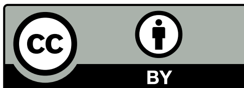
2011–12

Annual Report

Queensland Health

Queensland Government



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Letter of compliance

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

Dear Minister

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

I certify that this annual report complies with:

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

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

Yours sincerely

Dr Tony O'Connell
Director-General

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Every day in
Queensland Health...

Non-admitted patient services in public hospitals

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

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

Admitted patient services in public hospitals

120 babies are born in acute public hospitals.

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

8531 people receive admitted care in acute public hospitals.

Residential services in aged care facilities

1309 people receive residential care in 20 aged care facilities.

13 HEALTH (13 43 25 84)

781 callers receive clinical advice from qualified nurses.

Radiation treatment

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

Dental

1727 adult dental appointments are provided.

1574 child and adolescent dental appointments are provided.

647 children and adolescents complete dental treatment.

Year in review

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr Tony O'Connell
Director-General
Queensland Health

Mandate

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

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

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

Our vision

Working together for a healthier Queensland.

Our purpose

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

Our values

Caring for people

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

Leadership

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

Partnership

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

Accountability, efficiency and effectiveness

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

Innovation

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

Strategic direction

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

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

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

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

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

3. Improve the equity of health outcomes

In Queensland, substantial health inequalities exist for:

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

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

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

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

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

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

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

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

Highlights for 2011–2012

The road to reform

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

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

Finding efficiencies in the face of rising costs

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

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

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

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

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

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

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

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

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

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

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

Finalising enterprise bargaining agreements

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

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

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

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

Providing healthcare to regional Queensland

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

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

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

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

Responding to growth in the south-east corner

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

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

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

Research

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

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

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

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

Payroll and rostering systems

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

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

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

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

Fraud management

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

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

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

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

Divisions and districts

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

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

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

Centre for Healthcare Improvement

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

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

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

Division of the Chief Health Officer

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

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

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

Clinical and Statewide Services Division

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

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

The division maintained its commitment to:

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

Health Planning and Infrastructure Division

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

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

Human Resource Services Division

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

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

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

Finance, Procurement and Legal Services Division

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

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

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

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

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

Information Division

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

Information Division provided:

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

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

Performance and Accountability Division

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

The division was responsible for:

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

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

Policy, Strategy and Resourcing Division

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

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

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

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

Office of the Director-General

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

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

Cairns and Hinterland Health Service District

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

Facilities are:

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

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

Cape York Health Service District

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

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

Central Queensland Health Service District

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

Central West Health Service District

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

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

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

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

Children's Health Services

Children's Health Services provides:

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

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

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

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

Darling Downs Health Service District

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

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

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

Gold Coast Health Service District

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

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

Mackay Health Service District

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

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

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

Metro North Health Service District

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

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

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

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

Metro South Health Service District

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

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

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

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

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

Mount Isa Health Service District

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

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

South West Health Service District

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

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

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

Sunshine Coast Health Service District

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

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

Torres Strait and Northern Peninsula Area Health Service District

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

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

Townsville Health Service District

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

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

West Moreton Health Service District

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

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

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

Wide Bay Health Service District

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

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

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

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

Overview of organisational changes

Director-General

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

Hospital and Health Services

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

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

Chief Nurse

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

Darling Downs–West Moreton Health Service District split

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

Finance, Procurement and Legal Services

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

Health Planning and Infrastructure

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

Human Resource Services

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

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

Financial highlights

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

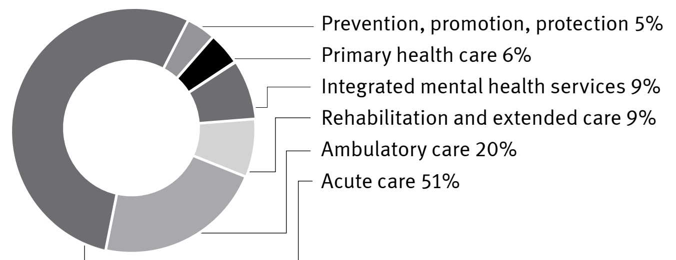
How the money was spent

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

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

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

Chart 1: Expense by major services



Income

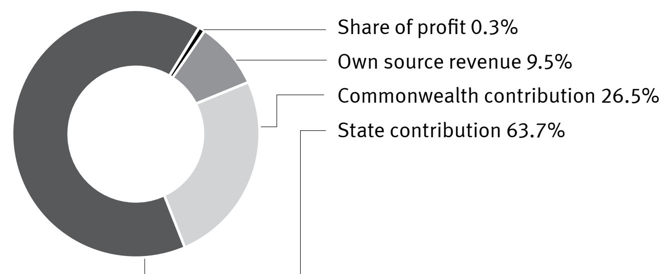
Queensland Health's income includes operating revenue and its share of profit in associates. The operating revenue is sourced from three areas:

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

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

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

Chart 2: Revenue by funding source



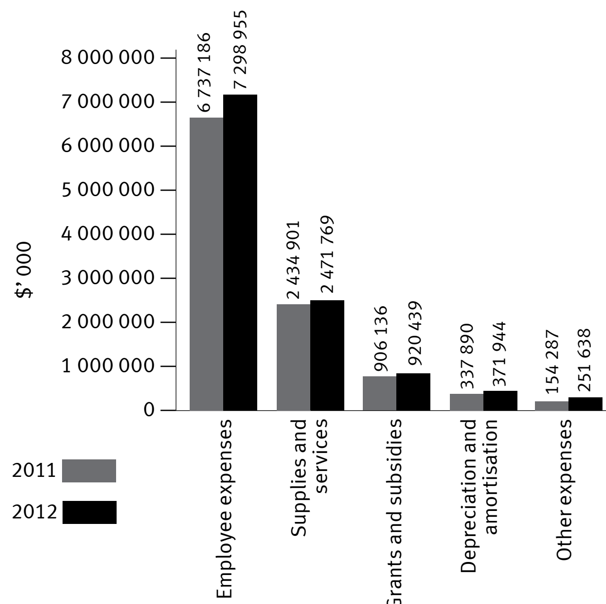
Expenses

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

The increase in expenses incurred includes:

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

Graph 1: Expense two-year comparison



Comparison of actual financial results with budget

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

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

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

Notes:

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

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

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

Notes:

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

Chief Finance Officer statement

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

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

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

Future outlook

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

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

Capital facilities intended for completion in 2012–2013 include:

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

Hospital and health services

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

Purchasing and performance

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

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

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

Activity based funding

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

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

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

National health funding pool

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

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