifery care models for rural women, and to advocate for programs that would help rural hospitals to build sustainable local midwifery workforces.

"The rural midwifery workforce is in a serious state because there are simply not enough midwifery graduates that want to work in rural areas," she said. "We need to grow our own workforce in rural and remote areas to ensure we have enough midwives to sustain future services in rural hospitals."

Ms Bousfield said her experience growing up in the country and working as a midwife with rural and remote women had given her the right experience for the job.

"My experience in midwifery is quite substantial. In 28 years of midwifery practice, I have worked in many different settings, from the Royal Women's Hospital in Melbourne, to Australia's only free-standing birth centre, and regional and rural maternity units.

"I have a Master's Degree in Midwifery Research and have been a midwifery lecturer at university. I also have a certificate in neonatal intensive care; I'm a trained lactation consultant and have coached many midwives and doctors in water birthing techniques.

"I am exceptionally passionate about midwifery and helping women get in the right mindset to make their labour much easier."

Celebrating our staff successes

Augathella graduate nurse trains on home turf

With the South West Hospital and Health Service, Melissa Russell was able to chart a unique path to her position as a graduate registered nurse at the Augathella Multipurpose Health Service (MPHS).

She graduated as a registered nurse in October 2013 and has been in the South West HHS graduate program since February 2014.

"I had always wanted to be a nurse because I liked being around people. But I didn't like living and studying in Toowoomba. I preferred to be at home in Augathella living more of a country life. I started at the Augathella MPHS as an Operational Services Officer but it didn't take me long to realise that I was still keen on nursing, so after six months I began studying a Diploma of Nursing through the Southern Queensland Institute of TAFE. Every Wednesday, I travelled four hours to Roma to link-up with classes in Toowoomba.

"It was the perfect environment for me. My colleagues helped me to study and I had the social life that I wanted, which included campdrafting on the weekends. In 2010, I graduated from TAFE as an Enrolled Endorsed Nurse. I worked at the Augathella MPHS and also did two days a week as a practice nurse at the Augathella Doctor's Surgery.

"I was interested in medical imaging and trained to become a rural and remote licensed X-ray operator. I have been taking X-rays since October 2011.

"The path I took is a little different to how many people become nurses, but it really suited me. I learned so much by working at the MPHS while I was studying. That hands-on experience has given me a lot of confidence now that I'm in the graduate program."

St George medical staff volunteer in Uganda

Seven St George medical professionals visited Uganda in June 2014 for a two-week stint providing volunteer medical assistance to villages in northern Uganda and around the capital, Kampala.

South West Hospital and Health Service Nursing Director Quality and Safety Robyn Brumpton was one of the seven St George volunteers that joined other health professionals from Newcastle, Brisbane and Toowoomba for the expedition that began on 19 June, coordinated by Christian charity group Watoto.

"It was an amazing trip but definitely not a holiday, there were challenges and some things were very confronting but it was a really valuable experience for all of us," Mrs Brumpton said of the trip.

"Each of the villages we were working in had about 1,000 kids that had been orphaned through war or HIV. The village medical clinics were basic and functional, with two clinical officers whose skill level was between a nurse and a doctor, plus a pathologist and one or two nurses.

"The health care was not that different to how we do things here, it was just a completely different setting and there were also access issues within the health system. We were able to utilise our skills, especially with midwifery, and our child health nurse did a lot of infant assessment.

"Some days and some cases were particularly tough to deal with. Every day we saw people with malaria and with HIV and even children with HIV – that was very difficult."

"We were able to help with complex cases and there were a few cases that local medical officers hadn't seen before, so we could help out there. We have also been able to offer suggestions on some possible improvements.

"As a team, we also learned from the Ugandan people. Their attitude was inspirational. People were always grateful for what they had.

"The trip was not a holiday for us. It was tough, challenging and emotional but we had a real treat at the end with a two-day safari. That was a bonus."

Quality and safety

The Quality and Safety Unit oversees the quality and safety framework within the South West Hospital and Health Service. A key function is to implement change through partnerships to achieve people-focused outcomes.

The unit guides the South West HHS to ensure that the service is compliant with legislative, regulatory and policy requirements of governing bodies, such as the Australian Commission on Safety and Quality in Healthcare (ACSQH), Health Quality and Complaints Commission (HQCC) and the Department of Health. The unit brings together a number of teams that support services across the South West, which involves the management of: patient safety; infection control; accreditation; medico-legal cases; health research; clinical governance framework; and risk management.

Patient safety

Clinical incidents that involve patients are reviewed by the patient safety team using a systematic approach.

Our clinical incident reporting database, PRIME, showed 1,312 clinical incidents were reported in the last year. This figure represents an increased number of reports from the previous year, by 200. Of these incidents, 97 per cent were minimal or caused no harm to the patient or resident.

In October 2013, the Statewide Bedside Safety Audit was undertaken in the South West HHS with the majority of indicators performing more favourably than statewide results by more than 10 per cent. This included completion of the allergies and alert section; falls risk screening, risk assessment and completed risk prevention plan; malnutrition risk screening and risk prevention plan; and pressure injury risk assessment. Pressure injury prevalence for hospital-acquired pressure injuries was 3 per cent which was 3 per cent below the statewide average and 7 per cent below the statewide benchmark. In regards to recognising and managing the deteriorating patient, 94 per cent of patients had a full set of observations completed on the Queensland Adult Deterioration Detection System (Q-ADDS) chart, which is a significant improvement on previous years. 100 per cent of residents in residential aged care were risk assessed for pressure injuries; falls and malnutrition; and had the allergy section correctly completed. Our results were between 3 per cent and 8 per cent better than the statewide average.

Changes made to the Waterlow Assessment Tool (adult pressure injury risk assessment) now enables staff to record a comprehensive skin assessment and specific pressure injury prevention and management plan. This enables the collection of this data during audits.

Risk assessments for venous thromboembolism (44 per cent) and medication action plan or medication history documentation (28 per cent) have improved in many facilities, but this remains an area for improvement across the service.

Work undertaken in adapting the National Safety and Quality Health Standards (NSQHS) into the South West HHS has provided positive accreditation results. Patient information bedside folders have been developed to provide consumer education for pressure injuries, falls and malnutrition prevention for each patient during their admission.

Infection control

The infection control program aims to maintain a high standard of infection prevention within all facilities, including aged care and oral health. The program includes signal infection surveillance; hand hygiene; sharps safety and use of retractable devices; vaccination management and immunisation; education; and sterilisation, aseptic non-touch technique monitoring and monitoring of an antimicrobial stewardship program.

The signal infection surveillance program focuses on all healthcare associated infections, such as occupational exposures, surgical site infections, multi-resistant organisms, catheter-related urinary tract infections and gastrointestinal infections.

The 2013–2014 data for healthcare-associated infections was 0.04 per cent of occupied bed days, reduced from 0.05 per cent in 2012–2013. Infections from all 13 inpatient / residential sites included:

- One bloodstream infection
- Two surgical site infections
- Six multi-resistant organism infections
- One catheter-associated urinary tract infection
- One gastrointestinal tract infection.

The hand hygiene program consists of auditors in all the inpatient facilities collecting compliance data according to the hand hygiene guideline. The national compliance data benchmark is 70 per cent and the South West HHS's most recent compliance audit average for all facilities was 75.46 per cent. Smaller facilities and smaller amounts of data collected do have an affect on this percentage.

Quality and safety

Service improvement

Accreditation

The service improvement team facilitates accreditation and quality improvement processes across the service.

Aged Care Standards and Accreditation Agency Ltd

The South West HHS's two aged care facilities have been re-accredited during 2013–2014 meeting all 44 expected outcomes.

Waroona Aged Care Facility's re-accreditation audit was conducted on 9 and 10 October, 2013 and has been accredited until 8 December, 2016.

Westhaven Aged Care Facility's re-accreditation audit was conducted on 24 and 25 June, 2014 and has been accredited until 20 September, 2017.

International Standards Organisation (AS/NZS ISO)

For the two week period between March 31 and April 11 2014, the South West HHS welcomed ten auditors from the Institute for Healthy Communities Certification (IHCAC) to our facilities for our recertification audit against the International Standards Organisation (AS/NZS ISO) Quality Management System (QMS) Standard. The South West HHS has agreed to a corrective action plan to address the seven non-conformances identified in the audit.

The South West HHS continues to be certified against AS/NZS ISO 9001:2008 until 14 March, 2017 with an annual surveillance audit to be conducted prior to April 2015.

National Safety and Quality Health Standards (NSQHS)

In 2011, the Australian Commission on Safety and Quality in Healthcare (ACSQH) introduced 10 Standards of Compliance for all Australian Hospitals.

1. Governance for safety and quality
2. Partnering with consumers
3. Preventing and controlling healthcare associated infections
4. Medication safety
5. Patient identification
6. Clinical handover
7. Blood and blood products
8. Preventing and managing pressure injuries
9. Recognising and responding to clinical deterioration
10. Preventing falls and harm from falls.

In conjunction with the ISO recertification audit in March and April 2014, the South West HHS was accredited against all of the 10 NSQHS Standards.

A mid-cycle assessment against standards one, two and three will be conducted by IHCAC prior to October 2015.

National Standards for Mental Health Service (NSMHS)

In conjunction with the ISO recertification audit and the NSQHS audit in March and April 2014, the South West HHS was audited against the National Standards for Mental Health Service (NSMHS).

A surveillance audit will be conducted on 28, 29 and 30 October, 2014 to review the corrective actions taken to address the non-conformance against meeting the requirements of the National Standards for Mental Health.

Clinical service improvement

Clinical Service Improvement

Key areas which have seen growth and sustainability within clinical improvement over the 2013–2014 include:

Standardisation processes: The emergency resuscitation trolleys across the service have been successfully standardised. The trolleys are now in the maintenance phase to standardise stock control of the items within the trolley. This will ensure cost effective resources and product numbers are adequate to meet the requirements of the facilities. These trolleys continue to be audited twice yearly for compliance and to gather feedback from clinicians in regards to change implementation. This feedback will further improve the effectiveness of the standardisation processes.

Productive Ward: The South West HHS has been one of the most successful health services in Queensland in implementing Productive Ward in terms of sustainability and measurable outcomes. This has been due to a number of key success factors, including ongoing stable governance through the network meeting. The active engagement and ongoing interest in the program continued to motivate the teams at each of the sites. Key factors in maintaining this momentum has been the continued support of leadership teams. The work of the facilitators has been invaluable in continuing to engage and guide their teams through the modules.

Perhaps the greatest success is that frontline teams have achieved a change in the way they think about, approach and address problems using an improvement methodology. These frontline teams should be acknowledged for their efforts. They have achieved a major cultural shift.

One of the main aims of the Productive Ward series is to give clinical staff more time at the bedside. In St George, the percentage of time nurses spend directly caring for patients has increased on day shifts from 35 per cent to 57 per cent, an increase of over 60 per cent. This represents the largest improvement in the state. It equates to an increase of one and a half hours of care provided directly at the bedside, per nurse, per morning shift.

Journey boards and Patient Flow Manager (PFM) installation: The installation and configuration of a further six journey boards is underway, with completion due in November 2014. The build of the Patient Flow Manager (PFM) program is unique to the needs of the service and will standardise and streamline reporting processes, such as handover reports; diet lists; and referral processes. The South West will be the first health service to incorporate the PFM program across all inpatient sites, including the two aged care facilities.

The Clinicians Only newsletter: These effective monthly newsletters continue as an education medium to highlight current patient safety events that have occurred within the service and/or across Queensland. These confidential case studies, which are de-identified, focus on a current patient safety event. These real-life scenarios include the recommendations and lessons learnt from the event. Publications include, but are not limited to:

- Escalation processes
- Crisis resource management
- Allergies and alerts
- Acute resuscitation plans
- Documentation.

Telehealth services

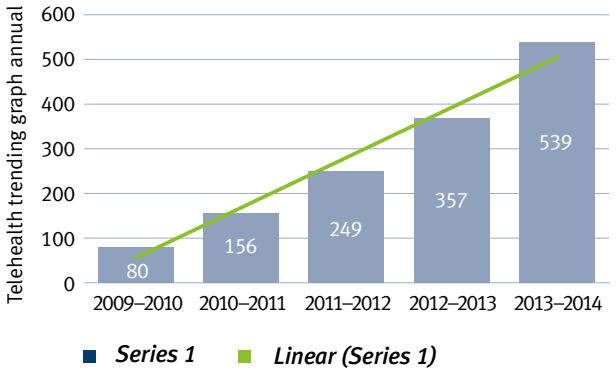
Telehealth services are progressively becoming an integral part of healthcare in the South West HHS. Telehealth is a mode of healthcare delivery which enables improved access to healthcare; reduced travel requirements and associated costs for patients, families and clinicians; and it provides education and peer support for clinicians. Telehealth services are continuing to increase for non-admitted, admitted, and emergency patients across the South West.

