# Annual Report 2013–2014

Great state. Great opportunity.

Queensland Government

ISSN: 2202-4972

**Public Availability Statement**
Copies of this publication can be obtained at www.health.qld.gov.au/townsville or phone the Senior Public Affairs Officer, Townsville Hospital and Health Service (07) 4433 1111.

The Townsville Hospital and Health Service 2013-2014 Supplement to the Annual Report is available online at www.health.qld.gov.au/townsville.

**2013-2014 Annual Report Feedback:**
Feedback is sought from users on key aspects of the Townsville Hospital and Health Service 2013-2014 Annual Report. A feedback survey tool can be accessed using the following URL www.qld.gov.au/annualreportfeedback

**Interpreter Service Statement**
Townsville Hospital and Health Service Annual Report 2013-2014.

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on (07) 4433 1111 and we will arrange an interpreter to effectively communicate the report to you.

## ACKNOWLEDGEMENT TO TRADITIONAL OWNERS

The Townsville Hospital and Health Service respectfully acknowledges the traditional owners and custodians both past and present of the land and sea which we service and declare the Townsville Hospital and Health Service commitment to reducing inequalities between Indigenous and non-indigenous health outcomes in line with the Australian Government's *Close the Gap* initiative.

# Letter of Compliance

**29 August 2014**

**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 2013-2014 and financial statements for the Townsville 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*
- 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 79 of this annual report or accessible at www.health.qld.gov.au/townsville.

Yours sincerely

**Mr John Bearne**
*Chair*
*Townsville Hospital and Health Board*

# Contents

# Robert Bliss and Brendan Porter

‘It is now 15 months since my accident. Looking back I can only praise all the staff, specialists, doctors and nurses throughout the hospital.

‘There was always one person that always dropped by to have a chat. This was Brendan, Clinical Nurse Consultant - Mental Health.

‘I admire Brendan’s amazing dedication to individuals and I will continue meeting up where possible as I still have many challenges ahead. Thank you for the hospital’s services providing this lifeline in my case and thank you, Brendan, for being a mate’s mate.’

**ROBERT BLISS**

# Year in Review

## BOARD CHAIR AND HEALTH SERVICE CHIEF EXECUTIVE

The Townsville Hospital and Health Service Board is delighted to present its second Annual Report.

The 2013-2014 year was the second year of operation of the Townsville Hospital and Health Service governed by its Board. The first year (2012-2013) was a steep learning curve for the Board. Successes were achieved in stabilising services and quality, improving performance and creating a positive financial position. This second year has demonstrated that our staff and executive team have continued their efforts to improve quality and provide safe care in an environment of increased demand, and put in place additional services under the guidance of the Board.

Alongside those achievements, we are proud to have concentrated on setting the strategic direction for the future of our services by engaging with our communities, stakeholders and staff whilst recognising the need to focus on the quality and safety of the care we offer. The Townsville Hospital and Health Service Strategic Plan 2014-2018 *(referred to as the Strategic Plan)* was approved in June 2014 following an extensive Board led engagement process right across the Health Service. A copy of the Strategic Plan can be accessed via the link at the bottom of the page.

Strategic Plan and the engagement of our staff and community. The Board has been ably assisted by the Minister for Health, the Honourable Lawrence Springborg MP.

The Department of Health has recognised our achievements and recommended to the Minister for Health that we should continue to keep operating surpluses generated to use for the benefit of our communities. Our efforts have also been rewarded with the early transfer of the responsibility for our staff, land and assets to the Hospital and Health Service's stewardship.

These markers of confidence will enable us to work even more proactively towards meeting the needs of our communities moving forward, to recruit and retain the very best workforce and to provide excellent education and research. Our plans to be the experts in care, health and research for our tropical communities may be seen as aspirational but the Board believes they are achievable.

> "These markers of confidence will enable us to work even more proactively towards meeting the needs of our communities moving forward ...

The Hospital and Health Service, through funding provided by the State Government and the investment of our operating surplus has provided additional services to the community. The region has seen more care offered closer to home with rural hospitals delivering more services and in more specialties than ever before. Developments in telemedicine as well as traditional inpatient and outpatient services were put in place. Our expanding Hospital in the Home program is a highly successful example. The foundations for better access to care for the Palm Island Community were laid with funding allocated and tenders let for a mobile health van and staff accommodation.

There are no longer any patients waiting for dental care or all three categories of surgery beyond the clinically recommended times. We have worked hard to make inroads into waiting times for outpatient services and expect strong results next year.

Part of the Hospital and Health Service Board's responsibility is to deliver the Government's health agenda set out in the *Blueprint for better healthcare in Queensland* which includes implementing our

The next twelve months will see more detailed service planning, the completion of The Townsville Hospital redevelopment and a continued shift of services closer to the home. The Board will increase our reporting to the community and establish expert leadership for quality and safety together with better systems. We have planned to focus on wider and closer engagement with staff, as we develop as a prescribed employer, and our ambitious research and education plans, which are currently developing.

We would like to thank our patients, communities, staff and stakeholders for their fantastic support in the last two years and assure them of our best efforts moving forward.

**John Bearne**
*Chair*
Townsville Hospital
and Health Board

**Julia Squire**
*Health Service Chief Executive*
Townsville Hospital
and Health Service

*http://www.health.qld.gov.au/townsville/Documents/executive/thhb-strategic-plan-2014-2018.pdf*

# Townsville Hospital and Health Service


## ABOUT

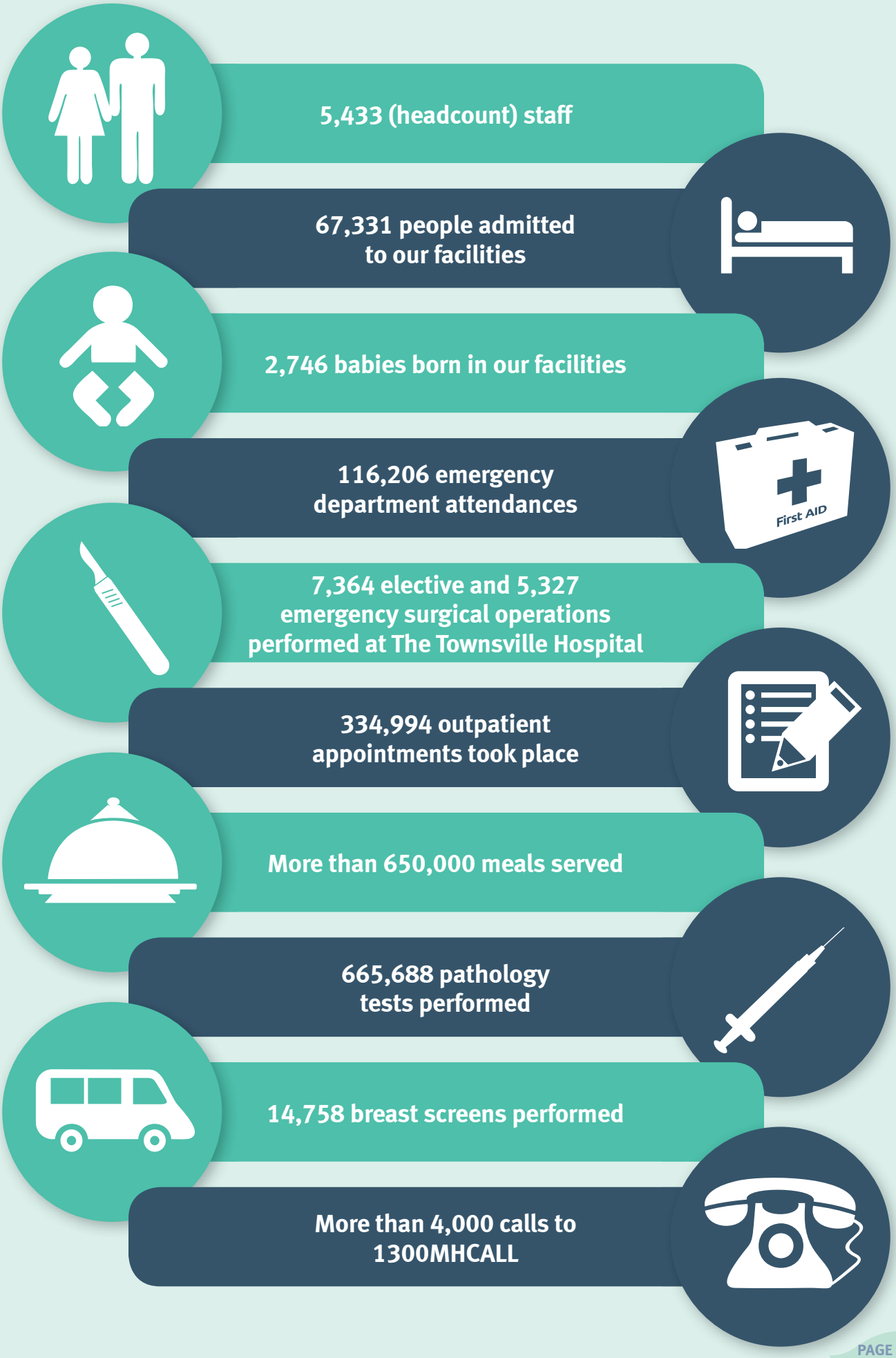
The Townsville Hospital and Health Service (now referred to as Townsville HHS) is the major provider of public health services in the local Townsville region, which includes the area north to Cardwell, south to Home Hill and west to Richmond. Townsville HHS includes the Local Government Areas of Burdekin, Charters Towers, Flinders Hinchinbrook, Palm Island, Richmond and Townsville and shares its borders with Cairns and Hinterland HHS, North West HHS, Central West HHS and Mackay HHS.

The Townsville HHS covers an area of approximately 148,210 square kilometres or 8.5 per cent of the total area of Queensland, serving a local population of over 240,000 which is forecast to grow by 27 per cent to more than 300,000 by 2026. It employs over 5000 staff and has an annual operating budget of more than $740 million.

The catchment area of Townsville HHS spans a population over 650,000 people and an area of approximately 750,000 square kilometres. The Townsville Hospital (now referred to as TTH) is one of the largest non-metropolitan hospitals in Australia. It is the referral hospital for the HHS and is the specialist tertiary referral hospital for Tropical North Queensland, and provides a comprehensive range of medical, surgical, emergency, obstetrics, paediatrics, mental health, critical care, specialist outpatient, and clinical support services to the Townsville HHS and North Queensland.

There are seven rural hospitals which provide a mix of general medicine, general surgery, obstetrics, emergency, outpatient and primary health services. There are two residential aged care facilities. In addition, there are community clinics and health centres across the region that provide community and primary health care services.

# 2013-2014 HHS Snapshot



# 2013-2014 Highlights

During the year the following achievements contributed to better and more effective care:

## REINVESTMENT OF 2012-2013 OPERATING SURPLUS

- An extra $7 million of care including more than 500 surgeries and 3,000 specialist medical and surgical outpatient appointments
- $3.5 million investment in a mobile health van and staff accommodation on Palm Island
- $2.5 million investment to improve facilities for residents at Eventide Residential Aged Care Facility in Charters Towers.

## CLOSING THE GAP

- Two Indigenous women completed the Indigenous Bachelor Midwifery Pilot Education Program. Both have been employed as graduate midwives at TTH
- Publication of the Aboriginal and Torres Strait Islander perinatal social and emotional wellbeing screening learning package
- Mental Health Service Group won the Mental Health Service Gold Award 2013 for excellence in mental health for the Cultural Information Gathering Tool
- 20 per cent more Indigenous women screened through BreastScreen
- Upgrade of renal dialysis services on Palm Island
- 40 per cent of HHS staff trained in Cultural Capability.

## CARE CLOSER TO HOME

- Commencement of a rural transfer coordinator to facilitate the appropriate transfer of patients from TTH closer to home
- Outreach cardiology clinics commenced in Charters Towers and Ingham
- North Queensland Persistent Pain Management Service established outreach services to Cairns, Mackay and Mount Isa
- More than 2,000 telehealth provider and receiver consultations with a 57% increase from the prior year
- Hospital in the Home service commenced and treated more than 100 patients, freeing up more than 300 bed days
- First patient treated with Stereotactic Ablative Body Radiotherapy, a radiation therapy technique that attacks tumours with sub-millimetre accuracy
- Delivery of two additional linear accelerators which treat cancer with high energy x-rays.

## CLINICAL REDESIGN

- SCALPEL project improved elective surgery performance through elective surgery modelling, emergency surgery patient journey, discharge pathways and preadmission processes
- Successful trial to implement a remote radiology reporting service to support timely analysis of breast screens
- Integration of the Patient Flow Manager leading to more continuity of care for emergency patients.

## STAFF CAPABILITY

- TTH is the first regional hospital in Australia accredited to offer a neurology training program.

## ENGAGE-MENT

- 13 community engagement sessions, 21 Townsville HHS engagement sessions and 15 individual consultation sessions resulting in a Strategic Plan that reflects the needs of the community we serve.

## PERFORMANCE

- $20 million operating surplus achieved
- No patients waiting longer than the clinically recommended time for general dental treatments
- No patients waiting longer than the clinically recommended times for elective surgery
- One of the lowest WorkCover premium rates of any Health Service in Queensland.

## REDEVELOPMENT AND NEW SERVICES

- Stages 3 to 5 of the Townsville Hospital Redevelopment Project are in progress with final completion in 2015. During the year the Central Energy Facility was commissioned and Phase One of the Townsville Cancer Centre was opened
- In January 2014, Townsville HHS opened the first North Queensland overnight inpatient facility and day therapy service for adolescents who live with a mental illness. The facility, the Josephine Sailor Adolescent Inpatient Unit and Day Service, caters for adolescents aged between 12 and 18 years and includes eight overnight beds as well as a day therapy service.

**MORE THAN 2,000**

**telehealth provider and receiver consultations**

**WITH A 57% INCREASE**

**from the prior year.**

# Our Organisation

## VISION, PURPOSE AND OBJECTIVES

The Townsville Hospital and Health Service Strategic Plan 2012-2016 (2013 Update) outlines the vision, purpose and objectives for the organisation.

### OUR VISION

Healthier people in our communities.

### OUR PURPOSE

To provide safe, effective and sustainable health services that people value and trust.

### OUR OBJECTIVES

The Townsville HHSs strategic objectives reflect our commitment to working with and for our communities. This is demonstrated by four key objectives:

- healthier North Queenslanders
- safety and quality comes first
- accessible and responsive services
- effective and accountable services and systems.

The Townsville HHS works closely with the Queensland Government to implement its *Blueprint for better healthcare in Queensland*, which is embodied within the principal themes of:

- health services focused on patients and people
- empowering the community and our health workforce
- providing Queenslanders with value in health services
- investing, innovating and planning for the future.

## ORGANISATIONAL STRUCTURE

Townsville HHS has an organisational structure which ensures that decisions are made as close to the patient as possible. It aims to foster innovation, engagement, responsibility and accountability, contributing to the Queensland Government's Public Sector Renewal Program.

The organisation has six service groups, each led by a Service Group Director, as a single point of accountability:

- Health and Well Being Service Group
- Indigenous Health Service Group
- Medical Service Group
- Mental Health Service Group
- Rural Hospitals Service Group
- Surgical Service Group

Commercial Services operate under the leadership of the Chief Finance Officer.

### HEALTH SERVICE CHIEF EXECUTIVE

The Townsville Hospital and Health Board (the Board) appoints the Health Service Chief Executive (HSCE) and delegates the administrative functions of Townsville HHS to the HSCE and those officers to whom management is delegated.

### TOWNSVILLE HOSPITAL AND HEALTH SERVICE SENIOR MANAGEMENT TEAM

The Senior Management Team (SMT) is the decision making body within the organisation. It is the team through which the HSCE discharges her responsibilities.

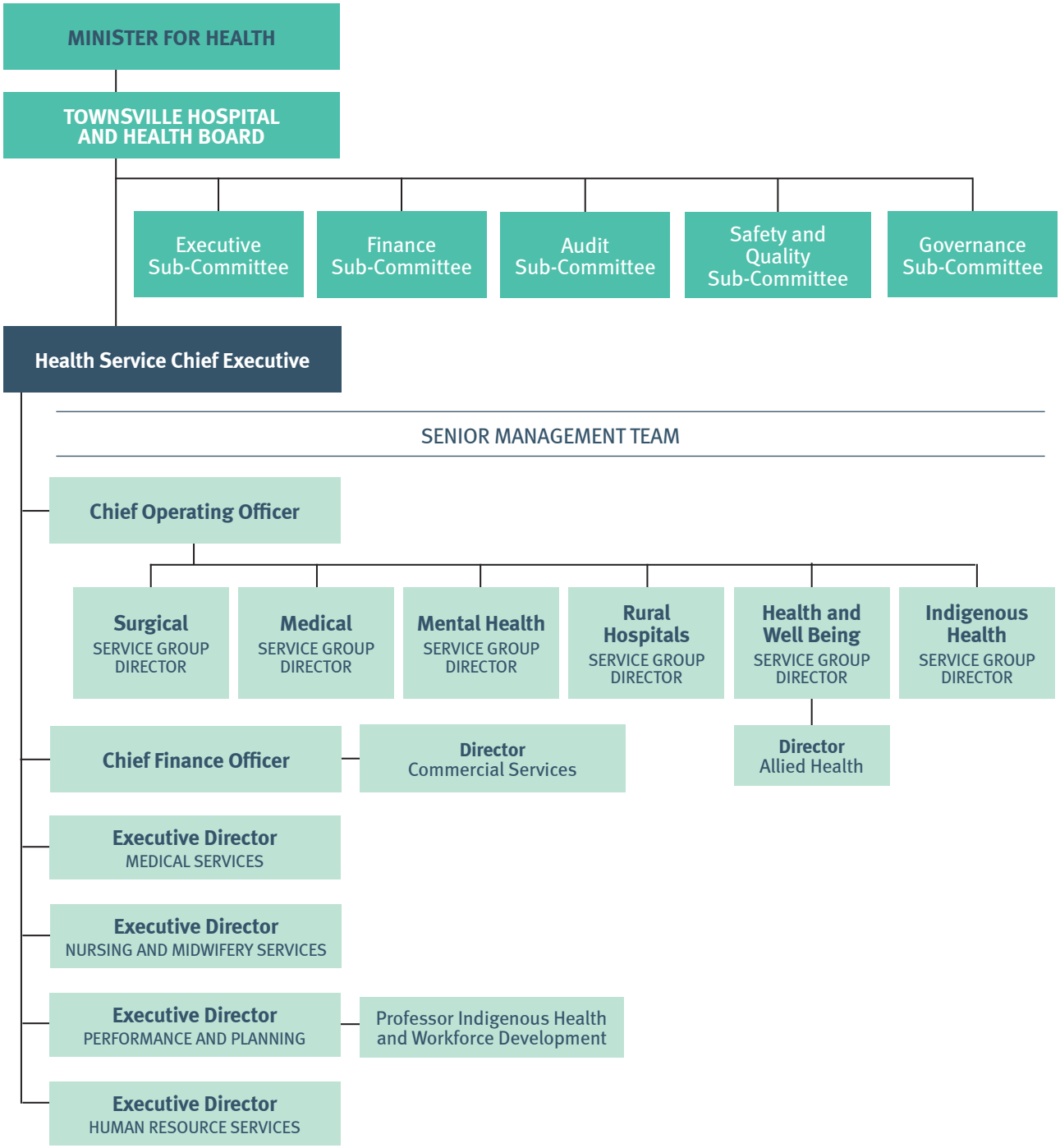
The membership of the SMT in 2013-2014 comprised:

- HSCE (Chair)
- Executive Directors (Medical Services, Human Resource Services, Nursing and Midwifery Services, Performance and Planning, Chief Finance Officer and Chief Operating Officer)
- Service Group Directors
- Director Commercial Services
- Advisors in Allied Health and Indigenous Health.

Senior Management Team members with strategic and operational portfolios undertake these using annual performance agreements in line with the requirements of the Service Agreement held with the Department of Health (DoH).

The advisory members of SMT: Director Allied Health and the Professor of Nursing – Indigenous Health and Workforce Development and the Executive Directors of Medical, and Nursing and Midwifery Services ensure that the organisation's professions and communities are properly represented.

# ORGANISATIONAL GOVERNANCE



# OUR BOARD

The Board comprises members appointed by the Governor of the State of Queensland, acting by and with the advice of the Executive Council and under the provisions of the *Hospital and Health Boards Act 2011* (The Act). The Governor has approved the appointments on the recommendation of the Minister for Health, the Honourable Lawrence Springborg MP.

The Board governs the Townsville HHS. It derives its authority from the The Act. Each Board member brings a broad range of skills, expertise and experience to the Board.

## ACHIEVEMENTS

The Board's major achievements for 2013-2014 include:

- setting the 2014-2018 Strategic Plan
- overseeing significant strategic and operational performance improvements including the elimination of long waiting times for elective surgery and dental care
- delivering financial sustainability and the reinvestment of operating surpluses for community benefit
- contributing to delivery of the Queensland Government's *Blueprint for better healthcare in Queensland*, including health services focused on patients and people and providing Queenslanders with value in health services
- setting a future direction for 2014 and beyond following extensive community, stakeholder and staff engagement processes
- focusing on the development of improved quality of care including improving services, staffing and care environments
- improving transparency, accountability and reporting to our communities
- engaging in developing strategic partnerships for the benefit of our communities
- investing in and developing research and teaching including setting out the first Board Research Strategy
- improving our Governance including audit processes for quality, accountability and probity, fraud and scrutiny of the work of the Executive
- making successful applications to control the human, capital and asset resource of the HHS from July 2014.

# BOARD MEMBER PROFILES

## JOHN BEARNE CHAIR

John Bearne is the inaugural Chair and is in his second term until 17 May 2016.

John is a Fellow of the Australian Institute of Company Directors and has 40 years experience in engineering and construction. A Townsville resident for 30 years he has substantial experience as Chair and Director of numerous commercial and not-for-profit organisations including Townsville Enterprise, the Jezzine Barracks Community Trust and the Australian Technical College of North Queensland. He is also a former President of the Townsville Chamber of Commerce.

John's current Board positions include Chair of the Economic Development Strategic Advisory Committee of Townsville Enterprise, Chair of the Jezzine Barracks Community Trust, Member of the Queensland Health Health Services Support Agency Advisory Board and Board member of the Townsville Hospital Foundation.

