South West Hospital and Health Service

2012–13 **Annual Report**

Great state. Great opportunity.

Queensland Government

Communication objective
This Annual Report aims to:

- describe our performance by communicating our achievements and performance for 2012–13.
- be accountable and transparent by enabling the Minister for Health and Parliament to assess our efficiency and effectiveness.

Public availability statement
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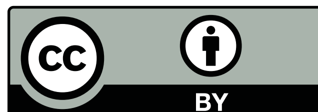

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Principal business address
Roma Hospital Campus
197 – 235 McDowall Street
ROMA QLD 4455

Contact us

Phone: (07) 4624 2851

Email: SWHHS_Board@health.qld.gov.au

Post: PO Box 1006, Roma QLD 4455

Website: **www.health.qld.gov.au/southwest/**

Letter of compliance

The Honourable Lawrence Springborg MP
Minister for Health
Member for Southern Downs
GPO Box 48
Brisbane QLD 4001

5 September 2013

Dear Minister

I am pleased to present the Annual Report 2012–13 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 64–65 of this annual report or accessed at **www.health.qld.gov.au/southwest/**

Yours sincerely

Dr Julia Leeds
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 2012–13*. 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 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) was 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 the South West 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).

Dr Julia Leeds
Board Chair

Graem Kelly PSM
Health Service Chief Executive

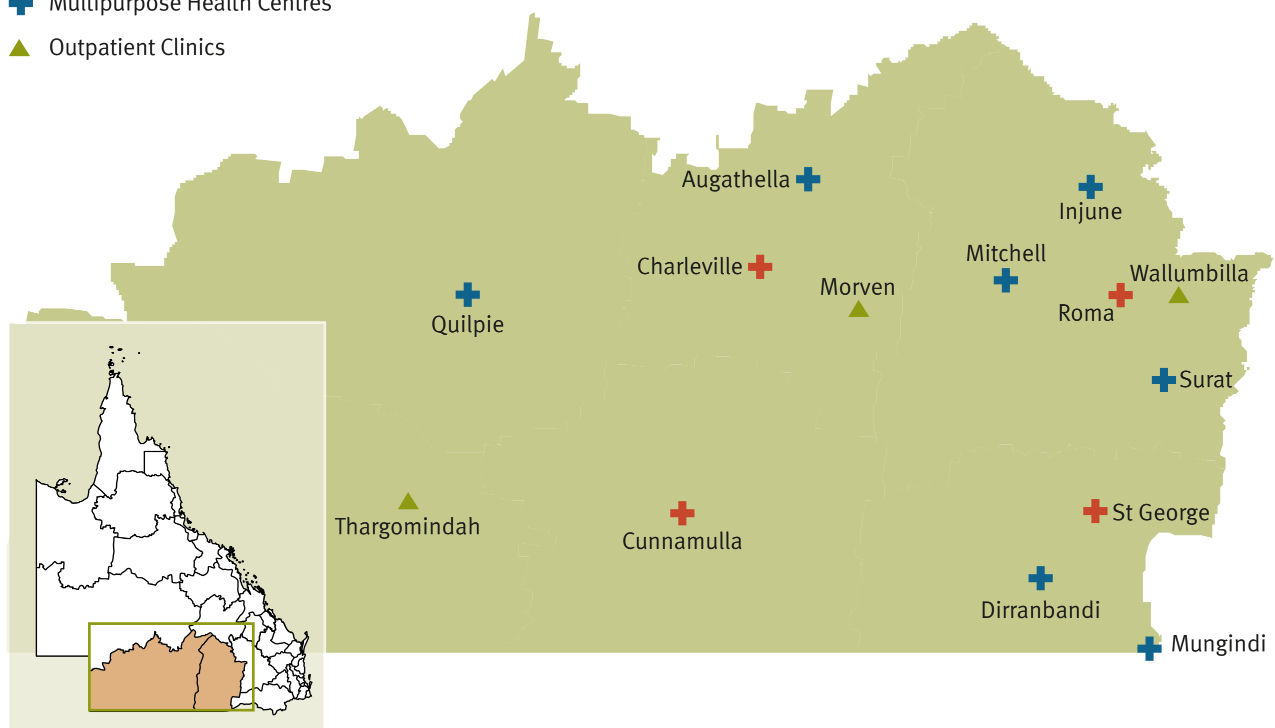
Key highlights 2012–13

- South West Hospital and Health Board commenced
- Board Members appointed by the Governor-in-Council
- Staff excellence and leadership recognised at annual Service Awards and Australia Day Awards
- Health Service Chief Executive appointed
- Caseload Midwifery Model of Care at Roma Hospital commenced
- Long-stay Older Persons building works at Surat and Injune completed
- Successful partnership with Maranoa Regional Council to extend the Multipurpose Health Service in Mitchell
- Multipurpose Health Services commenced at Surat and Injune
- Surat Multipurpose Health Service opened by the Minister for Health, the Honourable Lawrence Springborg
- Significant service planning process commenced
- *Strategic Plan 2013–17* developed and approved
- Community Advisory Networks established across all facilities
- Consumer and Community Engagement Strategy adopted
- Clinician Engagement Strategy adopted
- Protocol with Darling Downs and South West Queensland Medicare Local approved
- Flying Obstetrician and Gynaecological Services/Flying Surgical Services reviewed and service plan developed
- Injune Multipurpose Health Service celebrated 50 years of service
- Planning for introduction of sub-acute care unit at Roma Hospital
- Preliminary planning for the Rural and Remote Infrastructure Renewal Program for Roma and Charleville Hospitals undertaken
- Significant increase in use of telehealth services
- International Standards Organisation accreditation maintained
- Aged Care Standards and Accreditation Agency Standards maintained for Westhaven and Waroona aged care facilities
- National Safety and Quality Health Service Standards one, two and three – accreditation achieved
- Successful Nurse Graduate Program expanded
- South West HHS exceeded State results by greater than 10 per cent in state-wide bedside safety audit
- All facilities met the 85 per cent target set for positive inpatient feedback for April–June 2013 with very positive comments recorded
- Clinical Governance improvements achieved through standardisation, productive ward and journey boards
- Final year dental students offered placements to work in Roma
- Medical students placed at Roma and St George Hospitals
- Exploring new medical models of service delivery

Looking ahead 2013–14

- Enhancement of community engagement processes and a customer focused culture
- Strengthening of partnerships both internally and externally
- Development and implementation of comprehensive surgical services based on service plan
- Delivering Closing the Gap initiatives
- Implementation of 10 standards under National Safety and Quality Health Service Standards
- Development of a Human Resources Plan
- Completion of a Health Service Plan
- Development of Strategic Asset and Maintenance Plans
- Development of Information Technology Plan
- Development of Communication Plan
- Development of a Financial Management Plan
- Optimise available Commonwealth Revenue streams and Own Source Revenue opportunities
- Implementation of an electronic administrative record keeping system
- Expansion of the introduction and implementation of e-health systems
- Implementation of proactive health promotion programs

South West Hospital and Health Service



Board Chair Report

It gives me great pleasure to write my report as Board Chair for the first Annual Report 2012–13 of the South West Hospital and Health Service (South West HHS). Our theme is "New beginnings, celebrating our successes" and 2012–13 has most certainly been a time of new beginnings as we have embarked on a journey of major reform within the health sector. Whilst there have no doubt been challenges it has been an exciting time; a time of renewal and opportunity. There have been wonderful successes and achievements on many fronts and these are evident through the pages of this report.

The South West HHS was established 1 July 2012 as part of the National Health Reform Agreement of August 2011. The Service is a statutory body with legal obligations derived from the *Hospital and Health Boards Act 2011* and other State and Commonwealth legislation. The South West Hospital and Health Board was established for the role of controlling the South West HHS. The Board is accountable for the performance and actions of the Service to the Minister for Health and Parliament. The Board has prescribed obligations from the Department of Health and Queensland Government Policies.

The Board was tasked with improving the health outcomes for the Service's geographic area.

Government values were established to guide this outcome:

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

Government priority areas for action were identified:

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

The National Health Reform Agreement and subsequent *Hospital and Health Boards Act 2011* instigated an unprecedented reform of health care across Queensland with progressive devolution of responsibility and authority for healthcare to 17 Hospital and Health Boards and Hospital and Health Services. All are unique and have faced enormous challenges in the year since establishment.

Board responsibility

The inaugural Board of eight was reappointed in May 2013 with an additional member appointed at that time making a total of nine on the Board. All are non-executive directors. The Board focus is on the strategic direction of the Service. Strategy combined with organisational culture and fiscal responsibility will develop a sustainable and financially viable system of healthcare delivery for the South West.

The Board commissioned an extensive service planning process to facilitate evaluation and potential redesign of health service delivery across the South West. This process, in combination with a system review prescribed by the Minister, will validate strategic direction for the future.

The Health Service Chief Executive (HSCE) and Executive Management Team (EMT) are responsible for the organisational management of the Health Service with appropriate delegated authority as determined by the Board.

Board structure

The Board is skills based and diverse in geographic location, gender, age and experience, bringing a wealth of knowledge to Board deliberations. The Board is remunerated according to Attorney-General's Department guidelines.

Board meetings and committees

The Board has scheduled monthly meetings with additional meetings as required. The Board travels across the Service as frequently as possible within a financially responsible framework. The Board has a committee structure as prescribed by the *Hospital and Health Boards Act 2011*. The Executive, Finance, Audit and Risk, and Quality and Safety Committees meet regularly and have not been delegated decision making powers but make recommendations to the Board.

South West HHS

The Board and Service have had a successful and challenging first year of operation. The *Hospital and Health Boards Act 2011* initiated the biggest change in health care delivery for many generations. The Service was well positioned to embrace the new system as a result of the hard work and dedication of the previous District Chief Executive Officer and all staff. Clinical systems, processes and standards were amongst the highest in the state with improvement being required in financial processes.

Challenges

The externally prescribed rapid process of change was a difficult process for all in the Service. The Board had an enormous workload in establishing a functional service. Care and diligence has been applied to this process.

The Board has fully supported the HSCE and the EMT as service delivery has been realigned to evidence based need. Service agreements indicated that budget cuts and prescribed productivity gains and staffing targets must be met. First round voluntary redundancies occurred to achieve targets. The additional budget reduction midyear was an enormous burden for the Service and precipitated a second round of staff redundancies. Unlike the first round not all of these staff nominated voluntarily and the process of change, often difficult, became more unsettling for many in the community.

The Board recognises that restructure of health service models is required to develop and maintain a sustainable and viable health service in the South West that uses taxpayer funds in a financially responsible way taking into consideration community service obligations. This process will continue based on evidence as it comes to hand.

The Board faces many other challenges. The tyranny of distance impacts in many ways. The expansive geography of the South West with multiple small facilities and aged infrastructure will be an issue into the future. Permanent staffing, particularly medical and appropriately skilled staff, is an issue across the entire rural sector. The Service has worked diligently to address these issues. The distinction between hospital and primary care is blurred in the rural sector and the Service provides much of the primary care in the area. Simply, the geography, population and its distribution is a negative cost driver for service provision.

Achievements

Financial

The Service delivered a $6.019 million surplus. This amount will be kept as retained earnings. This position puts the Service in a sound position for the next financial year when further productivity targets are anticipated.

Clinical

The Service has maintained its excellent record of clinical standards and safety and continues to rank amongst the highest in the State for many indicators including patient satisfaction surveys, maternity consumer surveys and occupational health and safety. It has had outstanding ISO Audit Reports and is one of the first hospital and health services to achieve the first three National Safety and Quality Health Service (NSQHS) Standards. These results are indicative of the quality and dedication of all staff in the Service.

Community and stakeholder engagement

The Board has established Community Advisory Networks (CANs) in all communities with our health facilities. This system has been based on the very successful CANs associated with Multipurpose Health Services in many of our communities. CANs are to enhance and support their local facilities and engage in strategic discussion with the Board as appropriate. This system of community engagement allows equitable representation across all communities in strategic discussion.

The Board has engaged in regular communication with local government and has established relationships with Darling Downs and South West Queensland Medicare Local (DDSWQML) and other health care providers. Cooperation and collaboration with all in the health care sector will reduce duplication and waste and enhance sustainability of health care services across the Service.

Acknowledgements

There are many who must be acknowledged for the successful results for the Board and the Service in the first year of operation. First and foremost, every member of staff of the Service whose dedication, skill and tenacity has maintained a highly functioning clinical and support service despite many changes and challenges. The Minister and Director General and their staff have been unwavering in their support of the Board. The HSCE and the EMT have maintained the momentum for improvement and reinvigoration of the Service and the Executive Services Manager and team whose continued support and governance preparation are invaluable.

Finally, I must acknowledge my fellow Board Members, a diverse group of highly skilled individuals who have come together and created a functional and successful Board in the face of an enormous workload, the challenge of a new legislative structure, uncertainty of autonomy and government targets and expectations, community angst and very real risk of personal reputational damage.

The Board operates within a complex health sector which is undergoing fundamental and rapid change. The population of the rural and remote sector has low standards of health literacy and an increased burden of disease when compared to the urban demographic adding additional challenges for the Service and other health care providers. Addressing these issues, with individuals and communities taking increasing responsibility for improved measurable outcomes and redesign of healthcare systems, based on evidence of need, will be essential for healthcare into the future.

The Board is well positioned to develop and deliver a sustainable, financially viable and responsible healthcare model to deliver improved healthcare outcomes for all in the Service to achieve its key strategic goal and comply with government values and priority areas for action.

Dr Julia Leeds
Board Chair

Health Service Chief Executive Report

"I am personally convinced that one person can be a change catalyst, a transformer in any situation, any organisation. Such an individual is yeast that can leaven an entire loaf. It requires vision, initiative, patience, respect, persistence, courage and faith to be a transforming leader."

Stephen R. Covey (born 1932)

It is with great pleasure and thanks I take this opportunity to report in the inaugural Annual Report for the South West Hospital and Health Service (South West HHS) as the Chief Executive. As the quote stated by Stephen R Covey leads us to understand, change is possible with excellence in leadership. The success it can ultimately bring is only achievable by a unified vision built on the support of stakeholders and staff to deliver agreed outcomes. This fits in nicely to our theme for this year's Annual Report, "New beginnings, celebrating our successes". In my report I will take you through the year identifying the turbulence associated with the challenges we faced. I will acknowledge the great work and successes the Board and staff have achieved, and detail what are the expectations of the upcoming year.

I am appreciative and wish to acknowledge the support from the Honourable Lawrence Springborg MP, Minister for Health and his staff, the Director-General, Department of Health, Dr Tony O'Connell MB, BS, FANZCA, FCICM, GAICD, FCHSM (Hon) and his team, the Honourable Tanya Plibersek MP, Minister for Health and Minister for Medical Research, Ms Elizabeth Cain and her team, Department of Health and Ageing, Queensland State Office and the Mayors of all local councils for providing great assistance. Thank you to all our volunteer groups, hospital and multipurpose health service auxiliaries, Friends of Westhaven, Mens' Sheds for their great work and the continued assistance of our 14 CANs.

It is with humble regard to the great work and support of the staff throughout the South West HHS that I say to you we have made the first steps of many to achieve the Board's goal of being recognised as a leading rural hospital and health service for the nation.

It has been a difficult year and in hindsight one which has shown great courage and conviction by staff to remain focused on providing excellence in health care across the service. We had critical challenges thrown upon us as we leapt forward into the unknown of a statutory body, forming a new Board under the capable leadership of Dr Julia Leeds, putting in place a new Chief Executive, having to meet targets in staff reductions and in budgetary savings outlined for the next two years and care for our communities, and providing safe and competent healthcare.

The South West Hospital and Health Board has been determined and vigilant in their responsibilities and must be congratulated as the Service leads on many state benchmarks most notably in maternity, occupational health and safety, financial, closing the gap and others. We also continued to meet the requirements of accreditation and met fully Standards one, two and three of the NSQHS Standards.

I thank my executive team for their excellent work and support, for without them and the collaboration and actions of staff we could never have achieved the results we did.

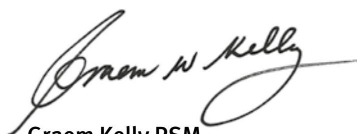
In amongst this, we had to sell the messages of what was being required of us by the government to implement the reform agenda focusing on local accountability and decision making. We had to enable the winds of change to take strength and give direction to the Service doing more with less. It was daunting and not for the faint hearted. It should be recognised that only with all on board could we hope to deliver the expectations government had set out for us. There were many obstacles and constraints that made our efforts difficult.

The time lines for processing, the ill defined systems of support, the tyranny of distance and number of facilities and communities we work with and our ability to keep all our communities and key stakeholders informed were always challenging.

Please be confident if we had been allowed we would have done things differently. I do sincerely apologise to any and all who felt we could have done better. Not seeking to excuse this, I would request understanding that there were many complexities. We needed to respect timelines in budgets, industrial laws, union agreements, individual's rights, treasury requirements and then we were still expected to win hearts of communities. This was at the same time as bedding down the new health service identity, devolving processes and setting strategic direction. Success was not easy. We have achieved the required budgetary savings we needed for the next two years. We have now an organisational structure that is more sustainable and it can deal with the service needs of the area. We have not been just about reducing staff positions but have maturely sought to re-engineer our structure and as a result of this created some new positions. We have done this so we may better achieve our and your expectations for improved customer service.

We have commenced service planning to allow us to build context and direction for the Service and have master planning to quickly follow this. We have expanded dental services, put in place more graduate nurses, reduced locum costs and numbers of shifts in locum nursing. There has been the introduction of new nurse lead maternity services and a continued and refashioning of the Flying Obstetric and Gynaecological Service to make it more sustainable. We look forward to reinvigorating our range of services with a broader base of public surgical services and we have funding committed to the introduction of a new sub-acute service which will allow rehabilitation and geriatric evaluation and management to be provided more locally in the South West. We are determined to better engage our services in addressing local Aboriginal and Torres Strait Islander health issues, look to offer opportunities for trainee positions and to set comprehensive plans for Information Technology and workforce management and planning. We will use an expected community dividend of around $6 million for this year to build us a way forward for a break even position for the 2013–14 year and to also give us an opportunity for settling down and addressing specific needs the Service has in meeting our principal strategic goal of '*person centred care*'.

It has been a tough year and yet with pride it is one on which we are building a sustainable future. I again must thank the Board for their professionalism and support, the executive team for their diligence and hard work and to all staff at all levels for their commitment and collaboration.



Graem Kelly PSM
Health Service Chief Executive

Our organisation

About South West Hospital and Health Service

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 residing 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 the 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 state-wide service plans that apply to the Service and undertake further service planning that aligns with the state-wide 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 other services, the department and 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; and
- 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 Misconduct 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 the 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, which is on an emergency basis. Some outpatient services are provided by visiting clinicians and/or through telehealth.

The Service operates a number of community and allied health service and outpatients clinics providing 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 and health promotion programs.

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

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

Caring for people

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

Leadership

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

Partnership

We will work collaboratively and respectfully with other service providers and partners as this is fundamental to our success.

Accountability, efficiency and effectiveness

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

Innovation

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

Responsibility

We recognise the need to follow through and make sure things happen – this applies to all staff.

Teamwork

We value the need to work together as a team within each professional stream, multidisciplinary teams, and across a range of health care providers. Team work is an essential element to sustaining quality health care in rural and remote locations.

Our organisation

About South West Hospital and Health Service

Our operating environment

Statutory obligations

With the commencement of the Board, a number of statutory obligations were required to be met. This involved the development and publication of a Strategic Plan and Engagement Strategies and Protocols.