In 2013–2014, non-admitted telehealth service events increased by 51 per cent and admitted telehealth events have significantly increased since the introduction of the Geriatric Evaluation and Management (GEM) service for sub-acute patients. Emergency telehealth capability continues to expand with the introduction of the Telehealth Emergency Management Support Unit (TEMSU).

Increases in telehealth events for the South West can be attributed to:

- The permanent appointment of dedicated telehealth staff
- Establishing standardised procedures for conducting telehealth clinical consultations
- Education for staff
- Promotion of telehealth services to the wider community
- Increased telehealth services for admitted, non admitted and emergency patients.

South West HHS Telehealth: Non-admitted occasions of service



Quality and safety

Health information

The Health Information Team supports the implementation of best-practice procedures that provide a framework for effective, high quality management of clinical records across electronic and paper-based systems in both acute and community settings. This team also supports the production and reporting of high quality activity data and financial information across the South West HHS through the effective implementation and use of information systems and engagement with clinical, administrative and executive team members.

Services provided include:

- Clinical coding and review of documentation standards
- Collation and reporting of non-admitted service events
- Clinical forms management
- Governance of processes for clinical records management from creation and integration of records to archiving and destruction
- Access to information under the *Right to Information Act 2009 and Privacy Act 2009* to include education relating to confidentiality and overall release of information
- Training and support in the use of clinical information systems such as the Enterprise Discharge Summary, The Viewer, Operating Room Management Information System (ORMIS), Hospital Based Corporate Information System (HBCIS), and the Emergency Department Information System (EDIS).

Glossary of acronyms

ABF	Activity based funding
ACSQH	Australian Commission on Safety and Quality in Healthcare
AHPRA	Australian Health Practitioner Regulation Agency
AICD	Australian Institute of Company Directors
AMS	Aboriginal medical service
ARR	Annual report requirements
AS	Australian standard
AS/NZS ISO	Australian/New Zealand International Standards Organisation
ASIC	Australian Securities and Investment Commission
ASQCH	Australian Commission on Safety and Quality in Healthcare
ATODS	Alcohol, Tobacco and Other Drug Service
ATSIC	Aboriginal and Torres Strait Islander Commission
BPF	Business Planning Framework
CACPs	Community Aged Care Packages
CAN	Community Advisory Network
CDMD	Chronic Disease Multidisciplinary Care Team
CE	Chief Executive
CFO	Chief Finance Officer
CSCF	Clinical Services Capability Framework
COAG	Council of Australian Governments
COO	Chief Operations Officer
CWAATSICH	Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health
DAMA	Discharged themselves against medical advice
DDSWQML	Darling Downs and South West Queensland Medicare Local
DON	Director of Nursing
DPC	Director People and Culture
EDC&AH	Executive Director Community and Allied Health
EDMS	Executive Director Medical Services
EDONM	Executive Director of Nursing and Midwifery
EEO	Equal employment opportunity
EMT	Executive Management Team
FAA	*Financial Accountability Act 2009*
FOG	Flying Obstetrician and Gynaecologist
FPMS	*Financial and Performance Management Standard 2009*
FSS	Flying Specialist Services
FTE	Full-time equivalent
GEM	Geriatric Evaluation and Management
GP	General practitioner
HHS	Hospital and Health Service
HPID	Health Planning Infrastructure Division
HQCC	Health Quality Complaints Commission
HR	Human resources
HHSPF	Hospital and Health Services Performance Framework
ICHAC	Institute for Healthy Communities Certification
ISO	International Standards Organisation
KPI	Key performance indicators
LSOP	Long stay older patients
MOHRI	Minimum Obligatory Human Resources Information
MPHS	Multipurpose Health Service
MRSA	Methicillin Resistant Staphylococcus Aureus
NACCHO	National Aboriginal Community Controlled Health Organisation
NDQS	Nursing Director Quality and Safety
NHRA	National Health Reform Agreement
NSMHS	National Standards for Mental Health Service
NSQHS	National Safety and Quality Health Standards
OPD	Outpatients department
PFM	Patient Flow Manager
PWD	People with disabilities
QA	Quality Activity
QADDS	Queensland Adult Deterioration Detection System
QAIHC	Queensland Aboriginal and Islander Health Council
QMS	Quality Management System
RDAQ	Rural Doctors Association (Queensland)
RFDS	Royal Flying Doctor Service
SAPFIR	SAP Assets Procurement Finance Information Resource
SCoH	Standing Council on Health
TAFE	Technical and Further Education
TEMSU	Telehealth Emergency Management Support Unit
TIR	Telecommunications Infrastructure Replacement
VTE	Venous Thromboembolism

Glossary of terms

Acute care is care in which the clinical intent or treatment goal is to:

- Manage labour (obstetric)
- Cure illness or provide definite 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.

Ambulatory health services cover physiotherapy, speech and occupational therapy, optometry, radiography, dietetics, podiatry, social work, speech pathology, oral health and pharmacy.

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

Hospital and Health Service (HHS) is a separate legal entity established by Queensland Government to deliver public hospital services.

Journey boards are visual, interactive tools that can be utilised within clinical areas to assist with the management of patient flow, improve clinical handovers and team communication, improve discharge planning and potentially reduce patient length of stay.

Know your numbers is a tool developed to raise community awareness and detection of cardiovascular disease and type 2 diabetes (in New South Wales and Queensland). Know your numbers promotes the importance of regular blood pressure and type 2 diabetes risk assessment checks through opportunistic health checks.

Medicare Locals were established by the Commonwealth to coordinate primary health care services across all providers in a geographic area. They work closely with the HHSs to identify and address local health needs.

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

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

Nurse Practitioner is 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 is a non-admitted health service provided or assessed by an individual at a hospital or health service facility.

Outpatient service is an 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.

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

PRIME is a clinical incident reporting database.

Primary health care services focus on promoting healthy lifestyles to reduce the burden of disease. Services include Aboriginal and Torres Strait Islander health, child health, community health nursing, mobile women's health, mental health (adult and child), sexual health, chronic disease management, aged care assessment team, home and community care, young people's support program and alcohol, tobacco and other drugs services.

Productive ward is about "Releasing Time to Care": The Releasing Time to Care Program (The Productive Ward) is a product that has been developed by the National Health Service Institute for Innovation and Improvement in England. The Productive Ward offers a systematic way of delivering safe, high quality care to patients across all clinical areas, within existing resources. The philosophy behind the program is to help front line clinicians release time to care.

Promotion, protection and prevention services are designed to promote health, prevent disease and prolong life through communicable disease control, environmental health, health promotion, health surveillance and epidemiology and public health nutrition.

Public patient is one who elects to be treated as a public patient, so cannot chose 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 is a hospital that offers free diagnostic services, treatment, care and accommodation to eligible patients.

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

Rehabilitation and extended care services across the South West encompass residential aged care, palliative care, respite and geriatric care.

Statutory bodies are non-departmental government bodies, established under an Act of parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.

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

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

The board is the South West Hospital and Health Board.

The service is the South West Hospital and Health Service.

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	Page 1
Accessibility		
Table of contents Glossary	ARRs – section 10.1	Page 2
Public availability	ARRs – section 10.2	Inside front cover
Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 10.3	Inside front cover
Copyright notice	*Copyright Act 1968* ARRs – section 10.4	Inside front cover
Information Licensing	*QGEA – Information Licensing* ARRs – section 10.5	Inside front cover
General information		
Introductory Information	ARRs – section 11.1	Pages 6–7
Agency role and main functions	ARRs – section 11.2	Pages 8–9
Operating environment	ARRs – section 11.3	Pages 10–15
Machinery-of-government changes	ARRs – section 11.4	Page 8
Non-financial performance		
Government objectives for the community	ARRs – section 12.1	Page 20
Other whole-of-government plans / specific initiatives	ARRs – section 12.2	Page 20
Agency objectives and performance indicators	ARRs – section 12.3	Pages 20–25
Agency service areas, service standards and other measures	ARRs – section 12.4	Pages 26–27
Financial performance		
Summary of financial performance	ARRs – section 13.1	Pages 16–19
Governance – management and structure		
Organisational structure	ARRs – section 14.1	Pages 28–29
Executive management	ARRs – section 14.2	Pages 31–41
Related entities	ARRs – section 14.3	Page 8
Government bodies	ARRs – section 14.4	

Summary of requirement	Basis for requirement	Annual report reference
Governance – management and structure		
Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* (section 23 and Schedule) ARRs – section 14.5	Page 38
Governance – risk management and accountability		
Risk management	ARRs – section 15.1	Page 49
External scrutiny	ARRs – section 15.2	Page 49
Audit committee	ARRs – section 15.3	Page 49–50
Internal audit	ARRs – section 15.4	Page 50
Public Sector Renewal	ARRs – section 15.5	Page 26
Information systems and record keeping	ARRs – section 15.6	Page 51
Governance – human resources		
Workforce planning, attraction and retention and performance	ARRs – section 16.1	Pages 52–53
Early retirement, redundancy and retrenchment	Directive No.11/12 *Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	Page 53
Open Data		
Open data	ARRs – section 17	Inside front cover
Financial statements		
Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	Page 5-44
Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	Page 5-45 – 5-46
Remuneration disclosures	*Financial Reporting Requirements for Queensland Government Agencies* ARRs – section 18.3	Page 5-38 – 5-42

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2009*

ARRs *Annual report requirements for Queensland Government agencies*

Feedback survey form

The South West Hospital and Health Service is interested in hearing your feedback on its *Annual Report 2013–2014*. Please help us by taking a few minutes to complete this survey so that we can continue to improve the quality of our annual report.

How to complete the survey

An electronic version of this survey is available on South West HHS's website at **www.health.qld.gov.au/southwest/**

Alternatively, please return the completed survey to: **SWHHS_Board@health.qld.gov.au**

Please select the appropriate response.

1. **The level of detail in the annual report was:**
   - ○ too high
   - ○ appropriate
   - ○ not enough
   - ○ nowhere near enough

2. **The writing style and language used in the annual report was:**
   - ○ too complex
   - ○ just right
   - ○ too simple
   - ○ far too simple

3. **Overall, I found the presentation of the annual report to be:**
   - ○ excellent
   - ○ good
   - ○ average
   - ○ poor

4. **Overall, how do you rate the value of the information in the annual report:**
   - ○ highly valuable
   - ○ valuable
   - ○ of some value
   - ○ of no value

5. **Overall I found the annual report to be:**
   - ○ of very low quality
   - ○ of low quality
   - ○ of average quality
   - ○ of high quality
   - ○ of very high quality

6. **What category of user of this annual report are you?**
   - ○ academia
   - ○ community/consumer
   - ○ elected official
   - ○ employee
   - ○ federal/state/local government
   - ○ health professional
   - ○ health service provider
   - ○ student
   - ○ other (please specify)

Do you have any other comments or feedback on the South West HHS annual report?

Do you have any suggestions for how South West HHS could improve its annual report in the future?

Thank you for your comments.