## MICHELLE MORTON DEPUTY CHAIR

Michelle Morton is an inaugural board member and is in her second term until 17 May 2016. Michelle was appointed as deputy board chair on 27 July 2012.

Michelle is a Graduate of the Australian Institute of Company Directors. Michelle has a Bachelor of Laws (Hons) and is a Solicitor of the Supreme Court of Queensland.

Michelle is a managing partner at wilson/ryan/grose Lawyers. Michelle specialises in workplace relations law, including employment litigation, unfair dismissals, adverse actions and discrimination claims, preparation of employment contracts, policies and procedures for employer entities.

In 2003, Michelle was awarded the Queensland Regional Women's Lawyer Award.

## DR KEVIN ARLETT

Dr Kevin Arlett was initially appointed to the Board on 29 June 2012, with his current term ceasing on 17 May 2017.

Kevin is a Fellow of the Australian Institute of Company Directors. He is a general practice partner in the Townsville and Suburban Medical Practice, a Fellow of the Royal Australian College of General Practice, and the current Chair of the Townsville-Mackay Medicare Local.

Kevin has also served on the state bodies of General Practice Queensland (GPQ) as a Director and Chairman, as well as serving as the GPQ representative on Health Workforce Queensland for three years, also as a Director.

### GLEN CERUTTI

Glen Cerutti was initially appointed to the Board on 29 June 2012, and his second term ceases on 17 May 2016.

Glen is a Fellow of the Australian Institute of Company Directors, a former member of the Townsville Committee of the Australian Institute of Company Directors and a Fellow of the Tax Institute.

He has a Bachelor of Economics. He is a Certified Practising Accountant and has worked in Ingham for more than 40 years. He is an experienced Director of for-profit financial institutions and not-for-profit community organisations in the Ingham area and has been a member of various Board Committees including risk, audit and remuneration.

### LYNETTE MCLAUGHLIN

Lynette McLaughlin was initially appointed on 7 September 2012 and her current appointment ends on 17 May 2017.

Lyn has a wealth of Board and Local Government experience including as Chair of the Queensland Local Government Grants Commission and Deputy Chair of Regional Development Australia (Townsville and North West Queensland). She has served on the Boards of sports and recreational bodies across Queensland. Lyn is a member of the James Cook University Council.

Lyn is a qualified primary school teacher, and has also served as Mayor of Burdekin Shire Council from 2004 to 2012. She had previously been elected as a Councillor in 1994 and 1997.

### ROBERT (DONALD) WHALEBOAT

Donald Whaleboat was originally appointed to the Board on 27 July 2012 and is now in his second term, which concludes on 17 May 2016.

Donald is a Torres Strait Islander and a long standing member of the Aboriginal and Torres Strait Islander community in Townsville. Donald holds a Masters of Public Health, Bachelor of Health Science and a Certificate in Governance. Donald has been the chairperson of the Townsville Aboriginal and Torres Strait Islander Corporation for Health Services (trading as TAIHS) since 2011.

Donald is a senior lecturer at the School of Medicine and Dentistry, James Cook University.

### DR ERIC GUAZZO OAM

Dr Eric Guazzo was initially appointed to the Board on 29 June 2012, with his current term ending on 17 May 2017.

Eric is a Member of the Australian Institute of Company Directors and has a university qualification in business management. Eric is a member of a broad range of Clinical Boards, Authorities and Colleges and has served in the public and private sector. Eric is an Associate Professor at the James Cook University Medical School and contributes to undergraduate teaching.

Eric has been in combined public/private neurosurgery practice based in Townsville since 1994. He is a Senior Visiting Medical Officer with Queensland Health and the Director of the Department of Neurosurgery for the North Queensland region.

In June 2013, he was awarded the Order of Australia Medal (OAM) for his services to neurosurgery.

### SUSAN PHILLIPS

Susan Phillips was appointed to the Board on 7 September 2012 and her current term ends on 17 May 2016.

Susan is a Member of the Australian Institute of Company Directors. Susan is the owner/operator of Charters Towers Self Storage.

Susan has held a board member position with the Self Storage Association of Australasia since 2012 and is a member of the Advisory Committee for the Dalrymple Trade Training Centre in Charters Towers. Susan's interest in tourism is evidenced in her memberships of the Townsville Enterprise Tourism Advisory Committee, Townsville Enterprise Drive Tourism and Signage Committee, Queensland Information Centres' Association and the Great Tropical Drive Steering Committee.

In 2006, Susan was awarded the Richard Power Memorial Award for the Most Outstanding Contribution to Tourism.

### PROFESSOR IAN WRONSKI AO

Professor Ian Wronski AO commenced his appointment on the Board on 29 June 2012. He is now in his second term which ceases on 17 May 2017. Ian is Deputy Vice Chancellor of the Division of Tropical Health and Medicine at James Cook University.

Ian holds a Bachelor of Medicine and Bachelor of Surgery, Diploma of Tropical Medicine and Hygiene, Diploma of the Royal Australian College of Obstetricians and Gynaecologists, Master of Public Health in Health Policy and Management, and a Master of Science in Epidemiology. Ian is currently Chair of the Australian Council of Pro Vice Chancellors and Deans of Health Sciences and the Queensland Clinical Education and Training Council. Ian is a Fellow of various faculties and colleges.

In 2014, Ian was made an Officer of the Order of Australia for his distinguished service to higher education.

# EXECUTIVE DIRECTORS PROFILES

## JULIA SQUIRE HEALTH SERVICE CHIEF EXECUTIVE

Julia joined the Townsville HHS in November 2012 as Health Service Chief Executive.

Julia has a Bachelor of Arts (Hons) Geography, a postgraduate Diploma in Health Services Management, and is a Member of the Australian Institute of Company Directors.

Julia has been a Health Service Chief Executive since 1999, working at Executive and Board levels for 20 years with a health management career spanning 27 years. She has worked at Department and National levels in senior positions in policy and change management, predominantly in the United Kingdom National Health Service until her move to Townsville.

## MARLENE COCHRANE
### INTERIM EXECUTIVE DIRECTOR NURSING AND MIDWIFERY SERVICES

Marlene has worked for Queensland Health for the past 10 years in a range of senior nursing and management roles mostly in supporting the rural services aligned to this health service.

Prior to reconnecting with Queensland Health in 2004 following further tertiary education and performing senior nursing roles in the private sector, Marlene's specialist background was neonatal intensive care and midwifery, both nationally and internationally.

## DR ANDREW JOHNSON
### EXECUTIVE DIRECTOR MEDICAL SERVICES

Andrew was appointed as Executive Director Medical Services in July 2000.

He graduated in 1988 in Medicine, attained a Masters in Health Administration in 1995 and was admitted as a Fellow at the College of Administrators in 1997.

Andrew worked as a doctor in the Royal Australian Air Force before moving into medical management in Sydney and Cairns, then moving to Townsville. In 2014, Andrew was appointed as a Pre-Eminent Staff Specialist and is an Adjunct Associate Professor with James Cook University.

## PATRICK SHEEHAN
### EXECUTIVE DIRECTOR HUMAN RESOURCE SERVICES

Pat joined The Townsville HHS as Executive Director Human Resource Services in June 2014.

Pat holds a Masters of Business Administration and a Bachelor of Applied Science (Applied Psychology). He is a Certified Professional of the Australian Human Resources Institute, and a member of the International Society of Performance Improvement.

Pat has worked as head of human resources in several large commercial organisations in Australia and overseas.

## SHAUN ELDRIDGE
### CHIEF FINANCE OFFICER

Shaun joined The Townsville HHS as Chief Finance Officer in November 2013.

Shaun holds a Bachelor of Business in Accounting, is a Certified Practising Accountant, and has a Masters of Business Administration. He is a current member of the Australian Health Services Financial Management Association.

Shaun had previously worked in Victorian health industry finance and corporate services roles for 19 years.

## KIERAN KEYES
### CHIEF OPERATING OFFICER

Kieran joined the Townsville HHS as Chief Operating Officer in December 2012.

He holds a Masters of Business Administration, a Bachelor of Nursing Science, and is a Graduate of the Australian Institute of Company Directors.

Kieran has held executive roles in the Wide Bay and Metro North Hospital and Health Services, as well as within the Department of Health.

## ANTHONY WILLIAMS
### EXECUTIVE DIRECTOR PERFORMANCE AND PLANNING

Anthony was appointed to the role of Executive Director Performance and Planning in April 2013.

Anthony has a Masters of Professional Accounting, Masters of Business Administration, Bachelor of Nursing Science, and is a Graduate of the Australian Institute of Company Directors.

Anthony has held various senior leadership roles within the organisation.

# SENIOR MANAGEMENT TEAM PROFILES

### ROBYN ADAMS
**DIRECTOR ALLIED HEALTH**

As Director Allied Health, Robyn has worked in Queensland Health since 2008.

Robyn holds a bachelor qualification in an allied health profession, graduate qualifications in health service management and is currently a PhD candidate.

Robyn has worked in public, private and aged-care sectors. She also has an extensive background as a university lecturer with James Cook University and statewide and nationally representing rural and allied health services.

### MICHAEL CATT
**SERVICE GROUP DIRECTOR – MENTAL HEALTH**

Michael was appointed as Service Group Director Mental Health in August 2013 and has worked within the Townsville HHS since 2010.

Michael is a Registered Nurse, has post graduate qualifications in Mental Health Nursing, and also holds a Masters of Business Administration.

Michael has previously worked in various clinical and senior management roles within Queensland Health in the mental health field.

### VALERIE GILMORE
**SERVICE GROUP DIRECTOR - MEDICAL**

Valerie joined the Townsville HHS as Medical Service Group Director in September 2013.

She completed her general nurse training in 1988 and midwifery training in 1991 and has a Bachelor of Science (Hons) in Professional Development in Nursing and Masters of Business Administration.

Valerie has held various executive director roles within Northern Ireland Health and Social Care.

### VICKI CARSON
**SERVICE GROUP DIRECTOR - HEALTH AND WELL BEING**

Vicki was appointed as Service Group Director Health and Well Being in July 2013.

Vicki combines a clinical nursing background with a higher degree in public health and tropical medicine.

Vicki has held various nursing leadership roles across the organisation.

### LISA DAVIES-JONES
**SERVICE GROUP DIRECTOR - SURGICAL**

Lisa took up her position as Service Group Director Surgical Services in September 2013.

Lisa is a United Kingdom qualified registered nurse and holds a post-graduate diploma in management.

Lisa has a nursing and service redesign background, holding senior leadership positions in the public and private sectors in the United Kingdom.

### SCOTT GODDARD
**DIRECTOR COMMERCIAL SERVICES**

Scott joined the Townsville HHS in July 2013.

Scott has a Masters of Business Administration, a Masters of Arts and a Diploma of Project Management.

With more than 25 years' experience in managing large multi-disciplinary teams he has worked with major organisations in both the private and public sectors.

### JUDY MORTON
SERVICE GROUP DIRECTOR – RURAL HOSPITALS

Judy commenced as Service Group Director for Rural Hospitals in August 2013 relocating from Bundaberg where she was Director of Nursing Rural and Family Services.

She qualified as a Registered Nurse in 1988, completed a Bachelor of Science in Public Health in 2000 and a Post Graduate Certificate in Health Management in 2011.

Judy has management experience nationally and internationally in both public and private health systems.

### LIZA TOMLINSON
SERVICE GROUP DIRECTOR – INDIGENOUS HEALTH

Liza was appointed to her current role of Service Group Director Indigenous Health in September 2013.

Liza has a Bachelor of Applied Science (Biology), Graduate Diploma in Nutrition and Dietetics, Graduate Diploma of Education (Secondary) and a Masters of Health Service Management.

Liza has held various management roles across the Townsville HHS.

### ROIANNE WEST
EXPERT ADVISER AND PROFESSOR OF NURSING INDIGENOUS HEALTH AND WORKFORCE DEVELOPMENT

Roianne is a descendant of the Kalkadoon people from North-West, Queensland.

Roianne has more than 20 years of experience in Indigenous health and commenced in the Health Service in January of 2009.

A university-trained Registered Nurse with a Masters in Mental Health Nursing and a PhD, Roianne was the first in the country to be appointed to the position of Nursing Director for Indigenous health and then to the Professor of Indigenous Health and Workforce Development in a joint position between the Townsville HHS and Griffith University.

Roianne is a Director on the National Board of the Council of Aboriginal and Torres Strait Islander Nurses.

## New project helps rural patients recover closer to home

Patients from rural areas can now recover at their local hospitals after treatment at TTH, allowing beds at TTH to be prioritised for acutely unwell patients and enabling rural patients to be looked after closer to home.

Director of the Townsville HHS's rural hospitals service group Judy Morton said the rural transfer project was an excellent option for local patients to return more quickly to hospitals within rural areas.

The project involves transfers from TTH to hospitals at Ingham, Charters Towers, Ayr, Home Hill, Richmond and Hughenden.

Patients suitable for the project include those needing long-term treatments, dressings or who are awaiting nursing home placement.

It is also a good option for some post-operative patients who have had their surgery at TTH and can continue their recovery closer to home at their local hospital, surrounded by loved ones.

More than 150 patients were transferred between January 2014 and June 2014, with the occupancy of the rural facilities increasing by seven per cent for the same period.

# OPERATING ENVIRONMENT

## AGENCY ROLE AND FUNCTIONS

Under the *Act*, Townsville HHS is the principal provider of public health services for the community within its geographical area. It is an independent statutory body, governed by the Board, which is accountable to the local community and the Minister for Health.

Under the Commonwealth and State Government Health Reforms, Townsville HHS became a Hospital and Health Service on 1 July 2012. Under the *Act*, the DoH is responsible for the overall management of the public health system including statewide planning and monitoring the performance of hospital and health services. A formal Service Agreement is in place between the DoH and Townsville HHS. This Service Agreement defines the outcomes that are to be met by Townsville HHS and how its performance will be managed.

## MACHINERY OF GOVERNMENT

As part of the health reform agenda, the ownership of land and buildings will be transferred from DoH to the Townsville HHS on 1 July 2014.

Also on 1 July 2014 the HHS will become a prescribed employer. Effective from this date all HHS staff will become employees of the Townsville HHS.

## GOVERNMENT'S OBJECTIVES FOR THE COMMUNITY

Townsville HHS has maintained its enthusiasm to contributing to the Queensland Government's statement of objectives for the community, by providing services that are efficient, effective and sustainable, whilst remaining flexible to changing community and Government expectation. The following are examples of how Townsville HHS has contributed directly to the ethos of the Government's statement of objectives in 2013-2014:

### Grow a four pillar economy

Based on a strong foundation from the previous year, the Townsville HHS has contributed to the Government's commitment of returning the State Budget to surplus, by delivering a positive operating result in 2013-2014.

### Invest in better infrastructure and better planning

Alongside routine infrastructure investment and progression of The Townsville Hospital Redevelopment Project, the HHS reinvested part of its 2012-2013 surplus during 2013-2014. This reinvestment includes funding additional staff accommodation and a Mobile Health Clinic for Palm Island residents, improved facilities for residents at Eventide Residential Aged Care Facility in Charters Towers and improved facilities for sub-acute services.

### Revitalise front-line services

Townsville HHS has actively progressed strategies during the year, delivering better access to emergency, specialist outpatient and surgical services for North Queenslanders by:

- implementing a National Outpatient Access Target (NOAT) meeting and audits to reduce outpatient waiting lists
- ongoing partnership with the DoH on clinical redesign projects to provide streamlined and improved services eg. SCALPEL
- significant reduction in long-wait surgical and dental waiting lists.

### Restore accountability in government

The Townsville HHS continued to embed the Board-approved strategies for Consumer, Community and Clinician Engagement by reviewing and updating the Strategic Plan to reflect community requirements.

During the year the Townsville HHS has:

- worked with the Townsville-Mackay Medicare Local on health assessments, informing the strategic priorities for the new Strategic Plan and a health pathways program to improve access to care
- provided opportunities for consumer and community members to contribute to various committees and groups, including Board Sub-Committees, redevelopment user groups and the Consumer, Community and Clinician Engagement Committee
- enhanced public engagement including using HHS twitter and Facebook, a dedicated townsvillehhs-engagement email address, maximising print and electronic media opportunities, ongoing contribution to the Department's *My Hospitals* website and the DoH news page, and publishing the summaries of Board meetings.

## QUEENSLAND PUBLIC SERVICE VALUES

The Townsville HHS values of Integrity, Compassion, Accountability, Respect and Engagement (*ICARE*) support the organisation to deliver services that are safe, efficient, effective and sustainable. They complement Queensland's public service values which include:

- *Customers first* – know your customer; deliver what matters; make decisions with empathy
- *Ideas into action* – challenge the norm and suggest solutions; encourage and embrace new ideas; work across boundaries
- *Unleash potential* – expect greatness; lead and set clear expectations; seek, provide and act on feedback
- *Be courageous* – own your actions, successes and mistakes; take calculated risks, act with transparency
- *Empower people* – lead, empower and trust; play to everyone's strengths; develop yourself and those around you.

## PUBLIC SECTOR RENEWAL PROGRAM

Townsville HHS continued to embed the program's themes of employee engagement, better customer experience, reduced cost to Queenslanders and improved productivity as part of everyday business. These themes were achieved through the engagement of staff in the Strategic Plan development process, positive results in the emergency department (ED) patient satisfaction survey and employee opinion survey, a $141 improvement in the cost per weighted activity unit (WAU) and providing 1.8 per cent more activity than was purchased by the DoH within own resources.

## *BLUEPRINT FOR BETTER HEALTHCARE IN QUEENSLAND*

Townsville HHS maintains its commitment to assisting the Government deliver on the Blueprint's four themes which are:

- health services focused on patients and people
- empowering the community and our health workforce
- providing Queenslanders with value in health services
- investing, innovating and planning for the future.

The following are examples of how Townsville HHS has implemented programs/strategies to address these objectives:

**Health services focused on patients and people**

Townsville HHS undertook a number of clinical service redesign processes to ensure the organisation can continue to improve its services. Examples include SCALPEL (Elective Surgery) and XRAY Vision (Medical Imaging review).

A stronger emphasis on treating patients closer to home, improved collaboration and streamlining of services has removed duplication and improved efficiency and access to care. Examples include an increased utilisation of telehealth in rural facilities and provision of specialist outreach programs such as surgery, cardiac and pain clinics outside of the tertiary facility.

**Empowering the community and our workforce**

Townsville HHS has actively worked on strengthening public and private partnerships. The implementation of the Consumer, Clinician and Community Engagement Strategy has continued including a focus on informing the priorities for the Strategic Plan, which gives the staff and the community ownership of the plan going forward. The Board-approved Strategic Plan is effective 1 July 2014.

**Providing Queenslanders with value in health services**

Townsville HHS continues to improve its models of care and ways of working, to ensure that the health system is both effective and maximises health outcomes from the available resources. This approach is not just confined to clinical service delivery, but also in the support structures that underpin the service delivery. Examples include entering the contestable energy market, which has delivered real dollar savings to the HHS in terms of energy utilisation, as well as improvements in freight, courier and perishable-food arrangements that have considerably reduced costs for the organisation. This has been in line with Government objectives, with the HHS actively investigating options for partnerships with non-government and private organisations.

A key mechanism in delivering additional opportunities for the HHS is the Townsville HHS Business Improvement Framework which has been designed to support the effective and efficient delivery of safe, high-quality and locally responsive health services. The HHS has established a standing Business Improvement Committee to further these goals.

**Investing, innovating and planning for the future**

Townsville HHS is building a highly skilled, capable and sustainable workforce, through partnerships with university and vocational education partners. With a growing research profile and a Board-approved Research Strategy, the HHSs communities are benefitting from the intellectual contribution that staff are making to the organisation.

The health service is investing in long-term service planning and infrastructure, involving stakeholders in planning activities to ensure future health services have the capacity and capability to meet the changing needs of the community.

## WHOLE OF GOVERNMENT PLANS

Townsville HHS works in partnership with both the Commonwealth and State Governments in delivering improved health outcomes for the community. During 2013-2014, the HHS has delivered on the following key initiatives:

**Oral Health**

The target of zero patients waiting more than the clinically recommended maximum time on the general care waiting list was achieved jointly by HHS investment and with National Partnership Agreement funding. In July 2013, there were 693 patients waiting longer than the clinically recommended maximum time of two years on the general care dental waiting list. In February 2014 the target of zero patients was achieved, and continues to be maintained.

**Closing the Gap**

The HHS has continued to deliver Closing the Gap initiatives, to improve health outcomes for Indigenous people, and National Partnership Agreements including the Indigenous Early Childhood Development and the Closing the Gap in Indigenous Health Outcomes.

The HHS has progressed specific partnership arrangements with key stakeholders in response to the key objectives contained within the Palm Island Health Action Plan. This has included the establishment of The Palm Island Health Advisory Group, formation of the Palm Island Stakeholders Group (jointly chaired by the HSCE and Palm Island Mayor), progression of Indigenous Health workers through the Certificate IV in Primary Health Care and implementation of adult health checks. A number of other strategies are on track for completion before the end of the calendar year, including the completion of the Home and Community Care building construction, delivery of the Palm Island mobile health van and additional staff accommodation on Palm Island.

In relation to Indigenous Hospital Liaison staff at TTH, the HHS has established a team in the ED two shifts per day, seven days per week to support Indigenous patients in the ED and support staff in providing optimal culturally sensitive care. Feedback from this has been very positive.

*Liela Murison and Elizabeth Phillips*

### INCREASE IN SCREENING FOR INDIGENOUS WOMEN

There was a 20 per cent increase in the number of Indigenous women undergoing breast screens in the 2013-2014 financial year compared to 2012-2013.

Clinical coordinator BreastScreen Dr Janet Lengren said a key factor in the increase was the work of Townsville HHS Indigenous cancer care coordinator Liela Murison.

"Liela worked with our mobile screening teams in key Indigenous communities including Palm Island, Mount Isa and Camooweal as well as at the Townsville Aboriginal and Torres Strait Islander Health Service and the Townsville Correctional Facility," she said.

"Liela's presence on the mobile van in these areas ensured that Aboriginal and Torres Strait Islander women were screened in a more culturally appropriate and comfortable environment.

"Her work has seen a marked improvement in the numbers of Indigenous women being screened for breast changes and breast cancer."

## STRATEGIC RISKS AND CHALLENGES

Townsville HHS operates in a dynamic environment, which has been characterised over the past two years by reform aimed to achieve decision-making and accountability that is more responsive to local health priorities, stronger clinician, consumer and community participation, and a more 'seamless' patient experience across sectors of the health system.