An interim Strategic Plan was developed and published by 1 October 2012 as required by Section 9 of the *Financial and Performance Management Standard 2009*. A Consumer and Community and Engagement Strategy was developed and published to promote consultation with health consumers and members of the community about the provision of health services and a Clinician Engagement Strategy was developed and published to promote consultation with health professionals in accordance with Section 40 of the *Hospital and Health Boards Act 2011*. An engagement protocol was developed and published with the DDSWQML to promote cooperation between the Service and the Medicare Local in the planning and delivery of health services in accordance with Section 42 of the *Hospital and Health Boards Act 2011*.

Nature and range of operations

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

The Service encompasses a vast area and is bordered by three states with services being provided to 16 individual facilities located across a vast geographical area, covering 21 per cent of the State of Queensland. Roma is the primary clinical hub with St George and Charleville as secondary clinical hubs providing services to the communities and surrounding areas of Augathella, Cunnamulla, Dirranbandi, Injune, Mitchell, Morven, Mungindi, 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, Murweh Shire, Paroo Shire and Quilpie Shire.

We employ 818 staff across the administrative, operational and clinical fields each contributing a rich diversity of skills, knowledge and experience. Our operating budget for 2012–13 was $114,587,762. 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 we treated 7,283 acute inpatients, 33,727 emergency presentations, 53,969 outpatients and delivered 280 babies.

The Service contains four hospitals (in Charleville, Cunnamulla, Roma and St George); seven MPHSs (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. The Cunnamulla Hospital is being currently considered for development to transition to the MPHS model. The Service is also responsible for two residential aged care facilities; Waroona in Charleville and Westhaven in Roma.

The services provided span a continuum of care including promotion, protection and prevention, primary health care, 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.

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.

Telehealth services are provided across the Service. Considerable effort is being directed into expanding telehealth services as there is significant potential for this service to support health care delivery in rural and remote locations by removing the physical and social distances between health professionals and patients.

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 specific to the 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 department patients. These centres provide a range of health services not all of which are provided by South West HHS. 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 and oral health services, 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 does depend 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 continue 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, 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.

Allied health services provided 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 hubs centres of Charleville, Roma and St George.

Our strategic risks, opportunities and challenges

Strategic risks

The Service has a number of strategic risks 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 Resources Plan will be developed to ensure strategies are in place to address recruitment and retention of permanent staff, impacts on accommodation and building of 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 which will lead to pride and workplace satisfaction
- **Contemporary relevance** – Innovation and contemporary practice and service delivery models will be explored and implemented
- **Access and tyranny of distance** – Evidence based service delivery models to meet local health needs and changing environments e.g. population, burden of disease, economy and medical advances will be implemented
- **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
- Enhance more cost and time effective access to specialist services

Challenges

Challenges include:

- Managing the complex process of care delivery 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 and in regional and rural areas
- An ageing workforce
- Ageing buildings and information and communication technology infrastructure impacting 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 the economic and financial environment
- Improving the health literacy of communities
- Responding to advances in treatment and developing technologies
- Changing the communities and health workers focus to the prevention of illness and maintenance of good health
- Implementation of 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

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 are served which is forecast to increase only marginally by 2021. At June 2011, 11.8 per cent of the Service's population was Indigenous, 4 per cent of the population were born overseas and 1.3 per cent of the population speak a language other than English at home. With the large geographical spread, the various communities are unique and have their own individual health needs. The tyranny of distance creates significant challenges for the population in being able to access services.

Within this demographic some areas of the South West are experiencing unprecedented growth with the coal seam gas development with a significant transient population of fly-in fly-out staff who are serviced by 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) are 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, 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 now being facilitated by the DDSWQML where primary healthcare partners work together to improve service delivery coordination and develop opportunities.

Medicare Local

A protocol has been developed and agreed to between the Service and the DDSWQML. The purpose of this protocol is to promote co-operation in the planning and delivery of services working towards a 'Seamless Continuum of Care'. It is recognised that improved service delivery and outcomes will be achieved through strengthening relationships and integration of health services across government providers, non-government providers, private providers and the community. Both the Service and DDSWQML are committed to undertaking a joint planning exercise and this will occur once both organisations have completed their individual service plans.

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 met with local government representatives on a number of occasions. This occurred when the Board visited facilities across the Service and also when representatives attended regional local government meetings to receive and provide feedback to key local government representatives.

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 supporting 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, Indigenous groups, special interest groups, individuals and our staff.

Community engagement

Consumer and community engagement is integral to delivering quality health services. The Service is committed to providing high quality, safe and sustainable health services and recognises that in order to do this, genuine partnership between patient, consumers and providers is important to achieve the best possible outcome. This commitment ensures appropriate processes, practices and actions within the organisation that support engagement across the spectrum from informing to empowering and will be widely promoted to those engaging with consumers and the community.

The Consumer and Community Engagement Strategy has been developed to assist in planning meaningful and transparent engagement that is encouraged throughout the organisation. As an organisation we face constraints and have to make difficult resource decisions. It is important to the Service that the community understands these challenges and actively participates in consultation to identity and explore a diverse set of ideas and positive outcomes.

An initiative of the Board was to establish a CAN at each facility. CAN groups were already in existence across MPHS sites as a requirement of the Department of Health and Ageing funding. As these networks were successful the Board decided to replicate the structure across the Service. The CAN provides valuable feedback to local facilities at an operational level and provides strategic feedback to the Board. Chairs of CAN groups meet with the Board via videoconference/teleconference on a quarterly basis.

Throughout the year the Board travelled to all 16 facilities across the diverse South West area with the exception of Injune which will be visited in August 2013. On these occasions the Board took the opportunity to meet with staff and CAN members.

Machinery of government changes

The South West HHS was set up as statutory body on 1 July 2012 in accordance with the *Hospital and Health Boards Act 2011*. South West HHS is responsible to the Queensland Parliament through the Minister for Health. The Service is responsible for specific statutory functions in accordance with Section 19 of the *Hospital and Health Boards Act 2011*. These functions were previously the responsibility of Queensland Health.

The South West HHS has a defined service area to which public health services are provided in accordance with the terms of the Service Agreement. Under the Service Agreement, the State, as the Department of Health, purchases public hospital and other services from the South West HHS and funding is provided. The agreement reflects local health care needs of individual communities. While the South West HHS operates independently it is still part of a larger, national and state system with the Department of Health providing oversight of the service performance.

Queensland Health, now known as the Department of Health, focuses on policy and planning to ensure state-wide consistency of service access and quality across Queensland. Their other critical role is to support the hospital and health service to deliver the highest standard of care to patients. The Department of Health is represented by the Director-General. Under Section 47 of the *Hospital and Health Boards Act 2011* the Director-General may develop and issue health service directives. The Director-General and the Service negotiate and enter into a Service Agreement for a specified period.

Our organisation

Key priorities 2013–14

Key priorities for 2013–14 include:

- providing person-centred care
- improving systems and processes
- achieving expectations set out in the Service Plan
- undertaking master planning for Roma and Charleville Hospitals
- reviewing models of service delivery
- supporting the government's commitments to revitalise frontline services for families and deliver better infrastructure
- working in synergy with the Department of Health strategic objectives
- achieving expectations outlined in the *Blueprint for better healthcare in Queensland*
- negotiating a sustainable budget
- enhancing engagement and developing closer working relationships with patients, families, community groups, general practitioners and other primary health providers

Strategic objectives of the Service are:

- **Person centred:** South West Hospital and Health Service (South West HHS) will, in all it does and say, 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 and Hospital and Health Service 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

Section 77 (2)(b) of the *Financial Accountability Act 2009*, requires the nominated Chief Finance Officer (CFO) of each department to provide the Accountable Officer with a statement about whether the financial internal controls of the department are operating efficiently, effectively and economically.

As an independent statutory body, the South West Hospital and Health Service (South West HHS) is not required to have the CFO provide this statement. However, as a measure of best practice, as CFO, I have provided the Health Service Chief Executive and Board with a statement that the financial internal controls of the South West HHS are operating efficiently, effectively and economically.

Financial summary

In its first year as an independent statutory body, the South West HHS has managed its contractual obligations for the delivery of hospital and health care services on behalf of the Department of Health in a fiscally responsible and professional manner, delivering agreed outputs, and reported an operating surplus of $6.019 million.

The Service remains committed to managing its financial performance and minimising our liabilities and risks. Our financial performance is closely monitored by the Board and its governance committees.

We are operating in a tightening fiscal environment while costs and demands for services are increasing. It is imperative we make good financial decisions in resource allocation and expenditure, as well as maximising revenue opportunities.

We will continue to review and improve our service delivery to ensure we are achieving the most effective outcomes while delivering value for money.

For a comprehensive set of financial statements covering all of the South West HHS's activities see the Financial Statements of this Annual Report.

Josh Carey
Chief Finance Officer

Table 1: Financial snapshot

Financial Snapshot	2012–13 $(000)
Income	118,300
State contributions	83,361
Commonwealth contributions	27,955
Own sourced revenues	6,984
Expenses	112,280
Employee expenses	69,749
Supplies and services	36,426
Depreciation and amortisation	4,529
Other expenses	1,576
Operating surplus/(deficit)	6,019
Total assets	108,178
Total liabilities	7,855
Net assets/(liabilities)	100,323
Employee expenses ($000)	69,749
Number of employees as 30 June (FTE)	662

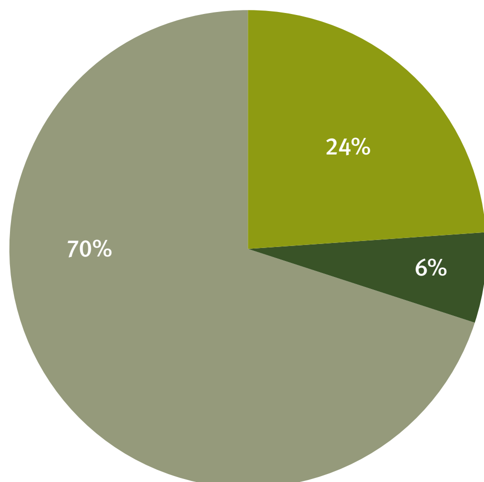
Our income – where the funds come from

The South West HHS's main sources of income include operating revenues from both the State and Australian (Commonwealth) Governments. Operating revenue is sourced from three areas:

- State contributions
- Commonwealth contributions and grants
- Own sourced revenue generated from user charges, grants and other revenue

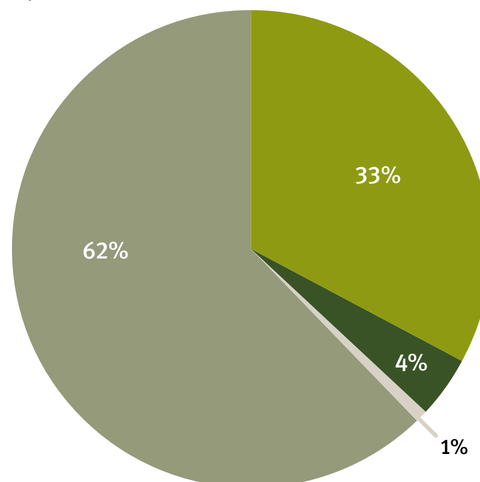
South West HHS's total income for 2012–13 was $118.3 million. Of this, the State contribution was $82.8 million (70%), Commonwealth contribution and grants was $27.9 million (24%), and own sourced revenue (user charges and other revenue) $6.9 million (6%).

Chart 1: Income by funding sources for the year ended June 2013



Commonwealth contributions	24%
Own sourced revenues	6%
State contributions	70%

Chart 2: Expenses by major category for the year ended June 2013



Supplies and services	33%
Depreciation and amortisation	4%
Other expenses	1%
Employee expenses	62%

Our expenses – how the funds are spent

The South West HHS's total expense for 2012–13 was $112.2 million. Salaries and wages, and supplies and services costs account for most of our expenditure. Employee expenses account for 62 per cent of total expenses, approximately 32 per cent of the supplies and services costs are a result of payments to contract medical and nursing staff required to provide clinical services to the HHS.

Our assets

The South West HHS held assets totalling $108.2 million at 30 June 2013. In its first year of operation the South West HHS acquired its assets through the Minister for Health approving the transfer notice including land and buildings via a three year concurrent lease (representing its right to use the assets) to the HHS from the Department of Health. The majority of the assets are in land and buildings associated with hospitals, aged care facilities and community health centres.

Our liabilities

The South West HHS held liabilities totalling $7.8 million. Our liabilities consist primarily of trade creditors $3.1 million, and the Department of Health $4.6 million.

Our financial performance

Comparison of actual financial results with budget

South West HHS actual result in comparison to its final adjusted budget as per final agreed Service Level Agreement for 2012–13.

Table 2: Operating statement for the year ended 30 June 2013

	Notes	2012–13 Actual	2012–13 Adjusted Budget	Variation
		$'000	$'000	
Income				
• User Charges	1	6,088	3,989	53%
• Grants and other contributions		111,293	110,378	1%
• Interest		23	–	
• Other revenue	2	863	234	269%
Total Revenue		**118,267**	**114,601**	**3%**
• Gains		33	–	
Total Income		**118,300**	**114,601**	**3%**
Expenses				
• Employee expenses		662	662	0%
• Health service labour expenses	3	69,087	77,931	-11%
• Supplies and services	4	36,426	29,606	23%
• Grants and subsidies		9	–	
Depreciation and amortisation		4,529	4,545	-0%
Impairment losses	5	41	16	158%
Other expenses	6	1,526	1,840	-17%
Total Expenses		**112,280**	**114,601**	**-2%**
Operating Results for the year				
Operating Results for the year		**6,019**	–	

Notes:

1. The increase is mainly due to accounting policy change to recognise salary recoveries as revenue, previously reported as offset to expense, as well as higher than expected locally receipted revenues relating to private patient bed fees, private practice billings
2. The increase is mainly due to revenue recoveries from the Department of Health
3. The decrease is mainly due to higher contract agency nursing and medical labour, reported as supplies and services, therefore lower internal health service labour expense
4. The increase is mainly due to higher contract agency nursing and medical labour
5. The increase is mainly due to higher than expected bad debts written off
6. The decrease is mainly due to lower than expected audit and legal expense

Our performance

Government objectives for the community

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

- 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 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 hospital and local health services
- Value for money for taxpayers
- Openness

The focus of the *Strategic Plan for 2012–16* was actioning the government priorities as identified on pages 22–26.

The Service is committed to working closely with the Queensland Government to implement the *Health Priorities for Action*, and *Blueprint for better healthcare in Queensland* which sets four principle themes for the provision of health services in Queensland being:

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

Other whole-of-government plans/specific initiatives

The South West HHS had a number of obligations in relation to agreements between the Commonwealth and Queensland Governments. These related to residential aged care facilities, health services and Medical Specialist Outreach Assistance Program (MSOAP). The Service has been able to meet its obligations. The Queensland Government has articulated its long-term strategy to eliminate the health gap and to sustain health status improvement for Indigenous Queenslanders under *"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 Indigenous Queenslanders. The South West HHS has a number of partnerships with Aboriginal Medical Services to help improve health service coordination for Indigenous communities. It is also important that culturally and responsible health services are delivered and an Aboriginal and Torres Strait Islander Cultural Practice Program is mandatory for all staff and provides them with knowledge and skills to support culturally appropriate care.

Mental health and alcohol and other drug treatment services are provided and align with the principles, priorities and outcomes in the *Fourth National Mental Health Plan*, *Queensland Plan for Mental Health 2007–17, 2011–12 Queensland Drug Action Plan* and the *National Drug Strategy 2010–15*. 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 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 2012–13

In line with the government objectives and priorities the Strategic Plan provided a road map for improved performance and enhanced services. The plan provides a framework for planning, monitoring and accountability to our communities.

The Board developed an Interim Strategic Plan focusing on the whole of government's state-wide plans, policies and actions to improve health outcomes.

The South West HHS's key priorities for 2012–13 included:

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

Our strategic priorities

Strategy	Outcome
Priorities: Improved Access	
Create designated primary care clinics and proactively market the services of the hospitals	• Monthly community and allied health clinics advertised • Planning meetings held with DDSWQML • Assistance with marketing currently being investigated
Improve access to after-hours services through engagement of nurse practitioners, physician assistants and partnerships with Medicare Local and general practitioners	• Planning discussions held with DDSWQML and working towards agreed actions
Improve access through coordination, utilisation and promotion of visiting specialists such as MSOAP	• HSCE and Executive Director Medical Services (EDMS) participating in meetings with CheckUP and plans under development for program
Reduce waiting lists for specialist services	• Stage 1 of service plan project – Review of Flying Obstetrician and Gynaecological (FOG) services undertaken and service plan developed • Tenders to be called for the provision of FOG services • FSS to be reviewed during the forthcoming year
Examine opportunities for increased theatre utilisation to reverse patient flows	• Opportunities being reviewed under the service planning project which is due for completion by August 2013
Explore alternate ultrasonography and Computed Tomography Services within the Service to the local area and neighbouring hospitals	• Arrangements with private provider being explored
Promote and market the availability of services within the service to the local area and neighbouring hospitals	• Communication Plan to be developed in 2013–14
Work in partnership with local authority family support workers and other service providers	• Collaborative working relationships established • Participation in monthly meetings • Implementation of working models of care

Strategy	Outcome
Priorities: Work with Medicare Locals	
Negotiate and execute working partnerships with Medicare Local	• Arrangements established through negotiation and execution of a joint protocol between the Service and DDSWQML
Participate in the development of a joint Primary Health Care Plan	• South West HHS and DDSWQML representatives hold regular meetings • Joint Primary Health Care Plan scheduled for development in 2013–14 once both services have completed individual service planning
Priorities: Maternal and Child Health	
Build partnerships with referring hospitals and general practitioners for antenatal and postnatal care	• Collaborative clinics at GP clinics and Aboriginal Medical Services (AMS) held in Charleville, Cunnamulla, Roma and St George • Mums and Bubs Program implemented
Priorities: Chronic Disease	
Increase local programs to promote health and wellbeing	• Service planning being undertaken to establish requirements to implement evidence based programs
Develop and implement chronic disease prevention campaigns	• Lighten Up Program reviewed and renamed "Create a New You" • "Create a New You", 12 Week Challenge Program, Healthy Challenge Program delivered
Priorities: Engage with Queensland Aboriginal and Islander Health (QAIHC)	
Assist Indigenous groups with health service plan partnering with the Medicare Local and the Queensland Aboriginal and Island Health Council	• Cultural Practice Programs delivered • Service agreement under development
Implement and monitor cultural competencies within the workplace	• Cultural competencies part of mandatory workplace training • Additional training provided through customer service training
Utilise collaborative data and analyse to improve outcomes for Indigenous people	• Sharing of data part of service agreement development
Reform	
Priorities: Decentralise	
Seek clear funding arrangements for health services in rural and remote areas and identify potential funding incentives	• External review on funding model and financial sustainability completed by Paxton Partners Pty Ltd • Service Agreement and window amendments successfully negotiated
Review of medical service delivery models to achieve sustained and feasible outcomes	• Service planning being undertaken to establish requirements to implement evidence based programs