Contacts

Health Service Chief Executive	44 – 46 Bungil Street, Roma QLD 4455	(07) 4505 1570
Chief Operations Officer	44 – 46 Bungil Street, Roma QLD 4455	(07) 4505 1565
Chief Finance Officer	44 – 46 Bungil Street, Roma QLD 4455	(07) 4505 1530
Executive Director Medical Services	197 McDowall Street, Roma QLD 4455	(07) 4624 2868
Executive Director of Nursing and Midwifery	44 – 46 Bungil Street, Roma QLD 4455	(07) 4505 1536
Executive Director Community and Allied Health	44 – 46 Bungil Street, Roma QLD 4455	(07) 4505 1513
Director People and Culture	44 – 46 Bungil Street, Roma QLD 4455	(07) 4505 1502
Nursing Director Quality and Safety	Victoria Street, St George QLD 4487	(07) 4620 2226
Manager Executive Services / Board Secretariat	44 – 46 Bungil Street, Roma QLD 4455	(07) 4505 1544
Consumer and Community Liaison Officer	44 – 46 Bungil Street, Roma QLD 4455	(07) 4505 1534
Indigenous Health Co-ordinator	44 Bungil Street, Roma QLD 4455	(07) 4624 2912
Augathella Multipurpose Health Service	Cavanagh Street, Augathella QLD 4477	(07) 4656 7100
Charleville Hospital	72 King Street, Charleville QLD 4470	(07) 4650 5000
Cunnamulla Hospital	56 Wick Street, Cunnamulla QLD 4490	(07) 4655 8100
Dirranbandi Multipurpose Health Service	Cnr Jane and Cowildi Streets, Dirranbandi QLD 4486	(07) 4625 8222
Injune Multipurpose Health Service	Fifth Avenue, Injune QLD 4454	(07) 4626 1188
Mitchell Multipurpose Health Service	Ann Street, Mitchell QLD 4465	(07) 4623 1277
Morven Outpatient Clinic	Warrego Highway, Morven QLD 4468	(07) 4654 8288
Mungindi Multipurpose Health Service	Barwon Street, Mungindi NSW 2406	(02) 6753 2166
Quilpie Multipurpose Health Service	30 Gyrica Street, Quilpie QLD 4480	(07) 4656 0100
Roma Hospital	197-234 McDowall Street, Roma QLD 4455	(07) 4624 2700
St George Hospital	Victoria Street, St George QLD 4487	(07) 4620 2222
Surat Multipurpose Health Service	Ivan Street, Surat QLD 4417	(07) 4626 5166
Thargomindah Outpatient Clinic	Dowling Street, Thargomindah QLD 4492	(07) 4655 3361
Wallumbilla Outpatient Clinic	Raslie Road, Wallumbilla QLD 4428	(07) 4623 4233
Charleville Community and Allied Health	2 Eyre Street, Charleville QLD 4470	(07) 4650 5300
Roma Community and Allied Health	Arthur Street, Roma QLD 4455	(07) 4624 2977
St George Community and Allied Health	Victoria Street, St George QLD 4487	(07) 4620 2222
Charleville Patient Travel Subsidy Scheme	72 King Street, Charleville QLD 4470	(07) 4650 5006
Roma Patient Travel Subsidy Scheme	44 Bungil Street, Roma QLD 4455	(07) 4505 1511
Waroona Residential Aged Care Facility	72 King Street, Charleville QLD 4470	(07) 4650 5200
Westhaven Residential Aged Care Facility	Parker Street, Roma QLD 4455	(07) 4624 2600

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South West Hospital and Health Service

ABN 22 877 041 939

Financial Statements – 30 June 2014

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General Information

These financial statements cover the South West Hospital and Health Service (SWHHS or South West Hospital and Health Service).

The Southwest Hospital Health Service was established on 1st July 2012 as a statutory body under the *Hospital and Health Boards Act 2011*.

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

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

Roma Hospital Campus
McDowall Street
Roma QLD 4455

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

For information in relation to the Hospital and Health Service's financial statement please visit the website. www.health.qld.gov.au/southwest/

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

Statement of Comprehensive Income
for the year ended 30 June 2014

	Notes	2014 $'000	2013* $'000
Income from Continuing Operations			
User charges	3	6,306	6,162
Government funding	4	100,059	101,994
Grants and other contributions	5	10,874	9,298
Interest		19	23
Other revenue	6	451	789
Total revenue		117,709	118,267
Gains on sale of assets		-	33
Total Income from Continuing Operations		**117,709**	**118,300**
Expenses from Continuing Operations			
Employee expenses	7	1,025	662
Health service labour expenses	8	66,517	69,087
Supplies and services	9	41,327	36,426
Grants and subsidies		18	9
Depreciation and amortisation	10	5,196	4,529
Impairment losses	11	84	41
Other expenses	12	1,613	1,526
Total Expenses from Continuing Operations		**115,780**	**112,280**
Operating Results from Continuing Operations		**1,929**	**6,019**
Other Comprehensive Income			
Items that will not be reclassified subsequently to Operating Result			
Increase/(decrease) in Asset Revaluation Surplus	21	(441)	2,814
Total items that will not be reclassified subsequently to Operating Result		(441)	2,814
Total Other Comprehensive Income		(441)	2,814
Total Comprehensive Income		**1,488**	**8,833**

* Comparatives have been adjusted to enhance disclosures of government funding previously included in receipt of grants and other contributions and for correction of error (see Note 30)

The accompanying notes form part of these statements

South West Hospital and Health Service

Statement of Financial Position
as at 30 June 2014

	Notes	2014 $'000	2013 * $'000
Current Assets			
Cash and cash equivalents	13	17,424	9,036
Receivables	14	996	3,787
Inventories	15	629	628
Other	16	179	38
Total Current Assets		19,227	13,488
Non-Current Assets			
Property, plant and equipment	17	87,704	90,586
Total Non-Current Assets		**87,704**	**90,586**
Total Assets		**106,931**	**104,074**
Current Liabilities			
Payables	18	11,022	7,831
Accrued employee benefits	19	23	24
Unearned revenue	20	51	1
Total Current Liabilities		11,096	7,856
Total Liabilities		**11,096**	**7,856**
Net Assets		**95,835**	**96,218**
Equity			
Contributed equity		85,514	87,385
Accumulated surplus/(deficit)		7,948	6,019
Asset revaluation surplus	21	2,373	2,814
Total Equity		**95,835**	**96,218**

* Comparatives have been adjusted for correction of error (see Note 30)

The accompanying notes form part of these statements

Statement of Changes in Equity
for the year ended 30 June 2014

	Accumulated Surplus	*Asset Revaluation Surplus (Note 22)*	*Contributed Equity*	*TOTAL*
	$'000	*$'000*	*$'000*	*$'000*
Balance as at 1 July 2012	-	-	-	-
Operating Result from Continuing Operations	6,019	-	-	6,019
Other Comprehensive Income				
Increase in Asset Revaluation Surplus	-	2,814	-	2,814
Total Comprehensive Income for the year	6,019	2,814	-	8,833
Transactions with Owners as Owners:				
Net assets received (transferred during year via machinery-of-Government change) Note 2 (h) *			87,192	87,192
Net assets received (transferred under Administrative Arrangement Note 2 (h) at 1 July 2012)	-	-	(1,024)	(1,024)
Non appropriated equity injections (Minor Capital works) Note 2 (e)			5,744	5,744
Non appropriated equity withdrawals (Depreciation funding) Note 2 (e)	-	-	(4,526)	(4,526)
Total changes to contributed equity	-	- -	87,385	87,385
Balance as at 30 June 2013	6,019	2,814	87,385	96,218
	$'000	*$'000*	*$'000*	*$'000*
Balance as at 1 July 2013	6,019	2,814	87,385	96,218
Operating Result from Continuing Operations	1,929	-	-	1,929
Other Comprehensive Income				
Increase (Decrease) in Asset Revaluation Surplus	-	(441)	-	(441)
Total Comprehensive Income for the Year	1,929	(441)	-	1,488
Transactions with Owners as Owners:				
Net assets received (transferred during year via machinery-of-Government change) Note 2 (h)			912	912
Non appropriated equity injections (Minor Capital works) Note 2 (e)			2,405	2,405
Non appropriated equity withdrawals (Depreciation funding) Note 2 (e)	-	-	(5,189)	(5,189)
Net Transactions with Owners as Owners	-	-	(1,872)	(1,872)
Balance as at 30 June 2014	7,948	2,373	85,513	95,835

* Comparatives have been adjusted for correction of error (see Note 30)

The accompanying notes form part of these statements

South West Hospital and Health Service

Statement of Cash Flows
for the year ended 30 June 2014

	Notes	2014 $'000	2013 $'000
Cash flows from operating activities			
Inflows:			
User Charges		7,469	8,722
Government funding*		94,236	95,399
Grants and other contributions		12,942	9,298
Interest receipts		19	23
GST input tax credits from ATO		2,453	1,942
GST collected from customers		100	85
Other receipts		446	857
		117,666	**116,324**
Outflows:			
Employee expenses		(916)	(632)
Health service labour expenses		(65,638)	(69,087)
Supplies and services		(40,156)	(32,782)
Grants and subsidies		6	(526)
GST paid to suppliers		(2,290)	(2,396)
GST remitted to ATO		(106)	(70)
Other		(748)	(1,436)
		(109,848)	**(106,929)**
Net cash provided by operating activities	22	**7,818**	**9,395**
Cash flows from investing activities			
Inflows:			
Sales of property, plant and equipment		12	32
Loans repaid		3	-
Outflows:			
Payments for property, plant and equipment		(1,850)	(2,512)
Net cash used in investing activities		**(1,835)**	**(2,480)**
Cash flows from financing activities			
Inflows:			
Cash transferred in under administrative arrangement		-	363
Equity Injections		2,405	1,758
Net cash provided by financing activities		**2,405**	**2,121**
Net increase in cash and cash equivalents		**8,388**	**9,036**
Cash and cash equivalents at the beginning of the financial year		9,036	-
Cash and cash equivalents at the end of the financial year		**17,424**	**9,036**

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

The accompanying notes form part of these statements

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1. Objectives and Principal Activities of the South West Hospital and Health Service

South West Hospital and Health Service (SWHHS) was established on 1 July 2012, as a not-for-profit statutory body under the *Hospital and Health Boards Act 2011*.

The HHS is responsible for providing primary health, community and public health services in the area assigned under the *Hospital and Health Boards Regulation 2012* . The South West HHS covers an area of 319,870 square kilometres in South West Queensland, and services an estimated population of 26,188 people

This includes responsibility for the direct management of four hospital facilities (Charleville, Cunnamulla, Roma and St George), seven multipurpose health services (MPHS), three community clinics and two residential aged care facilities - Waroona in Charleville and Westhaven in Roma.

Funding is obtained predominately through the purchase of health services by the Department of Health on behalf of both the State and Australian Government (refer Note 2(g)). In addition, health services are provided on a fee for service basis mainly for private patient care.

SWHHS provides services and outcomes as defined in a publicly available service agreement with the Department of Health (as manager of the public hospital system).

2. Summary of Significant Accounting Policies

(a) Statement of Compliance

The 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 Act 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 the Hospital and Health Service is a not-for-profit statutory body it has applied those requirements applicable to not-for-profit entities. Except where stated, the historical cost convention is used.

(b) The Reporting Entity

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

(c) Trust Transactions and Balances

South West Hospital and Health Service acts in a fiduciary trust capacity in relation to patient trust accounts. Consequently, these transactions and balances are not recognised in the financial statements. Although patient funds are not controlled by HHS, trust activities are included in the audit performed annually by the Auditor-General of Queensland. Note 27 provides additional information on the balances held in patient trust accounts.

(d) User Charges, Penalties and Fines

User charges and fees are recognised as revenues when earned and can be measured reliably with a sufficient degree of certainty. This involves either invoicing for related goods/services and/or the recognition of accrued revenue. Revenue in this category primarily consists of hospital fees (GP's private patients), reimbursements of pharmaceutical benefits, and sales of goods and services.

2. Significant Accounting Policies continued

(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 block funded. 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.

Depreciation funding

SWHHS 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 SWHHS. Theses outlays are funded by the State through the Department of Health as equity injections throughout the year. In 2013-14 the value of assets transferred was $2.405 million ($5.744 million in 2012-13).

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 SWHHS, funding received from the Department has been reclassified from grants received to government funding revenue. Comparatives have been restated to improve transparency across the years.

(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 if the services would have been purchased if they had not been donated and their fair value can be measured reliably. Where this is the case, an equal amount is recognised as revenue and an expense.

South West receives corporate services support from the Department of Health for no cost. Corporate services received include payroll services, accounts payable services, finance transactional services, taxation services, supply services and

2. Significant Accounting Policies continued

(f) Grants and Contributions continued

information technology services. As the fair value of these services is unable to be estimated reliably, no associated revenue and expense is recognised in the Statement of Comprehensive Income.

(g) Other Revenue

Other revenue primarily reflects recoveries of payments for contracted staff from third parties such as universities and other government agencies as well as recoveries of insurance claims from the Queensland Insurance Scheme.

(h) Administrative Arrangements

In 2012-13, 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.

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

	2013	
	$'000	
Cash and cash equivalents	363	
Receivables	3,951	
Inventories	368	
Other	15	
Property, plant and equipment	86,808	(see Note 30)
Payables	(4,348)	
Contributed equity	87,156	

SWHHS 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

In 2014, the Minister for Health signed an enduring designation of transfer for property, plant and equipment between Hospital and Health Services (HHS) and the Department of Health. This transfer is recognised through equity when the Chief Financial Officers of both entities agree in writing to the transfer. During this year a number of assets have been transferred under this arrangement.

	2014	*2013*
	$'000	*$'000*
Transfer in - practical completion of projects from the Department *	929	4,942
Net transfer of property plant and equipment to / from the Department	1,475	802
	2,405	5,744

* 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 SWHHS.

Non-operational housing - whole of Government initiative

Under a whole of Government initiative, management of all Government owned general purpose housing was transferred to the Department of Housing and Public Works on 1 July. As SWHHS does not possess legal title, the current leasing arrangement with the Department of Health will cease on these assets, representing approximately $6.4 million of buildings at 30 June 2014.