Townsville HHS has identified a number of strategic risks and challenges within its current Strategic Plan 2012-2016 (2013 Update). These are:

**Sustainability of services and our people**

Demand for health services will continue to rise over the coming decades with an anticipated increase in hospitalisation rates for chronic and co-morbid conditions. This is due in part to the increase in life expectancy and reduction in death rates for many diseases. Strategies to meet future health service demand, including recruitment and retention of a skilled workforce to implement changing models of care and service delivery is required. The HHS will also need to implement efficient and effective professional support structures and staff-resourcing models for the provision of care, with a specific and tailored focus for the rural and remote sites to ensure their ongoing sustainability.

**National health reforms**

Increased devolvement of responsibility from the DoH to the HHS has been a key part of the reform process with greater accountability for the HHS in terms of ownership, control and ongoing management of personnel (prescribed employer) and land and buildings effective 1 July 2014. These additional responsibilities bring risk and opportunity which the Board is cognisant of.

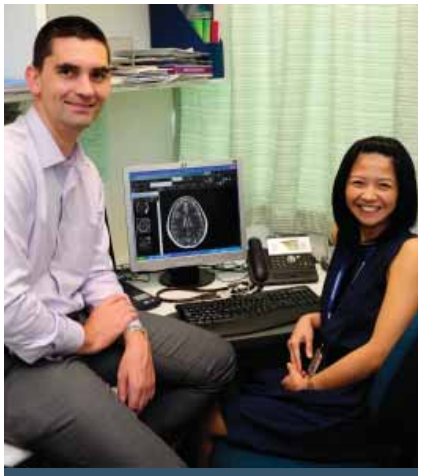
**Infrastructure maintenance**

The rural facilities within the HHS, particularly Charters Towers Hospital, Eventide Residential Aged Care Facility, and the Richmond and Hughenden Hospitals are ageing and require significant investment in replacement and maintenance which will be incorporated into HHS and Statewide capital planning.

## STRATEGIC OPPORTUNITIES

There are a number of opportunities that exist for Townsville HHS over the next four years including:

- establishing public-private partnerships to utilise unused built infrastructure
- collaborating with partners to better integrate local health services and drive improvements in health outcomes across the entire health system
- promoting the transfer of knowledge into improved health outcomes through research initiatives such as those expected from the Translational Research Facility at James Cook University (JCU)
- reviewing staff structures, particularly nursing services, to achieve the best possible outcomes
- utilising contestability processes to ensure best value
- improving workforce efficiency and supply through the judicious use of technology including eHealth and workforce planning tools
- integrating and strengthening leadership for quality and clinical governance and patient safety program
- developing a Townsville HHS Indigenous Health Strategy for service supply and workforce expansion
- furthering the improvement of the patient journey by redesigning clinical pathways
- improving access and reducing waiting times in ED
- developing outpatient and specialist diagnostic services looking towards an integrated wait time
- embedding a culture of financial and performance accountability throughout the organisation
- investing in developing and expanding our workforce capability and fostering emerging talent
- encouraging, empowering and motivating our staff to add value to our health services
- actively engaging clinicians to achieve innovative models of care, including those that promote wellness in our communities
- building on the community engagement program to become core business.



*Dr Craig Costello, Neurologist and Dr Linda Tjoa, Neurology Trainee.*

## THE TOWNSVILLE HOSPITAL HAS AUSTRALIA'S FIRST REGIONAL NEUROLOGY TRAINEE

The Townsville Hospital has this year become the first regional hospital in Australia accredited to offer a neurology training program to boost the ranks of neurologists practising in the region.

Dr Linda Tjoa started her traineeship in February 2014 and said she was delighted to be the first trainee in the in-demand specialty in regional Australia.

Townsville Hospital neurologist and deputy chair of the Australian New Zealand Association of Neurologists' Regional Neurology Committee Dr Craig Costello said Dr Tjoa's position was the first fully accredited regionally based training position in the country.

"All other training programs for neurology are in major metropolitan centres," he said.

"Her training position is a feather in the cap of TTH and is a way of increasing the number of neurologists practising in Queensland and in the country as a whole," Dr Costello said.

# Our Services

## FACILITIES

The provision of clinical services is supported by the Queensland Health Clinical Service Capability Framework for Public and Licensed Private Health Facilities. The framework outlines the minimum services, workforce and support service requirements to deliver safe and quality health services.

**Our major hospital**
- The Townsville Hospital

**Our rural hospitals**
- Ayr
- Charters Towers
- Home Hill
- Hughenden
- Ingham
- Palm Island
- Richmond

**Our Community clinics/health centres**
- Cardwell
- Kirwan
- Magnetic Island
- North Ward
- Vincent

**Our Residential Aged Care Facilities**
- Eventide
- Parklands

### SPECIALTIES AND SERVICES

Townsville HHS delivers a full suite of tertiary level health services, including:

- addiction medicine
- aged care and gerontology
- allied health
- anaesthetics
- burns
- cancer care including chemotherapy, radiation therapy, brachytherapy, haematology, medical oncology and bone marrow transplantation
- cardiology
- cardiothoracic surgery
- clinical microbiology
- colorectal surgery
- ear, nose and throat surgery
- emergency medicine
- endocrinology
- gastroenterology
- general medicine
- general surgery
- gynaecology
- head and neck surgery
- hepatology
- hyperbaric medicine
- infectious diseases
- intensive and critical care
- maternal-fetal medicine
- medical imaging including computed tomography, magnetic resonance imaging, nuclear medicine, positron emission tomography scanning and interventional radiology
- mental health services including adolescent and adult
- neonatal intensive care
- neurology
- neurosurgery
- obstetrics
- ophthalmology
- orthopaedics
- paediatrics
- paediatric intensive care
- paediatric surgery
- pain medicine
- palliative care
- pathology
- plastic and reconstructive surgery
- rehabilitation
- renal dialysis
- respiratory medicine
- rheumatology
- sleep medicine
- specialist outpatient
- upper gastrointestinal surgery
- urogynaecology
- urology
- vascular surgery

### COMMUNITY SERVICES

Health services delivered in the community include:

- Aboriginal and Torres Strait Islander Health
- alcohol, tobacco and other drugs services
- BreastScreen
- home and community care
- long-term conditions
- mental health
- older persons
- oral health
- public health
- refugee health
- tropical public health
- sexual health

The Townsville HHS also provides health care for offenders in Townsville correctional facilities.

### SERVICE GROUP PROFILES

**Health and Well Being Service Group**

The Health and Well Being Service Group is a diverse work group that includes acute and community services:

- allied health
- Cleveland Youth Detention Centre
- community services
- older person community services
- offender health
- women's and children's health

**Indigenous Health Service Group**

The Service Group includes Joyce Palmer Health Service and the Indigenous Hospital Liaison Officers of TTH.

**Medical Service Group**

The Medical Service Group offers a comprehensive range of tertiary services including:

- cancer services
- emergency medicine
- internal medicine
- pharmacy services

**Mental Health Service Group**

The clinical services managed by the Service Group include:

- adult mental health service
- alcohol and other drugs service and specialist services
- child, adolescent, and young adult services
- rehabilitation services
- rural, remote, and Indigenous services

**Rural Hospitals Service Group**

The Service Group provides health care services to all rural and remote areas located within Townsville HHS, and manages three district hospitals (Ayr, Charters Towers and Ingham), three community hospitals (Home Hill, Hughenden and Richmond), two primary care centres (Magnetic Island and Cardwell) and two residential aged care facilities (Eventide and Parklands).

**Surgical Service Group**

The Service Group offers a comprehensive range of services delivered on the Townsville and rural hospital sites including:

- cardiac services
- critical care service
- diagnostic services
- perioperative services
- surgical services

**Commercial Services**

Commercial Services encompasses the major non-clinical services of the Townsville HHS such as Building Engineering and Maintenance Services, Infrastructure Management, Support Services, Food Services, Health Security, Information and Technology Services, Business Continuity and Emergency Management and Preparedness, Commercial Contracts and Risk Management, Clinical Products Advisory, Switchboard, Travel Services and Mail.


## COMMUNITY

Townsville HHS is projected to have a modest population growth between 2012 and 2026, which is expected to be around 27 per cent compared to the Queensland average of 29 per cent.

Townsville HHS has an ageing population in line with the general Queensland population forecast. The highest percentage growth rate in the Townsville HHS is projected for people 75 years and over at 110 per cent, followed by the 65-74 years age group at 90 per cent. By comparison, the 0–14 and 15–24 year age groups are expected to only increase by 15.3 per cent and 11.6 per cent respectively.

Townsville HHS has one of the highest Indigenous resident populations in Queensland. More than seven per cent of the Townsville HHS resident population is estimated to be of Aboriginal and Torres Strait Islander origin, which is double that of the 3.5 per cent for Queensland as a whole.

There is 11.3 per cent of the population that identifies as being born overseas. Of residents born overseas, 31.7 per cent speak a language other than English at home.

The leading causes of burden of disease in Townsville HHS are cancer, coronary heart disease, stroke and injury.

## PARTNERS

Townsville HHS is supported by a number of health service providers and partners, delivering a broad range of services.

The Aboriginal Community Controlled Health Service provides medical and dental care, chronic disease management clinics, social and emotional wellbeing services, a youth shelter, a volatile substance use service, crisis accommodation and child health services.

James Cook University, in collaboration with the HHS, provides teaching and research as an integral component of supporting formal and informal service networks within Townsville HHS.

The Townsville-Mackay Medicare Local provides a focused integrated primary health care system to make access to local health services easier for people in the communities it services. This is done by engaging with doctors and other health care professionals in service delivery, coordination, education and strategic planning to improve the patient journey across the primary health care continuum.

The Royal Flying Doctor Service plays a vital role in the provision of emergency retrieval and primary health care services to rural and remote area communities in North Queensland.

The Queensland Ambulance Service plays a key role in providing emergency and non-emergency transport, paramedical services and training.

Retrieval Services Queensland provides clinical coordination for the aeromedical retrieval and transfer of all patients from parts of northern New South Wales to the Torres Strait. Specialist medical and nursing coordinators in paediatric, neonatal and high-risk obstetrics also support the clinical coordination of these patients by road to metropolitan areas of Queensland.

Mater Health Services North Queensland provides private hospital and medical services to Townsville and the North Queensland region.

The Australian Red Cross, Ronald McDonald House and the Leukaemia Foundation provide low-cost accommodation on the grounds of TTH. It is available for patients and their families while they are accessing health services in Townsville.

**LYLE GUILFOYLE AND DR MICHAEL YOUNG**

# New initiative creates hospital at home

Patients who would otherwise require a stay in hospital are now being treated at home as part of the Hospital in the Home (HiTH) initiative launched in February 2014 between the Townsville Hospital and Health Service and Blue Care. HiTH is a partnership between the two agencies to provide high-quality nursing and medical care to selected patients in their own homes.

Lyle Guilfoyle, 68, recently presented to The Townsville Hospital's emergency department with a serious infection. He knew he didn't want to spend time in hospital and was delighted when told he was excellent candidate for HiTH.

"The service allows for home visits up to three times a day for observations, intravenous medication, wound dressings and nursing care allowing patients to recuperate from their illness in the comfort of their own homes," HiTH Co-coordinator Dr Michael Young said.

Dr Young said the decreased stress of a hospital stay aided recovery. "When people are comfortable and feeling better within themselves, they will generally be on the road to recovery more quickly," he said.

Mr Guilfoyle said he had nothing but praise for the program. "It was wonderful," he said. "The nurses were professional, on time and knew what they were doing. "I received all the care I would have in hospital so I knew I was on the right road. "I felt much better being in my own surroundings and it was very refreshing to see this help was available. "I would recommend it to anyone," he said.

# Our People

## WORKFORCE PLANNING, ATTRACTION, RETENTION AND PERFORMANCE

Townsville HHS is committed to the development of its workforce and recognises the importance of managing the entire employment continuum, from effective recruitment to productivity and performance, work-home-life balance, staff retention, and flexibility in down-shifting and retirement.

As a prescribed employer, greater focus on workforce planning, new roles and engagement are being put in place.

### WORKFORCE

#### Workforce profile

Townsville HHS employs more than 5,400 staff by headcount. In June 2014, these included:

| MOHRI Headcount | | % |
|---|---|---|
| Managerial and Clerical | 787 | 14% |
| Medical incl.VMOs | 632 | 12% |
| Nursing | 2,517 | 46% |
| Operational | 823 | 15% |
| Trade and Artisans | 39 | 1% |
| Professional and Technical | 635 | 12% |
| **Total** | **5,433** | **100%** |

By Minimum Obligatory Human Resources Information (MOHRI) full time equivalent (FTE), the percentage by stream shows minimal change.

| MOHRI Occupied FTE | | % |
|---|---|---|
| Managerial and Clerical | 700 | 15% |
| Medical incl.VMOs | 562 | 12% |
| Nursing | 2,025 | 44% |
| Operational | 709 | 15% |
| Trade and Artisans | 39 | 1% |
| Professional and Technical | 565 | 12% |
| **Total** | **4,600** | **100%** |

Additional profile information includes:

- Frontline clinical services grew from 2,483 MOHRI occupied FTE in June 2013 to 2,587 in June 2014
- 70 per cent of the workforce is based at TTH, with the remaining 30 per cent based within Townsville HHS rural hospitals and community settings
- 425 staff separated from the health service, equating to a turnover rate of just below 13 per cent and a permanent separation rate of 8 per cent.

These changes reflect the organisational change and successful implementation of a local establishment management strategy.

#### Workforce diversity

Building a culturally competent and inclusive workforce is a key focus for the Townsville HHS. During 2013-2014, the Townsville HHS established a structured approach to diversity developing a suite of plans. At 30 June 2014, and based on information collected from the equal employment opportunity employee census form, the HHSs workforce identified themselves as:

- 12 per cent from non-english speaking backgrounds
- 3 per cent of Aboriginal and/or Torres Strait Islander origin
- 3 per cent live with a disability (defined as a medical condition including sensory, physical, intellectual, mental health and neurological conditions likely to last for two or more years).

Townsville HHS works in partnership with JCU and Technical and Further Education to establish and develop further career pathways to support the development of Indigenous nurses and midwives to join the Townsville HHS.

#### Aboriginal and Torres Strait Islander cultural capability

Townsville HHSs key local priority is to improve health outcomes for Aboriginal and Torres Strait Islander communities. The HHS works towards achieving this by ensuring staff undertake the Cultural Practice Program and to engage with Indigenous communities in designing more effective services. Almost 40 per cent of the HHS workforce were trained in 2013-2014.

#### Key workforce indicators

Townsville HHS monitors key workforce indicators such as sick leave, work cover and overtime. The health service has developed performance reports that are reviewed each month and form part of the overall performance management agenda for the purpose of monitoring trends and taking corrective action if required.

As a prescribed employer the HHS will develop more appropriate indicators moving forward.

#### Flexible working arrangements and work-life balance

Townsville HHS continues to promote strategies to help the workforce balance life and work demands. A review of the employment status across the HHS shows that the popularity of part-time work continues to increase, particularly in the nursing stream which is the largest component of workforce with 55 per cent currently working part time.

#### Workforce support services

Townsville HHS provides support services for staff to build a positive workplace experience. The following areas reflect this commitment:

- candidate care coordination team
- employee assistance program
- employee relations team
- nursing clinical support unit
- medical support services unit

**Workforce planning**

An established Strategic Workforce Planning Framework in line with the Organisational Integrated Planning Framework provides clear guidance in developing Townsville HHS Service Group Strategic Workforce Plans. All workforce plans are reviewed by a panel who, in turn, identify organisation-wide strategies and feeders for workforce planning, aimed at assisting the organisation in achieving its strategic objectives.

During the year the Townsville HHS undertook the following activities:

**Attraction strategies**

- supporting work-life balance through family friendly rostering practices
- supporting clinical placements, showcasing the organisation and providing a positive experience for those students who seek future employment in their chosen profession
- post-graduate medical education unit (PGMEU) has supported 70 interns, 39 elective students from across Australian and overseas Medical Schools, 36 work experience students and 15 observerships in the past 12 months
- supporting medical student placements, through a structured program in partnership with JCU.

**Recruitment strategies**

- participating in the Smart Futures for North Queensland Careers Expo 2014
- recruitment advertising utilising print and online media both nationally and internationally
- supported Indigenous cadetships into graduate programs
- supported the Students in Nursing Program
- supported the Registered Nurse and Enrolled Nurse Graduate Program.

**Retention strategies**

- support for reward and recognition, including length-of-service awards, allied health awards and allied health showcase, Townsville Health research week awards, nurse, intern, registrar, rural registrar and consultant of the year awards
- special mention letters and presentation from Executive Director of Nursing and Midwifery Services for patient compliments
- trainee recognition certificates for excellence and improvements
- scope of practice initiatives and career pathways
- promotion of diversity in portfolio careers for medical staff, support of training programs and sub-specialty areas


**VOLUNTEERS**

The volunteer service was established 25 years ago and is managed by the Townsville Hospital Foundation. With a team of 150 volunteers, it has become an essential part of Townsville HHS. Townsville Hospital Foundation, as a whole, prides itself on the enduring commitment and passion shown by its volunteers.

during medical internship, recognition of successful completion of fellowship exams, and regular monthly meetings with medical society association with representation and agenda on junior medical officer concerns transparent allocation process.

**Employee performance management framework**

**Orientation**

- *Health Service Orientation* that all staff commencing employment within the Townsville HHS are required to complete before they commence work, with 789 new staff attending during 2013-2014
- *Workplace induction* that employees are required to complete within their first week of employment, which consists of fire evacuation procedures, work area operations and processes
- *Medical Orientation*, a case-based format for intern orientation, which combined with online resources and workshops, has ensured that all 70 interns completed all of their mandatory orientation and training prior to commencing work.

**Performance Appraisal and Development**

Townsville HHS continued the program of education in performance management to support supervisors and managers to improve performance in their teams.

Key enhancements were made during the year to the local package of tools for performance appraisal and development (PA&D) to strengthen the link to organisational key performance indicators (KPIs) and provide a guide to assist the employee and manager to complete the process.

As at 30 June 2014, approximately 56 per cent of employees had an up to date PA&D.

**Industrial and employee relations consultative forums**

The Townsville HHS Consultative Forum (Townsville HHSCF) is the body that oversees the local consultative forum across the health service, meeting regularly throughout the year. Reporting to the Townsville HHSCF are several local consultative forums that also meet regularly throughout the year. The consultative structure within the Townsville HHS encourages the resolution of matters at the local level wherever possible, with a key focus on maintaining productive, respectful relationships with all stakeholders.

**Early retirement, redundancy and retrenchment**

During the period, five employees received redundancy packages at a cost of $546,679. Employees who were offered a redundancy and did not accept were offered case management for a set period of time, where reasonable attempts were made to find alternative employment placements. At the conclusion of this period, and where it is deemed that continued attempts of ongoing placement were no longer appropriate, employees yet to be placed were terminated and paid a retrenchment package. During the period one employee received a retrenchment package at a cost of $26,387.

## OCCUPATIONAL HEALTH AND SAFETY

Achieving the highest practicable occupational health and safety standards continues to be a core goal for the Townsville HHS. A comprehensive external audit of the HHSs health and safety management systems was carried out in 2013.

In the audit findings, the Townsville HHS conformed with all core health and safety responsibilities and was assigned a 92 per cent rating across all audited elements. While no major non-conformances were identified, a number of recommendations were made to develop and enhance some operational procedures. These were all accepted and actioned.

Health and safety management systems and procedures were also reviewed, revised and developed in 2013-2014. Among other procedures the Townsville HHS reviewed and expanded processes for:

- Hazard Identification and Risk Assessment and Control
- Managing OHS Risks for Contractors
- Consultation on Health and Safety
- Managing Health and Safety Incidents
- Accessing Health and Safety Information and Maintaining Systems

An occupational health and safety management development program was initiated in 2013 and is continuing. This has the objective of ensuring managers are coached and supported in meeting their health and safety accountabilities and have effective systems and procedures aligned to their operational needs.

**WorkCover**

The Townsville HHS is improving workplace health and safety as well as providing workplace rehabilitation through early return-to-work programs, regardless of whether the injury/illness is sustained in the workplace or at home.

As a result, the Townsville HHS WorkCover premium rate continued to remain favourable against the Queensland Industry Rate (Hospitals – except Psychiatric Hospitals) - 0.760 against 1.297. The Townsville HHS also continues to achieve favourable results against the 2013-2014 Service Agreement – WorkCover vs. Standard FTE indicator achieving 0.24 per cent at 30 June 2014 against a target 0.40 per cent.

## EDUCATION, SKILLS AND TRAINING

Townsville HHS provides strong undergraduate and post-graduate teaching programs in medicine, nursing and midwifery, dental and allied health in partnership with universities including JCU, the University of Queensland, Queensland University of Technology and Griffith University. Townsville HHS encourages and resources staff to further their education by obtaining higher level tertiary degrees such as masters, PhD and higher doctorate.

The following functions provide support to education for all HHS Staff:

- staff development unit
- Townsville skills centre
- occupational violence prevention unit
- library
- PGMEU

**Medical Education and Training**

The main goals of our education and training strategy are to “attract the best, train them better and retain them”, by incorporating the following philosophy to serve our community better:

- respond to the changing clinical needs of our communities in prevention, early detection treatment, rehabilitation, disability and aged care and end of life care through highest standards of evidence-based clinical skills in a multidisciplinary manner
- be socially responsible by adopting cost-effective practice
- advocate for patient and collegial welfare and take a stance on Closing the Gap in equity initiatives to benefit the health of disadvantaged groups including rural, remote and Indigenous populations
- respect cultural diversity and practices in a culturally sensitive manner
- strive for excellence through innovation and research.

As the premier teaching and tertiary hospital of North Queensland, TTH in collaboration with its rural and community partners provides training for undergraduates of JCU and post-graduate medical officers.

Training programs are available for almost all the medical specialties and sub-specialties as part of national and state-wide networks and specialist colleges.

TTH is the first regional hospital in Australia accredited to offer a neurology training program to boost the ranks of neurologists practising in the region.

In 2013-2014, TTH cardiothoracic advanced trainee Dr Anand Iyer (recently appointed as a consultant surgeon) placed first in Australia at the final examinations of the Royal Australian College of Surgeons.