Strategy	Outcome
Priorities: Board oversight	
Rotate Board meetings around the Service	• Board meeting held in St George in November 2012 • CAN quarterly meeting held in Quilpie in February 2013
Increase the Board profile and learning the business	• Board governance education and information sessions held by McCullough and Robertson, Department of Health Ministerial Taskforce, Paxton Partners Pty Ltd, SAP Asset Procurement and Finance Information Resource Project (SAPFIR), Rural Doctors Association Queensland, Australian Medical Association Queensland • Board visited all facilities within the South West during its first year of operations with the exception of one facility
Priorities: Empower local communities	
Work with local government to promote the romance of rural areas to attract and recruit permanent doctors nationally and internationally	• Regional local government meetings attended by Board Chair, Board representatives and HSCE • Board Chair provides communiqués to Mayors within the region • HSCE maintains dialogue with Mayors
Build and maintain a positive and safe workplace culture and relationships with stakeholders and partners	• Engagement strategy developed to maintain and monitor relationships with partners and stakeholders • Contract safety orientation program has been initiated by Occupational Health and Safety Team • Visitor and contractor sign-in procedure in place for all facilities and buildings
Priorities: Ensure a smooth transition	
Continue to build the capacity of the Service to achieve earned autonomy	• Capacity continuing to be developed • Finance and recruitment services responsibility transferred to the Service
Develop and train our leaders to be role models and change managers	• Educative sessions held for leadership team at Health Service Management Forum • Participation in the Public Sector Service Commission
Promote and market the Service, its programs, initiatives, good news stories and successes	• Regular media releases produced • Monthly staff newsletter distributed to all staff and key stakeholders • Board Chair communiqués for Mayors • Board meeting summaries published on web • Programs and services showcased at Health Expo in Roma

Strategy	Outcome
Focusing resources on front line services	
Priorities: Identify wasteful expenditure	
Apply existing nursing business planning framework principles at hub facilities	• Business planning framework documents developed for Charleville, Roma and St George hub hospitals in line with organisation restructure
Review delivery of frontline services exploring opportunities to partner with other stakeholders and develop agreements, e.g. Medicare Local to deliver enhanced service delivery models and improved health outcomes	• Service Agreement developed for Child Mental Health Services and physiotherapy at Wallumbilla and Cunnamulla • Partnering with Goondir Health Services in women's health, child development services and diabetes continued
Priorities: Streamline bureaucracy	
Review all current service delivery models for non-frontline support services	• Service planning being undertaken to establish requirements to implement evidence based programs
Priorities: Manage expenditure growth	
Identify and develop revenue raising opportunities	• Own Source Revenue Committee developed and includes multidiscipline membership
Priorities: Improve financial management	
Identify partnership opportunities with resource companies	• Service planning project including stakeholder engagement and opportunities with resource companies in the region
Establish benchmarks for services to measure outcomes	• Expenditure per Weighted Activity Unit being reported for like-size facilities of the South West • Benchmarking to be developed and implemented for comparison with other rural facilities
Build financial management expertise through ongoing education and empowerment of clinical and non-clinical managers	• Financial management training conducted for line managers • Manual developed for line managers in relation to financial management
Continue to embed the Performance Management Framework to drive financial performance and accountability	• Performance Management Framework implemented across facilities • Performance Management Framework reviewed and being refined
Develop finance team capability and capacity	• Development plan produced and implemented for finance staff
Restoring accountability and confidence in the health system	
Priorities: Improve transparency of expenditure	
Identify and manage risks in accordance with the Risk Management Framework	• Risk management undertaken within the Department of Health Risk Management Framework • Risk workshop conducted with Board Members • Risk management processes to be further reviewed in line with updates of the Department of Health framework

Our performance

Our strategic priorities

Strategy	Outcome
Foster and embrace openness and transparency	• Performance Management Framework implemented • Internal Auditor engaged to implement the 2012–13 Internal Audit Plan • Independent review by Paxton Partners Pty Ltd on financial sustainability • Service planning project underway
Develop and maintain systems to provide meaningful feedback to the community	• CANs established across all facilities • Board meets with CANs on a quarterly basis • Local CAN meetings are held at all facilities • Board met face to face with all CANs with exception of Injune CAN throughout the year whilst visiting the various health facilities
Promote and enhance communication strategies	• Communications Plan to be developed in 2013–14
Priorities: Culture of frank/fearless advice	
Develop strong partnerships and collaborate with key stakeholders including Medicare Local, government, non-government agencies and other service providers	• DDSWQML Board representatives met with South West HHS Board in May 2013 to progress initiatives • The Service participates in regular meetings of the South West Interagency Group where service providers in the region meet to progress integrated care delivery and initiatives
Build positive relationships to encourage open and constructive feedback	• Meetings held with Mayors, CANs, State and Federal Members
Develop a capability framework to build skills, knowledge and behaviours	• Human Resources Plan programmed for development in 2013–14
Priorities: Planning	
Develop and implement sustainable projects to address identified needs and deliver the best possible outcomes	• Sub-acute care unit planned for implementation at Roma Hospital • Rural Health Outreach Fund planning and consolidation currently underway with CheckUP
Priorities: Infrastructure	
Develop facility master plans for the South West hub hospitals	• Master planning to be undertaken following completion of the service planning project
Progress approved infrastructure upgrades and strong advocacy for the infrastructure needs of South West	• Planning commenced under the Rural and Remote Infrastructure Program for upgrades at Charleville and Roma in conjunction with Health Planning and Infrastructure Division • Backlog and Maintenance Enhancement Program funding received for discrete projects

A review of the Strategic Plan was undertaken in the early part of 2013 for the ensuing four year period. The *Strategic Plan 2013–17* is aligned to the principal themes contained in the *Blueprint for better healthcare in Queensland*. The core areas for the *Strategic Plan 2013–17* are: person centred; 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.

Performance domains

The Service Agreement underpinned by a legislative framework between the Department of Health and South West HHS 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 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
- Closing the gap
- Mental health and alcohol and other drugs.

Our performance in these areas is outlined on the following pages.

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 State-wide and Commonwealth plans. The framework is a supporting document to the Service Agreement between the Service 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.

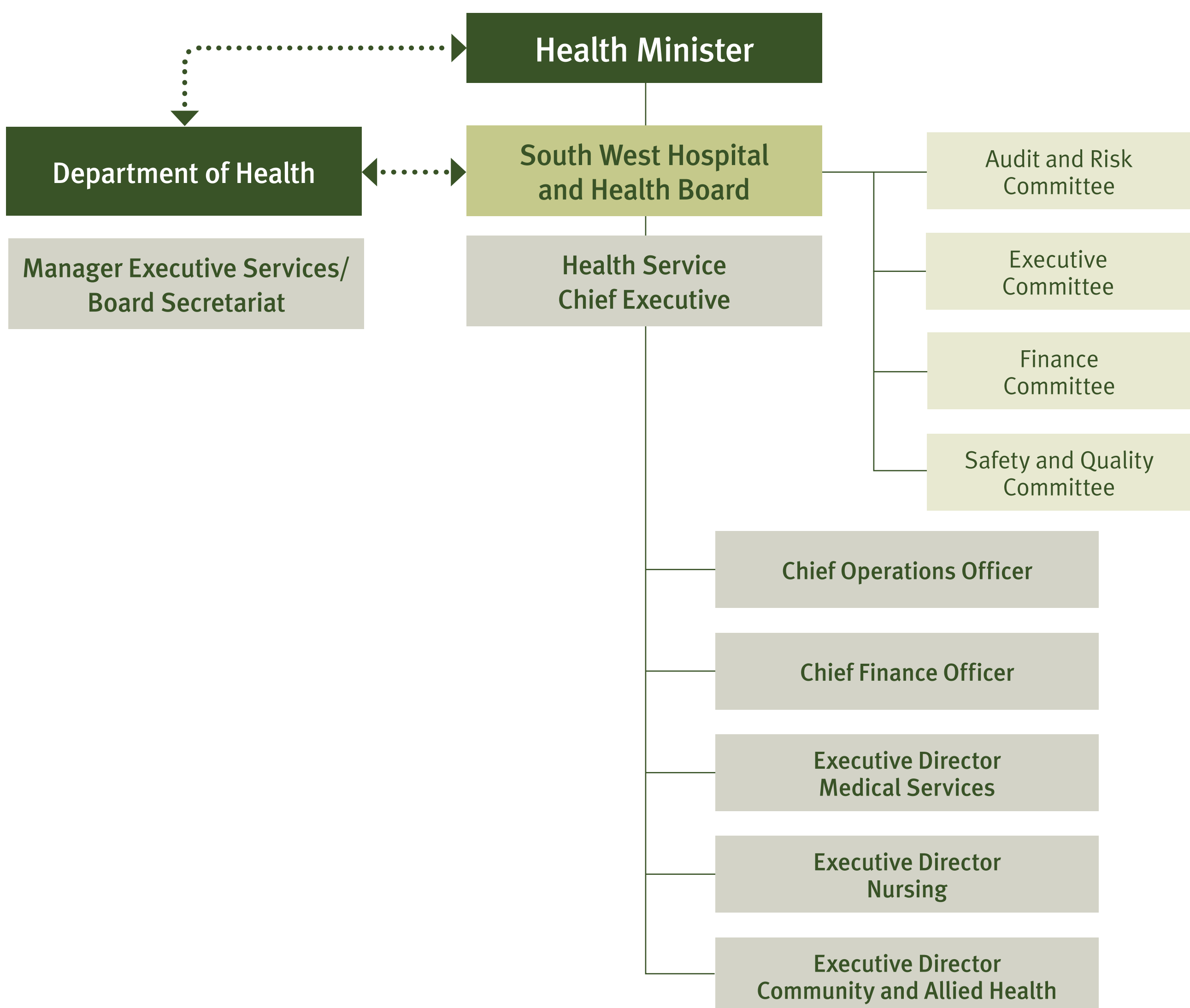
As a commitment to continue to drive performance the Service developed a Service Performance Management Framework relating to activity performance, budget performance and quality of patient care and outcomes. This framework involves a system of reporting performance against specified key performance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

			Latest Result / YTD Result
Safety and quality			
E1	Never events	**Result**	**0**
E2	Hospital acquired 3rd and 4th stage pressure injuries (FY Target is 5% of 2010–11 actuals)	FY Tgt	0
		Qtr 4	**0**
E3	Healthcare-associated *Staphylococcus aureus* (including MRSA) bacteraemia – SAB)	Target	–
		Result	**–**
The South West HHS achieved required targets for all required Safety and Quality escalation KPIs for 2012–13.			
Access			
E9	Activity (WAU):	Target	10,153
	Total	**Result**	**9,929**
	Inpatients (including critical care)	Target	3,699
		Result	**3,486**
	Outpatients	Target	2,435
		Result	**3,072**
	Sub-acute	Target	1,143
		Result	**881**
	Emergency department	Target	2,774
		Result	**2,396**
	Mental health	Target	102
		Result	**94**
Activity variance is largely due to the introduction of triage category level reporting for small hospitals in 2012–13, as well as conversion of Injune and Surat Hospitals to Multipurpose Health Services, therefore changing the reporting of activity for non-acute long-stay patients. Outpatient activity has increased due to the South West HHS now providing general practice in the communities of Cunnamulla, Dirranbandi, Injune and Quilpie.			
Efficiency and financial performance			**– $ Deficit / $ Surplus**
E10	YTD operating position	Target	$0
		Result	**$6,019**
		Variance (Favourable/– Unfavourable)	**$6,019**
E11	Full-year forecast operating position	Target	$0
	(Agreed position by HHS)	**Result**	**$2,365**
		Variance (Favourable/– Unfavourable)	**$2,365**
E12	Own source revenue target	Budget	$4,136
	(User Charges only)	**Result**	**$5,277**
		Variance (Favourable/– Unfavourable)	**$1,141**
E13	YTD average FTE (MOHRI FTE)	Target	717
		Result	**675**
		Variance (Favourable/Unfavourable)	**-42**
The South West HHS exceeded required targets for all required Efficiency and Financial Performance escalation KPIs for 2012–13.			

			Latest Result / YTD Result
Closing the gap			
E14.1	Indigenous status – reporting of 'not stated' on admission	Target	1.0%
		Result	**5.4%**
E14.2	Community follow-up (within 1 – 7 days) post mental health discharge	Target	55.0%
		Result	–
E14.3	Patients who discharged themselves against medical advice (DAMA)	Target	2.47%
		Result	**4.12%**
E14.4	Aboriginal and Torres Strait Islander Cultural Practice Program participants	Target	22.5%
		Result	**17.9%**
The South West HHS continues to work towards ongoing improvement of Closing the Gap KPIs.			
Mental Health and Alcohol and Other Drug Treatment			
E15.1	Ambulatory service contacts	Target	100.0%
		Result	**241.3%**
E15.2	Ambulatory service contacts: duration (hours)	Target	100.0%
		Result	**233.2%**
E15.3	Accrued patient days in block-funded mental health facilities	Target	95.0%
		Result	–
E15.4	Closure of ATODS client intake	Target	2.0
		Result	**1.1**
The South West HHS continues to work towards ongoing improvement of Mental Health and Alcohol and Other Drug Treatment KPIs.			

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 Board is an independent statutory body appointed by the Governor-in-Council and commenced with eight Board Members who have a significant role in providing astute leadership, strategic direction, a client focus, financial accountability, ethical behaviour and effective planning. An additional member was added when the Board was reappointed on 18 May 2013. The Board is a professional skills-based Board with members having skills and expertise in health management, primary health care, clinical, business management, financial management, compliance, legal and knowledge of consumer and community issues.

The Board is responsible for setting the strategic direction for the HHS and, with the HSCE, will be accountable for its performance. The HSCE is appointed by the Board and reports to the Board. The Board has responsibility for delivery of hospital and health services in accordance with the terms of the Service Agreement.

The Board is legally accountable for the hospital and health services operation and sets the policies to guide the service achieve objectives. Advice and recommendations are provided by the HSCE on key strategic issues. The HSCE 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.

Name	Office	No. of meetings attended	% Attendance *(since appointment commencement)*	Original appointment	Current term of appointment
Dr Julia Leeds	Chair	12	100%	18.05.12 – 17.05.13	18.05.13 – 17.05.14
Heather Hall *(02.11.12 – 17.05.13)*	Deputy Chair	12	100%	27.07.12 – 17.05.13	18.05.13 – 17.05.14
Lindsay Godfrey *(18.05.13 – Current)*	Deputy Chair	2	100%		18.05.13 – 17.05.14
Michael Cowley	Member	11	92%	29.06.12 – 17.05.13	18.05.13 – 17.05.14
James Hetherington	Member	10	100%	07.09.12 – 17.05.13	18.05.13 – 17.05.14
Lyn Kajewski	Member	11	92%	29.06.12 – 17.05.13	18.05.13 – 17.05.14
Sheryl Lawton	Member	10	83%	27.07.12 – 17.05.13	18.05.13 – 17.05.14
Richard Moore	Member	11	92%	29.06.12 – 17.05.13	18.05.13 – 17.05.14
Karen Prentis	Member	12	100%	29.06.12 – 17.05.13	18.05.13 – 17.05.14

The Board meets on a monthly basis and its usual place of meeting is Roma. However, as part of its commitment to meet outside Roma, a Board meeting was held in St George in November 2012. During the 2012–13 year there were 12 Board meetings. As part of meeting in St George, the Board also took the opportunity to tour facilities and meet with CAN members in the southern sector of the Service. A further visit to western facilities was made in February 2013 where the Board held its quarterly CAN meeting at Quilpie.

Board decision making is supported by Board briefing papers and a number of standing items are on Board agendas, e.g. risk, compliance and community engagement. The HSCE along with the Chief Operations Officer (COO) and CFO attend all Board meetings. On occasion executive members are invited to be present to provide further explanation and clarification to the Board on matters before them.

During the year the Board also invited guests to provide presentations to them. This included President of Rural Doctors Association (Queensland) (RDAQ) Dr Adam Coltzau and Dr Dan Halliday; Director-General, Dr Tony O'Connell; Bill Brett, Ministerial Taskforce and Heather Watson, McCullough and Robertson. The Minister for Health, the Honourable Lawrence Springborg met with the Board on a number of occasions including the opening of the MPHS facility at Surat.

In March 2013 the Board conducted an in house evaluation of its effectiveness and it is planned to engage the services of an external party towards the end of the year to undertake a formal assessment and evaluation of the performance of the Board.

Dr Julia Leeds,
Board Chair

Dr Leeds (Fielding) lives on a cattle property 120km south east of Charleville which she owns in partnership with her husband and where, for some time, she educated her children on Charleville School of Distance Education.

She has spent the vast majority of her medical career working in rural medicine in Charleville. She has worked as a medical officer for the Royal Flying Doctor Service and Queensland Health, as a solo general practitioner and in the local Aboriginal Medical Service, Charleville and Western Areas Aboriginal and Torres Strait Islander Community Health (CWAATSICH). She currently divides her clinical time between The Wesley Breast Clinic in Brisbane and CWAATSICH.

She joined the Board of the Royal Flying Doctor Service (Queensland Section) as a member in 2003 and was appointed Chair in 2009. She continues as a Director.

Dr Leeds is on the Board of DDSWQML. DDSWQML coordinates and facilitate health services in the community to improve the patient journey and equitable access to appropriate care.

The South West HHS and DDSWQML work in a cooperative and collaborative way to ensure improved health outcomes for all in the community.

She has been widely involved in the local community and has been a member of the Queensland Rural Women's Network, a not-for-profit organisation building the capacity of rural, regional and remote women, and South West Natural Resource Management Ltd which works with the community, Landcare, traditional owners, and local government and industry groups to achieve sustainable natural resource management, and foster landcare and catchment management ethics.

Dr Leeds is also a member of Breast Cancer Network Australia, the peak national organisation for Australians affected by breast cancer, consisting of a network of more than 67,000 individual members and 287 member groups.

She is a graduate of the Australian Institute of Company Directors and a strong advocate for continuing education of directors.

Heather Hall
Deputy Chair (2 November 2012 to 17 May 2013)

Ms Hall has almost 20 years experience working in community healthcare. Ms Hall is currently Community Services Officer for Anglicare Southern Queensland Rural and Remote, a position she has held for 10 years. Previously, Ms Hall worked as Clinical Nurse and Acting Clinical Nurse Coordinator at Roma Hospital, and as Community Nurse for Blue Care in Roma.

Ms Hall has extensive experience in high level advisory and board positions. Ms Hall is currently an Aged Care Auditor for Aged Care Standards and Accreditation Agency, ensuring the highest standards of care are met by Queensland's aged care facilities. She is also a Board Member for 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, Non-General Practice 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 and was a finalist in the Management Excellence Awards for Rural and Remote Manager of the Year.

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 is currently enrolled in a Graduate Diploma in Business Management.

She has performed various roles in Zonta from Member to President to Area 4 Director and is currently the treasurer of the Roma Rednecks Mud Racing Club.

Lindsay Godfrey

Deputy Chair (18 May 2013 to Current)

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.

Mr Godfrey is currently Mayor of the Paroo Shire Council at Cunnamulla. He holds and has held various positions including Chair, South West Regional Economic Development Board; Board of Wideland Insurance 1999–2005; Ministerial appointment to Wool Working Party to manage Woolpoll 1999–2000; Ministerial appointment to Woolgrower Advisory Group 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 United Graziers Association 1998–1999; President of the South West Division of the United Graziers Association 1997–1999; South West Strategy Representative 1996–1999; Inaugural Chairman of South West Strategy NRM Group 1998–1999; Fire Warden Kungie Fire Brigade 1990; President Cunnamulla Polocrosse Club (late 1980s) and Regional Economic Development Officer Paroo Shire Council during the early 1990s.