2. Significant Accounting Policies continued

(i) Special payments

Special payments include ex gratia expenditure and other expenditure that the HHS is not contractually or legally obligated to make to other parties. In compliance with the *Financial and Performance Management Standard 2009* , the HHS maintains a register setting out details of all special payments exceeding $5,000. The total of all special payments (including those of $5,000 or less) is disclosed separately within Other expenses (Note 12). However, descriptions of the nature of special payments are only provided for special payments greater than $5,000.

(j) Cash and Cash Equivalents

For the purposes of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques receipted but not banked at 30 June as well as deposits at call with financial institutions and cash debit facility. SWHHS operational bank accounts form part of the Whole-of-Government banking arrangement with the Commonwealth Bank of Australia.

Debit facility
Hospital and Health Service has access to the Whole-of-Government debit facility with limits approved by Queensland Treasury and Trade.

(k) Receivables

Trade debtors are recognised at their carrying value less any impairment. The recoverability of trade debtors is reviewed on an ongoing basis at an operating unit level. Trade receivables are generally settled within 120 days, while other receivables may take longer than twelve months.

Impairment of financial assets

Throughout the year, SWHHS assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes financial difficulties of the debtor, changes in debtor credit ratings and current outstanding accounts over 120 days. The allowance for impairment reflects SWHHS'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. Increases in the allowance for impairment are based on loss events as disclosed in Note 28 (c). All known bad debts are written off when identified.

(l) 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.

(m) Other non-financial assets

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

(n) Assets classified as held for sale

Assets held for sale consist of those assets that management has determined are available for immediate sale (highly probable within the next twelve months) in their present condition rather than through continuing use. There are no assets held for resale in 2014 (2013 nil).

In accordance with *AASB 5 Non-current Assets Held for Sale and Discontinued Operations* , when an asset is classified as held for sale, its value is measured at the lower of the asset's carrying amount and fair value less costs to sell. Any

2. Significant Accounting Policies continued

(n) Assets classified as held for sale continued

restatement of the asset's value to fair value less costs to sell (in compliance with AASB 5) is a non-recurring valuation. Such assets are no longer amortised or depreciated upon being classified as held for sale.

As outlined in Note 2 (h,) land and buildings under the operational control of SWHHS were transferred from the Department of Health under a Deed of Lease. As the Department continues to be the registered owner, SWHHS has a legal impediment to selling these assets. Where land and buildings are identified as held for sale by SWHHS, the Deed of Lease is partially surrended and the assets are returned to the Department for sale. SWHHS, under the partial leasing arrangement is required to effectively maintain and operate these assets until their disposal.

(o) Property, Plant and Equipment

Acquisition of assets

Actual cost is used for the initial recording of all non-current physical and intangible asset acquisitions. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use, including architects' fees and engineering design fees. However, any training costs are expensed as incurred . Items or components that form an integral part of an asset are recognised as a single (functional) asset.

Where assets are received free of charge from another Queensland Government entity (whether as a result of a machinery-of-Government change or other involuntary transfer), the acquisition cost is recognised as the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation. Assets acquired at no cost or for nominal consideration, other than from an involuntary transfer from another Queensland Government entity, are recognised at their fair value at the date of acquisition in accordance with AASB 116 Property, Plant and Equipment.

South West Hospital and Health Service holds property, plant and equipment in order to meet its core objective of providing quality healthcare that Queenslanders value. Items of property, plant and equipment with a cost or other value equal to more than the following thresholds and with a useful life of more than one year are recognised at acquisition. Items below these values are expensed on acquisition.

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

Land improvements undertaken by SWHHS are included with buildings.

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 HHS 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.

Legislation to enable the transfer the ownership of land and buildings was passed by State Parliament on 20 June 2012. A sub committee with representatives from the HHSs and the Department has been established to develop protocols to enable this transfer to occur. A project is in place to facilitate this process with ownership transfer to all HHS to be completed by mid 2015.

While the Department of Health retains legal ownership, effective control of these assets was transferred to the SWHHS. Under the terms of the lease the HHSs has full exposure to the risks and rewards of asset ownership however proceeds from the sale of major infrastructure assets cannot be retained by SWHHS, with funds to be returned to Consolidated Fund (the State).

2. Significant Accounting Policies continued

(o) Property, Plant and Equipment continued

SWHHS 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.

AASB 117 *Leased Assets* is not applicable to land and buildings, as no consideration in the form of lease payments are required under the agreement and accordingly fails to meet the criteria in section 4 of this standard for recognition.

(p) Revaluations of non-current physical assets

Land and buildings are measured at fair value in accordance with AASB 116 *Property, Plant and Equipment* , AASB 13 Fair Value Measurement and Queensland Treasury and Trade's *Non-Current Asset Policies for the Queensland Public Sector* . These assets are reported at their revalued amounts, being the fair value at the date of valuation, less any subsequent accumulated depreciation and impairment losses where applicable.

In respect of the abovementioned asset classes, the cost of items acquired during the financial year has been judged by management to materially represent their fair value at the end of the reporting period.

Plant and equipment, is measured at cost in accordance with the *Non-Current Asset Policies* . The carrying amounts for plant and equipment at cost should not materially differ from their fair value.

Land and building classes measured at fair value, are revalued on an annual basis either by comprehensive valuations or by the use of appropriate and relevant indices undertaken by independent professional valuers/quantity surveyors. Comprehensive revaluations are undertaken at least once every five years. However if a particular asset class experiences significant and volatile changes in fair value (i.e. where indicators suggest that the value of the class has changed by 20% or more since the previous reporting period), that class is subject to specific appraisal in the reporting period, where practical, regardless of the timing of the last specific appraisal. Assets under construction are not revalued until they are ready for use.

For financial reporting purposes, the revaluation process is determined by the SWHHS Board. The SWHHS Chief Finance Officer reports to the Audit Committee and the full SWHHS Board regarding the outcomes of SWHHS Chief Finance Officer recommendations arising from the revaluation processes.

The fair values reported by SWHHS are based on appropriate valuation techniques that maximises the use of available and relevant observable inputs and minimise the use of unobservable inputs (refer to Note (q)).

Where assets have not been specifically appraised in the reporting period, their previous valuations are materially kept up-to-date via the application of relevant indices. The HHS ensures that the application of such indices results in a valid estimation of the assets' fair values at reporting date. Land is measured at fair value on a rolling basis. The latest valuation was at 30 June 2013 was conducted by Davis Langdon.

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, a revised estimates of individual asset's depreciated replacement cost, or an interim indices which approximates movement in market prices for labour and other key resource inputs, as well as changes in design standards as at reporting date. These estimates are developed by independent quantity surveyors.

The independent valuers and quantity surveyors provides assurance of their robustness, validity and appropriateness

2. Significant Accounting Policies continued

(p) Revaluations of non-current physical assets continued

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

Early in the reporting period, the HHS reviewed all fair value methodologies in light of the new principles in AASB 13. Some minor adjustments were made to methodologies to take into account the more exit-oriented approach to fair value under AASB 13, as well as the availability of more observable data for certain assets (e.g. Land and general purpose buildings). Such adjustments - in themselves - did not result in a material impact on the values for the affected property, plant and equipment classes.

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

On revaluation, accumulated depreciation is restated proportionately with the change in the carrying amount of the asset and any change in the estimate of remaining useful life. Materiality concepts under AASB 1031 Materiality are considered in determining whether the difference between the carrying amount and the fair value of an asset is material. Separately identified components of assets are measured on the same basis as the assets to which they relate.

(q) Fair value measurement

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

Observable inputs are publicly available data that are relevant to the characteristics of the assets/liabilities being valued, and include, but are not limited to, published sales data for land and residual dwellings.

Unobservable inputs are data, assumptions and judgements that are not available publicly, but are relevant to the characteristics of the assets/liabilities being valued. Significant unobservable inputs used by SWHHS include, but are not limited to, subjective adjustments made to observable data to take account of the specialised nature of health service buildings and on hospital-site residential facilities, including historical and current construction contracts (and/or estimates of such costs), and assessments of physical condition and remaining useful life. Unobservable inputs are used to the extent that sufficient relevant and reliable observable inputs are not available for similar assets/liabilities.

A fair value measurement of a non-financial asset takes into account a market participant's ability to generate economic benefit by using the asset in its highest and best use or by selling it to another market participant that would use the asset in its highest and best use.

All assets and liabilities of the HHS for which fair value is measured or disclosed in the financial statements are categorised within the following fair value hierarchy, based on the data and assumptions used in the most recent specific appraisals:

* level 1 - represents fair value measurements that reflect unadjusted quoted market prices in active markets for identical assets and liabilities;
* level 2 - represents fair value measurements that are substantially derived from inputs (other than quoted prices included in level 1) that are observable, either directly or indirectly; and
* level 3 - represents fair value measurements that are substantially derived from unobservable inputs.

2. Significant Accounting Policies continued

(q) Fair value measurement continued

None of SWHHS's valuations of assets or liabilities are eligible for categorisation into level 1 of the fair value hierarchy. As 2013-14 is the first year of application of AASB 13 by SWHHS, there were no transfers of assets between fair value hierarchy levels during the period. More specific fair value information about the HHS's property, plant and equipment is outlined in Note 17.

(r) Depreciation

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

Assets under construction (work-in-progress) are not depreciated until they reach service delivery capacity. Service delivery capacity relates to when construction is complete and the asset is first put to use or is installed ready for use in accordance with its intended application. These assets are then reclassified to the relevant classes within property plant and equipment. Where assets have separately identifiable components that are subject to regular replacement, these components are assigned useful lives distinct from the asset to which they relate and are depreciated accordingly.

In accordance with Queensland Treasury and Trade's Non-current Asset Policy Guideline 2, SWHHS has determined material specialised health service buildings are complex in nature. A review was undertaken to assess whether the componentisation of building assets with separate useful lives assigned to component parts would make a material difference to the depreciation expense for the year. The review indicated that the difference was not material, this review will be repeated in the 2015 financial year.

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

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

Class	Depreciation rates
Buildings and Improvements	2.5% - 3.33%
Plant and equipment	5.0% - 20.0%

Leased 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. SWHHS has no other assets subject to finance lease.

(s) 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 possible impairment exists, SWHHS determines the asset's recoverable amount (higher of value in use and fair value less costs to sell). Any amount by which the asset's carrying amount exceeds the recoverable amount is considered an impairment loss. An impairment loss is recognised immediately in the Statement of Comprehensive Income, unless the asset is carried at a revalued amount, in which case the impairment loss is offset against the asset revaluation surplus of the relevant class to the extent available.

2. Significant Accounting Policies continued

(s) Impairment of non-current assets continued

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. Refer also Note 2 (p).

(t) Payables

Payables are recognised for amounts to be paid in the future for goods and services received. Trade creditors are measured at the agreed purchase/contract price, gross of applicable trade and other discounts. The amounts are unsecured and normally settled within 30 - 60 days.

(u) Financial instruments

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

Financial instruments are classified and measured as follows:

- Cash and cash equivalents - held at fair value through profit or loss
- Receivables - held at amortised cost
- Payables - held at amortised cost

South West Hospital and Health Service does not enter into transactions for speculative purposes, nor for hedging. Apart from cash and cash equivalents, the HHS 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 SWHHS are included in Note 28.

(v) Employee benefits and Health Service labour expenses

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

(i) Health Service labour expenses

In 2013-14 the South West Hospital and Health Service was not a prescribed employer and accordingly all non-executive staff were employed by the department. Provisions in the HHB Act enable HHS to perform functions and exercise powers to ensure the delivery of its operational plan.

Under this arrangement:

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

As a result of this arrangement, the Hospital and Health Service treats the reimbursements to the Department of Health for departmental employees in these financial statements as health service labour expenses and detailed in Note 8. In addition to the employees contracted from the Department of Health, the Hospital and Health Service has engaged employees directly. The information detailed below relates specifically to the directly engaged employees.

2. Significant Accounting Policies continued

(v) Employee benefits and Health Service labour expenses continued

(ii) Hospital and Health Service's directly engaged employees

SWHHS classifies salaries and wages, rostered days-off, sick leave, annual leave and long service leave levies and employer superannuation contributions as employee benefits in accordance with *AASB 119 Employee Benefits* (Note 7). Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at current salary rates. As SWHHS expects such liabilities to be wholly settled within 12 months of reporting date, the liabilities are recognised at undiscounted amounts.

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

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

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. SWHHS was admitted into this arrangement effective 1 July 2012. Under this scheme, a levy is made on SWHHS 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 all HHS's. No provision for annual leave is recognised in SWHHS' financial statements as the liability is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting* .