While the Townsville Clinical School of the School of Medicine and Dentistry located at TTH coordinates the undergraduate education, the directors of training forum provides advice and strategic direction on overall education and training matters within the Townsville HHS. The PGMEU manages education and training matters related to interns and resident medical officers.

## RESEARCH

Townsville HHS continues to build on the strong partnerships in research with the university sector. A new appointment during 2013-2014 was the Professor of Nursing for Indigenous Health and Workforce Development, a partnership between Townsville HHS and Griffith University which has a strong focus on strengthening Indigenous health research.

Research highlights from Townsville HHS staff during the year include:

- $10 million in medical research grants
- $1.8 million in allied health research grants
- 100 medical publications
- 30 nursing publications
- 28 allied health publications.

Research approvals include 45 clinical research, 13 clinical trials of a drug, 27 health/social science research and 14 other.

**Townsville Health Research Week**

Townsville Health Research Week is held annually and is a partnership between the Townsville HHS, JCU and the Northern Clinical Training Network. It celebrates the research success of doctor, nurse and allied health staff and students and academic staff of JCU. Oral and poster presentations, invited keynote speakers, research workshops and the “Great Debate” are key features. Abstracts are published in the Annals of the Journal of the Australian College of Tropical Medicine.

### Medical Research

Research activities among medical officers and students in collaboration with JCU and other universities are increasing. In addition to individual research activities, Townsville HHS hosts two research centres namely the Queensland Research Centre for Peripheral Vascular Disease and the Tropical Centre for Telehealth Practice and Research.

### Queensland Research Centre for Peripheral Vascular Disease at TTH

This centre boasts the reputation as one of the leaders in vascular research in the world with numerous grants and publications. The clinical research is conducted within TTH, and the laboratory work is conducted within the premises of the School of Medicine and Dentistry at JCU.

### Tropical Centre for Telehealth Practice and Research

One of the areas of expertise of the region is the growth in telehealth, given the large geographic distances HHS patients have to travel for specialist care. The telehealth agenda in the future will be nurtured under the premises of the Tropical Centre for Telehealth Practice and Research (TC-TPR).

Taking advantage of the success of the Townsville Teleoncology Network as national leaders in telehealth for cancer care, the TC-TPR is created to drive the uptake of multidisciplinary telehealth models (to provide care closer to home for rural patients), evaluate the outcomes of these models and train our clinicians in the provision of high-quality care through telehealth.

### Townsville Centre for Clinical Research

Townsville HHS multidisciplinary research in the future is being nurtured by the Townsville Centre for Clinical Research (TCCR), which has the main focus of fostering clinical research under the umbrella of the Australian Institute of Tropical and Health Medicine. Within the TCCR, the research support unit provides advice and guidance on ethics and governance, and statistical and epidemiology support to facilitate research projects.

### Nursing research

The Tropical Health Research Unit for Nursing and Midwifery Practice, a joint initiative between the Townsville HHS and the School of Nursing, Midwifery and Nutrition at JCU coordinates nursing and midwifery research, mentors novice researchers, and ensures that research makes a difference to the lives of people living in the tropics.

### Allied Health and Health Practitioner Research

The Northern Queensland Health Practitioner Research Capacity Development Initiative was a joint initiative between Queensland Health and JCU from 2010-2014, with a Professor and Senior Research Fellow appointed to Townsville HHS to develop the research capacity of health practitioners. The initiative has seen a considerable growth in research capacity and importantly, the research findings are informing improvements in clinical practice.

### Research training

Research training workshops are conducted each month within the Townsville Clinical School along with various small group tutorials on specific aspects of research including end note, literature search and many others. Presenters of the monthly workshop are experts in their field of research from all over North Queensland.

From left: Jessica Bowron, Maletta Seriat holding baby Elma, May Seriat and Dr Yoga Kandasamy.

## EYE AND KIDNEY HEALTH FOCUS FOR FIRST-OF-ITS-KIND STUDY ON PRE-TERM BUBS

This year, TTH recruited its first baby for a first-of-its-kind, four-year study into the long-term effects of premature birth and low birth weight on eye and kidney health.

Born on 28 June, tiny Elma Seriat from Thursday Island was born at 27 weeks' gestation and was the first baby recruited by neonatologist Dr Yoga Kandasamy for his landmark study. The study follows Dr Kandasamy's earlier research which showed that babies born early are at risk of developing renal problems because their kidneys hadn't finished growing.

"My first study was restricted to babies while they were in hospital," he said.

"This new study will follow babies once they leave hospital for a further 24 months.

"This makes it the first longitudinal study of its kind in the world."

The study is funded by an $850,000 research grant over four years from the National Health and Medical Research Council.

Dr Kandasamy's study will track the kidney and eye health and development of between 150 and 200 pre-term and low birth-weight babies at The Townsville Hospital with a particular focus on Indigenous babies.

"Around 25 to 30 per cent of our babies in The Townsville Hospital's neonatal intensive care unit at any given time are Indigenous," he said.

"The study will recruit and follow a cohort of premature and low birth-weight babies, both Indigenous and non-Indigenous, and a comparative group of term babies.

"The babies will undergo six monthly monitoring of their renal and retinal microvascular (blood vessels in the eye) development over the first 24 months of their lives," he said.

Dr Kandasamy will be assisted in the study by registered nurse Indigenous health and medical research Jessica Bowron.

Ms Bowron said the study was important to her as an Aboriginal registered nurse.

"This study is very important to me as Aboriginal and Torres Strait Islander communities have higher rates of end-stage renal disease compared to non-Aboriginal and Torres Strait Islander Australian communities," she said.

"I feel this study will help achieve early intervention, early detection of abnormal kidney function and the development of kidney disease."

Elma's mother Maletta Seriat said she was pleased her little girl was the first baby to be part of such a significant study.

"I'm very happy for Elma to be part of this study with Dr Yoga and Jess," she said.

# Our Governance

## COMMITTEES

The Board met 14 times during the reporting year, and is supported by five Sub-Committees to assist in carrying out its functions and responsibilities:

- Executive Sub-Committee
- Finance Sub-Committee
- Safety and Quality Sub-Committee
- Audit Sub-Committee and
- Governance Sub-Committee.

The membership of the Board Sub-Committees includes non-Board members in a voluntary capacity. These members bring expertise to the committees and make a significant and valued contribution to Board and Sub-Committee objectives.

The achievements of these Sub-Committees during 2013-2014 are:

### Executive Sub-Committee

The Executive Sub-Committee focused on planning, performance, engagement and human resources. It oversaw:

- the improved waiting times and productivity of clinical services
- the development of the approved Strategic Plan and associated engagement activities and
- improved activity, delivery and monitoring of occupational health and safety, ensuring the safety of all staff and visitors to Townsville HHS facilities.

Townsville HHS has one of the lowest WorkCover premium rates of any Health Service in Queensland at 0.760 for 2013-2014 (compared to the industry average of 1.297), reflecting its dedication to workplace health and safety. This was close to a seven per cent decrease from the prior year.

### Finance Sub-Committee

The Finance Sub-Committee extended its activities from reporting and stewardship to strategic financial and capital planning, asset management and costing, revenue and budgeting including delivering:

- refinement of reporting to the Board to allow for enhanced decision-making ability
- stronger focus on strategic financial issues facing the Townsville HHS
- $20 million budget surplus whilst still achieving clinical activity targets.

### Safety and Quality Sub-Committee

The Safety and Quality Sub-Committee has provided leadership for and scrutiny of patient safety programs, reporting, and incident review. It ensures that:

- systems and structures are in place to ensure the delivery of safe and effective care
- it receives regular reports from the Clinical Council and reviews performance on a "Clinical Scorecard" which helps identify areas which potentially require attention and explanation
- the results of audits and reviews of clinical quality are reported, and the Committee receives regular updates on any serious clinical adverse events
- the monitoring and governance processes have been progressively strengthened and continue to develop to provide robust assurance to the Board that the services of Townsville HHS are being delivered to appropriate standards, and that when things do go wrong, strong steps are taken to learn and prevent recurrence.

### Audit Sub-Committee

The Audit Sub-Committee provides independent assurance and assistance to the Board on:

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

The Audit Sub-Committee meets bi-monthly or as required by the Chair. The function of the Audit Sub-Committee is to:

- assess the adequacy of Townsville HHS financial statements, having regard to:
  - the appropriateness of the accounting practices used and compliance with prescribed accounting standards under the *Financial Accountability Act 2009*
  - external audits of Townsville HHS financial statements and information provided by Townsville HHS about the accuracy and completeness of the financial statements
- monitor Townsville HHS compliance with its obligation to establish and maintain an internal control structure and systems of risk management
- ensure that policies and procedures are in place and comply with the *Financial Accountability Act 2009*
- establish an internal audit function for Townsville HHS under the *Financial Performance Management Standard 2009*
- oversee the relationship between Townsville HHS and the Queensland Audit Office (QAO)
- assess external audit reports for Townsville HHS and the adequacy of actions taken by it as a result of the reports
- monitor the adequacy of Townsville HHSs management of legal and compliance risk and internal compliance systems.

### Achievements of the Audit Sub-Committee

Achievements of the Audit Sub-Committee include:

- working with internal auditors to complete the second year audit program on time and within budget
- completion of 19 internal audits
- contract register oversight
- unqualified auditor opinion on last internal audit
- development of a comprehensive 12 month audit schedule and an audit outline cycle for the next four years
- working on developing the Strategic Risk Register.

The Audit Sub-Committee assists the Board by providing advice and assurance in the discharge of their responsibilities through effective oversight of the risk, control and

compliance frameworks and fiscal responsibilities underpinning The Townsville HHSs corporate governance, as required under the *Financial Accountability Act 2009* and other prescribed legislation.

The Audit Sub-Committee operates under a charter and has due regard to the Queensland Treasury and Trade's Audit Committee Guidelines: Improving Accountability and Performance published in June 2012. The Chair of the Committee provides a report to the Board about the issues and outcomes of each meeting.

Membership of the Audit Sub-Committee comprised three Board members and one external representative:

- Dr Eric Guazzo – Chair;
- Mrs Susan Phillips – Deputy Chair;
- Mr John Bearne and
- Mr Bill Buckby (non-Board Member).

The Audit Sub-Committee's work is supported by a number of regular attendees at its meetings including our outsourced internal auditor Mr Sean Rooney of Price Waterhouse Coopers, QAO's contracted external auditor Mr Ian Beaton, Mr Mike Reid of Ernst and Young and QAO representative Mr Bryan Steele.

In 2013-2014, the Audit Sub-Committee met six times and reviewed numerous matters including the redesigned risk policy and framework, internal and external audit reports, financial statements and the internal audit plan of 2014-2015.

**Internal Audit**

The Townsville HHS internal audit operates under its own charter and reports directly to the Audit Sub-Committee. The charter aligns with the International Standards for Professional Practice of Internal Auditing developed by the Institute of Internal Auditors.

The primary role of internal audit is to conduct independent, objective and risk-based assurance activities. The scope of the work is set out in the approved Strategic Internal Audit Plan 2012-2013 to 2014-2015 and the detailed internal audit plan 2013-2014. The program was delivered through an outsourced contractual arrangement with Price Waterhouse Coopers.

In line with its charter, the Audit Sub-Committee oversaw the internal audit program, including the review of report findings and management responses. The areas audited related to leave management, financial management and budgetary processes, revenue processes, clinical governance processes, accreditation review and human resources.

## RISK MANAGEMENT

The Townsville HHSs risk management framework complies with the *Financial Accountability Act 2009* and is based on the International Standard AS/NZS ISO 31000:2009 Risk Management – Principles and Guidelines.

The Health Service engaged external expertise in the redesign of both the policy and framework during 2013-2014. The Townsville HHS is ensuring that the risk framework is firmly embedded within the organisation, that is, that risk is considered at every level of the organisation and forms part of normal business process.

The service has three interconnected registers - operational, tactical and strategic - which are updated and reviewed at a minimum three times a year or as driven by business need. Effective risk monitoring is achieved through regular reporting to the SMT with the Board and the Audit Sub-Committee having oversight of the process and strategic risk registers.

During 2013-2014, the HHSs Internal Auditors undertook as part of their internal audit program, a review of HHS processes around fraud risk. Whilst fraud risk is integrated into the HHS broader risk framework it was considered timely to review the control framework around this risk with a view to making improvements in processes and ensuring a higher level of control exists.

## EXTERNAL SCRUTINY

The operations of Townsville HHS are subject to regular scrutiny from external agencies. These include:

- QAO
- Coroner
- Health Quality and Complaints Commission
- Australian Health Practitioner Regulation Authority
- Australian Council on Healthcare Standards
- National Association of Testing Authorities (NATA) Australia
- Crime and Misconduct Commission
- Postgraduate Medical Education Council of Queensland
- Medical Colleges and others.

Townsville HHS also maintains accreditation status for:

- Parklands and Eventide residential aged care facilities through the Australian Aged Care Standards Accreditation Agency
- Baby Friendly Hospital Initiative
- medical college reviews.

Townsville HHS also assists the Pathology Department achieve accreditation through the NATA Australia.

Townsville HHS governance framework supports internal mechanisms to monitor and report on corrective actions taken to implement recommendations made from external agencies.

In 2013-2014, Parliamentary reports tabled by the Auditor General which considered the performance of the Health Services more broadly included:

- Right of private practice in Queensland public hospitals (Report 1 2013-2014)
- Results of audit: Hospital and Health Services entities 2012-2013
- Right of private practice: Senior medical officer conduct

The Townsville HHS considered the findings and recommendations contained in these reports and where appropriate has taken action to implement recommendations or address issues raised.

## *PUBLIC SECTOR ETHICS ACT 1994*

The Code of Conduct for the Queensland Public Service (the Code) has been in place since 2011 and applies to all health service employees. The Code reflects the principles of integrity and impartiality, promoting the public good, commitment to the system of government, accountability and transparency. It was designed to be relevant for all public sector agencies and their employees, reflecting the amended ethics principles and values contained in the *Public Sector Ethics Act 1994*.

The Townsville HHSs Strategic Plan 2012-2016 (2013 Update) values of Integrity, Compassion, Accountability, Respect, and Engagement (ICARE) underpin the Public Sector ethics principles and Code of Conduct.

The Code and the HHSs values are reflected in the Health Service Orientation and in local work unit induction. The annual PA&D process includes clearly articulated reviews of performance against Townsville HHSs values.

Training in the Code is delivered either in face to face sessions or via the on-line

Queensland Health Ethics, Integrity and Accountability e-learning course on the iLearn site. The course outlines how health service employees can contribute to a workplace that incorporates integrity and accountability as part of day-to-day performance of duties, and for managers it provides guidance on ethical decision-making. Training completion is recorded on the Townsville HHSs Staff Education Database.

As at 30 June 2014, 4,560 public officials of Townsville HHS completed the mandatory training, either on-line or during Townsville HHS orientation with a current compliance rate of 75 per cent.

The Townsville HHS Professional Standards Framework (the Framework) refers back to the Code and to the DoH and Health Service values and includes a complaint mechanism which supports the public and staff wishing to make complaints about ethical matters.

Information about the Framework and the complaints mechanism is available to both the public and to employees via the Townsville HHS website. The Framework also assists managers to deal with such complaints.

## INFORMATION SYSTEMS AND RECORD KEEPING

Recordkeeping practices within Townsville HHS are governed by the *Public Records Act 2002*, Information Standard 40: Record keeping and information Standard 31: Retention and Disposal of public Records.

All Townsville HHS employees are made aware of their roles and responsibilities regarding security, privacy, confidentiality and management of records at staff orientation, continuing education and training through staff development and through procedural governance.

An electronic document record management system is used for the management of non-clinical records including Executive files and contracts database. System training has been provided for all end users and system administrators. Online resources including records management governance, procedures and training modules to support staff in their administrative record-keeping practices are being developed.

### ieMR - INTEGRATED ELECTRONIC MEDICAL RECORD

The ieMR solution will enable clinicians and supporting staff to access a single view of a patient's medical record. The ieMR will be a mixture of both scanned and direct entry components, and supports the transition from paper to digital records.

TTH will implement Release One and Release Two functionalities simultaneously and will include:

- advanced growth chart
- progress notes
- screening tools
- haemodialysis module
- alerts and allergies module
- electronic ordering, results and reports
- clinical summary

Review of clinical forms for use in digital format has continued, as well as training needs identification for systems users, and infrastructure installation.

# Our Performance

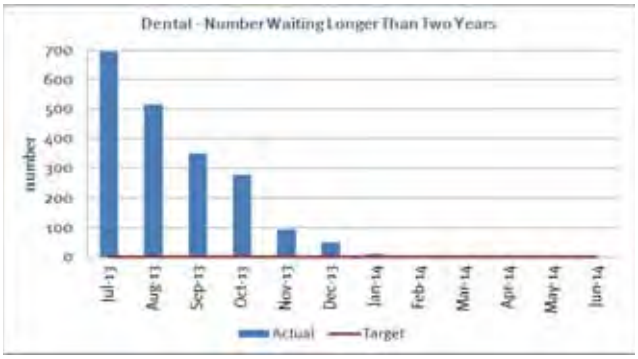
## PERFORMANCE HIGHLIGHTS FOR THE YEAR

### Townsville HHS was dedicated to improving the Oral Health, National Elective Surgery Target (NEST), National Emergency Access Target (NEAT) and Specialist Outpatient outcomes throughout the year.

These indicators support the Statement of Government Health Priorities, the National Partnership Agreements on Improving Public Hospital Services and Treating More Dental Patients, the Queensland State Budget Service Delivery Statement and the DoHs Service Agreement.

**Dental**

Funding provided through the National Partnership Agreement – Treating More Dental Patients supported the continued partnerships with private community dentists. This successful scheme has ensured no patients waited longer than the clinically recommended time of two years for general dental care. This was a significant decrease from 693 in July 2013 and 2,593 in February 2013.




## Dental long waits reduced to zero

A combined allocation from the National Partnership Agreement and the Townsville HHS has reduced the number of patients waiting longer than the clinically recommended time of two years for general dental care to **zero**, from 2,593 in February 2013 and 693 in July 2013.

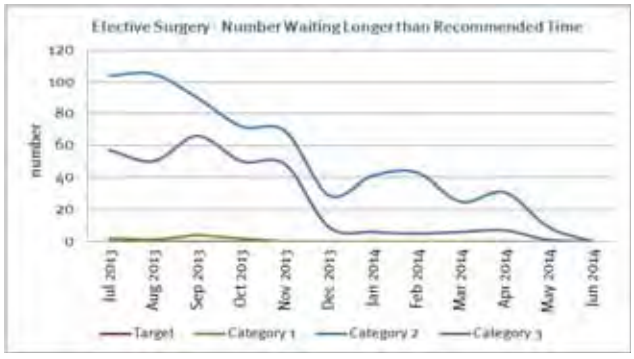
### Elective Surgery

Townsville HHS achieved the target for treating all category one, two and three elective surgery patients in the recommended times:

- category 1 – 100 per cent treated in time
- category 2 – 94 per cent against a target of 94 per cent
- category 3 – 98 per cent against a target of 97 per cent




The improvements in treated in time are as a result of decreasing the number of patients waiting longer than the clinically recommended timeframe across all three categories to zero.

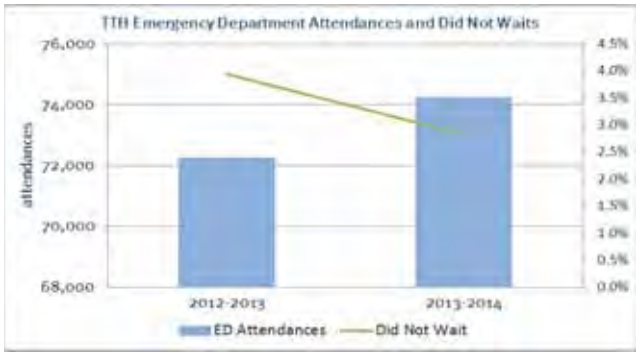



### Emergency Department

Year to date NEAT improved from 74 per cent in July 2013 to 76 per cent in June 2014. The targets for patients seen within the recommended timeframes for each category were achieved, with improvements seen in:

- category 3 seen within 30 minutes from 72 per cent to 78 per cent
- category 4 seen within 60 minutes from 66 per cent to 77 per cent
- category 5 seen within 120 minutes from 83 per cent to 90 per cent

The ED treated 2.8 per cent more patients than the previous year, and the rate of patients who did not wait for treatment decreased from 3.9 per cent in 2012-2013 to 2.8 per cent in 2013-2014.



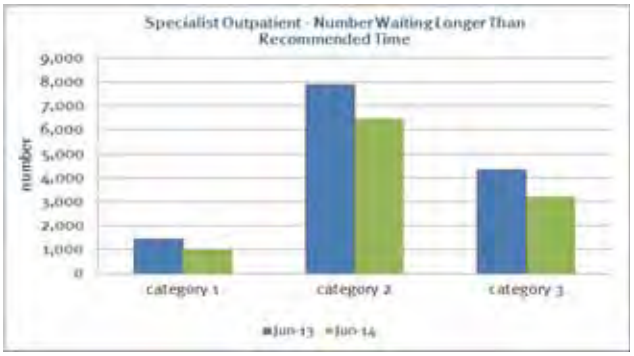

### Specialist Outpatients

Significant improvements were made to the total number of people waiting longer than the clinically recommended timeframe for specialist outpatient appointments, with a reduction of 2,981 patients, a 22 per cent improvement from June 2013. This was made up of:

- reduction in category 1 of 449 patients, a 31 per cent improvement from June 2013
- category 2 long waits reduced by 1,400 patients, an improvement of 18 per cent from June 2013.
- category 3 reduced by 1,132 patients, an improvement of 26 per cent from June 2013.

Waiting-in-time rates for specialist outpatients appointments also improved:

- category 1 waiting within 30 days from 32 per cent in June 2013 to 42 per cent in June 2014
- category 2 waiting within 90 days from 22 per cent in June 2013 to 28 per cent in June 2014
- category 3 waiting within 365 days from 48 per cent in June 2013 to 53 per cent in June 2014



# Service Standards

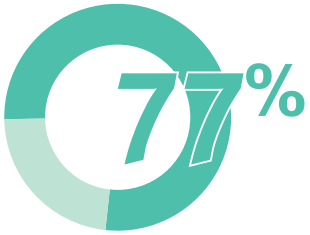
The following table outlines the Townsville HHSs performance against the 2013-2014 Service Delivery Statement.