Mr Godfrey holds the following qualification: Bachelor of Business (Economics and Ethics) University of Southern Queensland 1995 and has participated in the Australian Rural Leadership Program, Course 4 1998.

Michael Cowley, *Board Member*

Mr Cowley is a St George local and Director of Fox and Thomas Business Lawyers. He has spent more than 10 years advising individuals, business and the rural sector on legal issues. Michael understands and appreciates the legal issues which affect rural communities and the business, 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.

Mr Cowley's practice covers a wide range of legal issues with his particular expertise being in the areas of rural property, water entitlements, business structuring and succession and estate planning. He is a member of the Queensland Law Society, New South Wales Law Society, Downs and South-West Queensland Law Association and Law Australasia.

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

James Hetherington, *Board Member*

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 from that time.

Mr Hetherington is currently Finance Director and Secretary for 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 within the South West.

Sheryl Lawton, *Board Member*

Ms Lawton is the Chief Executive Officer (CEO) of Charleville Western Areas Aboriginal and Torres Strait Islander Community Health Ltd (CWAATSICH Ltd). Born in Augathella, near Charleville in Queensland, Sheryl has held the CEO role at CWAATSICH for 12 years. Her appointment followed a lifetime of experience and involvement in primarily community-based health in the Charleville area.

In her community work, Ms Lawton has held a number of previous positions: Secretary/Treasurer of the Charleville Aboriginal Housing Company, Chairperson/Administrator of the Mitchell Aboriginal Housing Company, Chairperson and Deputy Chairperson of Aboriginal and Torres Strait Islander Commission (ATSIC) Goolburri Regional Council and Administrator of the Goolburri Aboriginal Land Corporation.

Other positions held include membership of the Joint Ministerial Advisory Committee on Housing from 1989 to 1996 and, in addition, Ms Lawton was the Deputy Chairperson of the Queensland Aboriginal and Islander Health Council (QAIHC) for seven years, and Chair of QAIHC for the past year.

Richard Moore, *Board Member*

Richard Moore is the Queensland and Pacific Manager at the Australian Institute of Company Directors, the peak body for directors, offering 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. He started his career as a Geological Data Engineer in the oil and gas industry. He has more than 25 years experience in general management, both here and overseas, including over 20 years in senior management positions.

Mr Moore is a graduate of the Australian Institute of Company Directors Course and the Harvard University Corporate Governance program. In addition to his executive role, he is currently a non-executive Director of Townsville-Mackay Medicare Local Board and Queensland Private Enterprise Centre Inc.

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

Karen Prentis, *Board Member*

After early career appointments in the banking sector and Queensland Treasury, Ms Prentis's focus and expertise developed predominantly in the area of corporate governance, compliance and risk management. Ms Prentis gained significant industry experience in senior executive positions with listed entities in the financial services industry. Ms Prentis's 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 in Brisbane to help guide and facilitate issues that affect the financial services industry.

Ms Prentis is a non-executive 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 Australian Securities and Investments Commission (ASIC).

Ms Prentis has a Bachelor of Economics and a Master of Administration.

Lyn Kajewski, *Board Member*

Ms Kajewski has worked in the banking industry for 16 years, followed by 20 years involvement in the local timber industry which lead to liaising with State Government Ministers, senior bureaucrats, industry and the wider community to achieve industry resource security. Between 2000 and 2004, Ms Kajewski served on Roma's Council as a Councillor responsible for ambulance, tourism and the Murray-Darling Basin. She then 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 as: Chairperson, Church Council, Maranoa Uniting Church in Australia; Chairperson, Easter In The Country Inc, Roma; Chairperson, Roma Tourism; Chairperson, Sustainable Cypress Management Group; Committee Member, St John's Parents and Friends; Treasurer, Play Group – Roma; Member, Local Ambulance Committee; Committee Member, Roma Day Surgery Centre Committee (establishment of); Committee Member, Maranoa Combined Christian Churches Flood Appeal 2012 and Student Coordinator, World Education Program, Roma.

Ms Kajewski's contribution to the rural community and industry was formally recognised when she received the Roma Community Award for Contributions to the 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.

Ms Kajewski is a member of the Australian Institute of Company Directors.

Board remuneration

The Governor-in-Council approves the remuneration arrangements for Hospital and Health 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*. 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 Pages 107–108.

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 (4) committees to assist it in carrying out its responsibilities.

The committees are:

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

The Board Committees make recommendations to the Board. Each committee operates within 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 not undertaken during the 2012–13 year however, this is scheduled for the forthcoming year.

Corporate governance

Audit and Risk Committee

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

No. of Board Members: 2	**No. of non-Board Members:** 2
Board Members: • Karen Prentis *(Chair)* • Richard Moore	**Non-Board Members:** • Lesley Lalley • Meryl Brumpton
Frequency of meetings: Quarterly*[1]	**No. of meetings held 2012–13:** 5

Executive Committee

Purpose: Governance responsibilities, strategic planning, service agreement and engagement strategies

No. of Board Members: 9	**No. of non-Board Members:** –
Board Members: • Full Board	**Non-Board Members:**
Meetings held: Quarterly*[2]	**No. of meetings held 2012–13:** 7

Finance Committee

Purpose: Financial position

No. of Board Members: 4	**No. of non-Board Members:** 3
Board Members: • James Hetherington *(Chair)* • Michael Cowley • Sheryl Lawton • Lyn Kajewski	**Non-Board Members:** • Lesley Lalley • Graem Kelly • Josh Carey
Meetings held: Quarterly	**No. of meetings held 2012–13:** 4

Safety and Quality Committee

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

No. of Board Members: 2	**No. of non-Board Members:** 4
Board Members: • Heather Hall *(Chair)* • Dr Julia Leeds	• Dr Tom Gibson • Robyn Brumpton • Chris Small • Jenny Flynn
Meetings held: Quarterly	**No. of meetings held 2012–13:** 4

*[1] Special meetings may be called if required

*[2] Executive committee business is dealt with as a segment to the Board meeting

External appointments to board committees

Ms Lesley Lalley was appointed to 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 HSCE and CFO attend Finance Committee meetings; the COO attends the Audit and Risk Committee meetings; the EDMS, Executive Director of Nursing (EDON), the Executive Director of Community and Allied Health (EDC&AH) and the Nursing Director Quality and Safety (NDQS) attend the Safety and Quality Committee meetings.

Public Sector Ethics Act 1994

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 describing 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 Service has adopted a number of key values to guide decision making, culture and practice. These include caring for people, leadership, partnership, accountability, efficiency and effectiveness, innovation, responsibility and teamwork. 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 thereafter familiarise 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 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 hospital and health 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 Service's 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 report to the EMT, i.e. finance, corporate governance and clinical governance. These committees also hold monthly meetings.

Executive member profiles

Name	Position	Dates
Graem Kelly	Health Service Chief Executive	17.09.12 – 30.06.13
Meryl Brumpton	Acting Health Service Chief Executive	01.07.12 – 16.09.12
	Chief Operations Officer	17.09.12 – 30.06.13
Josh Carey	Chief Finance Officer	01.07.12 – 30.06.13
Dr Martin Byrne	Executive Director of Medical Services	01.07.12 – 12.02.13
Dr Tom Gibson	Executive Director of Medical Services	21.01.13 – 30.06.13
Chris Small	Executive Director of Nursing Services	01.07.12 – 30.06.13
Jenny Flynn	Executive Director of Community and Allied Health	01.07.12 – 30.06.13

Graem Kelly PSM

Health Service Chief Executive

Mr Kelly was appointed as HSCE in August 2012 and commenced in the role in September 2012. He has extensive experience in the health industry having previously been employed in executive management positions as Chief Executive Officer/Director of Nursing; Castlemaine Health and Maldon Hospital, Robinvale District Health Services and Kaniva Hospitals.

Mr Kelly holds a Masters of Business Administration, a Graduate Diploma in Rural Health and a Bachelor Applied Science (Nursing). As an executive he is motivated and is willing to be challenged. This is evident in his leadership style and his engagement of staff and community to succeed and be awarded and recognised at both a State and Federal level. He has a rich history as a leader and in 2001 he was awarded a Public Service Medal and in 2004 was selected for sponsored participation in the Australian Rural Leadership Program. He has strong strategic insight and the ability to drill into critical issues which means he consistently delivers strategically desired results. His balance in management, leadership and clinical skills brings insight into his role and yet he also creates a supportive work place culture with strong financial controls and responsible accountability.

Meryl Brumpton

Chief Operations Officer

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

Josh Carey

Chief Finance Officer

Mr Carey was appointed District CFO, South West Health Service District in December 2010. He has worked for Queensland Health for the past six years in both the South West and Central Queensland Health Service Districts. In this time, Mr Carey has worked in a number of senior finance and business management roles.

He holds a Bachelor's Degree in Commerce (Finance and Accounting), and plans to undertake the CPA program in 2014. Mr Carey's areas of interest include working with clinicians to develop financially sustainable clinical models, promoting financial policy and strategies and developing the financial management skills of clinical managers, business managers and finance staff.

Jenny Flynn

Executive Director of Community and Allied Health

Mrs Flynn has worked in the Queensland Government for more than 20 years in a number of departments including Queensland Health, Education Queensland and Disability Services Queensland. She commenced in her role as District Director Community and Allied Health in April 2009. Mrs Flynn has a Bachelor of Social Science and a Graduate Certificate in Collaborative Practice. She has worked extensively in rural communities across the South West HHS.

Christopher Small

Executive Director of Nursing

Mr Small was appointed as the District Director of Nursing in August, 2009. Prior to this he was substantively the Director of Nursing of Mitchell Hospital since 2001.

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 evidenced based acute and emergency care is given, but also on creative health promotion and chronic disease programs to address the broadening burden of disease in rural communities. Mr Small also has a strong interest in quality, patient safety and clinical governance. He has worked in a range of positions both in the public and private sectors including roles as quality manager across a group of hospitals, clinical nurse in anaesthetics and recovery and nurse unit manager of a medical/high dependency unit ward. He sits on a number of state committees to ensure the future 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.

Dr Martin Byrne

Executive Director of Medical Services

Dr Martin Byrne was the EDMS until February 2013 having commenced in this role in 2011. While Dr Byrne performed this role he was also the Director of Medical Services at the Roma Hospital and held that role since July 2010.

Dr Byrne's qualifications included a Bachelor of Applied Science, Bachelor of Medicine/Bachelor of Surgery, Fellow of Royal Australian College General Practitioners, Fellowship in Advanced Rural General Practice, Fellowship of Australian College of Rural and Remote Medicine, Diploma of Royal Australian and New Zealand College of Obstetricians and Gynaecologists and Graduate Australian Institute of Company Directors. He is a Senior Lecturer at the University of Queensland.

Dr Tom Gibson

Executive Director of Medical Services

Dr Tom Gibson was appointed as the EDMS in January 2013. Dr Gibson has worked as a rural General Practitioner/Surgeon/Obstetrician/Teacher in New Zealand, Tanzania and most recently in the Kimberley enjoying rural Australia.

Throughout his career he 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.

Service governance committees

Three service wide governance committees have been established to assist in carrying out responsibilities. The committees are:

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

Executive Member Report

Chief Operations Officer

Scope

Deputy to the Chief Executive; management and oversight of MPHSs; management of assets and facilities, fleet vehicles, food services and catering, cleaning, porterage, waste disposal, equipment, linen and laundry services; executive sponsor of the Corporate Governance Committee.

Achievements/outcomes

Multipurpose Health Services

Injune and Surat gained MPHS status for the provision of high care and community aged care packages.

Extensions to both Injune and Surat MPHSs were commissioned to provide dedicated aged care friendly environments including en-suite bedrooms, living and dining areas, verandas and outdoor areas.

Maranoa Regional Council constructed a 10 bed low care extension to the Mitchell MPHS and handed this over to the Service in May 2013. Additional Commonwealth funding was received to operate this facility.

Capital infrastructure, repairs and maintenance

Major items in the repairs and maintenance program for the year saw refurbishment of bathrooms at Roma Hospital, internal repaint of Charleville Hospital, replacement of the sewer line at Mungindi, repairs to air conditioner systems at Mungindi and Waroona, and a replacement program of television systems in our MPHSs for the introduction of digital television.

Our capital program saw major items being new air-conditioning systems at Roma Hospital laundry and St George kitchen and installation of driveways and carports at some of our on-site accommodation.

Announcement of a $3million upgrade to each of Roma and Charleville Hospitals to meet critical infrastructure issues such as electrical, fire safety, plumbing and lift works under the Rural and Remote Infrastructure Program was made. Preliminary work commenced June 2013.

Significant funding was received under the Department of Health's Maintenance Enhancement and Priority Capital Programs to provide essential infrastructure works at Dirranbandi, Roma and St George Hospitals, covering electrical and fire safety issues.

Operational services restructure

Restructure involved with the voluntary redundancy process allowed us to commence critically analysing long standing processes in our operational services workforce and introduce improved efficiencies, better work practices and introduce some new cleaning equipment.

Financial and performance reporting was increased over the year to enable a more robust review of each site's performance against some key targets. Our MPHS and Corporate Support areas are now more aware of their cost drivers and risks.

Thank you to my staff for their contribution and efforts. It has been the great teamwork that has created the many successes we have achieved over the past twelve months. My sincere thanks to you all.

Future directions – looking ahead

- Master planning for Roma and Charleville sites will occur.
- All Roma-based executive and service wide support staff will be consolidated into the one location at the Support Service Building, Bungil Street, Roma.
- The Telecommunications Infrastructure Replacement Program will see Information Technology enhancements at Charleville and Roma campuses.
- The $3 million critical infrastructure projects at Charleville and Roma will occur, involving significant planning around the continued operation of our facilities as this work proceeds.
- Further programming of maintenance and upgrade of our building assets.
- Coordinator of Operational Services appointed and will be reviewing and strengthening our compliance with food services and cleaning standards.

Executive Director of Medical Services

Scope

Management and oversight of service-wide medical services; also holds position of Director Medical Services for Roma Hospital; credentialing and recruitment of medical staff; flying specialist services including surgical services and obstetrician and gynaecological service; general practice; jointly sponsors the Clinical Governance Committee in conjunction with the Executive Director of Nursing.

Achievements/outcomes

Medical workforce

For the hub sites of Charleville and Roma a recruiting campaign is currently underway to employ rural procedural trainee doctors to staff these sites following completion of their procedural skills training. We have currently been successful in appointing four of these medical officers and it is hoped that more of these appointments will be made to Charleville and Roma in the coming two to three months. Initiatives are currently underway to achieve a locum free work environment within the South West HHS. If successful this should alleviate the need for the employment of locums in Charleville and Roma which would be advantageous. It is planned to work in partnership with the local general practices to ensure recruited medical officers also gain experience in general practice. Such partnerships are a very important part to the future plan for this area.

Satellite sites have had a challenging year. A number of sites remain without regular medical officers including Cunnamulla, Dirranbandi, Injune and Quilpie. Unfortunately, the medical officer in Mitchell has recently announced his retirement. With the lack of regular medical officers in these sites again the services have been dependent on locums to staff both the hospital and general practices which by default come under the control of the Service.

St George currently remains well staffed with a suitable workforce and again is the strong point of the Service. Roma Hospital has continued to develop with regular medical officer meetings and regular education sessions enhancing the working environment of the medical officers who work there. Medical students play an important role in the life of Roma Hospital. It has been great to have two long-term students for the whole of the year.

Flying Specialist Services

The FSS continues to be staffed by locums but approval has now been given for the appointment of regular staff for the flying obstetrician position. It is anticipated that this will be filled on a job share basis by two to four clinicians and a tender document for this is currently going out to market. It is hoped that very soon thereafter a similar tender for the flying surgeon will be able to be implemented. Having regular medical officers in these important positions will greatly enhance the quality of the service provided. Work is currently underway to develop the service at each site and to define the scope of the service and the expectations of the host hospitals as well.

Staff retention

This year has presented numerous challenges in terms of staff retention. This remains the largest issue for medical services in the Service. The lack of regular medical staff in many locations has made the Service reliant on locum medical officers. Engagement of locum medical officers is very expensive to maintain and also presents a challenge for communities in relation to continuity of care.

In summary, 2012–13 has been a year of challenges in terms of medical staffing but also a year where the potential for development of a medical workforce has become clear with the commencement of some exciting changes in the way medical services are provided into the Service. I thank the staff for the valuable contribution they have made over the past twelve months.

Future directions – looking ahead

- The plan for 2014 is to seek to engage groups of regular medical officers on a job share basis on a non-locum basis to fill medical officer positions at various sites where it has been difficult to recruit to, with a portion of income being derived from the proceeds of the general practice. It is hoped that such positions are attractive to a sufficient number of medical officers so that our reliance on locums will decrease and will also enable us to use Commonwealth funding for the provision of the commonwealth service and general practice.
- Transition of pharmacy and radiography services from Allied Health to the line management within the EDMS portfolio as from commencement of July. The transition of these important clinical services is appropriate in terms of further clinical development of services at our hub sites.
- Development of a locum free workforce in the Service.
- Further development of clinical services at hubs sites.
- Recruitment of flying obstetrician and flying surgeon.

Executive Director of Nursing

Scope

Management and oversight of nursing profession and nursing standards across the South West HHS; management of facilities at Charleville , Roma and St George and the aged care facilities of Waroona Multipurpose Centre and Westhaven Residential Aged Care facility; jointly sponsors the Clinical Governance Committee in conjunction with the Executive Director of Medical Services.

Achievements/outcomes

Midwifery

Midwifery Group Practice caseload models established in Roma, developed in Charleville and Cunnamulla and in planning for St George. These models will ensure that the Service is offering women centred practice and flexible options to those who can birth in our hospitals, and for those who cannot, a facilitated pathway into maternity services away, and then a pathway back into postnatal services on their return.

Graduate Nursing Program

The Graduate Nursing Program has been substantially expanded this year from 15 to 38 first year registered nurses undertaking their first year of work being enhanced through a supported program. This program ensures that beginning registered nurses are offered continued support, learning whilst they transition to employment. The program has many benefits ensuring the Service is supporting the profession through nurturing the junior work force into nursing, encouraging staff into rural and remote areas by offering positions and placements in a supported way and ensuring the level of education that they require to become a competent rural and remote nurse. The program also ensures that we are utilising staff to ensure continuity by eliminating the Service's reliance on agency locum nursing staff and the costs associated with this.

Business Planning Framework

A substantial body of work to determine our nursing workforce requirements commenced this year and will continue into next year as part of our commitment to the implementation of the Business Planning Framework (BPF), nursing workload resourcing tool. This is part of our nursing enterprise bargaining agreement requirements. Work commenced with the MPHSs, Charleville and Cunnamulla and will continue this year with Roma, St George and the community health nursing positions. The project looked at nursing positions against facility activity and occupancy, and the nursing establishments were adjusted accordingly. This work had not been undertaken for many years. All hospital and health services were allocated a position to review and develop the BPF profiles for each facility and unit in conjunction with hospital management. The Service is currently being established.

Essentials of Care Program

An Essentials of Care Program was established to address some of the identified nursing standards that require reviewing across the Service. A steering committee of senior nurse leaders has been established and a nursing practice framework was developed. This will be progressively implemented to all nursing staff next year and will guide nursing practice and patient and resident expectations. The steering committee has also been working to expand the Productive Ward Program into other facilities across the service and to develop a continuity pathway to streamline a patient's journey from being an acute admitted patient into a discharged community based client in a seamless transition. Once completed, the pathway will ensure that there is a decreased length of stay in hospital and then shifting of care into a comprehensive community follow-up model.