Long Service Leave

Under the Queensland Government's Long Service Leave Scheme, a levy is made on SWHHS to cover the cost of employees' long service leave. The levies are expensed in the period in which they are payable. 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 reimbursement process on behalf of the HHS. No provision for long service leave is recognised in the HHS' financial statements as the liability is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting* .

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

2. Significant Accounting Policies continued

(v) Employee benefits and Health Service labour expenses continued

Board members and Visiting Medical Officers are offered a choice of superannuation funds and SWHHS pays superannuation contributions into a complying superannuation fund. Contributions are expensed in the period in which they are paid or payable. SWHHS's obligation is limited to its contribution to the superannuation fund. Therefore no liability is recognised for accruing superannuation benefits in the Hospital and Health Service'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 disclosures on key executive management personnel and remuneration.

(w) Unearned revenue

Monies received in advance primarily for rental income and fees for services yet to be provided are represented as unearned revenue.

(x) Insurance

The Department of Health insures property and general losses above a $10,000 threshold through the Queensland Government Insurance Fund (QGIF). Health litigation payments above a $20,000 threshold and associated legal fees are also insured through QGIF. QGIF collects from insured agencies an annual premium intended to cover the cost of claims occurring in the premium year.

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 SWHHS 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 to the department.

(y) Contributed equity

Non-reciprocal transfers of assets and liabilities between wholly-owned Queensland Government entities as a result of machinery-of-Government changes are adjusted to Contributed Equity in accordance with Interpretation 1038 Contributions by Owners Made to Wholly-Owned Public Sector Entities.

(z) Federal taxation charges

SWHHS is a State body as defined under the Income Tax Assessment Act 1936 and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). 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 SWHHS reimbursed to/from the department on a monthly basis. GST credits receivable from, and GST payable to the ATO, are recognised on this basis. Refer to Note 14.

(aa) Issuance of Financial Statements

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

2. Significant Accounting Policies continued

(ab) Critical accounting judgements and key sources of estimation uncertainty

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

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

- Property, plant and equipment – Note 17
- Contingencies – Note 25

The Australian government passed its *Clean Energy Act* in November 2011 which resulted in the introduction of a price on carbon emissions made by Australian businesses from 1 July 2012. The withdrawal of the carbon pricing mechanism by the government in July 2014 is not expected to have a significant impact on SWHHS's critical accounting estimates, assumptions and management judgements.

(ac) Rounding and comparatives

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

Comparative information has been restated where necessary to be consistent with disclosures in the current reporting period. In particular, separate disclosure of government funding (Note 4), previously part of (Note 5) grant and other contributions, and a correction of an error (Notes 17 and 30) resulting from overstated/understated property values in the 2012-13 valuation report have resulted in comparative figures being restated.

(ad) New and revised accounting standards

The only Australian Accounting Standard changes applicable for the first time as from 2013-14 that have had a significant impact on the HHS's financial statements are those arising from AASB 13 *Fair Value Measurement* , as explained below. 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 impact of AASB 13 relate to the fair value measurement methodologies used and financial statement disclosures made in respect of such assets and liabilities.

SWHHS 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. Note 2 (q) explains some of the principles underpinning the additional fair value information disclosed. Most of this additional information is set out in Note 18 Property Plant and Equipment.

A revised version of AASB 119 *Employee Benefits* became effective for reporting periods beginning on or after 1 January

2. Significant Accounting Policies continued

(ad) New and revised accounting standards continued

2013 with the majority of changes to be applied retrospectively. Given SWHHS's circumstances, the only implication for the HHS was the revised concept of 'termination benefits' and the revised recognition criteria for termination benefit liabilities. 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, termination benefits need to be measured according to the AASB 119 requirements for 'other long-term employee benefits'. Under the revised standard, the recognition and measurement of employer obligations for 'other long-term employee benefits' will need to be accounted for according to most of the requirements for defined benefit plans.

The revised AASB 119 includes changed criteria for accounting for employee benefits as 'short-term employee benefits'. However, as the HHS is a member of the Queensland Government central schemes for annual leave and long service leave this change in criteria has no impact on the HHS's financial statements as the employer liability is held by the central scheme. The revised standard also includes changed requirements for the measurement of employer liabilities/assets arising from defined benefit plans, and the measurement and presentation of changes in such liabilities and assets. SWHHS makes employer superannuation contributions only to the QSuper defined benefit plan, and the corresponding QSuper employer benefit obligation is held by the State. Therefore, those changes to AASB119 will have no impact on the HHS.

AASB 1053 *Application of Tiers of Australian Accounting Standards* became effective for reporting periods beginning on or after 1 July 2013. AASB 1053 establishes a differential reporting framework for those entities that prepare general purpose financial statements, consisting of two Tiers of reporting requirements - Australian Accounting Standards (commonly referred to as 'Tier 1'), and Australian Accounting Standards - Reduced Disclosure Requirements (commonly referred to as 'Tier 2'). Tier 1 requirements comprise the full range of AASB recognition, measurement, presentation and disclosure requirements that are currently applicable to reporting entities in Australia. The only difference between the Tier 1 and Tier 2 requirements is that Tier 2 requires fewer disclosures than Tier 1.

Pursuant to AASB 1053, public sector entities like SWHHS may adopt Tier 2 requirements for their general purpose financial statements. However, AASB 1053 acknowledges the power of a regulator to require application of the Tier 1 requirements. In the case of SWHHS, Queensland Treasury and Trade is the regulator. Queensland Treasury and Trade has advised that it is its policy decision to require adoption of Tier 1 reporting by all Queensland government departments and statutory bodies (including SWHHS) that are consolidated into the whole-of-Government financial statements. Therefore, the release of AASB 1053 and associated amending standards has had no impact on SWHHS.

South West Hospital and Health Service 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 SWHHS has not applied any Australian Accounting Standards and Interpretations that have been issued but are not yet effective. SWHHS 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 South West Hospital and Health Service in future periods. The potential effect of the revised Standards and Interpretations on the Hospital and Health Service's financial statements is not expected to be significant but a full review has not yet been completed.

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

- AASB 1055 Budgetary Reporting applies to reporting periods beginning on or after 1 July 2014. SWHHS 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.

2. Significant Accounting Policies continued

(ad) New and revised accounting standards continued

The following new and revised standards apply as from reporting periods beginning on or after 1 January 2014:

- *AASB 10 Consolidated Financial Statements;*
- *AASB 11 Joint Arrangements;*
- *AASB 12 Disclosure of Interests in Other Entities;*
- *AASB 127 (revised) Separate Financial Statements;*
- *AASB 128 (revised) Investments in Associates and Joint Ventures;*
- *AASB 2011-7 Amendments to Australian Accounting Standards arising from the Consolidation and Joint* Arrangements Standards [AASB 1, 2, 3, 5, 7, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 1023 & 1038 and Interpretations 5, 9, 16 & 17]; and
- *AASB 2013-8 Amendments to Australian Accounting Standards - Australian Implementation Guidance for* Not-for-Profit Entities - Control and Structured Entities.

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, SWHHS has reviewed the nature of its relationships with entities that the HHS is connected with to determine the impact of AASB 2013-8. Currently SWHHS does not have control over any other entities.

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. SWHHS 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, SWHHS 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 Instrument* s and AASB 2010-7 A*mendments 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, 5, 10, 12,19 & 127] will become effective for reporting periods beginning on or after 1 January 2017.

The main impacts of these standards on SWHHS are that they will change the requirements for the classification, measurement and disclosures associated with SWHHS'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 AASB 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 approximate of fair value so 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.

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

2. Significant Accounting Policies continued

(ae) Voluntary Change in Accounting Policy

SWHHS 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 SWHHS.

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 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, SWHHS now recognises $94.1 million as Government funding revenue for 2013-14 rather than as grants revenue which occurred during 2012-13. The main effect is that the revenue is now recognised under the criteria detailed in AASB 118 Revenue for 2013-14, rather than under AASB 1004 Contributions in 2012-13. The revenue recognition criteria is described in Note 2E Funding Public Health Services and Note 2 (f) Grants and Other Contributions.

This change in accounting policy has been applied retrospectively with the effect that grants and other contributions revenue for 2012-13 has reduced by $97.5 million and funding public health services has increased by the same amount. A review of the balance of funding revenue currently classified as Grants and Other Contributions will be undertaken in 2014-15.

(af) Subsequent Events Note

Transfer of Housing Assets
As part of a whole of Government initiative, management of employee housing assets transitioned to the Department of Housing and Public Works (DPHW) on 1 July 2014. Legal ownership of housing assets will transfer to the DHPW on 1 July 2014. As at 30 June 2014 South West HHS held assets with a total net book value of $6.4 million under a Deed of Lease arrangement with the Department of Health. These housing assets initially transferred to South West HHS at no cost to SWHHS. Effective 1 July 2014, the Deed of Lease arrangement in respect of these assets will cease, and the assets will be transferred for no consideration to the Department of Health at their net book value as at 30 June 2014, prior to their transfer to the DHPW.

As this transfer will be designated as transaction with Owners, the transfer will be undertaken through the South West HHS's Equity account during 2014-15. Therefore, this transaction will have no impact on the Statement of Comprehensive Income in the 2014-15 Financial year.

Transfer of Legal Ownership of Health Service Land and Buildings
The control of health services land and buildings transferred to each Hospital and Health Service (HHS) at no cost to the HHS through deed of lease arrangements when HHS's were established on 1 July 2012. The Department of Health retained legal ownerhsip of the health services land and buildings, however the intention was for legal title of the assets to eventually transfer to each HHS.

Due to effective control of the assets transferring to HHSs, these assets are recognised within the financial statements of each 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 legal 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 South West HHS will occur from 1 July 2015. There is no material impact for the financial statemetns as these assets are already controlled and recognised by the HHS.

3. User charges

	2014 *$'000*	*2013* *$'000*
Sales of goods and services	1,847	2,184
Hospital fees	4,433	3,904
Rental income	25	74
	6,306	**6,162**

4. Government funding

	Share of funding		*2014*	*2013*
	State	Australian Government	*$'000*	*$'000*
National Health Reform*				
Block funding	32,836	18,486	51,322	58,645
Health, Teaching, Training & Research funding	429	255	684	-
General purpose funding	48,053	-	48,053	43,349
Total National Health Reform funding			**100,059**	**101,994**

* refer Note 2 (e). The Australian Government pays it share of National Health funding directly to the Department of Health, for on forwarding to the Hospital and Health Service.

5. Grants and other contributions

Australian Government grants		
Nursing home grants	4,257	3,750
Home and community care grants	1,223	1,273
Specific purpose - Multipurpose centre	4,606	3,819
Total Australian Government grants	10,086	8,842
Other		
Services received at below fair value		
Other grants	788	457
	10,874	**9,298**

6. Other revenue

Licences and registration charges	3	1
Recoveries	389	756
Other	57	32
Inventory stock adjustments	2	1
	451	**789**

7. Employee expenses

Employee benefits		
Wages and Salaries	799	455
Annual leave levy	56	35
Employer superannuation contributions	75	30
Long service leave levy	8	5

7. Employee expenses continued

	2014 $'000	2013 $'000
Employee related expenses		
Redundancies	-	-
Workers compensation premium	-	(0)
Payroll tax	31	22
Other employee related expense	56	116
	1,025	**662**

The number of employees including both full-time employees and part-time employees measured on a full-time equivalent basis (reflecting Minimum Obligatory Human Resource Information (MOHRI)) is:

	2014 Staff Nos.	2013 Staff Nos.
Number of Employees Refer to Note 2(v).	2	1

Note : Board members are included although they do not contribute to the MOHRI. Key executive management and personnel are reported in Note 29.

8. Health service labour expenses

	2014 $'000	2013 $'000
Department of Health - health service employees*	**66,517**	**69,087**

The Hospital and Health Service through service arrangements with the Department of Health has engaged a further 685 full-time equivalent persons (reflecting Minimum Obligatory Human Resource Infomration (MOHRI)). (2013 662 MOHRI) Refer to Note 2 (v) (i) for further details on the contractual arrangements.