## SEEN TIME IN EMERGENCY

| | Notes | 2013-2014 Target | 2013-2014 Actual |
|---|---|---|---|
| **Percentage of patients attending emergency departments seen within recommended timeframes:** | | | |
| 100% 2 MINUTES | | | |
| 89% 10 MINUTES | | | |
| 78% 30 MINUTES | | | |
| 77% 60 MINUTES | | | |
| 90% 120 MINUTES | | | |
| › Category 1 (within 2 minutes) | | 100% | 100% |
| › Category 2 (within 10 minutes) | | 80% | 89% |
| › Category 3 (within 30 minutes) | | 75% | 78% |
| › Category 4 ( within 60 minutes) | | 70% | 77% |
| › Category 5 (within 120 minutes) | | 70% | 90% |
| 14 MINUTES MEDIAN WAIT TIME IN EMERGENCY DEPARTMENT | | | |
| Percentage of emergency department attendances who depart within four hours of their arrival in the department | 1 | 2013: 77%<br>2014: 83% | 2013: 76%<br>2014: 76% |
| Median wait time for treatment in emergency departments (minutes) | | 20 | 14 |
| Median wait time for elective surgery (days) | | 25 | 29 |
| **Percentage of elective surgery patients treated within clinically recommended times:** | | | |
| 100% 30 DAYS | | | |
| 94% 90 DAYS | | | |
| 98% 365 DAYS | | | |
| › Category 1 (30 days) | | 2013: 100%<br>2014: 100% | 2013: 94%<br>2014: 100% |
| › Category 2 (90 days) | | 2013: 87%<br>2014: 94% | 2013: 77%<br>2014: 94% |
| › Category 3 (365 days) | | 2013: 94%<br>2014: 97% | 2013: 73%<br>2014: 98% |
| **Percentage of specialist outpatients waiting within clinically recommended times:** | | | |
| 42% 30 DAYS | | | |
| 28% 90 DAYS | | | |
| 53% 365 DAYS | | | |
| › Category 1 (30 days) | | 27% | 42% |
| › Category 2 (90 days) | | 20% | 28% |
| › Category 3 (365 days) | | 90% | 53% |

**1.8% MORE ACTIVITY DELIVERED THAN PURCHASED**

*Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit*




*Number of patients waiting more than the clinically recommended time for their general dental care*


| | Notes | 2013-2014 Target | 2013-2014 Actual |
|---|---|---|---|
| Total weighted activity units: | 2 | | |
| › Acute Inpatients | | 61,451 | 64,797 |
| › Outpatients | | 12,541 | 13,460 |
| › Sub Acute | | 6,956 | 7,020 |
| › Emergency Department | | 11,602 | 12,426 |
| › Mental Health | | 10,048 | 8,520 |
| › Interventions and Procedures | | 15,798 | 14,250 |
| Average cost per weighted activity unit for Activity Based Funding facilities | | $4,588 | $4,447 |
| Rate of healthcare associated *Staphylococcus aureus* (including MRSA) bloodstream (SAB) infections / 10,000 acute public hospital patient days | 3 | 1.5 | 0.8 |
| Number of in-home visits, families with newborns | | 4,202 | 3,872 |
| Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit | | ›60% | 77% |
| Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge | 4 | ‹12% | 13% |
| Ambulatory mental health service contact duration | | 68,759 – 84,386 | 50,063 |
| Number of patients waiting more than the clinically recommended time for their general dental care | | 0 | 0 |
| Year to date MOHRI average FTE | | 4,657 | 4,506 |

**NOTES:**

1. Calendar year target and actual.
2. WAU target published in the 2013-2014 Service Delivery Statement has changed through the window adjustment process.
3. Data as at December 2013.
4. Data as at May 2014.

# Summary of Financial Performance

## Townsville HHS achieved another strong financial outcome for the year ended 30 June 2014 recording a $20 million surplus. This represents 2.6 per cent of our revenue base of $754 million.

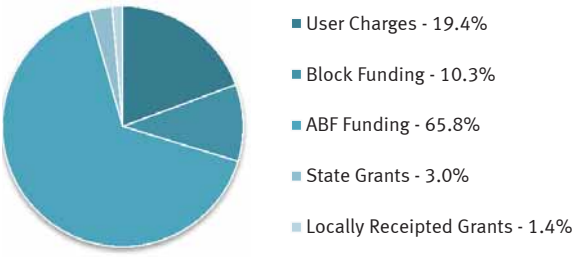
During 2013-2014, many of the benefits of the 2012-2013 organisational restructure were realised, ensuring sustainable service delivery into the future. Revenue strategies also favourably contributed to our result.

### WHERE FUNDS CAME FROM

Townsville HHS income from all funding sources was more than $753 million. Funding was primarily (65.8 per cent) derived from the activity based funding (ABF) model with DoH purchasing 118,396 WAUs of service with 120,473 units actually delivered.

Townsville HHS operates under a purchaser-provider model whereby DoH purchases health services from the HHS. Townsville HHS has a service contract with DoH which sets out the performance management framework. The framework uses KPIs as the basis for monitoring and driving performance.

Income by Funding Source




### WHERE FUNDING WAS SPENT

The total expenses for the Townsville HHS for 2013-2014 were $734 million, averaging a $2 million per day spend on servicing clients in Townsville and other regions of North Queensland. The largest percentage of spend was against labour costs including clinicians and support staff (70.2%).

Expenditure Breakdown


### HOW DID THIS COMPARE TO OUR BUDGET?

Townsville HHS budgeted for a break-even outcome for the financial year. The $20 million surplus was predominantly generated from:

- Additional revenue from non-core services such as reimbursement for salaries and other costs associated with projects ($5.1 million)
- An underspend in employee expenses from a combination of organisational restructure benefit, closer monitoring of specific expense areas, and some vacancies in specialist positions ($11.1 million).

### FUTURE OUTLOOK

The surplus generated for the Townsville HHS in the current financial year will be reinvested for better health outcomes for the community. Generation of a surplus allows reinvestment into capital building, equipment, and information technology infrastructure to ensure Townsville HHS is well placed to meet the ongoing needs of our growing community into the future.

## STATEMENT OF FINANCIAL POSITION FOR THE YEAR ENDED 30 JUNE 2014

| | 2013-2014 actual $000 |
|---|---|
| Current Assets | |
| Cash and cash equivalents | 79,739 |
| Receivables | 12,523 |
| Inventories | 6,002 |
| Other | 413 |
| **Total Current Assets** | **98,677** |
| Non Current Assets | |
| Property, Plant and equipment | 571,346 |
| Intangibles | 131 |
| Other | - |
| **Total Non Current Assets** | **571,477** |
| **Total Assets** | **670,154** |

| | 2013-2014 actual $000 |
|---|---|
| Current Liabilities | |
| Payables | 49,394 |
| Accrued employee benefits | 17 |
| Other | 630 |
| **Total Current Liabiliites** | **50,041** |
| **Total Liabilities** | **50,041** |
| **Net Assets/(Liabilities)** | **620,113** |
| Equity | |
| Capital/contributed equity | 517,084 |
| Accumulated surplus/(accumulated deficit) | 40,260 |
| Reserves: Asset revaluation reserve | 62,769 |
| **Total Equity** | **620,113** |

## STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 30 JUNE 2014

| | 2013-2014 actual $000 | 2013-2014 budget $000 | Variance % |
|---|---|---|---|
| Revenue | | | |
| User charges | 724,105 | 721,723 | 0.3% |
| Grants and contributions | 23,692 | 22,263 | 6% |
| Other revenue | 5,865 | 736 | 697% |
| Gains | 130 | - | 100% |
| **Total Revenue** | **753,792** | **744,722** | **1%** |
| Expenses | | | |
| Employee expenses | 515,293 | 526,357 | -2% |
| Supplies and services | 171,887 | 171,955 | 0% |
| Grant and subsidies | 4,518 | 4,322 | 5% |
| Depreciation and amortisation | 31,392 | 31,392 | 0% |
| Impairment losses | 1,458 | 1 | 100% |
| Other expenses | 9,338 | 10,695 | -13% |
| **Total Expenses** | **733,886** | **744,722** | **-1%** |
| Operating Surplus/(Deficit) | 19,906 | 0 | |

# Financial Statements

**FOR THE YEAR ENDED 30 JUNE 2014**

**Townsville Hospital and Health Service**
**Financial report**
**30 June 2014**

**Contents**



**General information**

The financial report covers Townsville Hospital and Health Service as an individual entity. The financial report is presented in Australian dollars, which are Townsville Hospital and Health Service's functional and presentation currency.

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

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

The financial report consists of the financial statements, notes to the financial statements and the director's declaration.

The head office and principal place of business of the THHS are:

100 Angus Smith Drive
Douglas Qld 4814

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

For information in relation to Townsville Hospital and Health Service's financial statements, email THSD-Feedback@health.qld.gov.au or Visit the Townsville Hospital and Health Service website at http://www.health.qld.gov.au/townsville/

**Townsville Hospital and Health Service**
**Statement of Comprehensive Income**
**For the year ended 30 June 2014**

| | Note | 2014 $'000 | 2013 $'000 |
|---|---|---|---|
| **Income** | | | |
| User charges and fees | 4 | 724,105 | 708,585 |
| Grants and other contributions | 5 | 23,692 | 22,609 |
| Other revenue | 6 | 5,865 | 4,235 |
| Gains | 7 | 130 | 27 |
| **Total Income** | | 753,792 | 735,456 |
| **Expenses** | | | |
| Health service employee expenses | 8 | (513,051) | (506,040) |
| Employee expenses | 9 | (2,242) | (2,510) |
| Supplies and services | 10 | (171,887) | (162,134) |
| Grants and subsidies | 11 | (4,518) | (4,732) |
| Depreciation and amortisation | 12 | (31,392) | (28,600) |
| Impairment losses | 13 | (1,458) | (3,256) |
| Other expenses | 14 | (9,338) | (7,830) |
| **Total Expenses** | | (733,886) | (715,102) |
| **Operating result of the year** | 26 | 19,906 | 20,354 |
| **Other comprehensive income** | | | |
| *Items that will not be reclassified subsequently to operating result* | | | |
| Increase in asset revaluation surplus | 25 | 62,769 | - |
| Other comprehensive income for the year | | 62,769 | - |
| **Total comprehensive income for the year** | | 82,675 | 20,354 |

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

**Townsville Hospital and Health Service**
**Statement of Financial Position**
**As at 30 June 2014**

| | Note | 2014 $'000 | 2013 $'000 |
|---|---|---|---|
| **Assets** | | | |
| **Current assets** | | | |
| Cash and cash equivalents | 15 | 79,739 | 56,281 |
| Trade and other receivables | 16 | 12,523 | 15,428 |
| Inventories | 17 | 6,002 | 5,581 |
| Other | 18 | 413 | 343 |
| Total current assets | | 98,677 | 77,633 |
| **Non-current assets** | | | |
| Property, plant and equipment | 19 | 571,346 | 434,798 |
| Intangibles | 20 | 131 | 193 |
| Total non-current assets | | 571,477 | 434,991 |
| **Total assets** | | 670,154 | 512,624 |
| **Liabilities** | | | |
| **Current liabilities** | | | |
| Trade and other payables | 21 | 49,394 | 46,200 |
| Accrued employee benefits | 22 | 17 | 40 |
| Unearned revenue | 23 | 630 | 404 |
| Total current liabilities | | 50,041 | 46,644 |
| **Total liabilities** | | 50,041 | 46,644 |
| **Net assets** | | 620,113 | 465,980 |
| **Equity** | | | |
| Contributed equity | 24 | 517,084 | 445,626 |
| Asset revaluation surplus | 25 | 62,769 | - |
| Accumulated surpluses | 26 | 40,260 | 20,354 |
| **Total equity** | | 620,113 | 465,980 |

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**Townsville Hospital and Health Service**
**Statement of Changes in Equity**
**For the year ended 30 June 2014**

| | Note | Contributed equity $'000 | Asset revaluation surplus $'000 | Accumulated surpluses $'000 | Total equity $'000 |
|---|---|---|---|---|---|
| Balance at 1 July 2012 | | - | - | - | - |
| Net assets received (transferred pursuant to the Hospital and Health Board Act 2011) | | 439,242 | - | - | 439,242 |
| Surplus for the year | | - | - | 20,354 | 20,354 |
| Other comprehensive income for the year | | - | - | - | - |
| Total comprehensive income for the year | | - | - | 20,354 | 20,354 |
| *Transactions with owners in their capacity as owners:* | | | | | |
| Non appropriated equity asset transfers | 24 | 20,424 | - | - | 20,424 |
| Non appropriated equity injections | 24 | 14,560 | - | - | 14.560 |
| Non appropriated equity withdrawal | 24 | (28,600) | - | - | (28,600) |
| Balance at 30 June 2013 | | 445,626 | - | 20,354 | 465,980 |

| | Contributed equity $'000 | Asset revaluation surplus $'000 | Accumulated surpluses $'000 | Total equity $'000 |
|---|---|---|---|---|
| Balance at 1 July 2013 | 445,626 | - | 20,354 | 465,980 |
| Surplus for the year | - | - | 19,906 | 19,906 |
| Other comprehensive income for the year | - | 62,769 | - | 62,769 |
| Total comprehensive income for the year | - | 62,769 | 19,906 | 82,675 |
| *Transactions with owners in their capacity as owners:* | | | | |
| Non appropriated equity asset transfers | 85,739 | - | - | 85,739 |
| Non appropriated equity injections | 17,111 | - | - | 17,111 |
| Non appropriated equity withdrawals | (31,392) | - | - | (31,392) |
| Balance at 30 June 2014 | 517,084 | 62,769 | 40,260 | 620,113 |

QAO certified statements

**Townsville Hospital and Health Service**
**Statement of Cash Flows**
**For the year ended 30 June 2014**

| | Note | 2014 $'000 | 2013 $'000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| User charges | | 695,412 | 678,743 |
| Grants and other contributions | | 22,717 | 22,536 |
| Interest received | | 309 | 334 |
| Other revenue | | 5,163 | 2,940 |
| Employee expenses | | (515,406) | (508,588) |
| Supplies and services | | (175,099) | (134,596) |
| Grants and subsidies | | (4,517) | (4,732) |
| Other expenses | | (2,344) | (10,047) |
| GST remitted | | (25) | (982) |
| Net cash from operating activities | 38 | 26,210 | 45,608 |
| **Cash flows from investing activities** | | | |
| Payments for property, plant and equipment | | (20,392) | (10,511) |
| Proceeds from sale of property, plant and equipment | | 529 | 67 |
| Net cash used in investing activities | | (19,863) | (10,444) |
| **Cash flows from financing activities** | | | |
| Proceeds from equity injections | | 17,111 | 21,117 |
| Net cash from financing activities | | 17,111 | 21,117 |
| Net increase in cash and cash equivalents | | 23,458 | 56,281 |
| Cash and cash equivalents at the beginning of the financial year | | 56,281 | - |
| Cash and cash equivalents at the end of the financial year | 15 | 79,739 | 56,281 |

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

**Townsville Hospital and Health Service**
**Notes to the financial statements**
**30 June 2014**

**Note 1. Objectives and principal activities**
The Townsville Hospital and Health Service (THHS) is an independent statutory body established on 1 July 2012 under the Hospital and Health Boards Act 2011. The Health Service provides a range of services across the care continuum and across service settings including

- Preventative and primary health care
- Ambulatory services
- Acute care
- Sub and non acute services
- Residential aged care services
- Mental health services
- Child and youth health services

The THHS is overseen by our local Hospital and Health Board with responsibility for providing public hospital and health services to a population of over 230,000 people. The THHS provides public hospital and health services and achieves health system outcomes in accordance with the service agreement with the Department of Health. The Health Service delivers services to the Local Government Areas of Burdekin, Charters Towers, Flinders, Hinchinbrook, Palm Island, Richmond and Townsville. The Townsville Hospital is evolving to become the major tertiary referral hospital for North Queensland and as such receives inter hospital transfers and patient retrievals by the Royal Flying Doctor Service (RFDS) and the Queensland Emergency Services (QES) rescue helicopter from throughout north and north west Queensland and offshore coastal areas. As a teaching hospital, the Townsville Hospital has close associations with James Cook University and Central Queensland University and provides academic and research support for medical, nursing and allied health staff and students

The THHS works with its service partners including Medicare Local to enhance access to health services that focuses on keeping people well. It ensures that the services delivered respond to community need and simpler, easy to access and available to all of the community. The THHS strives to deliver an effective and accountable service which meets performance targets. The outcomes that THHS service delivery are aligned to, include:

- Building healthier communities
- Focusing on individual health outcomes
- Working collaboratively
- Providing, efficient, effective and sustainable services
- Maintaining an exceptional workforce
- Leading excellence and innovation

**Note 2. Significant accounting policies**

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

**(a) New, revised or amending Accounting Standards and Interpretations adopted**
The THHS has adopted all of the new, revised or amending Accounting Standards and Interpretations issued by the Australian Accounting Standards Board ('AASB') that are mandatory for the current reporting period. The adoption of these Accounting Standards and Interpretations did not have any significant impact on the financial performance or position of the THHS.

Any new, revised or amending Accounting Standards or Interpretations that are not yet mandatory have not been early adopted. Certain new accounting standards and interpretations have been published that are not mandatory for 30 June 2014 reporting period and beyond. The THHS's assessment of the impact of these new standards and interpretations is set out below.

*AASB 9 Financial Instruments*
*AASB 9 Financial Instruments* includes requirements for the classification and measurement of financial assets. It was further amended by *AASB 2010-7* to reflect amendments to the accounting for financial liabilities. These requirements improve and simplify the approach for classification and measurement of financial assets compared with the requirements of *AASB 139*. The application date for this standard for the THHS is 1 July 2018. No assessment has been made of its impact on the financial report of the THHS at 30 June 2014.

*IFRS15 Revenue from Contracts with Customers*
*IFRS 15* establishes principles for reporting useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from an entity's contracts with customer. The application date for this standard for the THHS is 1 July 2017. No assessment has been made of its impact on the financial report of the THHS at 30 June 2014.

## Note 2. Significant accounting policies (continued)

The following Accounting Standards and Interpretations are most relevant to the THHS:

*AASB 1053 Application of Tiers of Australian Accounting Standards*
AASB 1053 Application of Tiers of Australian Accounting Standards became effective for reporting periods beginning on or after 1 July 2013. AASB 1053 establishes a differential reporting framework for those entities that prepare general purpose financial statements, consisting of two Tiers of reporting requirements- Australian Accounting Standards (commonly referred to as 'Tier1') and Australian Accounting Standards - Reduced Disclosure Requirements (commonly referred to as 'Tier2'). Tier 1 requirement comprise the full range of AASB recognition, measurement and presentation and disclosure requirements that are currently applicable to reporting entities in Australia. The only difference between the Tier 1 and Tier 2 requirements is that Tier 2 requires fewer disclosures than Tier 1.

Pursuant to AASB1053, public sector entities like THHS may adopt Tier 2 requirements for their general purpose financial statements. However AASB1053 acknowledges the power of a regulator to require application of the Tier 1 requirements. In the case of THHS, Queensland Treasury and Trade is the regulator. Queensland Treasury and Trade has advised that it is its policy decision to require adoption of Tier 1 reporting by all Queensland government departments and statutory bodies (including THHS) that are consolidated into the whole-of-Government financial statements. Therefore, the release of AASB1053 and associated amending standards has had no impact on THHS.

*AASB 13 Fair Value Measurement and AASB 2011-8 Amendments to Australian Accounting Standards arising from AASB 13*
The THHS has applied AASB 13 and its consequential amendments from 1 January 2013. The standard provides a single robust measurement framework, with clear measurement objectives, for measuring fair value using the 'exit price' and provides guidance on measuring fair value when a market becomes less active. The 'highest and best use' approach is used to measure non-financial assets whereas liabilities are based on transfer value. The standard requires increased disclosures where fair value is used.

The THHS reviewed its fair value methodologies (including instructions to valuers, data used and assumptions made) for land and buildings measured at fair value to assess whether those methodologies comply with AASB13. To the extent that the methodologies didn't comply, changes were made and applied to the valuations. None of the changes to valuation methodologies resulted in material differences from the previous methodologies.

AASB 13 has required an increased amount of information to be disclosed in relation to fair value measurements for both assets and liabilities. For those fair value measurements of assets or liabilities that substantially are based on data that is not 'observable' (i.e. accessible outside the HHS), the amount of information disclosed has significantly increased. Note 2(x) explains the principles underpinning the additional fair value information disclosed. The additional disclosures required under AASB13 are set out in Note 27.

*AASB 119 Employee Benefits (September 2011) and AASB 2011-10 Amendments to Australian Accounting Standards arising from AASB 119 (September 2011)*
The THHS has applied AASB 119 and its consequential amendments from 1 January 2013. The standard eliminates the corridor approach for the deferral of gains and losses; streamlines the presentation of changes in assets and liabilities arising from defined benefit plans, including requiring re-measurements to be presented in other comprehensive income; and enhances the disclosure requirements for defined benefit plans. The standard also changed the definition of short-term employee benefits, from 'due to' to 'expected to' be settled within 12 months. Annual leave that is not expected to be wholly settled within 12 months is now discounted allowing for expected salary levels in the future period when the leave is expected to be taken.

Given THHS's circumstances, the only implication for the HHS is the revised concept of 'termination benefits' and the revised recognition criteria for termination liabilities. If termination benefits meet the time frame criterion for 'short-term employee benefits' they will be measured according to the AASB119 requirements for 'short-term employee benefits'. Otherwise, termination benefits need to be measured according to the AASB119 requirements for 'other long-term employee benefits'. Under the revised standard, the recognition and measurement of employer obligations for 'other long-term employee benefits' will need to be accounted for according to the requirements for defined benefit plans. The revised AASB119 also includes changed criteria for accounting for employee benefits as 'short-term employee benefits'. However, as the HHS is a member of the Queensland Government central schemes for annual leave and long service leave this change in criteria has no impact on the HHS's financial statements as the employer liability is held by the central scheme. The revised standard also includes changed requirements for the measurement of employer liabilities/assets. The THHS makes employer superannuation contributions only to the QSuper defined benefit plan and the corresponding QSuper employer benefit obligations is held by the State. Therefore, those changes to AASB119 will have no impact on the HHS.