Models of Nursing Services

There have been a number of models of nursing services developed and reviewed over the year, some of these are the:

- Maternity models of care to ensure continuity of carer, women centred care, postnatal home visiting and transition of care to child health.
- Aged care models have been reviewed under the MPHS model to ensure viable flexible aged care solutions within small communities and in some instances the linkage of primary health care centres to MPHS to ensure the extension of community options and a more viable service in these communities.
- Rural model of care to incorporate general practice, community, hospital in the home, primary care assessments, acute and health promotion.
- Diabetes model of care.
- Surgical services.

Case Management Framework

In conjunction with the Community and Allied Health Team there was considerable work undertaken on the development of a case management framework. This framework, when implemented, will ensure that there is a consistent framework for clinicians to use to ensure continuity of care between differing professional groups; that complex care and co-morbidities are allocated a case manager to alleviate duplication of services and that the client receives the required services to assist in managing their complex care; and to ensure optimal health outcomes are achieved.

Clinician Engagement Strategy

A Clinician Engagement Strategy was developed and endorsed by the Board. This strategy sets out how the Board and the EMT are going to ensure that we are communicating in an effective way with our clinicians and that the clinicians have the ability to participate in the decision making of the Service.

Clinical Audit and Improvement Framework

A robust Clinical Audit and Improvement Framework is in place to ensure that nursing standards and care delivered is continually improving and developing to meet the needs of our patients, residents and clients. Some of our achievements have been a decrease in hospital acquired pressure areas, reduction in medication errors, falls prevalence and implementation of prevention strategies and increase in clinical equipment to assist with the improved delivery of care identified through audit. Improved customer satisfaction necessitating an increase in the satisfaction benchmark, bedside communication and handover and interaction has improved and is established at 100 per cent of sites.

Workforce

Recruitment of senior experienced generalist staff and specialist staff to undertake midwifery and theatre is an ongoing problem that will require innovative ideas and solutions. Our workforce data is indicating that in the next few years we will have an increasing problem with staff retiring. This will cause a staffing issue for the Service on top of the overall profession workload shortage that is talked about throughout the nursing professional bodies. This problem will see the Service needing to continue with our expanded graduate program to build some capacity and training of our staff to ensure competent registered and enrolled nursing staff. Adequate accommodation is a challenge as we increase our workforce numbers, The ability to accommodate them in staff quarters, residential housing and then the spiralling cost of rent is hindering the ability to attract and retain our staff.

I would like to take this opportunity to thank the nursing staff. As nurses we provide care, compassion and empathy with our clients and the nurses of the South West are exemplary deliverers of these qualities to their patients, residents and clients. This is well supported by the feedback we receive from our evaluation of care surveys and can be seen as you walk through the wards of our facilities.

Future directions – looking ahead

- Development and implementation of models of care that incorporate nurse practitioners and advance nursing roles in multidisciplinary teams to offer services that are delivered by the right people, in the right place at the right time. Some of this is to include:
  - Telehealth
  - Hospital in the home type services for low acuity admissions
  - Hospital in the nursing home
  - Increased aged care solutions and community packages
  - Case management
  - Nurse led primary care clinics.
- Nursing recruitment and retention strategy.
- Surgical services strategy.
- Nursing rural generalist education pathway.
- Improved university partnerships.
- Succession planning and development program.

Executive Member Report

Executive Director of Community and Allied Health

Scope

Management of program areas: allied health, mental health, oral health, healthy ageing, child and family and chronic disease.

Achievements/outcomes

Community and Allied Health Program

Community and Allied Health Program areas – healthy ageing, child and family and chronic disease introduced a centralised booking process which manages referrals, appointment bookings and scheduling as well as data collection for financial reporting. Initially these units were established in Roma (October 2012) and Charleville (January 2013). Oral health adult service also moved to a model of central bookings for their appointments.

Mums and Bubs Program

The child and family team have been busy establishing the Mums and Bubs Program as well as the Hearing Health Program. Mums and Bubs provides a seamless transition from the midwifery service to the child health service with a joint visit in the first four weeks following a birth. The Hearing Health Program is particularly exciting as it is a joint initiative with specialists utilising telehealth which prioritise our clients to be seen on a local waiting list instead of being placed on the much longer list in Toowoomba.

Resilience and recovery team

The resilience and recovery team finalised their work in the South West HHS in April 2013. The team was established due to the successive, massive flooding events in many areas of the Service. Mental health staff in the adult, child, youth and alcohol and other drugs teams are responsive to the mental health needs of the South West providing community based services.

Oral Health Services

Oral health care continues to be a priority with our dental teams providing services for adults and also children in schools. The team also participates in health promotion activities where possible. With the completion of the new clinics in Roma, the South West is now able to offer final year dental student placements and promote the possibility of working in the rural and remote settings post graduation.

Home and Community Care

Audits have been continuing in relation to standardising ongoing needs identification documentation and home and community care (HACC) data collection. Work is continuing with the three HACC coordinators and the healthy ageing program manager to standardise the procedures throughout the Service. Quarterly HACC business meetings have provided an opportunity to work collaboratively in areas of standardisation.

Telehealth services

The use of telehealth is increasing and is improving client contact with our clinicians when appropriate, as well as being utilised to provide specialist services such as cardiac services and hearing health. 50 per cent of clients in outlying centres receive chronic disease appointments via telehealth.

Health checks and care

Multidisciplinary clinics have been established across the Service to attempt to maximise the number of clients who are accessing appropriate health checks and care. Clients attending these clinics are now offered adult health checks in Charleville (as from June 2013) and this service will be progressively introduced through the Service. The number of adult health checks increased with more than 100 adult health checks done over the period January – May 2013 across the Service with most chronic disease clinical staff now being aware of the need for this intervention, and reportedly being confident to undertake these checks. More than 80 per cent of these clients were referred to their GP as a result of these checks, suggesting that a significant number of high risk clients have been identified in the community. A formal referral pathway has been established. Approximately 80 per cent of adult health checks undertaken in the community have been with Indigenous clients with many formally referred to a GP or Aboriginal Medical Service.

There has been a huge increase in community provision of basic health screening across the Service, with 'Know Your Numbers' being provided by the community nurse and backed up by the cardiac services clinical nurse when available. Approximately 538 people have accessed this community service with 122 referred on to their GP. While numbers prior to January are not available, it is reported by clinicians that these community services were only occasionally available prior to that time.

Diabetes risk assessment tools have been used in the community with approximately 73 clients from January–May 2013.

There is an accessible cardiac model of care in place which is arranged by a cardiac services coordinator.

Health promotion

The community and allied health team across all programs provided an extensive variety of opportunities to promote healthy lifestyles. These programs and events were held at many centres across the geographical area including Charleville, Cunnamulla, Eulo, Injune, Mitchell, Muckadilla, Quilpie, Roma, St George, Surat and Thargomindah. On a number of occasions we partnered with other providers including Aboriginal Medical Services, Queensland Police and other non-government organisations to assist in service delivery. Activities included: pit stops, lighten up programs, women's health nights, men's health nights, alcohol and other drugs minimisation programs and nutrition sessions. Other activities included Australia's healthy weight week, drug action week, think the drink, heart foundation walking group.

Community and Allied Health staff have participated in health promotion activities with 75 per cent of staff undertaking the adult health check and healthy lifestyle initiative in each work place. 75 per cent of staff participated in the popular 'Battle of the Bulge' at the commencement of the year which was organised by the health promotion team and this resulted in significant weight loss for many participants. There were 12 challenges with 52 teams covering more than 300 staff members. A number of staff attended the leaders' course relating to chronic disease self management.

The health service directory was updated for 2013 and community and allied health clinics were advertised on a monthly basis. Mapping of nutrition programs and services was also undertaken.

In conclusion, there have been many changes in staff which is a challenge for our Service. Community and Allied Health were fortunate to have minimal staff reductions as part of the voluntary redundancy program. We continue to be appreciative of the staff, past and present and for their contribution to our Service whether they are here a short time or for many years. Everyone in their own way contributes to the Service and brings skills and knowledge which enrich the workplace and value add to clinical care and service provision.

Future directions – looking ahead

- Continue to develop models to further enhance clinical care.
- Development and establishment of revenue raising capabilities of community and allied health services.
- Enhancement of stakeholder engagement with an emphasis on engagement with Aboriginal Health Services and formalising of these relationships with service agreements and memorandums of understanding.
- Further development of the relationship with the DDSWQML.

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/NZS) ISO Standard 31000:2009 for risk management.

A 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 for local site assessment and mitigation, 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. 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 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/extreme and is unable to be treated. Risk reports are provided to the Board on a regular basis.

External scrutiny

Coronial inquests

A Coroners Inquest was conducted into a death of a Charleville resident who had been an inpatient of the Charleville Hospital. The Coroner's findings were released in January 2013. The inquest investigated the death as well as the adequacy of medical, nursing and mental health care at Charleville Hospital. The Coroner made eight recommendations and referred five recommendations to the Department of Health for consideration and implementation as necessary. The Coroner did refer to the amount of work that had been undertaken by Charleville Hospital and the Service since the death to improve care.

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 2012–13 year was the first 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 had due regard to Queensland Treasury's *Audit Committee Guidelines*. The Audit and Risk Committee meets quarterly however, extraordinary meetings are scheduled as required.

Details of committee membership are detailed below:

Name	Appointment	Office	Remuneration
Karen Prentis	28.08.12 – Current	Chair	See Note 30(c) to Financial Statements
Richard Moore	28.08.12 – Current	Committee member	See Note 30(c) to Financial Statements
Lesley Lalley	22.04.13 – Current	External non-Board member	Nil, pro bono
Meryl Brumpton	28.08.12 – Current	Non-Board member, Employee	

The Chief Operations Officer attends 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 Board has also adopted an Audit and Assurance Framework which provides a structured approach to the establishment and operation of an appropriate internal control system and identifies a number of key areas such as internal controls in relation to operational and management control, financial compliance, safety and quality, safe practice and risk, review of internal audits, external audit and external reviews.

The committee has an oversight role in relation to the following:

- financial statements
- internal control
- internal audit
- external audit
- compliance

Financial statements

The committee assesses the adequacy of the Service's financial statements, having 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; 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
- internal audit charter
- audit and assurance framework
- revaluation methodology on land and buildings
- annual financial statements
- risk management
- escalation template

Internal audit

The Board adopted an Internal Audit Charter to provide the functional and organisational framework within which internal audit is to operate. The Charter sets out the nature, role, status, authority and responsibility of internal audit and has been developed considering the *Financial Accountability 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 management with recommendations to enhance current systems, processes and practices. This brings a systematic and disciplined approach to evaluate and improve the effectiveness of business risk management, control and governance processes.

During the 2012–13 year 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 purchasing to payment transaction cycle review, payroll transaction cycle review, delegations of authority review and fraud and misconduct prevention and control review. Following completion of the audit a report has been prepared and detailed action plans have been developed to address identified areas for improvement.

Compliance, risk and accountability

Public Sector Renewal Program

As part of refocusing the public service on government priorities and supporting the delivery of front line services in a constrained fiscal environment, the South West HHS undertook a number of initiatives to contribute to the renewal program. This included a two staged organisational restructure designed to streamline operations, implement contemporary models of practices and achieve financial savings. A number of positions were re-engineered within the operational stream. In addition, independent consultants Paxton Partners Pty Ltd were commissioned by the Minister for Health, the Honourable Lawrence Springborg, to undertake a review of health services and the financial position of the South West HHS. The review assessed the comparative efficiency of health facilities against the benchmarked data for other rural facilities as well as reviewing savings strategies and identifying further additional saving strategies, including a review of workforce levels, opportunities to increase efficiencies and opportunities to generate additional own-source revenue. The Service also co-operated with the contestability branch on state-wide initiatives and the Ministerial Taskforce in considering ways to address challenges faced.

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. Funding was received for the implementation of the *Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–33* in this financial year. Under the framework an Aboriginal and Torres Strait Islander Cultural Capability Plan for the year was developed focusing on priorities and strategies under four guiding principles of relationships and partnerships, communication, cultural respect and recognition and capacity building. A cultural capability training program has been developed for all staff.

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 Board and EMT have made a priority commitment to better engage with Indigenous communities and seek to promote cultural and linguistical engagement.

Information systems and record keeping

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.
A records management procedure is in place which describes the processes for ensuring that record management practices are guided by an effective policy and framework that supports legislative, administrative and business requirements.

Following the implementation of the *Hospital and Health Boards Act 2011* on 1 July 2012 responsibility for records was transferred from the Director-General of Queensland Health to the South West HHS. Records were transitioned by 30 June 2013. The Department of Health is working with Queensland State Archives to develop a Health Sector Retention and Disposal Schedule to cover all non-clinical records. Under the *Public Records Act 2002* the Department of Health remains responsible for permanent public records held in the Queensland State Archives archival collection. Consideration will be given to an electronic records management system in 2013–14.

Our people

The South West HHS imperative is to deliver the highest standards of safe, accessible, sustainable evidence based health care with a highly skilled and valued workforce that optimises the wellbeing of our community. This requires an engaged and productive workforce with the required skills and capabilities.

The People and Culture area is about providing services to support our staff to be safe and well at work, work under fair and equitable conditions, identify and access learning and development as well as being 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. People and Culture brings together a number of services through human resources, safety and wellbeing and our workforce development team to provide quality services to our staff.

Human resources

Our human resources area seeks to cultivate a superior service-orientated culture that provides benefits to employees that promote health, wellness and a sound work/life balance.

The main functions of the human resources unit include the provision of a strategic framework with systems and policies to align and guide the delivery of people management, liaison and specialist services involving recruitment, change management, case management, coaching and influencing and coordinating department enterprise bargaining and responses to industrial issues and direct service delivery including centralised and streamlined recruitment processing and a range of training packages.

Occupational Streams Summary

MOHRI occupied headcount and FTE

		End June 2012 *(baseline)*	June 2013	Variance from baseline	
				Increase	%
Medical *(including VMOs)*	Headcount	24.00	21.00	-3.00	-12.50%
	FTE	22.84	20.20	-2.64	-11.56%
Nursing	Headcount	384.59	380.64	-3.95	-1.03%
	FTE	308.92	300.89	-8.03	-2.60%
HP, professional and technical	Headcount	62.00	58.91	-3.09	-4.98%
	FTE	56.55	52.41	-4.14	-7.32%
Clinical streams	Headcount	470.59	460.55	-10.04	-2.13%
	FTE	388.31	373.50	-14.81	-3.81%
Managerial and clerical	Headcount	139.48	135.47	-4.01	-2.87%
	FTE	117.63	114.32	-3.31	-2.81%
Operational	Headcount	254.26	217.94	-36.32	-14.28%
	FTE	190.50	170.91	-19.59	-10.28%
Trades, artisans and general	Headcount	6.00	4.00	-2.00	-33.33%
	FTE	6.00	4.00	-2.00	-33.33%
Non clinical streams	Headcount	399.74	357.41	-42.33	-10.59%
	FTE	314.13	289.23	-24.90	-7.93%
Total streams	**Headcount**	**870.33**	**817.96**	**-52.37**	**-6.02%**
	FTE	**702.44**	**662.73**	**-39.71**	**-5.65%**

Our people

Profile

The workforce profile at 30 June 2013:

Full-time equivalent (FTE) staff establishment	662
Head count	818
Permanent retention rate	75.5%
Permanent separate rate	24.5%

The retention rate is the number of permanent staff employed by South West HHS at the start of the financial year and who remain employed at the end of the financial year, expressed as a percentage of total staff employed.

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

Throughout the year 29 complex human resources (HR) case files were managed.

	2011–12		2012–13	
Turnover	%	No.	%	No.
Management and clerical	15.59	21	23.78	31
Medical	24.29	6	40.65	9
Nursing	19.59	72	25.43	95
Operational	20.78	54	29.57	68
Trade and artisans	0.00	0	41.67	2
Professional and technical	32.90	19	28.72	18
Total		172		223

The above table indicates the staff turnover rates for the various streams which varies with planned retirements, organisational restructure and routine turnover.

Planning, attraction and retention

Workforce shortages are a major challenge and we recognise that workforce planning is critical to ensuring our ability to build a sustainable workforce into the future. During the next twelve months we will develop a Human Resources Plan that will include a Workforce Strategic Plan.

The Service has a number of strategies in place to attract and retain our people. These include:

- Growing our own initiatives linked with rural career pathways including the rural generalist, midwifery training and health practitioner
- Leadership development with locally developed and facilitated training which focuses on not only operational aspects of management but leadership qualities
- Partnerships with unions and other health care providers to enable and support flexible employment options, education delivery and innovative workforce models which meet the needs of the community
- Comprehensive education and training programs
- Implementation of reporting framework on workforce initiatives and processes
- Providing a safe environment and proactively managing occupational health and wellbeing
- Marketing the South West HHS through attendance at relevant health expos and conferences
- Conducting and analysing entry and exit interview data, workplace survey data and occupational health and safety data
- Analysing data from climate surveys and implementing actions to promote a positive work environment
- Identifying critical roles, critical service delivery needs and enhanced capability requirements to ensure we have a well-resourced and enabled team of people delivering quality patient outcomes
- Utilising development and mentoring strategies
- Focusing on accountability and leadership development to ensure qualified people to move up and take over when the current generation of managers move on

During the year, 155 formal recruitment processes were undertaken with 135 positions being filled. The average cost of recruitment advertising was approximately $155 per position.

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 agreeing on 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 with six monthly reviews also conducted to discuss progress.

Training and development

A number of training and development opportunities for managers and employees were provided during the year. These included recruitment and selection training; performance and appraisal development training for managers; understanding your position occupancy report; attendance management; performance and appraisal development information session for employees, developing and maintaining a supportive and safe workplace culture; resolving complaints at the local level; performance management and human resources training for managers and supervisors.

A robust orientation/induction 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 as well as being given an overview of the organisation and the environment in which they will operate. Mandatory training mandated by the relevant Commonwealth or State legislation, administrative policy, code of practice or directives is delivered. As well as face-to-face training, training in various modules is provided online. Mandatory training is continually monitored to ensure all employees maintain up-to-date skills and knowledge pertaining to their relevant area. Orientation and induction is undertaken within three months of the commencement of duties.

Workplace relations

The human resources unit provides advice to managers and employees on a range of people management issues including performance management; grievance management, equity issues and the interpretation and implementation of Department of Health Human Resources Policies and enterprise bargaining initiatives.

Staff recognition

The South West HHS values its workforce and has a number of ways in which staff are recognised for their contribution, dedication and performance. The annual staff awards are a highlight and 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. A celebration of our staff successes is highlighted on pages 56–57.

Our staff are also recognised through the annual Australia Day Awards, service achievements and through external awards. Various facilities have implemented an “Employee of the Month” and these celebrations are profiled in our monthly newsletter “The Pulse”.

Industrial relations

South West HHS is committed to open communication and appropriate consultation with employees through management-union forums. The District Consultative Forum meets 10 times per annum and is a shared table between South West HHS management and the trade unions.

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

Work-life balance

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. 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. The South West HHS had the second highest response rate across all hospital and health services in Queensland at 33.9 per cent. It is anticipated to receive a quick first impression of the survey in July with final reports being expected to be received mid – late September.

Early retirement, redundancy and retrenchment

A program of redundancies was implemented during 2012–13 in two stages. In stage one voluntary redundancies were offered by expression of interest while stage two was a targeted program. 48 voluntary redundancies in total were accepted. The total cost of the packages was $2,134,059. The full cost of the redundancies was funded by the government from consolidated funds.