9. Supplies and services

Building services	671	591
Catering and domestic supplies	1,456	1,372
Clinical supplies and services	2,558	2,104
Communications	527	595
Computer services	1,109	985
Consultants and contractors	14,291	12,276
Drugs	913	949
Electricity and other energy	2,005	1,810
Minor works including plant and equipment	313	330
Motor vehicles	167	270
Operating lease rentals	1,475	1,439
Other	1,208	1,006
Other travel	1,822	1,841
Pathology, blood and parts	2,158	1,362
Patient transport	4,728	4,659
Patient travel	1,779	1,638
Repairs and maintenance	4,146	3,199
	41,327	**36,426**

10. Depreciation and amortisation

	2014 *$'000*	*2013* *$'000*
Depreciation and amortisation expenses for the financial year were charged in respect of:		
Buildings and land improvements	3,668	3,188
Plant and equipment	1,528	1,341
	5,196	**4,529**

Queensland Treasury and Trade's Non Current Asset Policy (No 2) requires where significant components of a building are replaced at varying intervals i.e. different useful lives, and the impact is material to depreciation expense, componentisation is to be applied.

An assessment of the actual replacement cycle for components within special purpose buildings (representing 86% of buildings controlled by SWHHS) and the impact on depreciation expense has been undertaken by 30 June 2014. The difference in depreciation is not considered material. In 2014, twenty six complex buildings were revalued using depeciated replacement cost methodology. The useful lives were also reassessed by the valuer (based on physical inspection and review of replacement history) replacing a single useful life for the entire building with three useful lives (one per major component) reflecting the consumption and replacement patterns within SWHHS. There was no material impact on the depreciation expense as a result of this process.

11. Impairment losses

Plant and equipment	-	-
Impairment losses on trade receivables*	84	41
	84	**41**

* Refer Note 14.

12. Other expenses

Advertising	100	28
Bank fees	7	4
External audit fees*	242	62
Insurance**	744	962
Internal audit fees	114	108
Interpreter fees	4	4
Inventory written off	65	73
Losses from the disposal of non-current assets	(6)	17
Other	250	127
Other legal costs	86	138
Special payments - ex-gratia payments	6	3
	1,613	**1,526**

*Total audit fees paid to the Queensland Audit Office relating to the 2013-14 financial year are estimated to be $150,000 (2013: $154,000) including out of pocket expenses. There are no non-audit services included in this amount. During 2014 audit fees amounting to $94,000 were paid in relation to the 2013 financial year.

** 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 (x). The Under Treasurer's approval has been obtained for entering into the insurance contracts.

13. Cash and cash equivalents

	2014 *$'000*	*2013* *$'000*
Imprest accounts	7	7
Cash at bank*	17,106	8,684
QTC cash funds*	311	345
	17,424	**9,036**

* Refer Note 26 restricted assets

SWHHS'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 it charged interest or fees for accessing its approved cash debit facility. Any interest earned on the WoG fund accrues to the Consolidated Fund.

General trust bank and term deposits do not form part of the WoG banking arrangement and incur fees as well as earn interest. Cash deposited with Queensland Treasury Corporation earns interest, calculated on a daily basis reflecting market movements in cash funds. Rates achieved throughout the year range between 3.3% to 4.2% (2013: 3.5% to 5%).

14. Receivables

Trade debtors	191	808
Payroll receivables	626	537
Less: Allowance for impairment	(104)	(67)
Sub total	713	1,277
GST receivable	292	455
GST payable	(8)	(14)
Sub total	283	441
Government funding receivable	0	2,069
Total	**996**	**3,787**

Movements in the allowance for impairment loss

Balance at beginning of the year	68	-
Balance transferred in on establishment of HHS	-	55
Amounts written off during the year	(48)	(8)
Amount recovered during the year	-	(20)
Increase/(decrease) in allowance recognised in operating result	84	41
Balance at the end of the year	**104**	**68**

Trade debtors includes receivables of $0.2 million (2013: $3.1 million) from health funds (reimbursement of patient fees) and no amounts (2013: $2.069 million) from the Australian Government for Multi Purpose Health Services and Pharmacy Pharmaceutical Benefits Scheme claims.

15. Inventories

Inventories held for distribution - at weighted average cost		
Medical supplies and equipment	612	608
Catering and domestic	10	9
Other	6	11
	629	**628**

16. Other

Prepayments	179	38
	179	**38**

17. Property, plant and equipment

	2014 *$'000*	*2013* *$'000*
Land*		
At fair value	8,494	8,494
Buildings*		
At fair value	162,071	161,398
Less: Accumulated depreciation	(90,062)	(86,190)
	72,009	75,209
Plant and equipment		
At cost	16,989	15,290
Less: Accumulated depreciation	(10,170)	(9,139)
	6,819	6,151
Capital works in progress		
At cost	383	733
Total property, plant and equipment	**87,704**	**90,586**

* Refer Note 2 (o) and note 30

Land

Land is measured at fair value using independent revaluations by Davis Langdon Quantity Surveyors. Independent revaluations are performed with sufficient regularity to ensure assets are carried at fair value. The most recent valuation of land was as at 30 June 2013, South West considers the valuation and indexation frequency as necessary.

Building

Reflecting the specialised nature of health service buildings and on hospital-site residential facilities, fair value is determined using depreciated replacement cost methodology, due to there not being an active market for such facilities. 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, a revised estimates of individual asset's depreciated replacement cost, or an interim indices which approximates movement in price and design standards as at reporting date. These estimates are developed by independent quantity surveyors.

In 2013, SWHHS engaged independent quantity surveyors, Davis Langdon Australia Pty Ltd (Davis Langdon) to comprehensively revalue all buildings exceeding a predetermined materiality threshold and calculate relevant indices for all other assets.

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 internal records of the original cost, adjusted for more contemporary design/construction approaches 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. Area estimates were compiled by measuring floor areas of Project Services e-plan room or drawings obtained from SWHHS. Refurbishment costs were derived from specific projects and are therefore indicative of actual costs.

17. Property, plant and equipment continued

In determining the asset to be revalued the measurement of key quantities include:

- Gross floor area
- Number of floors
- Girth of the building
- Height of the building
- Number of lifts and staircases.

Significant judgement is also used to assess the remaining service potential of the facility, given local climatic and environmental conditions and records of the current condition of the facility.

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.

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

Category	Condition
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 regulation's 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 fitout and engineering services required (up to 70% of capital replace 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. Refer Note 2 (p) & (q) for further details on the revaluation methodology applied.

SWHHS has no plant and equipment with a written down value of zero still being used in the provision of services. (2013: nil)

17. Property, plant and equipment continued

Reconciliations of the carrying amount for each class of property, plant and equipment are set out below:

	Land	Buildings	Plant & equipment	Work in progress	Total
	$'000	$'000	$'000	$'000	$'000
As at 1 July 2012	-	-	-	-	-
Acquisitions through restructuring (Note 2 h) #	8,444	70,699	6,173	1,528	86,844
Acquisition major infrastructure transfers	-	(1,024)	-	-	(1,024)
Acquisitions	-	814	1,178	519	2,511
Disposals	-	-	(17)	-	(17)
Assets reclassified as held for sale	-	-	-	-	-
Transfer between classes	(282)	1,306	-	(1,024)	-
Transfers in from Public Health	-	4,277	-	(290)	3,987
Revaluation Increments/(decrements)	331	2,483	-	-	2,814
Impairment gains/(loss) recognised in equity	-	-	-	-	-
Depreciation charge	-	(3,346)	(1,183)	-	(4,529)
As at 30 June 2013	**8,494**	**75,209**	**6,151**	**732**	**90,586**

Reconciliations (including fair value levels refer Note 2 (q)) of the carrying amount for each class of property, plant and equipment are set out below:

	Land*		Buildings**		Plant & equipment	Work in progress	Total
	Level 2 $'000	Level 3 $'000	Level 2 $'000	Level 3 $'000	$'000	$'000	$'000
As at 1 July 2013	2,586	5,908	3,816	71,393	6,151	732	90,586
Acquisition major infrastructure transfers	-		-	-	-	-	-
Acquisitions	-		-	559	2,196	0	2,755
Disposals							
Transfer between classes	-		-	350	-	(350)	-
Transfers in from Public Health							-
Revaluation Increments/ (decrements)	-			(441)	-	-	(441)
Depreciation	-			(3,668)	(1,528)	-	(5,196)
As at 30 June 2014	**2,586**	**5,908**	**3,816**	**68,193**	**6,819**	**382**	**87,704**

* Land level 2 assets represent vacant land in an active market whereas level 3 assets are land parcels with no active market and/or significant restrictions.

** Buildings level 2 assets represent offsite residential dwellings in an active market whereas level 3 are special purpose built buildings with no active market.

refer Note 30 correct of error.

17. Property, plant and equipment continued

Level 2 & 3 significant valuation inputs and relationship to fair value

Description	Fair value at 30 June 2014	Significant unobservable inputs used in valuation	Possible alternative values for level 3 inputs	Sensitivity of fair value to change in level 3 inputs
Land where no active markets and/or significant restrictions apply	8,494	The professional valuation is based on usage and sale restrictions imposed from the Department of Health	n.a	n.a
Building - special purpose hospital facilities	72,009	Estimate of remaining economic lives. The current portfolio has a weighted average of just under 20 years	Varies from 5 to 37 years	A years variance in life would alter depreciation charge by approximately 5% on a weighted basis.
		Replacement cost estimates	During the current year cost indice movement was zero	An increase in the replacement cost will increase the depreciated replacement cost
		Cost to bring to current standard	During the current year cost indice movement was zero	An increase in the cost to bring a building up to standard will decrease the net book value
		Condition Rating	Varies from 3 to 5 (worst)	A change to a 5 rating will reduce the net book value to salvage value.

Level 3 inputs are defined as unobservable inputs for the asset or liability. Unobservable inputs have no market data and are developed using the best information available about the assumptions that market participants would use when pricing the the asset or liability. All land owned by SWHHS on which medical facilities are located are subject to restrictions on disposal imposed by the Department of Health. Accordingly there is no market for such land.

SWHHS owns 25 residential houses throughout the district which are not subject to this restriction with a net book value of $6.4 million. These assets would meet the criteria for level 2 in future valuations (ie using observable market data) however as these properties will be transferring to DHPW on 1 July 2014 no valuations were sought in 2014.

18. Payables

	2014	*2013*
	$'000	*$'000*
Trade creditors	9,733	4,294
Accrued health service labour - Department of Health*	1,288	3,535
Other	1	1
* Refer Note 2 (v) (i)	**11,022**	**7,831**

19. Accrued employee benefits

Salaries and wages accrued	12	24
Other employee entitlements payable	11	-
	23	**24**

20. Unearned revenue

	2014 *$'000*	*2013* *$'000*
Revenue in advance	51	1
	51	**42**

21. Asset revaluation surplus by class

Land		
Balance at the beginning of the financial year	331	-
Revaluation increment/(decrement)	-	331
Balance at the end of the financial year	331	331
Buildings		
Balance at the beginning of the financial year	2,483	-
Revaluation increment/(decrement)	(441)	2,483
Impairment gains (losses) through equity	-	-
Balance at the end of the financial year	2,042	2,483
Total	**2,373**	**2,814**

The asset revaluation surplus represents the net effect of revaluation movements in assets.

22. Cash flows

Reconciliation of operating result to net cash flows from operating activities

Operating Result	1,929	6,019
Non-cash movements :		
Depreciation and amortisation	5,196	4,529
Depreciation grant funding	(5,189)	(4,526)
Net (gain)/loss on disposal/revaluation of non-current assets	-	(15)
Impairment on receivables	-	72
Reversal of impairment loss receivables	36	41
Change in assets and liabilities after adjustment for transfers in form restructure*:		
(Increase)/decrease in receivables	2,597	564
(Increase)/decrease in GST receivables	163	(455)
(Increase)/decrease in inventories	(1)	(331)
(Increase)/decrease in prepayments	(141)	(23)
Increase/(decrease) in accounts payable	5,439	1,556
Increase/(decrease) in accrued contract labour	(2,247)	1,927
Increase/(decrease) in accrued employee benefits	(2)	24
Increase/(decrease) in GST payable	(6)	14
Increase/(decrease) in unearned funding revenue	50	-
Total non-cash movements	5,897	3,377
Cash flows from operating activities	**7,818**	**9,396**

* Refer Note 2 (g).

23. Non-cash financing and investing activities

Assets and liabilities received or transferred by the Hospital and Health Service are set out in the Statement of Changes in Equity and Note 2 (h).

24. Expenditure commitments

	2014	*2013*
(a) Non-cancellable operating leases	*$'000*	*$'000*

Commitments under operating leases at reporting date are inclusive of anticipated GST and are payable as follows:

Not later than one year	-	1,041
Later than one year and not later than five years	-	289
Total	**-**	**1,330**

SWHHS has non-cancellable operating leases relating predominantly to office and residential accommodation. Lease payments are generally fixed, but with escalation clauses on which contingent rentals are determined. No lease arrangements contain restrictions on financing or other leasing activities. The leases reported in 2013 have now been determined to be cancellable.