## Note 2. Significant accounting policies (continued)

*Voluntary change in accounting policy*

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

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

To align with this basis of funding provided by the Department of Health under a service agreement, THHS now recognises the 2013-14 funding of $724,105,000 as User Charges and Fees revenue for 2013-14 rather than as grants revenue which occurred in 2012-13. The main affect is that the revenue is now recognised under the criteria detailed in AASB 118 *Revenue* for 2013-14, rather than under AASB 1004 *Contributions* in 2012-13. The revenue recognition criteria are described in Note 2(k) revenue recognition for User charges and Fees and Note Grants and Other Contributions.

This change in accounting policy has been applied retrospectively with the affect that Grants and Other Contributions revenue for 2012-13 has reduced by $665,601,000 and User Charges and Fees revenue has increased by the same amount

**(b) Statement of Compliance**

The THHS has prepared these financial statements in compliance with S(43) of the *Financial and Performance Management Standard 2009* and S62(1) of the *Financial Accountability Act 2009.*

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

With respect to compliance with Australian Accounting Standards and Interpretations, the THHS has applied those requirements applicable to a not for profit entity, as the THHS is a not-for-profit entity. Except where stated, the historical cost convention is used. The financial statements are prepared using the Australian Dollar as the currency.

**(c) Rounding of Amounts**

Amounts in this report have been rounded off to the nearest thousand dollars, or in certain cases, the nearest dollar.

**(d) Critical accounting estimates**

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

**(e) The Reporting Entity**

The THHS was established under The Health and Hospitals Network Act 2011 (HHNA) with effect from 1 July 2012. The THHS is an independent statutory body and a reporting entity, which is domiciled in Australia. Accountable to the Minister of Health and to the Queensland Parliament, the THHS is primarily responsible for providing quality and safe public hospital and health services and for the direct management of the facilities within the region. On 17 May 2012, the Minister for Health introduced amending legislation into the Parliament to expand the functions of hospital and health services under the HHNA. The amended legislation is known as the Hospital and Health Boards Act 2011.

The financial statements include the value of all revenues, expenses, assets, liabilities and equity of the THHS. The THHS does not have any controlled entities.

The THHS major activities are disclosed in Note 1.

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

## Note 2. Significant accounting policies (continued)

**(g) Administrative Arrangements**
In 2012-13 certain balances were transferred from the Department of Health to the Hospital and Health Services. This was affected via a transfer notice signed by the Minister for Health, designating that the transfer be recognised as a contribution by owners through equity. The transfer notices were approved by the Director-General of the Department of Health and the Chair and Chief Executive of the THHS.

The value of the assets and liabilities transferred to the THHS were as follows:

| | $'000 |
|---|---|
| Cash | 23 |
| Trust Net Assets | 6,533 |
| Receivable | 15,498 |
| Inventory | 7,361 |
| Other assets | 524 |
| Property, plant and equipment | 432,333 |
| Intangible assets | 375 |
| Creditors | (23,409) |
| Net Equity | (439,242) |

*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 the THHS by the Minister of Health as a contribution by the State through equity. In 2013-14 the value of assets transferred was $85,739,000 ($20,424,000 in 2012-13) by the Department of Health to the THHS.

*Non-operational housing - whole of Government initiative*

Under a whole of Government initiative, management of Government owned general purpose housing was transferred to the Department of Public Works on 1 January 2014 with subsequent ownership to transfer on 1 July 2014. As THHS does not possess legal title, the current leasing arrangement with the Department of Health will cease on these assets. Total net book value of assets to be transferred is $6,603,000 (comprising of buildings $4,953,000 representing approximately 1% of buildings and land$1,650,000 representing .05% of land at 30 June 2014 (Note 36).

**(h) Going concern**

The THHS has prepared these financial statements on a going concern basis, which assumes that the THHS will be able to meet the payment terms of its financial obligations as and when they fall due. The THHS is economically dependent upon its Service Agreement with the Department of Health. The Service Agreement for 2014-15 has been agreed by the THHS with the Department of Health and the total contract of offer for 2014-15 is $767,000,000, effective 1 July 2014. Moreover, a Service Agreement Framework is in place for three years in order to provide the THHS with a level of guidance regarding funding commitments and purchase activity for 2015-16. Management believe that the terms and conditions of its funding arrangements under the Service Agreement Framework will provide the THHS with sufficient cash resources to meet its financial obligations for at least the next two years.

The THHS in accordance with *S18(2) &(3)* of the *HHB Act 2011* has the 'Shield of the Crown' in that it has the same immunities and privilege as the Crown and can rely on the *Crown Proceeding Act 1980*. Legal advice has been obtained which confirms that the statutory body represents the State. Under the *Crown Proceedings Act 1980* (CP Act) if a court makes a judgment concerning debts outstanding against the statutory body, the judgment is considered to be against the State. If the statutory body is unable to pay the amount outstanding, the Treasurer would be obliged to pay.

**(I) Fiduciary and Trust transactions and balances**
General Trust accounts incorporates monies received through fundraising activities, donations, bequests which are held by the THHS for a stipulated purpose and cash contributions arising from the Right of Private Practice arrangements that are specified for study, education and research activities. General Trust monies are held as restricted assets and are disclosed in Note 33.

The THHS manages patient trust accounts transactions as trustee. As THHS acts only in a custodial role in respect of these transactions and balances, they are not recognised in the financial statements. Patient funds are not controlled by the THHS but trust activities are included in the annual audit performed by the Auditor-General of Queensland and are disclosed in Note 34.

**(j) Special payments**
Special payments include ex gratia expenditure and other expenditure that the HHS is not contractually or legally obligated to make to other parties. In compliance with the *Financial and Performance Management Standard 2009* the HHS maintains a register setting out details of all special payments exceeding $5,000. The total of all special payments (including those of $5,000 or less) is disclosed separately within Other expenses (Note 14). However, descriptions of the nature of special payments are only provided for special payments greater than $5,000.

## Note 2. Significant accounting policies (continued)

**(k) Revenue recognition**
Revenue is recognised when it is probable that the economic benefit will flow to the THHS and the revenue can be reliably measured. Revenue is measured at the fair value of the consideration received or receivable.

*User charges, fees and fines*
User charges and fees controlled by the Health Service comprise service income and recoveries, pharmaceutical benefits scheme income and hospital fees (which mainly consist of private patient hospital fees, interstate patient revenue and Department of Veterans' Affairs revenue).

Private patient hospital fees revenue, interstate patient revenue and Department of Veterans' Affairs revenue is recognised when services are performed.

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

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

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

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

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

*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 is reciprocal in nature revenue is progressively recognised as it is earned according to the terms of the funding arrangements.

A review of the nature of service payments made to third parties and their subsequent disclosure was undertaken during 2013-14. As a consequence of this review, and to ensure consistency in classification between the Department of Health and THHS, funding received from the Department has been reclassified from grant revenue to user charges and fees. Comparatives have been restated to improve transparency across the years. In 2013 user charges and fees has been restated from $42,984,000 to $708,585,000 ($665,601,000 adjustment) with Grants and Contributions being revised from $688,210,000 to $22,609,000 ($665,601,000 adjustment).

*Other revenue*
Other revenue is recognised when it is received or when the right to receive payment is established. It primarily reflects recoveries of payments for contracted staff from third parties such as universities and other government agencies.

*Minor Capital Works*
Purchases of clinical equipment, furniture and fittings associated with capital works projects are managed by the THHS. These outlays are funded by the State through the Department of Health as equity injections throughout the year.

## Note 2. Significant accounting policies (continued)

### (l) Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with financial institutions, other short-term, highly liquid investments with original maturities of three months or less that are readily convertible to known amounts of cash and which are subject to an insignificant risk of changes in value. 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 debt facility. The THHS operational bank accounts form part of the whole-of-Government banking arrangement with the Commonwealth Bank of Australia. The THHS bank accounts are grouped within the whole-of-Government set-off arrangement with Queensland Treasury Corporation. The THHS does not earn interest on surplus funds and is not charged interest or fees for accessing its approved debit facility as it is part of the whole-of-Government banking arrangements.

*Restricted Cash*
The THHS receives cash contributions primarily from private practice clinicians and from external entities to provide for education, study and research in clinical areas. Contributions are also received from benefactors in the form of gifts, donations and bequests for stipulated purposes. This money is controlled by the HHS and forms part of the cash and cash equivalent balance however it is restricted in nature as it can only be used for specific purposes.

### (m)Trade and other receivables

Receivables comprise trade receivables, GST input tax credits receivables and service revenue receivable. Trade receivables are recognised at the amounts due at the time of sale or service delivery. Trade receivables are generally settled within 120 days, while other receivables may take longer than twelve months.

### (n) Impairment of financial assets

Throughout the year, the THHS 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 the THHS's assessment of the credit risk associated with the receivables balances and is determined based on historical rates of bad debts by category over the past three years and management judgement. Increases in the allowance for impairment are based on loss events as disclosed in Note 13. All known bad debts are written off when identified.

Other receivables are recognised at amortised cost, less any provision for impairment.

### (o) Inventories

Inventories consist mainly of pharmaceutical supplies and clinical supplies held for distribution. Inventories are measured at the lower of cost and net realisable value based on periodic assessments for obsolescence. Where damaged or expired items have been identified, provisions are made for impairment.

### (p) Other non-financial assets

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

### (q) Assets classified as held for sale

Assets held for sale consist of those assets that management has determined are available for immediate sale (highly probable within the next twelve months) in their present condition rather than through continuing use.

In accordance with AASB 5 *Non-current Assets Held for Sale and Discontinued Operations (NFP)*, when an asset is classified as held for sale, its value is measured at the lower of the asset's carrying amount and fair value less costs to sell. Any restatement of the asset's value to fair value less costs to sell (in compliance with AASB 5) is a non-recurring valuation. Such assets are no longer amortised or depreciated upon being classified as held for sale.

As outlined in Note 2 (g) land and buildings under the operational control of THHS were transferred from the Department of Health under a Deed of Lease. As the Department continues to be the registered owner, the THHS has a legal impediment to selling these assets. Where land and buildings are identified as held for sale by the THHS, the Deed of Lease is partially surrendered and the assets are returned to the Department for sale. The THHS under the partial leasing arrangement is required to effectively maintain and operate these assets until their disposal on 1 July 2014 (Note 36).

## Note 2. Significant accounting policies (continued)

### (r) Property, Plant and Equipment

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

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

Items of property, plant and equipment with a cost or other value equal to or 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* | |
|---|---|
| Buildings | $10,000 |
| Land | $1 |
| Plant and equipment | $5,000 |

The THHS holds property, plant and equipment in order to meet its core objective of providing quality healthcare that Queenslanders value. 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 THHS. Under the terms of the lease the 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 THHS, with funds to be returned to Consolidated Fund (the State).

THHS has 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.

AASB117 *Leased Assets* is not applicable to land and buildings, as no consideration in the form of lease payments are required under the agreement and therefore the criteria in section 4 of this standard for recognition are not met.

Legislation to enable the transfer of ownership of the land and buildings was passed by State Parliament on 20 June 2012. A sub-committee with representatives from the HHSs and the Department has been established to develop protocols to enable this transfer to occur. A project is in place to facilitate this process with ownership to all HHSs to be completed by mid-2015. The transfer of land and buildings to the THHS occurred on 1 July 2014.

***Depreciation***

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

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

In accordance with Queensland Treasury and Trade's Non Current Asset Policy Guidelines (NCAP's), THHS has determined material specialised health service buildings are complex in nature and as such the asset is physically capable of being disaggregated or componentised into smaller assets. The NCAP's further state a number of key criteria which are used to determine whether a complex asset shall be "componentised".

The four criteria are

a) separately Identifiable
b) require regular replacement
c) significant value (5-10% of total cost of the asset)
c) different estimated useful life from the complex asset.

## Note 2. Significant accounting policies (continued)

The NCAP's require that a component must meet all 4 criteria.

The THHS review of its assets revealed that there were no components that satisfied the significant value criteria for componentisation.

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

Useful lives for assets revalued are amended progressively as assets are inspected by the valuers.

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

| | |
|---|---|
| Buildings | 2.5% -3.3% |
| Plant and equipment | 5-20% |

***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. AASB117 *Leased Assets* is not applicable to land and buildings currently under Deed of Lease with the Department of Health, as no consideration in the form of lease payments are required under the agreement.

The THHS has no other assets subject to finance lease.

**(s) Revaluations of non-current physical assets**

The fair values reported by the THHS are based on appropriate valuation techniques that maximises the use of available and relevant observable inputs and minimise the use of unobservable inputs (refer to Note 2(x)).

Where assets have not been specifically appraised in the reporting period, their previous valuations are materially kept up to date via the application of relevant indices. The THHS ensures that the application of such indices results in a valid estimation of the assets' fair values at reporting date.

Land is measured at fair value each year using independent revaluations, desktop market revaluations or indexation by the State Valuation Service (SVS) within the Department of Natural Resources and Mines.

Buildings are measured at fair value utilising either independent revaluation (including market valuations or depreciation replacement cost), or applying an interim revaluation methodology developed by the external registered valuer. For interim revaluations a Building Price Index (BPI) is used.

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

Reflecting the specialised nature of the Health Service buildings, fair value is determined using depreciated replacement cost methodology. Depreciated replacement cost is determined as the replacement cost less the cost to bring to current standards.

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

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

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

## Note 2. Significant accounting policies (continued)

The model developed by the valuer creates an elemental cost plan using these quantities and the model includes multiple building types and is based on the valuer's experience of cost managing construction contracts. The cost model is updated each year and tests are done to compare the model outputs on actual recent projects to ensure it produces a true representation of the cost of replacement. The costs are at Brisbane prices and published location indices are used to adjust the pricing to suit local market conditions. Live project costs from across the state are also assessed to inform current market changes that may influence the published factors.
The key assumption on the replacement cost is that our estimate is based on replacing the current function of the building with a building of the same form (size and shape). This assumption has a significant impact if an asset's function changes.

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

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

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

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

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

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

Estimates of remaining life are based on the assumption that the asset remains in its current function and will be maintained. No allowance has been provided for significant refurbishment works in the estimate of remaining life as any refurbishment should extend the life of the asset.

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

The gross method of reporting comprehensively revalued assets has been adopted. 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. The proportionate method has been applied to those assets that have been revalued by way of indexation.

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's Non-current Asset Policies for the Queensland Public Sector.*

Early in the reporting period, the THHS reviewed all fair value methodologies in light of the new principles in AASB13. Some minor adjustments were made to methodologies to take into account the more exit-oriented approach to fair value under AASB 13, as well as the availability of more observable date for certain assets (e.g. land and general purpose buildings).

## Note 2. Significant accounting policies (continued)

Any revaluation increment arising on the revaluation of an asset is credited to the asset revaluation surplus of the appropriate class, except to the extent it reverses a revaluation decrement for the class previously recognised as an expense. A decrease in the carrying amount on revaluation is charged as an expense, to the extent it exceeds the balance, if any, in the revaluation surplus relating to that asset class. Materiality concepts under AASB1031 *Materiality* are considered in determining whether the difference between the carrying amount and the fair value of an asset is material.

**(t) Impairment of non-financial assets**
All non-current and intangible assets are assessed for indicators of impairment on an annual basis in accordance with AASB 136 *Impairment of Assets*. If an indicator of possible impairment exists, THHS 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. Refer also Note 2 (s)

**(u) Trade and other payables**
These amounts represent liabilities for goods and services provided to the THHS prior to the end of the financial year and which are unpaid. Due to their short-term nature they are measured at amortised cost and are not discounted. The amounts are unsecured and are usually paid within 30 - 60 days of recognition.

**(v) Financial instruments**

*Recognition*

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

*Classification and Measurement*

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 THHS does not enter into transactions for speculative purposes, or for hedging. Apart from cash and cash equivalents, the THHS 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 the THHS are included in Note 28.

**(w) Employee benefits and Health Service labour expenses**

Under section 20 of the *Hospital and Health Boards Act 2011* (HHB Act) - a Hospital and Health Service can employ health executives where a person was 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 2013-14 the THHS 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 acknowledges and accepts its obligations of these employees.
- The HHS is responsible for the day to day management of these departmental employees.
- The HHS reimburses the department for the salaries and on-costs of their employees.

As a result of this arrangement, the THHS treats the reimbursements to the Department of Health for departmental employees in these financial statements as health service employee expenses and detailed in Note 8.

In addition to the employees contracted from the Department of Health, the THHS has engaged employees directly. The information below relates specifically to the directly engaged employees.

## Note 2. Significant accounting policies (continued)

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

The THHS 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 10). Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at current salary rates. As THHS expects such liabilities to be wholly settled within 12 months of reporting date, the liabilities are recognised at undiscounted amounts.

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

Payroll tax and worker's 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.

*(a)Annual leave*

The Queensland Government's Annual Leave Central Scheme (ALCS) became operational on 30 June 2008 for departments, commercial business units, shared service providers and selected not for profit statutory bodies. The THHS was admitted into this arrangement effective 1 July 2012. Under this scheme, a levy is made on the THHS 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 reimbursements on behalf of all HHSs. No provision for annual leave is recognised in the THHS's financial statements as the liability is held on a whole of government basis and reported in those financial statements pursuant to AASB 1049 *Whole-of-Government and General Government Sector Financial Reporting.*

*(b)Long Service Leave*

Under the Queensland Government's Long Service Leave Scheme, a levy is made on the THHS to cover the cost of employee's 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 HHSs. No provision for long service leave is recognised in the THHS' financial statements as the liability is held on a whole of government basis and reported in those financial statements pursuant to AASB 1049 *Whole-of-Government and General Government Sector Financial Reporting.*

(c)*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 THHS'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.*

Board members and Visiting Medical Officers are offered a choice of superannuation funds and THHS pays superannuation contributions into a complying superannuation fund. Contributions are expensed in the period in which they are paid or payable. The THHS'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.

(d)*Key management personnel and remuneration*

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

**(x) Fair value measurement**

Assets and liabilities measured at fair value are classified, into three levels, using a fair value hierarchy that reflects the significance of the inputs used in making the measurements. Classifications are reviewed each reporting date and transfers between levels are determined based on a reassessment of the lowest level input that is significant to the fair value measurement.

## Note 2. Significant accounting policies (continued)

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

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

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

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

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

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

None of the THHS's valuations of assets or liabilities are eligible for categorisation into level 1 of the fair value hierarchy. As 2013-14 is the first year of application of AASB13 by THHS, there were no transfers of assets between fair value hierarchy levels during the period.

More specific fair value information about the HHS's property, plant and equipment is outlined in Note 27.

**(y) Unearned Revenue**

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

**(z) Insurance**

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

The Insurance Arrangements for Public Health Entities Health Service Directive (*directive number QH-HSD-011:2012*) enables Hospital and Health Services to be named insured parties under the Department's policy. For the 2013-14 policy year, the premium was allocated to each HHS according to the underlying risk of an individual insured party. The Hospital and Health Service premiums cover claims from 1 July 2012, pre 1 July 2012 claims remain the responsibility of the department, however the THHS must pay the $20,000 excess payment on these claims. Queensland Health pays premiums to Work Cover Queensland on behalf of all Hospital and Health Services in respect of its obligations for employee compensation. These costs are reimbursed to the department.

**(aa) 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*.

**(ab) Federal taxation charges**

The THHS is a State body as defined under the Income Tax Assessment Act 1936 and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and Goods and services Tax (GST). The Australian Taxation Office has recognised the Department of Health and the seventeen Hospital and Health Services as a single taxation entity for reporting purposes.

All FBT and GST reporting to the Commonwealth is managed centrally by the department, with payments/receipts made on behalf of the THHS reimbursed to/from the department on a monthly basis. GST credits receivable from, and GST payable to the ATO are recognised on this basis.

## Note 2. Significant accounting policies (continued)

### (ac) Corporate services received for no cost

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

### (ad) Arrangements for the provision of public infrastructure by other entities

The Department of Health , prior to the establishment of the THHS, has entered into a number of contractual arrangements with private sector entities for the construction and operation of public infrastructure facilities for a period of time on land now controlled by the THHS.

Although the land on which the facilities have been constructed remains an asset of the THHS, THHS does not control the facilities with these arrangements. Therefore these facilities are not recorded as assets. The THHS receives rights and incurs obligations under these arrangements including

- rights and obligations to receive and pay cash flows in accordance with the respective contractual arrangements and
- rights to receive the facility at the end of the contractual term.

The arrangements have been structured to minimise risk exposure for the THHS. THHS has not recognised any rights or obligations that may attach to those arrangements, other than those recognised under generally accepted accounting principles. Refer to Note 35.

## Note 3. Critical accounting judgements, estimates and assumptions

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

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

*Fair value measurement hierarchy*
The THHS is required to classify all assets and liabilities, measured at fair value, using a three level hierarchy, based on the lowest level of input that is significant to the entire fair value measurement, being: Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities that the entity can access at the measurement date; Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly; and Level 3: Unobservable inputs for the asset or liability. Considerable judgement is required to determine what is significant to fair value and therefore which category the asset or liability is placed in can be subjective.

The fair value of assets and liabilities classified as level 3 is determined by the use of valuation models. These include the use of observable inputs that require significant adjustments based on unobservable inputs.

*Valuation of land and buildings*
THHS engaged Davis Langdon and the State Valuation Service to provide both indices and valuations in relation to the THHS holdings of land and buildings. Valuations involve a degree of estimation and judgement. The valuation approaches are outlined in Note 2(s).

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

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

## Note 3. Critical accounting judgements, estimates and assumptions (continued)

*Impact of changes in the Clean Energy Act*

The Australian government passed its *Clean Energy Act* in November 2011 which resulted in the introduction of a price on carbon emissions made by Australian businesses from 1 July 2012.

From 2014, the government passed legislation to abolish the carbon tax. The withdrawal of the carbon pricing mechanism is not expected to have a significant impact on the THHS's critical accounting estimates, assumptions and management judgements.