Workforce development unit

The South West HHS places a high priority on delivering an improved education and training program and has a key focus on developing our graduate nurses, medical education, implementing the clinical services capability framework, leadership development, cross cultural awareness and mandatory training.

The workforce development unit provides educational leadership and supports workforce capability and sustainability of clinical, professional and organisational life-long learning. Facets of the workforce development framework include orientation and induction, transition to practice and ongoing competence, succession planning and career development. Through the delivery of quality education and training programs and targeted up-skilling, workforce competencies are enhanced and standards and efficiencies are improved.

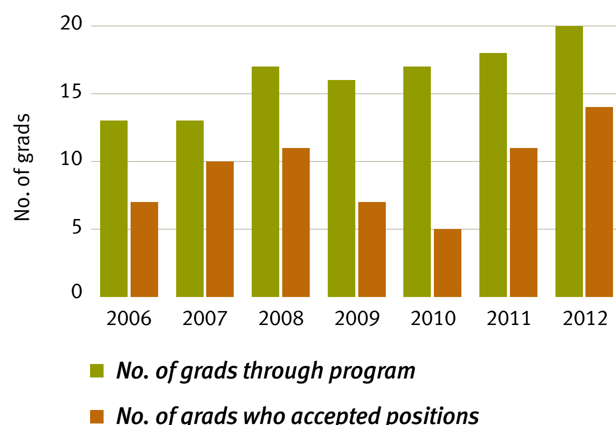
The Service increasingly supports students and staff through a variety of programs each requiring significant resources including undergraduate, graduate and post graduate programs and up skilling programs. The workforce development unit through external partnerships with universities and Technical and Further Education (TAFE) support students to gain rural and remote experience in all of our facilities utilising the preceptorship framework for support.

To achieve the highest requirement of trained staff, the workforce development unit supports the South West HHS in achieving these goals in the provision of train the trainer programs to ensure appropriate and adequate numbers of trainers are skilled to support staff in the annual competence of key skills in basic life support, medication safety and patient handling.

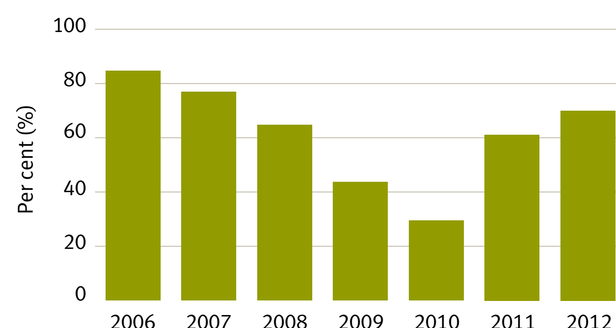
Nursing Graduate Program

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 flexibility to rotate through larger hub facilities to smaller MPHS facilities exposing the nurses to many experiences. The program supports nurses to train in advanced clinical skills such as cannulation, venipuncture and triage which are critical skills required in the rural nursing specialty. Our Nursing Graduate Program has been a huge success with our retention rate for 2012 being 70 per cent.

Number of graduate nurses who accepted positions within the South West HHS



Percentage of graduate nurses who have remained within South West HHS



Safety and wellbeing

The safety and wellbeing of our staff and providing a safe environment is integral to our purpose. We strive to achieve best practice in the management and performance of occupational health and safety. South West HHS operates within the Safety Management System Framework consistent with the Australian Standard (AS) 4801 designed to meet obligations under legislation and our Service Agreement.

South West HHS continues to review its performance and identify opportunities for improvements in safety performance. During the year a particular focus was facilitating election of health and safety representatives and identifying work groups. Additionally, there was a focus on assessing the need for test and tag requirements for electrical safety, identification and signing of all confined spaces and working at heights.

Highlights for the 2012–13 year included:

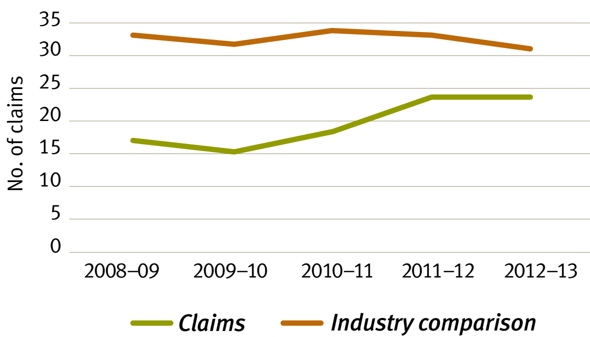
- Occupational health and safety training sessions were delivered face to face by occupational health and safety practitioners in areas of patient handling, occupational violence, fire safety, occupational health and safety orientation and harmonisation of occupational health and safety laws. Training was attended by 1,485 staff members
- Audit and inspections were conducted across work areas including hazardous chemicals; clinical and related waste; ladder safety and working at heights; electrical safety; plant; plant rooms; garden sheds; noise and property plant equipment; first aid; healthcare ergonomics; emergency planning; fire and safety; healthy lifestyles; staff accommodation security and level 2 fire inspections
- risk assessments across areas of occupational violence, patient and manual handling, electrical test and tag requirements, confined space identification, minor works, contractor management undertaken
- Fire and evacuation plans, fire signs and diagrams have been reviewed across all work areas
- Level 2 fire inspections have been undertaken

Indicator	2011–12	2012–13
Workplace incidents reported including near misses	226	195
OHS training sessions delivered	108	121
Auditing and inspections undertaken	230	334
Risk assessments undertaken	80	115
Level 2 fire inspections undertaken	18	17

Worker's compensation and injury management

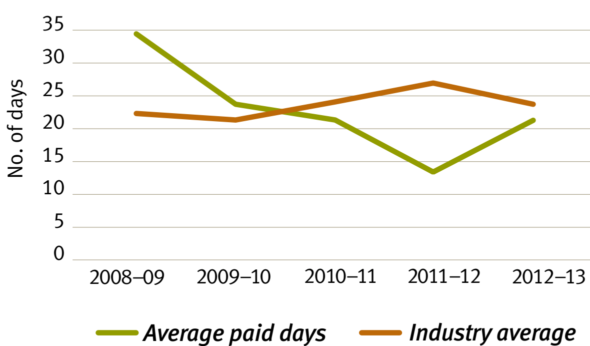
24 staff members made a WorkCover claim during 2012–13. The Service registered and managed these claims with WorkCover. South West HHS was below the health industry benchmark in Queensland (excluding psychiatric hospitals) of 31 claims, for a health service of our size.

New workcover claims



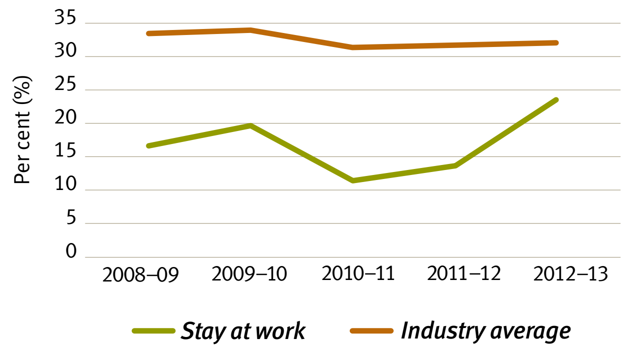
The average paid days of WorkCover claim intimated in 2012–13 was 21.40 which is less than the average paid days for WorkCover claims across the health industry in Queensland at 23.21 days.

Average paid days



Suitable duties programs have been managed by dedicated rehabilitation and return to work coordinators with return to work options remaining as close as possible to same tasks in same work area or similar tasks in same work area. Host employment was successful for two claims providing return to work options for injured workers. South West HHS is committed to workplace rehabilitation and have a 23.81 per cent stay at work average which is favourable against a 32.16 per cent record for comparable industries.

Rehabilitation and return to work



Celebrating our staff successes

Graduate nurse profile – Hayley Hampson

Hayley Hampson commenced her 12-month Graduate Nurse Program in 2007 which involved rotations of six months to Westhaven Aged Care Facility and Roma Hospital. Hayley stated:

"Westhaven was an amazing rotation which taught me the value of all nursing components. I was allowed an insight into the minds of the elderly and learnt so much about dementia and the different care components involved in the elderly. Working with the residents of Westhaven was such a great experience and I am so glad that I was given that opportunity as a graduate as it is not an area that I would have ever explored by myself."

"At Roma Hospital I was preceptored into each area (surgical, Outpatients Department (OPD) and theatre) and from my six months there I was able to develop the skills necessary to stay in Roma and work in all three areas as needed. I don't think this variety of opportunities exists in the city and it allowed me to develop into a multitasking role. Rurally, you care for every kind of patient imaginable and it really opens your eyes into the world of nursing in the rural setting."

"Being a graduate nurse out here was wonderful!! I have made some amazing friends and mentors and been given many different opportunities for professional development which focus on many areas in our nursing stream."

"Without the Graduate Nurse Program in South West HHS I believe I would never have had the opportunities that have led me to my qualifications today. The support, professional development and guidance that I have had whilst working in the South West HHS has given me every opportunity to develop and further my nursing career.

"I honestly think I have the best job in the world, working alongside amazing people and constantly developing and learning, all thanks to my rural nursing grad position."

Hayley's position as a McGrath Breast Care Nurse was established by the McGrath Foundation in June 2009. Based at Roma Hospital, Hayley provides physical, psychological and emotional support to local women experiencing breast cancer, as well as their families and carers, from diagnosis and throughout treatment.

Hayley feels privileged to be a McGrath Breast Care Nurse for South West HHS and has found it rewarding to support so many families over the last four years. Hayley has now completed her graduate certificate in Breast Cancer Care.

Celebrating our staff 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 by celebrating the staff awards.

The awards ceremony was held at St George on 1 November 2012 to coincide with a meeting of the Board. This was the third year of the service wide awards with 58 nominations being received. These awards are a great way for the hospital and health service 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 and vision of staff who work tirelessly to deliver high quality healthcare programs to their local communities. All staff are to be congratulated and recognised for their efforts.

Recipients of Individual Staff Awards 2012

Leadership and Culture Award

Recognises any employee who contributes to developing a leadership culture in relation to Queensland Health's core values.

Recipient: Beth King, Physiotherapist, St George

For empowering the South West HHS culture and work environment through leading by example.

Walks the walk as well as talks the talk. She provided key leadership during the recent flood crisis as well as the last four major flood events. Beth represents the Service at many local events, is a volunteer, community member, a clinical leader with excellent clinical skills and has a true leadership quality.

Partnering Improvement Award

Recognises employees/teams who have improved health care through partnering with an external source (community, other organisations etc.)

Recipient: Multipurpose Health Service Team, Quilpie

For working closely with Quilpie State College and Quilpie Shire Council by being involved in "Giving a child a meaningful education" (GAME); providing healthy morning teas for parents and children, providing links/ information to health services, access to social workers and information about health, ears, eyes, teeth, oral language and development. This program is a State finalist in the Showcase Awards for Excellence in Schools.

Indigenous Health Improvement Award

Appreciates the staff member who demonstrates an excellence in closing the gap with health care for Indigenous members of our community.

Recipient: Rodney Landers, Indigenous Health Coordinator

Rodney demonstrates leadership in championing strategies and programs which assist in closing the gap in the health status of Aboriginal people in the South West HHS region. He is a cultural facilitator for the cultural competency workshops throughout the Service. He also provides advice to senior management on cultural appropriateness of service delivery and in the development and implementation of any new initiatives.

Clinical Practice Excellence Award

For staff/team member who demonstrate excellence in clinical practice via either a process to improve patient care, or ease of work for staff.

Recipient: Alison Finlay, Clinical Nurse, Roma Hospital

For being enthusiastic, positive and encouraging staff to take part in productive ward programs. Shows integrity and responsibility for improving patient care. Leads by example and continuously advocates how clinical measures and strategies contribute to productive ward.

Improved Access Award

Aims to encourage the staff member who delivers/promotes access to health care.

Recipient: Home Care Team, Community and Allied Health, Charleville

This is a front-line service which provides a community-based service across a number of communities. The primary purpose is to provide domestic assistance and social support services to Home and Community Care (HACC) eligible clients.

Prevention and Promotion Award

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

Recipient: Roma Hospital Hikers, Roma Hospital

The Roma Hospital Hikers are a team of operational services staff who were formed in 2007 after learning that a number of operational services staff employed within the Roma Hospital, and some family members, were diagnosed with cancer-related illnesses. The team's purpose is to raise funds and awareness for the local network in Roma of the Queensland Cancer Foundation. Their commitment to working towards a common goal motivates the team and assists in fostering a culture of engagement.

Improvement Initiatives Award

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

Recipient: Matthew Elkins, Coordinator, Operational Services, St George Hospital

Since starting work at St George Hospital, Matthew has worked at improving the catering and domestic services. He has brought cleaning equipment up to standard ensuring occupational health and safety expectations are met. By working closely with the dietitian, the hospital menu was updated to ensure nutritional requirements were met. He developed a manual in order to reduce wastage and provide nutritious meals. Matthew is very knowledgeable about national food safety standards, policies, and legislation.

Australia Day Awards

Staff are also recognised through the annual Australia Day Awards for their contribution and achievement in making improvements and delivering public health services in regional Queensland.

While some staff received recognition for their high quality service delivery others received recognition for their leadership and the provision of community service during the 2012 floods.

Recipients of awards for 2013 were:

- Meryl Brumpton, Chief Operations Officer
- Chris Small, Executive Director of Nursing
- Jenny Flynn, Executive Director of Community and Allied Health
- Karen Twist, Administration Officer, Charleville Hospital
- Trish Coldwell, Allied Health Therapy Assistant, Charleville Hospital
- Angela Orupe, Allied Health Therapy Assistant, Charleville Hospital
- Patrice Robinson, Director of Nursing, St George Hospital
- Robyn Brumpton, Nursing Director Quality and Safety
- Elesia Grieve, Nurse Unit Manager, St George Hospital
- Ros King, Enrolled Nurse Advanced Practice, St George Hospital
- Beth King, Physiotherapist, Community and Allied Health, St George Hospital
- Jen O'Driscoll, Occupational Therapist, Community and Allied Health, St George Hospital
- Samantha Mawn, Nurse Unit Manager, Roma Hospital

Quality and safety

The quality and safety unit provides oversight of the clinical governance for quality and safety within the South West Hospital and Health Service (South West HHS). A key function is to implement change through partnership 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 quality and safety unit brings together a number of teams which support clinical services across the Service which involves the management of the following areas: patient safety, infection control, accreditation, medico-legal cases, health research and risk management.

Education

A key service provided by the unit is the delivery of education. Each Tuesday, education sessions are delivered across the Service through videoconferencing. In 2012–13, 789 staff attended these weekly sessions. These sessions are also recorded and can be viewed by staff later. The unit also provides other education sessions as required.

Patient safety

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

PRIME (clinical incident reporting database) showed 1,112 reported clinical incidents over the last year. 97 per cent of these incidents were minimal or no harm to the patient or resident.

In October 2012, the state-wide Bedside Safety Audit was undertaken. In 22 areas, the Service exceeded the State results by greater than 10 per cent. Since 2010, we have reduced our hospital acquired pressure injuries by 15 per cent. A local South West HHS audit in March 2013 indicated sustained and improved results in many fields since the October 2012 audit.

Bedside clinical handover has improved in all South West in-patient facilities and all facilities were 100 per cent compliant in documentation of allergies.

Venous thromboembolism (VTE) risk assessment and medication action plan or medication history documentation has improved in many facilities, but remains an area for improvement.

Considerable work has been undertaken in adapting the NSQHS Standards into the South West HHS in preparation for accreditation in 2014. A key area has been preparing for the introduction of a patient and family escalation of care system which will allow patients and their families to instigate a clinical review if they are unhappy with the care being provided.

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; sterilisation, aseptic non-touch technique monitoring and the implementation of a 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.

2012–13 data shows healthcare associated infections as 0.05 per cent of occupied bed days. Infections from all 13 inpatient/residential sites included:

- 5 bloodstream infections
- 3 surgical site infections
- 1 multi-resistant organism
- 2 catheter-associated urinary tract infections
- 5 gastrointestinal tract infections

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 for January – March 2013 averaged 76.9 per cent and the same audit period within the South West HHS was 81.22 per cent. Smaller facilities and smaller amounts of data collected do have an affect on this percentage.

Service improvement

Accreditation

The service improvement team facilitates accreditation processes across the Service.

In April and May 2013, the South West HHS welcomed six auditors to the Service for our annual surveillance audit against the International Standards Organisation (AS/NZS ISO) Quality Management System (QMS) Standard. The South West HHS continues to be certified against AS/NZS ISO 9001:2008 with a re-certification audit to be conducted on or before April, 2014.

National Safety and Quality Health Service (NSQHS) Standards

In 2011 the 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

As part of the mid-cycle assessment conducted in conjunction with the ISO surveillance audit in April/May 2013, the South West HHS was certified against Standards One, Two and Three of the NSQHS. Assessment against all 10 NSQHS Standards will be conducted prior to April 2014.

Internal audits

In 2012–13, the Service scheduled 1,179 internal audits with 1,094 internal audits completed. For this period there were 1,152 assigned tasks completed from the 316 Quality Activities created demonstrating continuous improvement.

Inpatient feedback surveys

In 2012–13 there were 2,157 inpatient feedback surveys returned. A benchmark was set by the EMT in July 2011 that all responses *below 75 per cent* very good/good and any negative comments required a Quality Activity (QA) to be completed and actioned accordingly. This benchmark was increased in July 2012 from 75 per cent to 85 per cent with only 1 QA with seven assigned tasks recorded during 2012–13.

The quarterly Inpatient Feedback Report April to June 2013 showed that all facilities met the 85 per cent targets in all criteria assessed with very positive comments recorded.

Procedures and work instructions

In 2012–13 the service improvement team facilitated consultation and endorsement of 89 procedures/work instructions and associated documents by the Clinical Governance Committee and 39 procedures/work instructions and associated documents by the Corporate Governance Committee.

Web-publishing

There were 198 documents published/ actioned on the Service website by the service improvement team.

Clinical service improvement

Several areas were key focuses for clinical improvement during 2012–13.

Standardisation: The review and implementation of a standardised resuscitation trolley across all facilities has been a large undertaking. As staff rotate through facilities across the South West and the State, it is important to maintain consistency of standards to ensure that in critical situations, it is easy to access equipment in a timely manner. Work to ensure that the contents and layout of all resuscitation trolleys were the same was commenced. This has involved significant clinical involvement and at times robust discussion. An audit process has identified recommendations which will be adopted.

Productive Ward is driving change to implement processes that give clinical staff more time at the patients' bedside. Charleville, Roma and St George have implemented productive ward since 2011 and have seen great results in decreasing patient incidents and improving the care given to patients. Augathella, Mitchell and Mungindi are now commencing productive ward in their facilities. This will be adopted using a hub and spoke model where the already established facilities will assist the 'new' facilities in the transition of the productive ward series. This was show cased at the Productive Ward Forum held in Brisbane and presented to facilitators across the State.

Journey Boards have been expanded from one in Roma to six; Charleville Hospital, Mitchell MPHS, St George Hospital, Waroona Aged Care Facility and Westhaven Aged Care Facility are in the process of installing their journey boards. Journey boards assist in standardising documentation processes, standardise clinical handovers and patient safety in regards to information sharing and continuity of care. The introduction of these boards into aged care facilities is setting a new standard for Queensland as these will be unique to the aged care sector. The journey boards will incorporate events crucial for aged care to maintain standardised processes, access funding requirements and time saving snapshots of resident care.