(b) Capital expenditure commitments

Material classes of capital expenditure commitments inclusive of anticipated GST, contracted for at reporting date but not recognised in the accounts are payable as follows:

	2014	*2013*	*2014*	*2013*
	$'000	$'000	$'000	$'000
	Buildings	Buildings	Plant and Equipment	Plant and Equipment
Not later than 1 year	-	-	-	-

SWHHS has commenced a tender process for approximately $4 million (2013 nil) worth of capital works although no formal contracts have been executed.

25. Contingent assets and liabilities

(a) Litigation in progress

As at 30 June 2014, the following cases were filed in the courts naming the State of Queensland acting through the South West Hospital and Health Service as defendant:

	2014 Number of cases	2013 Number of cases
Federal Court	0	0
Supreme Court	0	0
Magistrates Court	0	0
Tribunals, commissions and boards	1	1
	1	1

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). SWHHS's liability in this area is limited to an excess per insurance event of $20,000 - refer Note 2(x). As at 30 June 2014, SWHHS has 1 claim (2013: 1) currently managed by QGIF, some of which may never be litigated or result in payments to claims (excluding initial notices under Personal Injuries Proceedings Act). Tribunals, commissions and board figures represent the matters that have been referred to QGIF for management. SWHHS's legal advisers and management believe it would be misleading to estimate the final amounts payable (if any) in respect of the litigation before the courts at this time.

b) Native Title

As at 30 June 2014, the South West Hospital and Health Services does not have legal title to properties under its control, refer Note 2 (o). The Department of Health remains the legal owner of health service properties. Currently two of these properties are subject to a Deed of Grant in Trust (land is held by traditional owners) and recorded at nominal value.

25. Contingent assets and liabilities continued

b) Native Title continued

The Queensland Government's Native Title Work Procedures were designed to ensure that native title issues are considered in all land and natural resource management activities. All dealings pertaining to land held by or on behalf of the department must take native title into account before proceeding. These dealings include disposal, acquisition, development, redevelopment, clearing, fencing and the granting of leases, licences or permits and so on. Real Property Dealings may proceed on department owned land where native title continues to exist, provided native title holders or claimants receive the necessary procedural rights.

Queensland Health undertakes native title assessments over real property when required and is currently negotiating a number of Indigenous Land Use Agreements (ILUA) with native title holders. These ILUAs will provide trustee leases to validate the tenure of current and future health facilities. The National Title Tribunal reported a total of nil (2013: nil) native title claims against property under the control of the South West Hospital and Health Service.

26. Restricted assets

Contributions are also received from benefactors in the form of gifts, donations and bequests for stipulated purposes. At 30 June 2014, amounts of $330 thousand in General Trust, ($374 thousand 2012-13) were set aside. SWHHS has no Right of Private Practice Option B receipts and payments.

27. Fiduciary trust transactions and balances

SWHHS 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.

Patient Trust receipts and payments	*2014*	*2013*
Receipts	$'000	$'000
Patient trust receipts	1,219	1,103
Total receipts	1,219	1,103
Payments		
Patient trust related payments	1,215	1,135
Total payments	1,215	1,135
Increase/ in net patient trust assets	4	(32)
Patient trust assets opening balance 1 July 2013	229	261
Patient trust assets		
Current assets		
Cash at bank and on hand	234	228
Patient trust and refundable deposits	1	1
Total current assets	**235**	**229**

28. Financial Instruments

(a) Categorisation of financial instruments

SWHHS has the following categories of financial assets and financial liabilities:

Category	***Note***		
Financial assets			
Cash and cash equivalents	13.	17,424	9,036
Receivables	14.	996	3,787
Total		**18,420**	**12,822**

28. Financial Instruments continued

(a) Categorisation of financial instruments continued

	Note		2014 $'000	2013 $'000
Financial liabilities				
Financial liabilities measured at amortised cost:				
Payables		18.	11,022	7,831
Total			**11,022**	**7,831**

(b) Financial risk management

SWHHS'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 SWHHS's policy. These policies focus on the unpredictability of financial markets and seek to minimise potential adverse effects on the financial performance of SWHHS.

SWHHS 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

(c) Credit risk exposure

Credit risk is the potential for financial loss arising from a counterparty defaulting on its obligations. The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any allowance for impairment. The carrying amount of receivables represents the maximum exposure to credit risk. As such, receivables are not included in the disclosure below. Refer Note 13 for further information.

Credit risk is considered minimal given all SWHHS deposits are held by the State through Queensland Treasury Corporation.

Maximum exposure to credit risk	***Note***	***2014 $'000***	***2013 $'000***
Cash	13	17,424	9,036

No collateral is held as security and no credit enhancements relate to financial assets held by SWHHS.

No financial assets and financial liabilities have been offset and presented net in the Statement of Financial Position.

SWHHS manages credit risk through the use of a credit management strategy. This strategy aims to reduce the exposure to credit default by ensuring that the SWHHS invests in secure assets and monitors all funds owed on a timely basis. Exposure to credit risk is monitored on an ongoing basis.

Through out the year, SWHHS assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes financial difficulties of the debtor, changes in debtor credit ratings and current outstanding accounts over 120 days. The allowance for impairment reflects SWHHS'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 debt/group of debtors. If SWHHS determines that an amount owing by such a debtor does become uncollectible (after appropriate range of debt

28. Financial Instruments continued

(c) Credit risk exposure continued

recovery actions), that amount is recognised as a bad debt expense and written-off directly against receivables. In other cases where a debt becomes uncollectible but the uncollectible amounts exceeds the amount already allowed for impairment of that debt, the excess is recognised directly as a bad debt expense and written-off directly against receivables. Impairment loss expense for the current year regarding receivables is $36 thousand (2013: $13 thousand).

Ageing of past due but not impaired as well as impaired financial assets are disclosed in the following tables:

Financial assets past due but not impaired 2014

		Overdue $'000			
	Not overdue $'000	*Less than 30 days*	*30-60 days*	*61-90 days*	*More than 90 days*	*Total*
Receivables	491	146	39	42	99	817
Total	**491**	**146**	**39**	**42**	**99**	**817**

Financial assets past due but not impaired 2013

		Overdue $'000			
	Not overdue $'000	*Less than 30 days*	*30-60 days*	*61-90 days*	*More than 90 days*	*Total*
Receivables	487	267	72	67	452	1,345
Total	**487**	**267**	**72**	**67**	**452**	**1,345**

Individually impaired financial assets 2014

	Overdue $'000				
	Less than 30 days	*30-60 days*	*61-90 days*	*More than 90 days*	*Total*
Receivables (gross)	146	39	42	99	326
Allowance for impairment	(8)	(4)	(4)	(88)	(104)
Carrying amount	138	35	38	11	222

Individually impaired financial assets 2013

	Overdue $'000				
	Less than 30 days	*30-60 days*	*61-90 days*	*More than 90 days*	*Total*
Receivables (gross)	267	72	67	452	858
Allowance for impairment	-	-	-	(67)	(67)
Carrying amount	267	72	67	385	791

(d) Liquidity risk

Liquidity risk is the risk that SWHHS will not have the resources required at a particular time to meet its obligations to settle its financial liabilities. SWHHS is exposed to liquidity risk through its trading in the normal course of business and aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times. All financial liabilities are current in nature and will be due and payable within twelve months. As such no discounting of cashflows has been made to these liabilities in the Statement of Financial Position.

28. Financial Instruments continued

(e) Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises: foreign exchange risk; interest rate risk; and other price risk. SWHHS does not trade in foreign currency and is not materially exposed to commodity price changes. SWHHS 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 interest rate risk.

(f) Interest rate sensitivity analysis

Changes in interest rate have a minimal effect on the operating result of SWHHS. This is demonstrated in the interest rate sensitivity analysis below:

		2014 Interest rate risk			
	Carrying	*-1%*		*1%*	
Financial instrument	*amount*	*Profit*	*Equity*	*Profit*	*Equity*
	$'000	*$'000*	*$'000*	*$'000*	*$'000*
Cash and cash equivalents	311	(3)	(3)	3	3
Potential impact		*(3)*	*(3)*	*3*	*3*

(f) Interest rate sensitivity analysis

		2013 Interest rate risk			
	Carrying	*-1%*		*1%*	
Financial instrument	*amount*	*Profit*	*Equity*	*Profit*	*Equity*
	$'000	*$'000*	*$'000*	*$'000*	*$'000*
Cash and cash equivalents	345	(3)	(3)	3	3
Potential impact		*(3)*	*(3)*	*3*	*3*

With all other variables held constant, SWHHS would have a surplus and equity increase/(decrease) of $3 thousand (2013: $3 thousand increase / decrease).

(g) Fair value

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

29. Key executive management personnel and remuneration

(a) Key executive management personnel

The following details for key executive management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of SWHHS during 2013-14. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Position	Responsibilities	*Current Incumbents*	
		Contract classification and appointment authority	*Date appointed to position*
Health Service Chief Executive (HSCE)	Responsible for the overall leadership and management of the South West Hospital and Health Service to ensure that SWHHS meets its strategic and operational objectives. The HSCE is accountable to the Board for making and implementing decisions about the Hospital and Health Service business within the strategic framework set by the Board.	s24 & s70 Appointed by Board under Hospital and Health Board Act 2011 (Section 7 (3)).	17 Sept 12 to 12 April 2014
		s24 & s70 Temporarily appointed by Board under Hospital and Health Board Act 2011 (Section 7 (3)).	11 Nov 2014

29. Key executive management personnel and remuneration continued

(a) Key executive management personnel continued

Position	Responsibilities	*Current Incumbents*	
		Contract classification and appointment authority	*Date appointed to position*
Chief Operations Officer (COO)	Provides single point accountability for the functions of infrastructure and planning including service planning, capital works planning and delivery, facility engineering and maintenance. This position is also accountable for the function of the professional, operational and administrative support services.	DSO1 Appointed under Health Services Act 1991. District Health Services Employees Award - State 2012	17 Nov 2008 to 1 Apr 2014
		HES 2 Temporarily appointed under Hospital and Health Board (HHB) Act 2011	1 Apr 2014
Chief Finance Officer (CFO)	Responsible for management and oversight of the SWHHS finance framework including financial accounting processes, financial risk management, budget and revenue systems, activity measurement and reporting, performance management frameworks and financial-corporate governance systems. The CFO is also accountable for the promotion of the long term viability of the Hospital and Health Service.	DSO1 Appointed under Health Services Act 1991. District Health Services Employees Award - State 2012	10 Jan 2011 to 10 Feb 2014
		Agency contract temporarily appointed by the CE under Health Services Act 1991. District Health Services Employees Award - State 2012	2 Feb 2014
Executive Director, Medical Services (EDMS)	Strategic and professional responsibility for SWHHS medical workforce, and clinical governance. The EDMS leads the development and implementation of Hospital and Health Service wide strategies that will ensure the medical workforce is aligned with identified service delivery needs, and an appropriately qualified, competent and credentialed workforce is maintained.	Appointed under Health Services Act 1991. District Health Services SMO's & RMOs Award - State 2012	21 Jan 2013
Executive Director of Nursing (EDON)	Responsible for strategic and professional leadership of the nursing workforce . The EDON leads the development and implementation of Hospital and Health Service wide strategies that will ensure the nursing and midwifery workforce is aligned with identified service delivery needs. The EDON ensures an appropriately qualified and competent nursing and midwifery workforce is maintained, leading to the achievement of clinical excellence through education, professional development and research.	NRG11 Appointed under Health Services Act 1991, QH Nurses & Midwives Award - State 2012 - Section B Public Hospitals	14 Aug 2009
Executive Director, Community & Allied Health (DCAH)	Provides single point accountability and leadership for the Portfolio of Community and Allied Health within the Hospital and Health Service. The position provides high level leadership, strategic direction and advocacy in the professional management of community and allied health services across the Hospital and Health Service, including contribution to state-wide initiatives.	DSO1 Appointed under Health Services Act 1991. District Health Services Employees Award - State 2012	1 Jul 2009

29. Key executive management personnel and remuneration continued

(a) Key executive management personnel continued

Position	Responsibilities	*Current Incumbents*	
		Contract classification and	*appointed to*
Director, People and Culture (DP&C)	Responsible for provision of leadership and oversight of human resource, occupational health and safety functions, workforce planning and development, Indigenous training and development, and cultural awareness programs for the Health Service.	AO8 Appointed under Health Services Act 1991. District Health Services Employees Award - State 2012	26 Nov 2012
Nursing Director Quality and Safety (NDQ&S)	Responsible for leading the HHS in the provision of a clinical govenrnace framework including accreditation, risk management, research, medico-legal and mortality review processes and clinical performance reporting. Leads the Quality & Safety Unit in the South West to ensure a culture of safety, continuous quality improvement, clinical practice standardisation and the implementation and sustainability of the National Safety and Quality Healthcare Standards.	NGR9 Appointed under Health Services Act 1991, QH Nurses & Midwives Award - State 2012 - Section B Public Hospitals	24 Aug 2009

(b) Remuneration

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

Remuneration policy for the Service'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 and expense payments such as rental or loan repayments.