### Note 4. User charges and fees

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Service Income and Recoveries | 5,749 | 4,666 |
| Pharmaceutical Benefits Scheme | 12,451 | 5,185 |
| Public Patient Income | 7,448 | 7,912 |
| Private Hospital Bed Income | 10,475 | 10,742 |
| Income -Other Hospital Services | 15,972 | 14,479 |
| Department of Health - ABF | 329,585 | 281,206 |
| Australian Government - ABF | 166,712 | 145,010 |
| Department of Health - Block Funding | 49,082 | 73,597 |
| Australian Government - Block Funding | 28,680 | 32,012 |
| Department of Health - Tertiary Training | 2,699 | 15,705 |
| Australian Government - Tertiary Training | 1,606 | 6,831 |
| Department of Health - System Funding | 62,254 | 82,640 |
| Department of Health - Depreciation Revenue | 31,392 | 28,600 |
| | 724,105 | 708,585 |

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

To align with this basis of funding provided by the Department of Health under a service agreement, THHS now recognises the 2013-14 funding of $724,105,000 as User Charges and Fees revenue for 2013-14 rather than as grants revenue which occurred in 2012-13. The change has been applied retrospectively .

### Note 5. Grants and other contributions

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Australian Government - Specific purpose recurrent grants | 20,081 | 19,574 |
| Australian Government - Specific purpose capital grants | 945 | 1,046 |
| Other grants | 2,248 | 1,765 |
| Donations other | 344 | 105 |
| Donations non-current physical assets | 74 | 119 |
| | 23,692 | 22,609 |

### Note 6. Other revenue

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Interest | 309 | 334 |
| Rental income | 227 | 438 |
| Sale proceeds of non-capitalised assets | 10 | 16 |
| Health service employee expense recoveries | 2,564 | 2,095 |
| Fees, charges & recoveries | 2,755 | 1,352 |
| | 5,865 | 4,235 |

**Note 7. Gains**

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Gain on sale of property, plant and equipment | 130 | 27 |

**Note 8. Health Service employee expenses**

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Health Service employee expense | 508,989 | 502,080 |
| Health Service employee related expense | 4,062 | 3,960 |
| | 513,051 | 506,040 |

Refer to Note 2(w). Health service employee expenses represent the cost of Department of Health (DOH) employees contracted to the HHS to provide public health services. As established under the *Hospital and Health Boards Act 2011* the department is the employer for all health service employees (excluding persons appointed as a Health Executive) and recovers all employee expenses and associated on-costs from HHSs. All expenses of employees directly engaged by the Townsville HHS are shown under Note 9.

The Townsville HHS full time equivalent staff at 30 June 2014 including both Townsville HHS employees and DOH Health Service employees was 4,595 and 4,422 for 30 June 2013.

**Note 9. Employee expenses**

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Employee Expenses | 2,242 | 2,510 |

The Employee Expenses represent the cost of engaging board members and the employment of Health Executives who are employed directly by the THHS.

**Note 10. Supplies and services**

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Consultants and contractors | 11,201 | 7,574 |
| Electricity and other energy | 8,100 | 6,487 |
| Patient travel | 10,597 | 9,955 |
| Other travel | 2,326 | 2,052 |
| Water | 1,153 | 889 |
| Building services | 1,207 | 1,164 |
| Computer services | 3,303 | 2,628 |
| Motor vehicles | 526 | 540 |
| Communications | 6,528 | 6,661 |
| Repairs and maintenance | 14,842 | 14,534 |
| Expenses relating to capital works | 993 | 1,248 |
| Operating lease rentals | 3,728 | 4,152 |
| Drugs | 27,110 | 27,622 |
| Clinical supplies and services | 63,476 | 63,041 |
| Catering and domestic supplies | 11,587 | 11,225 |
| Other | 5,210 | 2,362 |
| | 171,887 | 162,134 |

### Note 11. Grants and subsidies

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Public hospital support services* | 3,730 | 3,671 |
| Other | 788 | 1,061 |
| | 4,518 | 4,732 |

* Public hospital support services include grants to our community based partners such as Townsville - Mackay Medicare Local.

### Note 12. Depreciation and amortisation

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Buildings | 19,810 | 18,125 |
| Plant and equipment | 11,520 | 10,293 |
| Software purchased | 62 | 182 |
| | 31,392 | 28,600 |

### Note 13. Impairment losses

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Impairment losses on receivables | 660 | 237 |
| Bad debts written off | 798 | 1,694 |
| Impairment losses on revaluation of land & buildings | - | 1,325 |
| | 1,458 | 3,256 |

### Note 14. Other expenses

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Audit fees* | 776 | 250 |
| Bank fees | 18 | 17 |
| Insurance** | 7,041 | 5,866 |
| Inventory written off | 50 | 98 |
| Losses from the disposal of non-current assets | 219 | 603 |
| Special payments - ex-gratia payments*** | 79 | 161 |
| Other legal costs | 544 | 214 |
| Journals and subscriptions | 225 | 236 |
| Advertising | 174 | 55 |
| Interpreter fees | 52 | 71 |
| Fees, Fines and Other Charges | 160 | 259 |
| | 9,338 | 7,830 |

*Refer to Note 32 for audit fees
**Includes Queensland Government Insurance Fund (QGIF) refer Note 2 (z).
***Special payments ex-gratia includes gifts and settlements in the nature of damages including loss or damage to a patient's personal effect refer Note 2(j).

**Note 15. Current assets - cash and cash equivalents**

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Cash at bank and on hand * | 69,582 | 47,799 |
| Restricted cash** | 10,157 | 8,482 |
| *Refer to Note 28 | 79,739 | 56,281 |

**Refer to Note 2(l) and Note 33.

**Note 16. Current assets - trade and other receivables**

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Trade receivables | 13,975 | 10,494 |
| Less: Provision for impairment of receivables | (2,458) | (1,798) |
| GST input tax credits receivable | 1,223 | 1,114 |
| GST payable | (217) | (132) |
| | 1,006 | 982 |
| Accrued Revenue - Department of Health | - | 5,750 |
| | 12,523 | 15,428 |

*Impairment of receivables*
The Townsville HHS has recognised an impairment provision of $2,458,000 (2014) and ($1,798,000 2013) in respect of impairment of receivables for the year ended 30 June 2014. The movement in the provision of $660,000 is recognised as an impairment loss in the operating result for the period (Note 13).

The ageing of the impaired receivables provided for above are as follows:

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| 0 to 30 days | 464 | 72 |
| 30 to 60 days | 146 | 232 |
| 60 to 90 days | 570 | 215 |
| greater than 90 days* | 1,278 | 1,279 |
| | 2,458 | 1,798 |

*Ineligible patients have been classified in the 'greater than 90 days' category as a significant percentage of these patients have accounts outstanding greater than 90 days.

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

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Opening balance | 1,798 | - |
| Transfers in as at 1 July 2012 | - | 1,561 |
| Amounts written- off during the year | (494) | (1,305) |
| Increase in allowance recognised in operating result | 1,154 | 1,542 |
| Closing balance | 2,458 | 1,798 |

### Note 17. Current assets - inventories (held at cost)

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Medical supplies and equipment | 5,816 | 5,383 |
| Catering and domestic | 26 | 33 |
| Engineering | 41 | 41 |
| Other | 119 | 124 |
| | 6,002 | 5,581 |

### Note 18. Current assets – other

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Prepayments | 413 | 343 |

### Note 19. Non-current assets - property, plant and equipment

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Land - at fair value | 32,485 | 34,251 |
| Buildings - at fair value | 746,841 | 572,504 |
| Less: Accumulated depreciation | (266,697) | (225,438) |
| | 480,144 | 347,066 |
| Plant and equipment - at cost | 123,101 | 109,454 |
| Less: Accumulated depreciation | (64,665) | (56,165) |
| | 58,436 | 53,289 |
| Capital works in progress - at cost | 281 | 192 |
| | 571,346 | 434,798 |

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

| | Land $'000 | Buildings $'000 | Plant and equipment $'000 | Capital works in progress $'000 | Total $'000 |
|---|---|---|---|---|---|
| Balance transferred at 1 July 2012 | 34,661 | 348,030 | 49,490 | 152 | 432,333 |
| Additions | - | 17,960 | 13,051 | - | 31,011 |
| Disposals | - | (604) | (267) | - | (871) |
| Revaluation decrements | (410) | (915) | - | - | (1,325) |
| Transfers in/(out) | - | 720 | 1,308 | 40 | 2,068 |
| Depreciation expense | - | (18,125) | (10,293) | - | (28,418) |
| Balance at 30 June 2013 | 34,251 | 347,066 | 53,289 | 192 | 434,798 |
| Additions | - | 90,586 | 15,525 | 89 | 106,200 |
| Disposals | - | (167) | (223) | - | (390) |
| Revaluation increments | 429 | 62,340 | - | - | 62,769 |
| Transfers in/(out) | (2,195) | 129 | 1,365 | - | (701) |
| Depreciation expense | - | (19,810) | (11,520) | - | (31,330) |
| Balance at 30 June 2014 | 32,485 | 480,144 | 58,436 | 281 | 571,346 |

Refer to Note 27 for fair value measurements.

## Note 19. Non-current assets - property, plant and equipment (continued)

*Impact of changes in useful lives medical equipment*

During 2014 the THHS commissioned Biomedical Technology Services (BTS), Health Support Agency (Townsville) to provide an updated register of the expected useful lives of medical equipment less than $200,000. The review resulted in a change in the useful lives of assets within this class from 10 years (standard) to 5-9 years. The change in useful lives of these assets resulted in an increase in depreciation expense for this asset class of $479,000.

## Note 20. Non-current assets – intangibles

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Software purchased - at cost | 1,906 | 1,906 |
| Less: Accumulated amortisation | (1,775) | (1,713) |
| | 131 | 193 |

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

| | Software purchased $'000 | Total $'000 |
|---|---|---|
| Balance transferred at 1 July 2012 * | 1,906 | 1,906 |
| Amortisation expense | (1,713) | (1,713) |
| Balance at 30 June 2013 | 193 | 193 |
| Amortisation expense | (62) | (62) |
| Balance at 30 June 2014 | 131 | 131 |

*Transferred pursuant to the *Hospitals and Health Boards Act 2011*

## Note 21. Current liabilities - trade and other payables

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Trade payables* | 49,394 | 46,200 |

*Refer to note 28.

## Note 22. Current liabilities - accrued employee benefits

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Salaries and wages accrued | 17 | 40 |

## Note 23. Current liabilities - unearned revenue

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Unearned other revenue | 630 | 404 |

### Note 24. Equity – Contributed

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Contributed equity opening balance | 445,626 | - |
| Balance transferred at 1 July 2012* | - | 439,242 |
| Non appropriated equity contributions | 102,850 | 34,984 |
| Non appropriated equity withdrawals | (31,392) | (28,600) |
| | 517,084 | 445,626 |

* Transferred pursuant to the *Hospitals and Health Boards Act 2011*

Equity contributions consists of cash funds provided for minor capital works $17,111,000 for 2014 ($14,560,000 for 2013) and assets transferred to the Townsville HHS $85,739,000 for 2014 ($20,424,000 for 2013). Equity withdrawal represents the contribution towards the capital works program undertaken by the DOH on behalf of the Townsville HHS.

Capital for the THHS comprises of accumulated surpluses and contributed equity. When managing capital, management's objective is to ensure the entity continues as a going concern as well as to meet service delivery outcomes as outlined in Note1.

### Note 25. Equity – revaluation surplus

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Asset revaluation surplus - land | 429 | - |
| Asset revaluation surplus - buildings | 62,340 | - |
| | 62,769 | - |

*Revaluation surplus*
The revaluation surplus is used to recognise increments and decrements in the fair value of land and buildings, excluding investment properties.

### Note 26. Equity - accumulated surpluses

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Accumulated surpluses at the beginning of the financial year | 20,354 | - |
| Surplus for the year | 19,906 | 20,354 |
| Accumulated surpluses at the end of the financial year | 40,260 | 20,354 |

### Note 27. Fair value measurement

The following tables detail the THHS's assets and liabilities, measured or disclosed at fair value, using a three level hierarchy, based on the lowest level of input that is significant to the entire fair value measurement, being:

Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities that the entity can access at the measurement date

Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. Land and buildings consist of residential properties and administrative facilities which are measured based on observable market valuations of comparable properties. Where a market revaluation method was not applied the land and buildings were revalued with indices. The carrying amounts of trade and other receivables and trade and other payables are assumed to approximate their fair values due to their short-term nature.

Level 3: Unobservable inputs for the asset or liability

## Note 27. Fair value measurement (continued)

| 2014 | Level 1 $'000 | Level 2 $'000 | Level 3 $'000 | Total $'000 |
|---|---|---|---|---|
| *Assets* | | | | |
| Trade Receivables | | 13,975 | | 13,975 |
| Land | - | 32,485 | - | 32,485 |
| Buildings | - | 5,786 | 474,358 | 480,144 |
| Total assets | - | 52,246 | 474,358 | 526,604 |
| *Liabilities* | | | | |
| Trade Payables | - | 49,394 | - | 49,394 |
| Total liabilities | - | 49,394 | - | 49,394 |

There were no transfers between levels during the financial year.

### Level 3 significant valuation inputs and relationship to fair value

| Description | Type for significant level 3, unobservable inputs | Unobservable inputs quantitative measures Ranges used in valuations | Unobservable inputs- general effect on fair value measurement |
|---|---|---|---|
| Buildings- Health services facilities (fair value $474m) | Replacement cost estimate | Hospitals $7,000 to $201,767,000 Other buildings $12,000 to $11,230,000 | Replacement cost is based on tender pricing and historical building cost data. An increase in the estimated replacement costs would increase the fair value of assets. A decrease in the estimated replacement costs would reduce the fair value of the assets. |
| | Remaining lives | 1 year to 64 years | The remaining useful lives are based on industry benchmarks. An increase in the estimated remaining useful lives would increase the fair value of the assets. A decrease in the estimated remaining useful lives would reduce the fair value of the assets. |
| | Condition rating | 1 to 5 | The condition rating is based on the physical state of the assets. An improvement in the condition rating would increase the fair value of the assets. A decline in the condition rating would reduce the fair value of the assets. |
| | Cost to bring to current standard (refurbishment cost) | Hospitals $109,000 to $21,922,000 Other buildings $326,000 to $2,164,000 | Costs to bring to current standards are based on tending pricing and historical building cost data. An increase in the estimated costs to bring to current standards would reduce the fair value of the assets. A decrease in the estimated costs to bring to current standards would increase the fair value of the assets. |

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

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

There are no other direct or significant interrelationships between unobservable inputs that materially impact fair value.

## Note 28. Financial instruments

***(a )Categorisation of Financial Instruments***

The fair values of financial assets and liabilities, together with their carrying amounts in the statement of financial position, for the THHS are as follows:

| | 2014 | | 2013 | |
|---|---|---|---|---|
| | Carrying amount $'000 | Fair value $'000 | Carrying amount $'000 | Fair value $'000 |
| *Assets* | | | | |
| Cash and cash equivalents | 79,739 | 79,739 | 56,281 | 56,281 |
| Trade receivables | 13,975 | 13,975 | 10,494 | 10,494 |
| | 93,714 | 93,714 | 66,775 | 66,775 |
| *Liabilities* | | | | |
| Trade payables | 49,394 | 49,394 | 46,200 | 46,200 |
| | 49,394 | 49,394 | 46,200 | 46,200 |

***(b) Financial risk management***

Risk management is carried out by senior finance executives ('finance') under policies approved by the Board of Directors ('the Board'). These policies include identification and analysis of the risk exposure of the THHS and appropriate procedures, controls and risk limits. Finance identifies, evaluates and hedges financial risks within the THHS's operating units. Finance reports to the Board on a monthly basis.

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

***(c) Market risk***

Market risk is the risk that the fair value of 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. Townsville HHS has interest rate exposure on the 24 hour call deposits and there is no interest rate exposure on its cash deposits. Townsville HHS does not undertake any hedging in relation to interest rate risk. Changes in interest rate have a minimal effect on the operating result of the HHS.

*Interest rate risk*

The impact of a reasonably possible change in interest rates has been assessed not to have a material impact on the Townsville HHS.

As at the reporting date, the THHS's exposure to liquidity and interest rate risk is:

| | 2014 | | 2013 | |
|---|---|---|---|---|
| | Weighted average interest rate % | Balance $'000 | Weighted average interest rate % | Balance $'000 |
| Cash | -% | 71,291 | -% | 48,130 |
| 24 hour call deposits | 3.41% | 8,426 | 3.80% | 8,151 |
| Trade Receivables | -% | 13,975 | -% | 10,494 |
| Trade Payables | -% | (49,394) | -% | (46,200) |
| Net exposure to cash flow interest rate risk | | 44,298 | | 20,575 |

Cash, trade receivables and trade payables are non-interest bearing.

***(d) Credit risk***

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.

Credit risk is considered minimal given all Townsville HHS deposits are held by the State through Queensland Treasury Corporation and the Commonwealth Bank of Australia.

Note 28. Financial instruments (continued)

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| **Maximum Exposure to Credit Risk** | | |
| Cash | 79,739 | 56,281 |

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| **Financial assets past due but not impaired** | | |
| Trade Receivables | | |
| Less than 30 days | 8,465 | 7,549 |
| 30-60 days | 1,273 | 620 |
| 61-90 days | 334 | 224 |
| more than 90 days | 1,445 | 303 |
| Total | 11,517 | 8,696 |

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| **Individual impaired financial assets** | | |
| Trade Receivables | | |
| Less than 30 days | 464 | 72 |
| 30-60 days | 146 | 232 |
| 61-90 days | 570 | 215 |
| More than 90 days | 1,278 | 1,279 |
| Total | 2,458 | 1,798 |

***(e) Liquidity risk***

Liquidity risk is the risk that the Townsville HHS will not have the resources required at a particular time to meet its obligations to settle its financial liabilities.

Townsville HHS is exposed to liquidity risk through its trading in the normal course of business. The HHS aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times. Townsville HHS has an approved overdraft facility of $7.5million under Whole-of-Government banking arrangements to manage any short term cash shortfall.

**Note 29. Key management personnel disclosures**

Remuneration policy for the key executive management personnel is set by the following legislation

- Hospital and Health Boards Act 2011 (HHBA)
- Industrial Award and Agreements.

The remuneration and other terms of employment for the key executive management personnel are specified in employment contracts. The Chief Executive is appointed in accordance with the provisions of section 33 of the HHBA, other executives appointed either in accordance with section 74 of the HHBA or in accordance with the relevant industrial award and agreement they are appointed under as Health Practitioner or Nursing Executives. Board members are appointed under the provision of section 23 of the HHBA for the Chair and Deputy Chair.

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

| *Name and position of current incumbents* | *Responsibilities* | *Contract classification & appointment authority* | *Appointment date* |
|---|---|---|---|
| John Bearne | Chair of THH Board (THHB) | HHB Act 2011 | 29/05/2012 |
| Michelle Morton | Deputy Chair of THHB and Chair of the Executive Sub-committee | HHB Act 2011 | 29/06/2012 |
| Glen Cerutti | Director and Chair of the Finance Sub-committee | HHB Act 2011 | 29/06/2012 |
| Dr Eric Guazzo | Director and Chair of the Audit Sub-committee | HHB Act 2011 | 29/06/2012 |
| Dr Kevin Arlett | Director and Chair of the Patient Safety & Quality Sub-Committee | HHB Act 2011 | 29/06/2012 |
| Lynette McLaughlin | Director | HHB Act 2011 | 07/09/2012 |
| Susan Phillips | Director | HHB Act 2011 | 07/09/2012 |
| Robert Whaleboat | Director | HHB Act 2011 | 27/07/2012 |
| Professor Ian Wronski | Director | HHB Act 2011 | 29/06/2012 |
| Professor Linda Shields | Director | HHB Act 2011 | 18/05/2013 *ceased 12/10/2013* |

**Note 29. Key management personnel disclosures (continued)**

**Key Executive Management**

| *Name and position of current incumbents* | *Responsibilities* | *Contract classification & appointment authority* | *Appointment date* |
|---|---|---|---|
| Chief Executive - Julia Squire | The CE is responsible for the efficient, effective and economic administration of the Townsville Hospital and Health Service (THHS) | S24/70 01 HHB Act 2011 | 26/11/2012 |
| Chief Operations Officer Kieran Keyes | The COO is responsible for the efficient operation of the Health Service providing strategic leadership and direction for the THHS service delivery | HES3-1 01 HHB Act 2011 | 01/12/2012 |
| Chief Finance Officer (CFO) Shaun Eldridge | The CFO is responsible for strategic leadership and direction over the efficient, effective and economic financial administration of the THHS | HES3-2 01 HHB Act 2011 | 18/11/2013 |
| Chief Finance Officer Ian Moody | The CFO is responsible for strategic leadership and direction over the efficient, effective and economic financial administration of the THHS | HES 3-5 01 HHB Act 2011 | 01/04/2013 *ceased 18/11/2013* |
| Executive Director Planning & Performance (EDPP) Anthony Williams | The EDPP is responsible for monitoring the performance of the THHS and ensuring the THHS has an effective planning function which satisfies both the strategic an operational aspects of the organisation | HES2-2 01 HHB Act 2011 | 01/07/2012 |
| Executive Director Nursing & Midwifery (EDN&M) Valerie Tuckett | The EDN&M is responsible for providing strategic and operational leadership of nursing and midwifery services of the THHS. | NRG12-1 01 HHB Act 2011 | 01/07/*2012* *ceased 04/04/2014* |
| Executive Director Medical Services (EDMS) Dr Andrew Johnson | The EDMS is responsible for medical service delivery of the THHS. | MMO13 01 HHB Act 2011 | 01/07/2012 |
| Executive Director People and Culture (EDPC) Louise Oriti | The EDPC provides strategic human resource management for the THHS | HES2-2 01 HHB Act 2011 | 01/07/2012 *ceased 16/08/2013* |
| Acting Executive Director Nursing & Midwifery (AEDN&M) Marlene Cochrane | The AEDN&M is responsible for providing strategic and operational leadership of nursing and midwifery services of the THHS. | NRG12-1 01 HHB Act 2011 | 05/08/2013 - **16/11/2013** 07/04/2014 |
| Acting Executive Director People and Culture (AEDPC) Estelle Bain | The AEDPC provides strategic human resource management for the THHS | HES2-2 01 HHB Act 2011 | 19/08/2013- 15/11/2013 |
| Executive Director People and Culture (EDPC) Patrick Sheehan | The EDPC provides strategic human resource management for the THHS | HES2-2 01 HHB Act 2011 | 02/06/2014 |

**Note 29. Key management personnel disclosures (continued)**

Remuneration packages for key management personnel comprise the following components:

- Short term employee benefits which include: - Base - consisting of base salary, allowances and leave entitlements expensed for the entire year or for that part of the year during which the employee occupied the specified position. Non-monetary benefits - consisting of provision of vehicle together with fringe benefits tax applicable to the benefit.
- Long term employee benefits include amounts expensed in respect of long service leave.
- Post-employment benefits include amounts expensed in respect of employer superannuation obligations.
- Redundancy payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu of notice on termination, regardless of the reason for termination.
- Performance bonuses are not paid under the contracts in place.
- Total fixed remuneration is calculated on a 'total cost' basis and includes the base and non-monetary benefits, long term employee benefits and post-employment benefits.

| 2014 | *Short-term employee expenses* | | | | | |
|---|---|---|---|---|---|---|
| *Key Executive Management Name and position* | *Monetary expenses $'000* | *Non-monetary benefits $'000* | *Post-employment benefits $'000* | *Long-term benefits $'000* | *Termination benefits $'000* | *Total $'000* |
| Chief Executive<br>Julia Squire | 336 | - | 34 | 6 | - | 376 |
| Chief Operations Officer<br>Kieran Keyes | 175 | 1 | 21 | 4 | - | 201 |
| Chief Finance Officer<br>Ian Moody | 103 | - | 10 | 2 | - | 115 |
| Executive Director People & Culture<br>Louise Oriti | 221 | - | 2 | - | 84 | 307 |
| Executive Director Medical Services<br>Dr Andrew Johnson | 457 | 1 | 36 | 10 | - | 504 |
| Executive Director Nursing & Midwifery<br>Valerie Tuckett | 261 | - | 17 | 1 | 116 | 395 |
| Executive Director Planning & Performance<br>Anthony Williams | 160 | - | 19 | 3 | - | 182 |
| Chief Finance Officer<br>Shaun Eldridge | 117 | - | 13 | 3 | - | 133 |
| Acting Executive Director Nursing & Midwifery<br>Marlene Cochrane | 120 | - | 9 | 2 | - | 131 |
| Acting Executive Director People & Culture<br>Estelle Bain | 45 | - | 3 | 1 | - | 49 |
| Executive Director People & Culture<br>Patrick Sheehan | 11 | - | 1 | - | - | 12 |

**Note 29. Key management personnel disclosures (continued)**

| 2013 | Short-term employee expenses | | | | | |
|---|---|---|---|---|---|---|
| *Key Executive Management Name and position* | *Monetary expenses $'000* | *Non-monetary benefits $'000* | *Post-employment benefits $'000* | *Long-term benefits $'000* | *Termination benefits $'000* | *Total $'000* |
| Chief Executive<br>Julia Squire | 179 | 7 | 18 | 3 | - | 207 |
| Chief Operations Officer<br>Kieran Keyes | 96 | - | 9 | 2 | - | 107 |
| Chief Finance Officer<br>Ian Moody | 43 | - | 5 | 1 | - | 49 |
| Executive Director People & Culture<br>Louise Oriti | 140 | - | 16 | 3 | - | 159 |
| Executive Director Medical Services<br>Dr Andrew Johnson | 455 | - | 31 | 5 | - | 491 |
| Executive Director Nursing & Midwifery Valerie<br>Tuckett | 171 | 15 | 21 | 4 | - | 211 |
| Executive Director Planning & Performance<br>Anthony Williams | 162 | - | 17 | 3 | - | 182 |
| Executive Director Allied Health<br>Robyn Adams | 148 | - | 17 | 3 | - | 168 |
| Executive Director Indigenous Health<br>Carl Grant | 118 | - | 13 | 2 | 69 | 202 |
| Chief Operations Officer<br>Shaun Drummond | 20 | - | 1 | - | 3 | 24 |
| Chief Executive<br>Karen Roach | 202 | 6 | 14 | 4 | 13 | 239 |
| Chief Operations Officer<br>Vivian Blake | 82 | 10 | 8 | 1 | 5 | 106 |

**Note 29. Key management personnel disclosures (continued)**

**2014**

| Board Members Name | Short-term employee expenses: Monetary expenses $'000 | Short-term employee expenses: Non-monetary benefits $'000 | Post-employment benefits $'000 | Long-term benefits $'000 | Termination benefits $'000 | Total $'000 |
|---|---|---|---|---|---|---|
| John Bearne | 76 | - | 7 | - | - | 83 |
| Michelle Morton | 36 | - | 3 | - | - | 39 |
| Glen Cerutti* | 45 | - | 3 | - | - | 48 |
| Dr Kevin Arlett | 36 | - | 3 | - | - | 39 |
| Professor Ian Wronski | 36 | - | 3 | - | - | 39 |
| Susan Phillips* | 43 | - | 3 | - | - | 46 |
| Robert Whaleboat | 36 | - | 3 | - | - | 39 |
| Dr Eric Guazzo | 36 | - | 3 | - | - | 39 |
| Lynette McLaughlin* | 43 | - | 3 | - | - | 46 |
| Professor Linda Shields | 10 | - | 1 | - | - | 11 |

* Allowances paid to Board Directors for travel arising from their remote locations are incorporated in short term benefits.

**2013**

| Board Members Name | Short-term employee expenses: Monetary expenses $'000 | Short-term employee expenses: Non-Monetary benefits $'000 | Post-employment benefits $'000 | Long-term benefits $'000 | Termination benefits $'000 | Total $'000 |
|---|---|---|---|---|---|---|
| John Bearne | 76 | - | 7 | - | - | 83 |
| Michelle Morton | 33 | - | 3 | - | - | 36 |
| Glen Cerutti | 39 | - | 3 | - | - | 42 |
| Dr Kevin Arlett | 33 | - | 3 | - | - | 36 |
| Professor Ian Wronski | 33 | - | 3 | - | - | 36 |
| Susan Phillips | 36 | - | 3 | - | - | 39 |
| Robert Whaleboat | 33 | - | 3 | - | - | 36 |
| Dr Eric Guazzo | 33 | - | 3 | - | - | 36 |
| Lynette McLaughlin | 26 | - | 2 | - | - | 28 |
| Professor Linda Shields | 3 | - | - | - | - | 3 |

* Allowances paid to Board Directors for travel arising from their remote locations are incorporated in short term benefits.

### Note 30. Contingent liabilities

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

| | 2014 cases | Increase cases | Decrease cases | 2013 cases |
|---|---|---|---|---|
| **Litigation in progress (Insured Claims)** | | | | |
| Person Injury Proceedings Act Claims | 46 | 3 | - | 43 |
| Health Quality Complaints Commission Claims | 9 | - | (4) | 13 |
| General Liability | 4 | - | (5) | 9 |
| | 59 | 3 | (9) | 65 |

Effective from 1 July 2012, The Townsville Hospital and Health Service joined the Queensland Government Insurance Fund (QGIF). Under the QGIF, the THHS would be able to claim back, less a $20,000 deductible, the amount paid to successful litigants. This includes any cases that existed at 1 July 2012 and cases that have arisen since that date. Queensland Health'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.

In respect of litigation in progress the THHS has 10 open non-insured claims with no contingency provided for at reporting date. In 2013 The THHS had a total non-insured contingency of $371,697 at reporting date.

**Native Title**

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

All business pertaining to land held by or on behalf of Queensland 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.

Queensland Health undertakes native title assessments over real property when required and is currently negotiating a number of Indigenous Land Use Agreements (ILUA) with native title holders. These ILUAs will provide trustee leases to validate the tenure of current and future health facilities. The National Title Tribunal reported a total of 16 claims 2012-13 with 1 claim lodged in relation to the Townsville Hospital and Health Service.

### Note 31. Commitments

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| *Capital commitments* | | |
| Committed at the reporting date but not recognised as liabilities, payable: | | |
| Property, plant and equipment | 1,037 | 177 |
| *Lease commitments - operating* | | |
| Committed at the reporting date but not recognised as liabilities, payable: | | |
| Within one year | 967 | 1,259 |
| One to five years | 1,742 | 2,231 |
| More than five years | 2,269 | 3,614 |
| | 4,978 | 7,104 |

### Note 32. Remuneration of auditors

During the financial year the following fees were paid or payable for services provided by Queensland Audit Office, the auditor of the agency, and unrelated firms:

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| *Audit services - Queensland Audit Office* | | |
| Audit of the financial statements | 286 | 244 |
| *Other services - unrelated firms* | | |
| Internal Audit Services* | 489 | 380 |

*In 2013 internal audit fees were classified as consultant expenses

### Note 33. Restricted Assets

At 1 July 2012 Queensland Health and pursuant with section 4 of the transfer notice -Designation of Transfer or Other dealing (*S307 (2) (a) of the Hospital and Health Board Act 2011*) General Trust Net Assets to the total value of $6,533,000 were transferred to the Townsville Hospital and Health Service.

A significant component of the General Trust funds held by the THHS is the Study Education and Research Trust Account, disclosed below. Under the Right of Private Practice agreement, funds generated by doctors after reaching the threshold allowable under the option B arrangement are held in trust for specific purposes of study, education and research activities.

General Trust Funds are managed on an accrual basis and form part of the annual general purpose financial statements. This money is controlled by the THHS and forms part of the cash and cash equivalents balance (refer Note15), however it is restricted in nature as it can only be used for the specific purposes. At 30 June 2014 amounts of ($10,157,000) (2013 $8,482,000) are set aside for the specified purpose of the underlying contributions

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| *Study Education and Research Trust* | | |
| Revenue | 3,014 | 2,465 |
| Education and Professional Development | (119) | (93) |
| Travel | (3) | (5) |
| Equipment | (139) | (94) |
| Other | (788) | (1,061) |
| Total Payments | (1,049) | (1,253) |
| Surplus for the year | 1,965 | 1,212 |
| Current Asset beginning of year | 5,612 | 4,400 |
| Current Asset end of the year | 7,577 | 5,612 |

### Note 34. Trust transactions and balances

The Townsville HHS is responsible for the efficient, effective and accountable administration of Patient Trust. Patients' monies/properties are held in a fiduciary capacity for the benefit of the patient to whom the duty is owed. As such, they are not recognised in the financial statements, but are disclosed below for information purposes.

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| **Trust receipts and payments** | | |
| *Receipts* | | |
| Patient Trust receipts | 4,712 | 4,749 |
| Refundable deposits | - | 4 |
| Total receipts | 4,712 | 4,753 |
| *Payments* | | |
| Patient Trust | (4,610) | (4,835) |
| Refundable deposits | (1) | (5) |
| Total payments | (4,611) | (4,840) |
| **Trust assets and liabilities** | | |
| *Current Assets opening* | | |
| Cash - Patient Trust | 627 | 713 |
| Refundable deposits | 1 | 2 |
| Total Current Assets | 628 | 715 |
| *Current Assets closing* | | |
| Cash- Patient Trust | 729 | 627 |
| Refundable deposits | - | 1 |
| | 729 | 628 |
| Net increase /(decrease) in cash- patient trust | 102 | (86) |
| Net increase/(decrease) in refundable deposits | (1) | (1) |

**Note 35. Arrangements for the provision of public infrastructure by other entities**

Public Private Partnership (PPP) arrangements operating for all or part of the financial year are as follows. Refer to Note 2(ad). The PPP is a Build-Own-Operate-Transfer (BOOT) arrangement,

| *Facility* | *Counterparty* | *Term of Agreement* | *Commencement Date* |
|---|---|---|---|
| Medilink | The Trust Company Ltd | 30 years | January 2012 |
| Goodstart Early Learning | The Trust Company Ltd | 32 years | February 2012 |
| | | | |

As of 30 June 2014 the THHS does not have legal title to properties under its control. The land where the facilities have been constructed is recognised as THHS's land, subject to separate operating lease on each of the facilities.

The THHS has not recognised any rights or obligations relating to these facilities other than those associated with land rental and the provision of services under these agreements. The THHS has the right to retain the rent in accordance with the Deed of Lease in the Transfer Notice.

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Other revenue recognised in relation to these arrangements by facility: | | |
| Medilink | 36 | 35 |
| Goodstart Early Learning | 13 | 13 |

*Medilink*

The developer has constructed an administrative and retail complex on the site at the hospital . Rental of $36,000 per annum escalated for CPI annually will be received from the facility owner up to January 2042. The facility owner operates and maintains the facility at its sole cost and risk.

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Inflows | | |
| Up to 1 year | 37 | 36 |
| More than 1 year but less than 5 years | 159 | 155 |
| More than 5 years but less than 10 years | 227 | 220 |
| Later than 10 years | 1,067 | 1,115 |

*Goodstart Early Learning centre*

The developer has constructed a childcare facility on the site at the hospital. Rental of $14,000 per annum escalated for CPI annually will be received from the facility owner up to February 2044. The facility owner operates and maintains the facility at its sole cost and risk.

| | 2014 | 2013 |
|---|---|---|
| Inflows | | |
| Up to 1 year | 14 | 13 |
| More than 1 year but less than 5 years | 59 | 58 |
| More than 5 years but less than 10 years | 85 | 85 |
| Later than 10 years | 439 | 456 |

### Note 36. Events after the reporting period

*1.Senior Medial Officer and Visiting Medical Officer Contract*

Effective 4 August 2014, Senior Medical Officers and Visiting Medical Officers transitioned to individual employment contracts.

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

As a direct employment relationship is established between contracted medical officers and their HHS employee related costs for contracted Senior Medical Officers and Visiting Medical Officers are recognised by the employing HHS (not the Department of Health) from the date the contracts are effective.

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

*2.Transfer of general purpose housing to the Department of Housing and Public Works*

As part of a whole-of-Government initiative, management of all non-operational housing transitioned to the Department of Housing and Public Works on 1 January 2014. Legal ownership of housing assets transferred on 1 July 2014. As housing assets are currently controlled by the THHS, this initiative does not have a material impact on the Financial Statements of the Townsville HHS.

*3. Prescribed Employer Project*

Currently, all staff except Health Service Chief Executives and health executive service (HES) employees (working in an HHS), are employed by the Director-General, Department of Health. In June 2012, amendments were made to the Hospital and Health Boards Act 2011, giving Hospital and Health Boards more autonomy by allowing them to become the employer of staff working for their HHS. HHSs are prescribed as employers by regulation, which is why the process is called the prescribed employer process.

As THHS became a prescribed employer on 1 July 2014, the THHS, not the Department of Health are to recognise employee expenses in respect of these staff. The Director-General of the Department of Health, continue to be responsible for setting terms and conditions of employment, including remuneration and classification structures, and for negotiating enterprise agreements.

It is anticipated that the THHS move to become a prescribed employer on 1 July 2014 does not have a material impact on the financial performance or position of the health service as all costs of staff working within the Health Service are currently brought to account as either Health Service employee costs or Department of Health Service employee costs. The change to prescribed employer will see the Department of Health Service employee costs be brought to account as THHS employee costs.

*4. Transfer of legal ownership of health service land and buildings to THHS*

Commencing 1 July 2014, legal title of health service land and buildings transferred from the Department of Health to the THHS. Refer to Note 2(r). As the THHS currently control these assets through Deed of Lease arrangements, there is no material impact to the accounts of the THHS upon transfer.

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

### Note 37. Economic dependence

The THHS's primary source of income is from the Department of Health for the provision of public hospital, health and other services in accordance with a service agreement with the Department of Health. The THHS's ability to continue viable operations is dependent on this funding. At the date of this report, management has no reason to believe that this financial support will not continue, particularly as the current service agreement covers the period from 1 July 2013 to 30 June 2016 refer to Note 2(h).

## Note 38. Reconciliation of surplus to net cash from operating activities

| | 2014 $'000 | 2013 $'000 |
|---|---|---|
| Surplus for the year | 19,906 | 20,354 |
| Adjustments for: | | |
| Depreciation and amortisation | 31,392 | 28,600 |
| Impairment of non-current assets | - | 1,325 |
| Write off of non-current assets | | |
| Net (gain)/loss on disposal of non-current assets | (140) | 806 |
| Revenue - contribution To DOH Capital Works in Progress Program | (31,392) | (28,600) |
| Assets donated revenue non cash | (74) | (119) |
| Assets transferred non cash | 815 | (2,026) |
| Change in operating assets and liabilities: | | |
| Decrease/(increase) in trade and other receivables | 2,821 | (981) |
| Decrease/(increase) in GST receivables | (24) | - |
| Decrease/(increase) in inventories | (421) | 1,781 |
| Increase in accrued revenue | - | (1,941) |
| Decrease/(increase) in prepayments | (70) | 183 |
| Increase/(decrease) in trade and other payables | 3,194 | (6,897) |
| Increase/(decrease) in employee benefits | (23) | 40 |
| Increase /(decrease) in other operating liabilities | 226 | 33,083 |
| Net cash from operating activities | 26,210 | 45,608 |

# Management Certificate

**Townsville Hospital and Health Service**
**Management certificate**
**30 June 2014**

**Townsville Hospital and Health Service**
**Management Certificate**

These general purpose financial statements have been prepared pursuant to Section 62(1) of the *Financial Accountability Act 2009 (the Act)*, Section 43 of the *Financial 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 the Townsville Hospital and Health Service for the financial year ended 30 June 2014 and of the financial position of the THHS at the end of that year.
**(c)** these assertions are based on an appropriate system of internal controls and risk management processes being effective, in all material respects, with respect to the financial reporting throughout the reporting period.

Julia Squire
**Chief Executive**
Townsville Hospital & Health Service
25-8-14

John Bearne
**Board Chair**
Townsville Hospital & Health Service
25 AUGUST 2014

QAO
certified statements

# Independent Auditor's Report

To the Board of Townsville Hospital and Health Service

**Report on the Financial Report**

I have audited the accompanying financial report of Townsville Hospital and Health Service, which comprises the statement of financial position as at 30 June 2014, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and certificates given by the Board Chair and Chief Executive.

*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 Townsville Hospital and Health Service for the financial year 1 July 2013 to 30 June 2014 and of the financial position as at the end of that year.

**Other Matters - Electronic Presentation of the Audited Financial Report**

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


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

Queensland Audit Office
Brisbane

# Compliance Checklist

| Summary of requirement | | Basis for requirement | Annual report reference |
|---|---|---|---|
| **Letter of compliance** | › A letter of compliance from the accountable officer or statutory body to the relevant Minister | ARRs – section 8 | page 2 |
| **Accessibility** | › Table of contents | ARRs – section 10.1 | page 3 |
| | › Glossary | ARRs – section 10.1 | page 80 |
| | › Public availability | ARRs – section 10.2 | inside cover |
| | › Interpreter service statement | *Queensland Government Language Services Policy*<br>ARRs – section 10.3 | inside cover |
| | › Copyright notice | *Copyright Act 1968*<br>ARRs – section 10.4 | inside cover |
| | › Information Licensing | *QGEA – Information Licensing*<br>ARRs – section 10.5 | inside cover |
| **General information** | › Introductory Information | ARRs – section 11.1 | page 5 |
| | › Agency role and main functions | ARRs – section 11.2 | page 10, 17 |
| | › Operating environment | ARRs – section 11.3 | page 6, 17, 19-21 |
| | › Machinery of government changes | ARRs – section 11.4 | page 17 |
| **Non-financial performance** | › Government's objectives for the community | ARRs – section 12.1 | page 17-18 |
| | › Other whole-of-government plans / specific initiatives | ARRs – section 12.2 | page 18 |
| | › Agency objectives and performance indicators | ARRs – section 12.3 | page 7, 8, 10, 27 |
| | › Agency service areas, and service standards | ARRs – section 12.4 | page 30-33 |
| **Financial performance** | › Summary of financial performance | ARRs – section 13.1 | page 34 |
| **Governance – management and structure** | › Organisational structure | ARRs – section 14.1 | page 11 |
| | › Executive management | ARRs – section 14.2 | page 12-16 |
| | › Related entities | ARRs – section 14.3 | n/a |
| | › Government bodies | ARRs – section 14.4 | n/a |
| | › Public Sector Ethics Act 1994 | *Public Sector Ethics Act 1994* (section 23 and Schedule)<br>ARRs – section 14.5 | page 28 |
| | › Queensland public service values | ARRs – section 14.6 | page 17 |
| **Governance – risk management and accountability** | › Risk management | ARRs – section 15.1 | page 28 |
| | › External scrutiny | ARRs – section 15.2 | page 28 |
| | › Audit committee | ARRs – section 15.3 | page 27 |
| | › Internal audit | ARRs – section 15.4 | page 28 |
| | › Public Sector Renewal | ARRs – section 15.5 | page 17 |
| | › Information systems and recordkeeping | ARRs – section 15.6 | page 29 |
| **Governance – human resources** | › Workforce planning, attraction and retention, and performance | ARRs – section 16.1 | page 23-26 |
| | › Early retirement, redundancy and retrenchment | *Directive No.11/12 Early Retirement, Redundancy and Retrenchment*<br>ARRs – section 16.2 | page 25 |
| **Open Data** | › Open Data | ARRs – section 17 | inside cover |
| **Financial statements** | › Certification of financial statements | FAA – section 62<br>FPMS – sections 42, 43 and 50<br>ARRs – section 18.1 | page 76 |
| | › Independent Auditors Report | FAA – section 62<br>FPMS – section 50<br>ARRs – section 18.2 | page 77-78 |
| | › Remuneration disclosures | *Financial Reporting Requirements for Queensland Government Agencies*<br>ARRs – section 18.3 | page 68-70 |

FAA Financial Accountability Act 2009
FPMS Financial and Performance Management Standard 2009
ARRs Annual Report Requirements for Queensland Government agencies

# Glossary

| | |
|---|---|
| ABF | Activity Based Funding |
| DoH | Department of Health |
| ED | Emergency Department |
| FTE | Full Time Equivalent |
| HHS | Hospital and Health Service |
| HHSCF | Hospital and Health Service Consultative Forum |
| HSCE | Health Service Chief Executive |
| JCU | James Cook University |
| KPI | Key Performance Indicator |
| MOHRI | Minimum Obligatory Human Resource Indicator |
| NATA | National Association of Testing Authorities |
| NEAT | National Emergency Access Target |
| NEST | National Elective Surgery Target |
| PA&D | Performance Appraisal and Development |
| PGMEU | Post Graduate Medical Education Unit |
| QAO | Queensland Audit Office |
| SMT | Senior Management Team |
| TTH | The Townsville Hospital |
| TCCR | Townsville Centre for Clinical Research |
| TC-TPR | Tropical Centre for Telehealth Practice and Research |
| WAU | Weighted Activity Unit |

Townsville Hospital and Health Service
2013–2014 Annual Report
www.health.qld.gov.au/townsville