The Clinicians Only Newsletter continues to be published monthly and incorporates significant patient safety events that are utilised as educational tools for the clinicians. These newsletters de-identify events that have occurred within the Service. Recommendations and key learnings are identified within these publications to assist in learning from these confidential case studies.

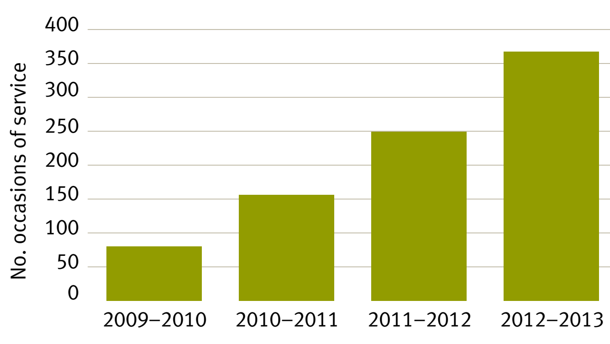
Telehealth services

Telehealth improves patient access to health care. It connects patients in their own communities with clinical services that are not provided in their community. This reduces travel and associated costs for patients, their families and health care providers.

Telehealth services have increased across the South West. Over a four year period telehealth services have increased by 458.75 per cent. This has been achieved through:

- Increased focus on telehealth
- Improved data collection processes
- Improved referral processes
- Increased awareness for patients and staff
- Increased availability of specialist telehealth services
- Increased pool of new equipment
- Staffing to support and facilitate telehealth services.

Telehealth occasions of service 2009–13



Glossary of terms

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

Journey board: visual, interactive tool 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: 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: Established by the Commonwealth to coordinate primary health care services across all providers in a geographic area. Will work closely with the HHSs to identify and address local health needs. Will be selected and funded by the Commonwealth. Rolled out progressively from 1 July 2013.

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

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

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

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

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

PRIME: 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: Productive wards are 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: A 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: Public Hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.

Glossary of terms

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

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

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

The Board: South West Hospital and Health Board.

The Service: South West Hospital and Health Service.

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
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
CE	Chief Executive
CFO	Chief Finance Officer
CFSC	Clinical Services Capability Framework
COAG	Council of Australian Governments
COO	Chief Operations Officer
CWAATSICH	Charleville and Western Aboriginal and Torres Strait Islander Community Health
DAMA	Discharged Themselves Against Medical Advice
DDSWQML	Darling Downs and South West Queensland Medicare Local
DON	Director of Nursing
DPC	Director of People and Culture
EDC&AH	Executive Director of Community and Allied Health
EDMS	Executive Director of Medical Services
EDON	Executive Director of Nursing
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
GAME	Giving a Child a Meaningful Education
GP	General Practitioner
HHS	Hospital and Health Service
HPID	Health Planning Infrastructure Division
HQCC	Health Quality Complaints Commission
HR	Human Resources
HSPF	Hospital and Health Services Performance Framework
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
NDQS	Nursing Director Quality and Safety
NSQHS	National Safety and Quality Health Service
OPD	Outpatients Department
PWD	People with disabilities
QA	Quality Activity
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
TIR	Telecommunications Infrastructure Replacement
VTE	Venous Thromboembolism

Compliance checklist

The characteristics of a quality annual report are that it:

- complies with statutory and policy requirements
- presents information in a concise manner
- is written in plain English
- provides a balanced account of performance – the good and not so good.

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2009*

ARRs *Annual report requirements for Queensland Government agencies*

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		
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Contacts

Health Service Chief Executive	197 McDowall Street, Roma QLD 4455	(07) 4624 2853
Chief Operations Officer	44 Bungil Street, Roma QLD 4455	(07) 4505 1565
Chief Finance Officer	44 Bungil Street, Roma QLD 4455	(07) 4505 1530
Executive Director of Medical Services	197 McDowall Street, Roma QLD 4455	(07) 4624 2868
Executive Director of Nursing	197 McDowall Street, Roma QLD 4455	(07) 4624 2860
Executive Director of Community and Allied Health	197 McDowall Street, Roma QLD 4455	(07) 4624 2818
Director People and Culture	44 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	197 McDowall Street, Roma QLD 4455	(07) 4624 2895
Consumer and Community Liaison Officer	197 McDowall Street, Roma QLD 4455	(07) 4624 2871
Indigenous Health Coordinator	197 McDowall Street, Roma QLD 4455	(07) 4624 2831
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
Community and Allied Health	2 Eyre Street, Charleville QLD 4470	(07) 4650 5300
Community and Allied Health	Arthur Street, Roma QLD 4455	(07) 4624 2977
Community and Allied Health	Victoria Street, St George QLD 4487	(07) 4620 2222
Patient Travel Subsidy Scheme	72 King Street, Charleville QLD 4470	(07) 4650 5006
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

Feedback survey form

South West HHS is interested in hearing your feedback on its Annual Report 2012–13. 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
   - not nearly 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.

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South West Hospital and Health Service

ABN 22 877 041 939

Financial Statements – 30 June 2013

South West Hospital and Health Service

Financial Statements
30 June 2013

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General Information

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

The South West Hospital and 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 2013

	Notes	2013 $'000
Income		
User Charges	3	6,088
Grants and other contributions	4	111,293
Interest		23
Other revenue	5	863
Total Revenue		118,267
Gains	6	33
Total Income		**118,300**
Expenses		
Employee expenses	7	662
Health service labour expenses	8	69,087
Supplies and services	9	36,426
Grants and subsidies	10	9
Depreciation and amortisation	11	4,529
Impairment losses	12	41
Other expenses	13	1,526
Total Expenses		**112,280**
Operating Results for the year		**6,019**
Other Comprehensive Income		
Increase in Asset Revaluation Surplus	21	2,814
Total Other Comprehensive Income		2,814
Total Comprehensive Income		**8,833**

The accompanying notes form part of these statements

South West Hospital and Health Service

Statement of Financial Position
As at 30 June 2013

	Notes	2013 $'000
Current Assets		
Cash and cash equivalents	14	9,036
Receivables	15	3,787
Inventories	16	628
Other	17	38
Total Current Assets		**13,488**
Non-Current Assets		
Property, plant and equipment	18	94,690
Total Non-Current Assets		**94,690**
Total Assets		**108,178**
Current Liabilities		
Payables	19	7,831
Accrued employee benefits	20	24
Total Current Liabilities		**7,855**
Total Liabilities		**7,855**
Net Assets		**100,323**
Equity		
Contributed equity		91,490
Accumulated surplus		6,019
Asset revaluation surplus	21	2,814
Total Equity		**100,323**

The accompanying notes form part of these statements

Statement of Changes in Equity
For the year ended 30 June 2013

	Accumulated Surplus	Asset Revaluation Surplus (Note 21)	Contributed Equity	TOTAL
	$'000	$'000	$'000	$'000
Balance as at 1 July 2012	-	-	-	-
Operating Result from Operations	6,019	-	-	6,019
Other Comprehensive Income				
Increase in Asset Revaluation Surplus	-	2,814	-	2,814
Total Comprehensive Income for the year	-	2,814	-	2,814
Transactions with Owners as Owners:				
Net assets received (transferred under Administrative Arrangement Note 2 (g) at 1 July 2012)	-	-	91,296	91,296
Net assets received adjustment 1 July 2012*	-	-	(1,024)	(1,024)
Equity injections**	-	-	5,744	5,744
Equity withdrawals***	-	-	(4,526)	(4,526)
Total changes to contributed equity	-	-	91,490	91,490
Balance as at 30 June 2013	6,019	2,814	91,490	100,323

*Adjustment based on correction to opening balances transferred 1 July 2012.

**Reimbursement from Department of Health for Assets purchased $955,616, Funding for minor capital works projects $802,000 and Net assets received (transferred during year via machinery-of-Government change) Note 2 (g) $3,986,159.

***Contribution towards capital works program undertaken by Department of Health on behalf of SWHHS $4,526,459.

The accompanying notes form part of these statements

South West Hospital and Health Service

Statement of Cash Flows
For the year ended 30 June 2013

	Notes	2013 $'000
Cash flows from operating activities		
Inflows:		
User Charges		8,722
Grants and other contributions		104,697
Interest received		23
GST input tax credits from ATO		1,942
GST collected from customers		85
Other		857
		116,324
Outflows:		
Employee expenses		(632)
Supplies and services		(101,869)
Grants and subsidies		(526)
GST paid to suppliers		(2,396)
GST remitted to ATO		(70)
Other		(1,436)
		(106,930)
Net cash provided by operating activities	22	**9,395**
Cash flows from investing activities		
Inflows:		
Sales of property, plant and equipment		32
Outflows:		
Payments for property, plant and equipment		(2,512)
Net cash used in investing activities		**(2,480)**
Cash flows from financing activities		
Inflows:		
Equity Injections		1,758
Cash transferred in under administrative arrangement (Note 2 (g))		363
Net cash provided by financing activities		**2,121**
Net increase in cash and cash equivalents		**9,036**
Cash and cash equivalents at the beginning of the financial year		-
Cash and cash equivalents at the end of the financial year		**9,036**

The accompanying notes form part of these statements

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1. Objectives and Principal Activities of the 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* (part of National Health Reform refer Note 2(g)). It is governed by a Hospital and Health Board that is accountable to the local community and the Queensland Minister for Health for its performance.

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 SWHHS covers an area of 319,870 square kilometres in South West Queensland and services an estimated population of 26 150 people.

This includes responsibility for the direct management of 4 hospitals, 7 multi-purpose health services (MPHS), 3 outpatient clinics, 2 residential aged care facilities and 2 community health centres.

Funding is obtained predominately through the purchase of health services by the Department of Health (DoH) - a combination of grants from the State Government via the DoH and the 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 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 2013, and other authoritiative 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. South West Hospital and Health Service does not have any controlled entities.

2. Significant accounting policies continued

(c) Trust Transactions and Balances

The 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 28 provides additional information on the balances held in patient trust accounts.

(d) User Charges, Taxes, Penalities and Fines

User charges and fees are recognised as revenues when earned and can be measured reliably with a sufficient degree of certainity. This involves either invoicing for related goods/services and/or the recognition of accrued revenue.

Revenue in this category primarily consists of hospital fees (private patients), residential accommodation fees, reimbursements of pharmaceutical benefits, and sales of goods and services.

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

(f) Other Revenue

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

(g) Administrative Arrangements under National Health Reform

Health Reform

On 2 August 2011, Queensland, as a member of the Council of Australian Governments signed the National Health Reform Agreement, committing to major changes in the way that health services in Australia are funded and governed. These changes took effect from 1 July 2012 and include:

- moving to a purchaser-provider model, with health service delivery to be purchased from legally independent hospital networks (statutory bodies to be known as Hospital and Health Services (HHSs) in Queensland);
- introducing national funding models and a national efficient price for services, with the majority of services to be funded on an activity unit basis into the future;
- defining a refocused role for state governments in managing the health system, including:
  - the use of purchasing arrangements and other levers to drive access and clinical service improvements within and across the HHSs
  - a responsibility to intervene to remediate poor performance, either at the state's initiative or in response to prompting by the National Health Performance Authority, which will publicly report on performance of the HHSs and healthcare facilities.

2. Significant accounting policies continued

(g) Administrative Arrangements under National Health Reform continued

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

Funding reforms

Funding is provided to the HHSs in accordance with Service Agreements.

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.

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

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

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

The HHS has entered into a Service Agreement with the Queensland Department of Health, which provides ongoing funding for the provision of services for the financial year ending 30 June 2014. This agreement was signed prior to 30 June 2013.

Opening Balances

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

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

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

2. Significant accounting policies continued

(g) Administrative Arrangements under National Health Reform continued

On the 3rd January 2013 a subsequent contribution of $203,379 by the Minister representing the fair value of specialist dental vans previously held by the DoH was transferred into the asset pool of SWHHS. This contribution was included in the opening balances on 1 July 2012.

The following assets and liabilities were transferred from the Department of Health on 1 July 2012 in accordance with a Transfer Notice approved by the Minister of Health.

	1 July 2012
	$'000
Cash and cash equivalents	363
Receivables	3,951
Inventories	368
Other	15
Property, plant and equipment*	90,948
Payables	(4,348)
Contributed equity	91,296

* Legal title to land and building has not been transferred as at 30 June 2013. The Department of Health retains legal ownership, however control of these assets was transferred to SWHHS, via a concurrent lease representing its right to use the assets. Under the Deeds of Lease, HHS 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).

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

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 by the Minister Health as a contribution by the State through equity.

(h) 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.

2. Significant accounting policies continued

(i) 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 due to agreed repayment plans in place.

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.

All known bad debts are written off when identified.

(j) Inventories

Inventories consist mainly of medical supplies held for distribution in hospitals and are provided to public admitted patients free of charge except for pharmaceuticals which are provided at a subsidised rate. Inventories are measured at weighted average cost, adjusted for obsolescence. Unless material, inventories do not include supplies held for ready use in the wards throughout the hospital facilities and are expensed on issue from SWHHS's main storage facilities.

(k) 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.

(l) 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.

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	$ 10,000
Land	$ 1
Plant and Equipment	$ 5,000

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

2. Significant accounting policies continued

(l) Property, Plant and Equipment - continued

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

The majority of assets in this first year of operation as a HHS, were acquired under this arrangement (initial values based on the fair value at 30 June 2012 in the Department of Health's records).

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.

While the Department of Health retains legal ownership, effective control of these assets was transferred to the HHS. Under the terms of the lease the HHS has full exposure to the risks and rewards of asset ownership.

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.

Land and buildings are measured at fair value in accordance with *AASB 116 Property, Plant and Equipment* and Queensland Treasury and Trade’s *Non-Current Asset Policies for the Queensland Public Sector*. Land is measured at fair value each year using independent revaluations, desktop market revaluations or indexation by the State Valuation Service within the Department of Natural Resources and Mines. Independent revaluations are performed with sufficient regularity to ensure assets are carried at fair value.

The Department of Health in 2010-11, engaged the State Valuation Office to comprehensively revalue all land holdings. Since then indices from independent sources have been applied to land values until the date of transfer to HHS on 1 July 2012.

In 2012-13 SWHHS engaged the State Valuation Service to provide indices for all land holdings at 14th February 2013 excluding properties which do not have a liquid market, for example properties under Deed of grant (recorded at a nominal value of $1.5).

Indices are based on actual market movements for each local government area issued by the Valuer-General. An individual factor change per property has been developed from review of market transactions, having regard to the review of land values undertaken for each local government area and has been approved by the Queensland Audit Office.

2. **Significant accounting policies** continued

(l) **Property, Plant and Equipment** - continued

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 price and design standards as at reporting date. These estimates are developed by independent quantity surveyors. In 2012-13, 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 historical and current construction contracts. Assets are priced using Brisbane rates with published industry benchmark location indices applied. Revaluations are then compared and assessed against current construction contracts for reasonableness. The valuation assumes a replacement building will provide the same service function and form (shape and size) as the original building but built consistent with current building standards.

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

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

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

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

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.

2. **Significant accounting policies** continued

(l) **Property, Plant and Equipment** - continued

Category	Condition
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. These estimates were developed by Davis Langdon.

Revaluation increments are credited to the asset revaluation surplus of the appropriate class, and decrements charged as an expense. As this is the first year of revaluation for the HHS there are no previous year balances in the asset revaluation reserves to enable decrements to be offset.

The Hospital and Health Service has adopted the gross method of reporting comprehensively revalued assets. This method restates separately the gross amount and related accumulated depreciation of the assets comprising the class of revalued assets. Accumulated depreciation is restated proportionally in accordance with the independent advice of the appointed valuers/quantity surveyors. The proportionate method has been applied to those assets that have been revalued by way of indexation.

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

Plant and equipment (other than major plant and equipment) is measured at cost net of accumulated depreciation and any impairment in accordance with Queensland Treasury and Trade's *Non-Current Asset Policies for the Queensland Public Sector*.

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.

Any expenditure that increases the capacity or service potential of an asset is capitalised and depreciated over the remaining useful life of the asset. Major spares purchased specifically for particular assets are capitalised and depreciated on the same basis as the asset to which they relate.

2. Significant accounting policies continued

(l) Property, Plant and Equipment - continued

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	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.

Impairment of non-current assets

All non-current and intangible assets are assessed for indicators of impairment on an annual basis in accordance with *AASB 136 Impairment of Assets.*

If an indicator of impairment exists, 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.

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.

(m) 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.

2. Significant accounting policies continued

(n) Financial instruments

Recognition

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.

Classification

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

The Hospital and Health Service does not enter into transactions for speculative purposes, nor for hedging. Apart from cash and cash equivalents, SWHHS 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 29.

(o) 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 service) a person employed previously in the department, as a health service employee. Where a HHS has not received the status of a "prescribed service", non executive staff working in a HHS remain legally employees of the Department of Health.

(i) Health Service labour expenses

In 2012-13 the South West Hospital and Health Service was not a prescribed service 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 the department acknowledges and accepts its obligations as the employer of these DoH employees.
- The HHS is responsible for the day to day managment 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 DoH, 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

(o) 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. Non-vesting employee benefits such as sick leave are recognised as an expense when taken.

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

Annual leave

The Queensland Government's Annual Leave Central Scheme (ALCS) became operational on 30 June 2008 for departments, commerical 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. No provision for annual leave is recognised in SWHHS' financial statements as the liabilty 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 liabilty 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

(o) 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 executive management personnel and remuneration

Key executive 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 30 for the disclosures on key executive management personnel and remuneration.

(p) 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 2012-13 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 remaining the responsibility of the department, however SWHHS must pay the $20,000 excess payment on these claims.

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

(q) Special payments

Special payments include ex gratia expenditure and other payments not under a contract. In compliance with the *Financial and Performance Management Standard 2009*, the HHS maintains a register of all details for special payments exceeding $5,000. Refer Note 13.

(r) Services received free of charge or for a nominal value

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

2. Significant accounting policies continued

(s) 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.*

(t) 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 exemption of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). The Australian Taxation Office has recognised the Department of Health and the seventeen Hospital and Health Services as a single taxation entity for reporting purposes.

All FBT and GST reporting to the Commonwealth is managed centrally by the department, with payments/ receipts made on behalf of the 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 15.

(u) Issuance of Financial Statements

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

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

The preparation of financial statements necessarily requires the determination and use of certain critical accounting estimates, assumptions and management judgements. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant, and are reviewed on an ongoing basis. Actual results may differ from these estimates. Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

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

- Receivables – Note 15
- Property, plant and equipment – Note 18
- Contingencies – Note 25
- Financial Instruments – Note 29

(w) 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. As the South West Hospital and Health Service commenced operations on 1 July 2012, there are no comparative figures in the financial statements.

2. Significant accounting policies continued

(x) New and revised accounting standards

The 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 2013:

- *AASB 9 Financial Instruments* applies to reporting periods beginning on or after 1 January 2015 and requires all financial assets to be subsequently measured at amortised cost or fair value. Financial assets can only be measured at amortised cost if: (a) the asset is held within a business model whose objective is to hold assets in order to collect contractual cash flows; and (b) the contractual terms of the asset give rise to cash flows that are solely payments of principal and interest. The only financial asset currently disclosed at amortised cost is receivables and as 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.