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

Short-term employee benefits which include:

- Base – consisting of base salary, allowances and leave entitlements paid and provided for the entire year or for that part of the year during which the employee occupied the specified position. Amounts disclosed equal the amount expensed in the Statement of Comprehensive Income.
- Non-monetary benefits – consisting of provision of vehicle and expense payments together with fringe benefits tax applicable to the benefit.
- Long term employee benefits include long service leave accrued.
- Post employment benefits include superannuation contributions.
- Redundancy payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu on termination, regardless of the reason for termination.
- 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.

29. Key executive management personnel and remuneration continued

(b) Remuneration continued

1 July 2013 - 30 June 2014

Position (date resigned if applicable)	*Short Term Employee Benefits*		*Long Term Employee Benefits*	*Post Emp. Benefits*	*Termination Benefits*	*Total Remuneration*
	Base $'000	*Non-Monetary Benefits $'000*	*$'000*	*$'000*	*$'000*	*$'000*
Health Service Chief Executive - Graem Kelly PSM to 12 Apr 2014	334	37	10	13	-	394
A/Health Service Chief Executive - Glynis Schultz from 11 Nov 2013	121	9	3	13	-	146
Chief Operations Officer - Meryl Brumpton	138	31	4	16	-	189
A/Chief Operations Officer - Wendy Jensen 13 Jan 2014 to 26 Jan 2014	10	-	-	1	-	11
Chief Finance Officer - Josh Carey to 10 Feb 2014	70	31	2	10	-	113
*A/Chief Finance Officer - Veronica Chung (contractor) from 2 Feb 2014	87	4	-	-	-	91
Executive Director, Medical Services - Tom Gibson	377	22	4	10	-	413
Executive Director of Nursing - Chris Small	128	-	4	19	-	151
A/Executive Director of Nursing - Patrice Robinson 23 Sept 2013 to 6 Oct	18	-	-	2	-	20
A/Executive Director of Nursing - Robyn Brumpton 02 Dec 2013 to 1 June	68	-	2	8	-	78
Executive Director, Community and Allied Health - Jenny Flynn to 12 Aug 2013	119	17	3	16	-	155
A/Executive Director, Community and Allied Health - Josh Freeman From19 Aug 2013	98	31	3	11	-	143

29. Key executive management personnel and remuneration continued

(b) Remuneration continued

1 July 2013 - 30 June 2014

Position (date resigned if applicable)	*Short Term Employee Benefits*		*Long Term Employee Benefits*	*Post Emp. Benefits*	*Termination Benefits*	*Total Remuneration*
	Base $'000	*Non-Monetary Benefits $'000*	*$'000*	*$'000*	*$'000*	*$'000*
A/Executive Director, Community and Allied Health - Annmarie McErlain	8	-	-	1	-	9
A/Executive Director, Community and Allied Health - Ninette Johnstone	9	-	-	1	-	10
Director People & Culture - Wendy Jensen	107	27	3	15	-	152
A/Director People & Culture - Kathleen Castles 13 Jan 14 to 25 Jan 2014	15	-	-	2	-	17
*A/Director People & Culture - Kylie Portelli Contractor 5 Feb 2014 to 10 Mar 2014	17	-	-	-	-	17
Nursing Director Quality & Safety - Robyn Brumpton	68	15	- 6	9	-	86
A/Nursing Director Quality & Safety - Leanne Patton 2 Dec 2013 to 12 Jan	67	-	2	8	-	77
A/Nursing Director Quality & Safety - Ann-Margaret Jakins 23 Sep 2013 to 13 Oct	9	-	-	1	-	10
A/Nursing Director Quality & Safety - Georgina Jones 6 Jan 2014 to 2 Feb	9	-	-	1	-	10

* payments to Recruitment Agencies not direct to employees

29. Key executive management personnel and remuneration continued

(b) Remuneration continued

1 July 2012 - 30 June 2013

Position (date resigned if applicable)	*Short Term Employee Benefits*		*Long Term Employee Benefits*	*Post Emp. Benefits*	*Termination Benefits*	*Total Remuneration*
	Base $'000	*Non-Monetary Benefits $'000*	*$'000*	*$'000*	*$'000*	*$'000*
Health Service Chief Executive - Graem Kelly PSM	190	53	4	21	-	268
A/Health Service Chief Executive - Meryl Brumpton 1 July 2012 to 16 Sept 2012, 21 Dec 2012 to 2 Jan 2012,28 Mar 2013 to 7 Apr 2013	41	-	-	6	-	47
Chief Operations Officer - Meryl Brumpton	89	38	3	13	-	143
A/Chief Operations Officer - Ross Lau 5 July 2012 to 5 Oct 2012	31	-	1	5	-	37
Chief Finance Officer - Josh Carey	113	26	3	14	-	156
A/Chief Finance Officer - Chris Keech 16 July 2012 to 14 Aug 2012	14	-	-	2	-	16
Executive Director, Medical Services - Tom Gibson	158	23	1	9	-	191
Executive Director, Medical Services - Martim Byrne 1 Jul 2011 to 12 Feb 2013	174	29	42	16	-	261
Executive Director of Nursing - Chris Small	143	-	3	17	-	163
A/Executive Director of Nursing - Robyn Brumpton 27 Jun 2012 to 5 Aug 2012	15	-	-	2	-	17

29. Key executive management personnel and remuneration continued

(b) Remuneration continued

1 July 2012 - 30 June 2013

Position (date resigned if applicable)	*Short Term Employee Benefits*		*Long Term Employee Benefits*	*Post Emp. Benefits*	*Termination Benefits*	*Total Remuneration*
	Base $'000	*Non-Monetary Benefits $'000*	*$'000*	*$'000*	*$'000*	*$'000*
A/Executive Director of Nursing - Toni-Anne Murray 24 Sep 2012 to 7 Oct 2012	3	-	-	-	-	3
District Director, Community and Allied Health	117	-	3	15	-	135

(c) Board remuneration

18 May 2014 - 17 May 2015

The South West Hospital and Health Service is independently and locally controlled by the Hospital and Health Board (Board). The Board appoints the health service chief executive and exercises significant responsibilities at a local level, including controlling (a) the financial management of the Service and the management of the Service's land and buildings (section 7 Hospital and Health Board Act 2011).

Board member	**Position**	**Appointment**	**Current Term of Appointment**
Dr Julia Leeds*	Chairperson	18 May 12 to 17 May 14	
Mr Lindsay Godfrey	Acting Chairperson	11 Nov 13 to 17 May 14	
Mr Lindsay Godfrey	Chairperson		18 May 2014 - 17 May 2017
Mr Lindsay Godfrey	Deputy Chair	18 May 13 to 10 Nov 13	
Mr Richard Moore	Deputy Chair		18 May 2014 - 17 May 2017
Ms Heather Hall	Board member	18 May 13 to 17 May 14	18 May 2014 - 17 May 2017
Mr James Hetherington	Board member	18 May 13 to 17 May 14	18 May 2014 - 17 May 2017
Ms Lyn Kajewski	Board member	18 May 13 to 17 May 14	18 May 2014 - 17 May 2015
Ms Sheryl Lawton	Board member	18 May 13 to 17 May 14	
Mr Richard Moore	Board member	18 May 13 to 17 May 14	
Ms Karen Prentis	Board member	18 May 13 to 17 May 14	18 May 2014 - 17 May 2017
Dr John Scott	Board member		18 May 2014 - 17 May 2015
Ms Fiona Gaske	Board member		18 May 2014 - 17 May 2015
Mr Michael Cowley	Board member	18 May 13 to 17 May 14	18 May 2014 - 17 May 2015

**Leave of Absence 11 November 2013 until appointment end*

29. Key executive management personnel and remuneration continued

(c) Board Remuneration continued

Remuneration paid or owing to board members during 2013-14 was as follows:

Board Member	*Short Term Employee Benefits*		*Post Emp. Benefits*	*Total Remuneration*
	Base $'000	*Non-Monetary Benefits $'000*	*$'000*	*$'000*
Board Chairperson - Dr Julia Leeds	48	13	5	66
Board Member (Deputy Chairperson) - Mr Lindsay Godfrey	14	-	1	15
Acting Chairperson - Mr Lindsay Godfrey	35	-	3	38
Chairperson - Mr Lindsay Godfrey	12	-	1	13
Board Member - Mrs Karen Prentis	29	-	2	31
Board Member - Ms Lyn Kajewski	29	-	2	31
Board Member - Mr Michael Cowley	33	-	2	35
Board Member - Ms Heather Hall	29	-	2	31
Board Member - Mr Richard Moore	24	-	2	26
Board Member - Ms Sheryl Lawton	24	-	2	26
Board Member - Mr James Hetherington	34	-	2	36
Board Member - Dr John Scott	5	-	-	5
Board Member - Ms Fiona Gaske	5	-	-	5

*Board members who are employed by either the HHS or the Department of Health are not paid board fees.

Remuneration paid or owing to board members during 2012-13 was as follows:

Board Member	*Short Term Employee Benefits*		*Post Emp. Benefits*	*Total Remuneration*
	Base $'000	*Non-Monetary Benefits*	*$'000*	*$'000*
Board Chairperson- Dr Julia Leeds	59	-	5	64
Board Member (Deputy Chairperson) - Mr Lindsay Godfrey	4	-	-	4
Board Member - Mrs Karen Prentis	29	-	2	31
Board Member - Ms Lyn Kajewski	28	-	2	30
Board Member - Mr Michael Cowley	30	-	2	32
Board Member - Ms Heather Hall	30	-	2	32
Board Member - Mr Richard Moore	28	-	2	30
Board Member - Ms Sheryl Lawton	28	-	2	30
Board Member - Mr James Hetherington	26	-	2	28

*Board members who are employed by either the HHS or the Department of Health are not paid board fees.

30. Correction of error

South West commissioned further valuation reports on its buildings during the 2014 financial year as part of its ongoing asset review process. For a single asset a comparison of the 2014 valuation with the June 2012 report identified that the previous floor area was over stated, resulting in an overstatement of the asset value as at 30 June 2012.

The building's net written down value at 30 June 2013 was overstated by $4.104 million with a corresponding overstatement of the net assets transferred under administrative arrangment on formation of SWHHS.
The error has been corrected by restating each of the affected financial statement line items, as set out below.

Financial Statement line item / balance affected	Note	Actual 2013 $'000	Correction of Error Adjustment $'000	Restated Actual 2013 $'000
Statement of Financial Position				
Property, plant & equipment	17	94,690	(4,104)	90,586
Total Non - Current assets		94,690	(4,104)	90,586
Total Assets		108,178	(4,104)	104,074
Net Assets		100,323	(4,104)	96,219
Contributed equity		91,490	(4,104)	87,386
Total Equity		100,323	(4,104)	96,219
Statement of Changes in Equity				
Net assets received (transferred during year via Machinery of Government change)		91,296	(4,104)	87,192
Total changes to contributed equity		91,489	(4,104)	87,385
Balance as at 30 June 2013		100,323	(4,104)	96,219
Notes to the Accounts				
Note 2 (h) Administrative Arrangements				
The value of assets and liabilties transferred to the South West Hospital and Health Service were as follows:				
Cash and cash equivalents		363	-	363
Receivables		3,951	-	3,951
Inventories		368	-	368
Other		15	-	15
Property, plant and equipment		90,912	(4,104)	86,808
Payables		(4,348)	-	(4,348)
Contributed equity		91,260	(4,104)	87,156
Notes to the Accounts				
Note 17				
Buildings*				
At fair value		165,502	(4,104)	161,398
Subtotal Buildings		79,313	(4,104)	75,209
Total Property Plant and Equipment		94,690	(4,104)	90,586
Note 17				
Buildings through restructuring (Note 2 h)		74,803	(4,104)	70,699

Certificate of South West Hospital and Health Service

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

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

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

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

Chair, SWHHS Board	Chief Executive Officer	Chief Finance Officer
25/08/2014	25/08/2014	25/8/2014

To the Board of South West Hospital and Health Service

Report on the Financial Report

I have audited the accompanying financial report of South West 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 Chair, 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

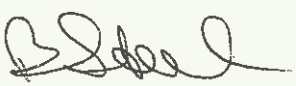
(b) in my opinion –

(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 South West 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

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Queensland
Government