- *AASB 13 Fair Value Measurement* provides a new definition of fair value, establishes a framework for measuring fair value, and requires extensive disclosures about fair value measurements. Disclosures will be extended to cover all assets and liabilities within the scope of AASB 13. Review of current fair value methodologies for compliance (including instructions to valuers, data used and assumptions made) for land and buildings measured at fair value will be necessary. To the extent that the methodologies don't comply, changes will be necessary. While this review is yet to be completed no substantial changes are anticipated.

- *AASB 119 Employee Benefits* applies to reporting periods beginning on or after 1 January 2013 with the majority of changes to be applied restrospectively. As the HHS is a member of the Whole of Government (WoG) Annual Leave Central Scheme, the WoG Long Service Leave Scheme and makes employer superannuation contributions only for defined benefits as part of the State's QSuper scheme, the impact of changes to this standard is expected to be minimal. The only implication for the HHS is the clarification of the 'concept of termination benefits', with the recognition criteria for these liabilities differing. If termination benefits meet the timeframe criterion for 'short-term employee benefits' they will be measured according to the AASB119 requirements for "short-term employee benefits', otherwise these benefits will need to be accounted for according to most of the requirements for defined benefit plans.

2. Significant accounting policies continued

(x) New and revised accounting standards continue

- *AASB 1053 Application of Tiers of Australian Accounting Standards* applies to reporting periods beginning on or after 1 July 2013. Essentially this standard allows for differential reporting frameworks, however Queensland Treasury and Trade has advised that it is its policy decision to require full disclosure and adoption of Tier 1 reporting by all Queensland government entitites consolidated into the whole-of-Government financial statements. Therefore, there is no change from the current reporting requirements applicable to SWHHS.

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.

(y) Other events

Restructure of Hospital and Health Service
In 2012-13, SWHHS's Board through the Executive Management Team, undertook a 2 stage organisational restructure of the Hospital and Health Service in an effort to contribute to required savings and reprioritise spending to frontline service delivery, stage 1 (voluntary redundancies via Expression of Interest) and stage 2 (targeted). 49 voluntary redundancies were accepted. The Cabinet Budget Review Committee (CBRC) endorsed that the Consolidated Fund will fund the full up-front cost of employees separating from eligible agencies under the early retirement, redundancy or retrenchment program.

Payroll system
Whilst employees are currently paid under a service arrangement using the Department of Health's payroll system, the responsibilty for the efficiency and effectiveness of this system remains with the department.

3. User Charges

	2013 *$'000*
Sales of goods and services	2,184
Hospital fees	3,904
	6,088

4. Grants and other contributions

	$'000 State	*$'000* Australian Government	*2013* *$'000*
Australian Government grants			
Nursing home grants			3,750
Home and community care grants			1,273
Specific purpose payments			3,819
Total Australian Government grants			8,842
National Health Reform (Share of funding)*			
Block funding	40,869	17,776	
General purpose funding	43,349	-	
Total National Health Reform funding			101,994
Other grants			457
			111,293

* The Australian Government pays it share of National Health funding directly to the Department of Health, for onforwarding to the Hospital and Health Service.

5. Other revenue

	2013 $'000
Licences and registration charges	1
Recoveries	756
Rental charges	74
Other	31
Inventory stock adjustments	1
	863

6. Gains

Gain on sale of property,plant and equipment	**33**

7. Employee expenses

Employee benefits	
Wages and Salaries	455
Annual leave levy*	35
Employer superannuation contributions*	30
Long service leave levy*	5
Employee related expenses	
Payroll tax	22
Other employee related expense	116
*	**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:

Number of Employees*	**1**

* Refer to Note 2(o).

Key executive management and personnel are reported in Note 30.

8. Health service labour expenses

Department of Health - health service employees*	**69,087**

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

9. Supplies and services

	2013 $'000
Consultants and contractors	12,276
Electricity and other energy	1,810
Patient travel	1,638
Patient transport	4,659
Other travel	1,841
Building services	591
Computer services	985
Motor vehicles	270
Communications	595
Repairs and maintenance	3,199
Minor works including plant and equipment	330
Operating lease rentals	1,439
Drugs	949
Clinical supplies and services	2,104
Catering and domestic supplies	1,372
Pathology, blood and parts	1,301
Other	1,067
	36,426

10. Grants and subsidies

Home and community care grants	**9**

11. Depreciation and amortisation

Depreciation and amortisation expenses for the financial year were charged in respect of:

Buildings and land improvements	3,346
Plant and equipment	1,183
	4,529

12. Impairment losses

Impairment losses on receivables	13
Bad debts written off	28
	41

13. Other expenses

	2013 $'000
External audit fees*	62
Bank fees	4
Insurance**	962
Inventory written off	73
Losses from the disposal of non-current assets	17
Special payments - ex-gratia payments	3
Other legal costs	138
Advertising	28
Interpreter fees	4
Contract internal audit fees	108
Other	126
	1,525

*Total audit fees estimated to be paid to the Queensland Audit Office relating to the 2012-13 financial year are $130,000. There are no non-audit services included in this amount.

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

14. Cash and cash equivalents

Imprest accounts	7
Cash at bank	8,684
QTC cash funds - 24 hour on call deposits	345
	9,036

SWHHS's operating bank account is 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 on call with Queensland Treasury Corporation earns interest, calculated on a daily basis reflecting market movements in cash funds. Rates achieved throughout the year range between 3.5% to 5%.

15. Receivables

	2013 $'000
Trade debtors	1,344
Payroll receivables	1
Less: Allowance for impairment	(67)
Sub total	1,277
GST input tax credits receivable	455
GST payable	(14)
Sub total	441
Grants receivable	2,069
Total	**3,787**

Movements in the allowance for impairment loss

Balance transferred in on establishment of HHS	55
Amounts written off during the year	(8)
Amount recovered during the year	(20)
Increase in allowance recognised in operating result	41
Balance at the end of the year	67

Trade debtors includes receivables from health funds (reimbursement of patient fees), residental accommodation fees and reimbursements from the Department of Health.

16. Inventories

Inventories held for distribution - at cost	
Medical supplies and equipment	608
Catering and domestic	13
Other	7
	628

17. Other current assets

Prepayments	38
	38

18. Property, plant and equipment

	2013 $'000
Land*	
At fair value	8,494
Buildings*	
At fair value	165,502
Less: Accumulated depreciation	(86,190)
	79,313
Plant and equipment	
At cost	15,290
Less: Accumulated depreciation	(9,139)
	6,151
Capital works in progress	
At cost	733
Total property, plant and equipment	**94,690**

* Refer Note 2 (g).

Land

Land is measured at fair value using independent revaluations, desktop market revaluations or indexation by the State Valuation Service within the Department of Natural Resources and Mines. Independent revaluations are performed with sufficient regularity to ensure assets are carried at fair value.

In 2012-13 SWHHS engaged the State Valuation Service to provide indices for all land holdings at 14th February 2013 excluding properties which do not have a liquid market, for example properties under Deed of grant. Indices are based on actual market movements for each local government area issued by the Valuer-General and were applied to the fair value of land transferred from the Department of Health on 1 July 2012. These land holdings were comprehensively revalued by the State Valuation Office in 2010-11 with indices from independ sources applied in 2011-12 by the department.

The 2012-13 revaluation program resulted in a increment of $331,043 to the carrying amount of land.

Buildings

An independent revaluation of 21 per cent of the (net book value) of the building portfolio was performed during 2012-13 by independent quantity surveyors Davis Langdon. Valuations were based on the estimated replacement cost less the cost to bring the building to current standards. 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.

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. Only 2% of assets have never had a comprehensive revaluation. Refer Note 2 (l) for further details on the revaluation methodology applied.

The buildings valuations for 2012-13 resulted in a net increment to the HHS's building portfolio of $2,482,623.

18. Property, plant and equipment continued

SWHHS has plant and equipment with an original cost of $587,450 or 3.8% of total plant and equipment gross value and a written down value of zero still being used in the provision of services.

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
Assets received through restructuring (Note 2 g) as at 1 July 2012	8,444	74,803	6,173	1,528	90,948
Assets received through restructuring adjustment as at 1 July 2012	-	(1,024)	-	-	(1,024)
Assets received from DoH for nil consideration	-	4,277	-	(290)	3,986
Acquisitions	-	814	1,178	519	2,512
Disposals	-	-	(17)	-	(17)
Transfer between classes	(282)	1,306	-	(1,024)	-
Revaluation Increments	331	2,483	-	-	2,814
Depreciation charge for the year	-	(3,346)	(1,183)	-	(4,529)
As at 30 June 2013	**8,494**	**79,313**	**6,151**	**733**	**94,690**

19. Payables

	2013
	$'000
Trade creditors	3,161
Department of Health payables*	4,660
Other	9
	7,831

*Department of Health payables are due to accrued health service labour (Note 2 (o) (i)) of $ 3,535,765 and other inter-entity reimbursements.

20. Accrued employee benefits

Salaries and wages accrued	24
	24

21. Asset revaluation surplus by class

	2013 $'000
Land	
Balance at the beginning of the financial year	-
Revaluation increment	331
Balance at the end of the financial year	**331**
Buildings	
Balance at the beginning of the financial year	**-**
Revaluation increment	2,483
Balance at the end of the financial year	**2,483**
Balance at the end of the financial year	**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

	2013 $'000
Operating Result	6,019
Non-cash movements :	
Depreciation and amortisation	4,529
Net gain on disposal of non-current assets	(15)
Net loss on inventory adjustments	72
Reversal of impairment loss receivables	41
General purpose funding - contribution towards capital works program	(4,526)
Change in assets and liabilities after adjustment for transfers in from restructure*:	
Decrease in receivables	564
Increase in GST receivables	(455)
Increase in inventories	(331)
Increase in prepayments	(23)
Increase in accounts payable	1,556
Increase in accrued contract labour	1,927
Increase in accrued employee benefits	24
Increase in GST payable	14
Total non-cash movements	3,376
Cash flows from operating activities	**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 (g).

24. Expenditure commitments

(a) Non-cancellable operating leases

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

	2013 *$'000*
Not later than one year	1,041
Later than one year and not later than five years	289
Total	**1,330**

South West Hospital and Health Service 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.

(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:

	2013 *$'000* Buildings*
Not later than one year	370
Later than one year and not later than five years	1,110
	1,480

*This represents SWHHS's share of backlog maintenance expenditure committed by the Department of Health.

25. Contingent assets and liabilities

(a) Litigation in progress

As at 30 June 2013, the following cases were filed in the courts naming the State of Queensland acting through the South West Hospital and Health Service as defendant:

	2013 Number of
Tribunals, commissions and boards	1
	1

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). The Hospital and Health Service's liability in this area is limited to an excess per insurance event of $20,000 - refer Note 2(p). Tribunals, commissions and board figures represent the matters that have been referred to QGIF for management. As at 30 June 2013, SWHHS has 2 claims currently managed by QGIF that are pre-proceedings, which may never be litigated or result in payments to claims (excluding initial notices under *Personal Injuries Proceedings Act*). 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.

25. Contingent assets and liabilities continued

b) Native Title

As at 30 June 2013, the South West Hospital and Health Services does not have legal title to properties under its control, refer Note 2 (g). 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.

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

All business pertaining to land held by or on behalf of the Department of Health must take native title into account before proceeding. Such activities include disposal, acquisition, development, redevelopment, clearing, fencing of real property including the granting of leases, licences or permits. Real Property Dealings may proceed on department owned land where native title continues to exist, provided native title holders or claimants receive the necessary procedural rights.

The Department of 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.

26. Events occurring after balance date

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

27. Restricted assets

Contributions are received from benefactors in the form of gifts, donations and bequests for stipulated purposes. At 30 June 2013, amounts of $373,639 in General Trust set aside for the specified purposes underlying the contribution. The General Trust amount forms part of the Cash and cash equivalents balance, refer Note 14.

28. Fiduciary trust transactions and balances

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

	2013
Fiduciary trust receipts and payments	*$'000*
Receipts	
Amounts receipted on behalf of Patients	1,103
Total receipts	1,103
Payments	
Amounts paid to or on behalf of Patients	1,135
Total payments	1,135
Increase/decrease in net Patients Trust Assets	(32)
Patient Trust Assets transferred from DoH on 1 July 2012	261
Fiduciary trust assets	
Current assets	
Cash at bank and on hand	228
Patient trust deposits	1
Total current assets	**229**

29. Financial Instruments

(a) Categorisation of financial instruments

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

Category	***Note***	***2013 $'000***
Financial assets		
Cash and cash equivalents	14	9,036
Receivables	15	3,787
Total		**12,822**
Financial liabilities		
Financial liabilities measured at amortised cost:		
Payables	19	7,831
Total		**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

29. Financial Instruments continued

(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 15 for further information.

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

	Note	*2013 $'000*
Maximum exposure to credit risk		
Cash	14	9,036

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

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.

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

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.

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 2012-13

	Not overdue $'000	*Overdue $'000*				*Total*
		Less than 30 days	*30-60 days*	*61-90 days*	*More than 90 days*	
Receivables	2,510	1,060	150	35	32	3,787
Total	**2,510**	**1,060**	**150**	**35**	**32**	**3,787**

29. Financial Instruments continued

Individually impaired financial assets 2012-13

	Overdue $'000				
	Less than 30 days	*30-60 days*	*61-90 days*	*More than 90 days*	*Total*
Receivables (gross)	5	2	3	57	67
Allowance for impairment	(5)	(2)	(3)	(57)	(67)
Carrying amount	**-**	**-**	**-**	**-**	**-**

Refer to note 15 for movements in the allowance for impairment loss.

(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. An approved debt facility of $1 million under Whole-of-Government banking arrangements to manage any short term cash shortfalls has been established. No funds had been drawn down against this debt facility as at 30 June 2013.

(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 risk

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

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

(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.

30. Key executive management personnel and remuneration

(a) Key executive management personnel

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

		Current Incumbents	
Position	*Responsibilities*	*Contract classification and appointment authority*	*Date appointed to position*
Health Service Chief Executive (HSCE) - Graem Kelly PSM	Responsible for the operations of the South West Hospital and Health Service. 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 2012
Chief Operations Officer (COO) - Meryl Brumpton	Provides single point accountability for the functions of human resources management, safety and well-being, workforce planning and development, infrastructure and planning (including service planning, capital works planning and delivery, facility engineering and maintenance), professional, operational and administrative support services.	DSO2 Appointed under Health Services Act 1991 (Section 24)	17 Nov 2008
Chief Finance Officer (CFO) - Josh Carey	Accountable for the overall financial management of the Hospital and Health Service, which includes planning, managing and reporting on the Hospital and Health Service fiscal performance. The CFO is also accountable for the promotion of the long term viability of the Hospital and Health Service and for ensuring that the distribution of funds across the Hospital and Health Service supports delivery of safe, high quality patient care and other Hospital and Health Services.	AO8 Appointed under Health Services Act 1991. District Health Services Employees Award - State 2012	10 Jan 2011
Executive Director, Medical Services (EDMS) - Tom Gibson	Provides professional leadership for the medical services of the Hospital and Health Service. 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 appropriately qualified, competent and credentialed workforce is maintained.	MEDC2 Appointed under Health Services Act 1991. District Health Services SMOs & RMOs Award - State 2012	21 Jan 2013

30. 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 (date resigned from position)*
Executive Director of Nursing (EDON) - Chris Small	Provides professional leadership for the nursing services of the Hospital and Health Service. 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 for the nursing and midwifery profession.	NRG11 Appointed under Health Services Act 1991. QH Nurse & Midwives Award - State 2012 - Section B Public Hospitals	14 Aug 2009
Director, Community & Allied Health (DCAH) - Jenny Flynn	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.	DSO2 Appointed under Health Services Act 1991 (Section 24)	1 Jul 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 rumuneration 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, expense payments such as rental or utilities.

30. Key executive management personnel and remuneration continued

(b) Remuneration continued.

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.
  - 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.

30. 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 Employment 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*	41	-	-	6	-	47
Chief Operations Officer - Meryl Brumpton	89	38	3	13	-	143
A/Chief Operations Officer - Ross Lau**	31	-	1	5	-	37
Chief Finance Officer - Josh Carey	113	26	3	14	-	156
A/Chief Finance Officer - Chris Keech***	14	-	-	2	-	16
Executive Director, Medical Services - Tom Gibson	158	23	1	9	-	191
Executive Director, Medical Services - Martin Byrne****	174	29	42	16	-	261

*1 Jul 2012 to 16 Sept 2012, 21 Dec 2012 to 2 Jan 2013 and 28 Mar 2013 to 7 Apr 2013.

**5 Jul 2012 to 5 Oct 2012.

***16 Jul 2012 to 14 Aug 2012.

****1 Jul 2011 to 12 Feb 2013.

30. 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 Employment Benefits*	*Termination Benefits*	*Total Remuneration*
	Base $'000	*Non-Monetary Benefits $'000*	*$'000*	*$'000*	*$'000*	*$'000*
Executive Director of Nursing - Chris Small	*143*	*-*	*3*	*17*	*-*	*163*
A/Executive Director of Nursing - Robyn Brumpton#	*15*	*-*	*-*	*2*	*-*	*17*
A/Executive Director of Nursing - Toni-Anne Murray^	*3*	*-*	*-*	*-*	*-*	*3*
District Director, Community & Allied Health - Jenny Flynn	*117*	*-*	*3*	*15*	*-*	*135*

#27 Jun 2012 to 5 Aug 2012.

^24 Sept 2012 to 7 Oct 2012.

(c) Board remuneration

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 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**	**Date of appointment**
Dr Julia Leeds	Chairperson	18 May 2012
Mr Lindsay Godfrey	Board member (Deputy Chair)	18 May 2013
Mrs Karen Prentis	Board member	29 June 2012
Ms Lyn Kajewski	Board member	29 June 2012
Mr Michael Cowley	Board member	29 June 2012
Mr Richard Moore	Board member	29 June 2012
Ms Heather Hall	Board member	27 July 2012
Ms Sheryl Lawton	Board member	27 July 2012
Mr James Hetherington	Board member	7 September 2012

30. Key executive management personnel and remuneration continued

(c) Board remuneration continue

1 July 2012 - 30 June 2013

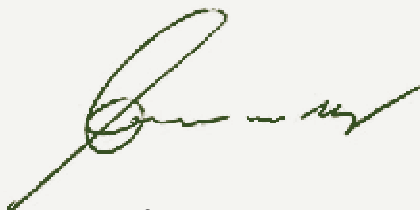
Position (date resigned if applicable)	*Short Term Employee Benefits*		*Long Term Employee Benefits*	*Post Employment Benefits*	*Termination Benefits*	*Total Remuneration*
	Base $'000	*Non-Monetary Benefits $'000*	*$'000*	*$'000*	*$'000*	*$'000*
Board Chairperson - Dr Julia Leeds	59	-	-	5	-	64
Board 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 - Mr Richard Moore	30	-	-	2	-	32
Board Member - Ms Heather Hall	28	-	-	2	-	30
Board Member - Ms Sheryl Lawton	28	-	-	2	-	30
Board Member - Mr James Hetherington	26	-	-	2	-	28

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 2013 and of the financial position of the Hospital and Health Service at the end of that year.



Dr Julia Leeds Chairperson, SWHHS Board	Mr Graem Kelly Health Service Chief Executive	Mr Josh Carey Chief Finance Officer
28/ 8 /2013	29/ 8 /2013	28 / 8 /2013

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 2013, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and certificates given by the Chairperson, Chief Executive and the Chief Finance Officer.

The Board's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

Independence

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

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

Opinion

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

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

(b) in my opinion –

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

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

Other Matters - Electronic Presentation of the Audited Financial Report

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

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

Queensland Audit Office
Brisbane

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September 2013