ANNUAL REPORT
2015–2016

Darling Downs Hospital and Health Service

Queensland Government

Darling Downs Hospital and Health Service
Annual Report 2015-2016

Open data

The Darling Downs Hospital and Health Service is committed to the Queensland Government's open data strategy. The following additional information has been published on the government's open data website to form part of our 2015-2016 annual report:

- consultancy expenditure
- overseas travel expenditure
- results against the Queensland Language Services Policy

This information is published at: www.qld.gov.au/data

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Attribution

Content from this annual report should be attributed as:
Darling Downs Hospital and Health Service Annual Report 2015-2016

Interpreter service statement

Darling Downs Hospital and Health Service 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) 4699 8412 and we will arrange an interpreter to effectively communicate the report to you.

Acknowledgement of Traditional Owners

Darling Downs Hospital and Health Service respectfully acknowledges the traditional owners of the land on which its sites stand.

Letter of compliance

The Honourable Cameron Dick MP
Minister for Health
Minister for Ambulance Services
GPO Box 48
Brisbane Qld 4001

Dear Minister

I am pleased to submit for presentation to the Parliament the Annual Report 2015-2016 and financial statements for the Darling Downs Hospital and Health Service.

I certify that this Annual Report complies with:

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

A checklist outlining the annual reporting requirements can be found at page 54 of this annual report.

Yours sincerely

Mr Mike Horan AM

Chair

Darling Downs Hospital and Health Board

07/09/2016

Table of contents

Board Chair report

Mr Mike Horan AM
Board Chair

It is with great pleasure that I present the fourth annual report of the Darling Downs Hospital and Health Service (DDHHS) as we continue to deliver contemporary health services across a diverse region. Once again the Board is proud of the high quality of clinical care provided by DDHHS staff to communities from all 26 of our facilities. Whilst there is an increasing demand on our services, I have complete faith with staff to rise, meet and exceed these challenges.

Once again 2015-2016 has seen an increase in activity across the health service. It is with pride that I note DDHHS is the only health service in Queensland that has zero patients waiting longer than clinically recommended for specialist outpatient appointments, and all patients waiting for elective surgery were also treated on time, despite a seven per cent increase in demand. None of these achievements could be managed without the DDHHS's frontline and support staff working diligently to support the health needs of our region.

For the fourth year in a row DDHHS has made a surplus, although smaller than previous years. This surplus will go back into providing improvements to clinical services, new equipment and infrastructure across the health service.

This year the Board announced the following new major infrastructure projects funded from the accumulated surplus:

- $8.1m seventh operating theatre for Toowoomba Hospital
- $2.6m new staff accommodation and private practice clinic at Miles Hospital

These projects further complement the large number of projects already funded, underway or completed from the surplus.

The Board farewelled two board members in May 2016, Dr Jeff Prebble and Mr Terry Fleischfresser. Jeff, a well respected and popular paediatrician, retired from the Board and from medical practice.

Jeff's genuine interest in the healthcare of women and children over the past 37 years was an invaluable addition to the Board from the outset in 2012. On behalf of the Board I thank him for his wisdom and friendship. Mr Terry Fleischfresser also completed his tenure with the Board in May 2016. Terry is a passionate advocate for the South Burnett area and I wish him well in his new endeavours.

The Board welcomed two new members, Ms Corinne Butler and Dr Ruth Terwijn in May 2016. Corinne has a background in human resources and business and Ruth is an experienced nurse manager and nursing academic. I am sure they will make an important contribution to the Board during their terms.

I thank all of the Board members for their unfailing commitment to engaging with communities and stakeholders across the health service and advocating for their healthcare needs. Only through continued collaboration with communities will we be able to continue to meet the expectations of our customers. I look forward to another three years as the Board Chair, a position I am proud and humble to hold. Healthcare is a cornerstone of the community that I have been privileged to represent over a long public career.

In January 2016 we farewelled our Health Service Chief Executive Dr Peter Bristow, after three-and-a-half years at the helm of the DDHHS. Dr Bristow gave 15 years of dedicated service to Toowoomba Hospital and the DDHHS and led a culture of respect, openness and learning throughout the health service. I thank him for his diligence and outstanding leadership as the inaugural DDHHS Health Service Chief Executive.

Finally, on behalf of the Board, I would like to congratulate and acknowledge the commitment and hard work of our new Health Service Chief Executive, Dr Peter Gillies, and his executive team who are focussed, as always, on delivering excellent healthcare across the whole of the DDHHS. I have absolute confidence in their ability to meet the challenges in delivering quality rural and regional healthcare in partnership with our communities.

Chief Executive report

Dr Peter Gillies
MBChB, MBA, FRACMA, GAICD
Chief Executive

Reflecting on the 2015-2016 Annual Report I am first and foremost proud of the hard work and dedication of DDHHS staff across the region. It is only through our people that the DDHHS is able to deliver quality healthcare to the communities that our health service covers.

In my first six months as Chief Executive it has been a pleasure to observe the improvements in access to services throughout the region – especially the increases in dental occasions of service, elective surgery and specialist outpatient appointments across all treatment categories. DDHHS also continues to increase the number of telehealth occasions of service, allowing patients to remain in their local community, but still access and receive specialist medical attention.

The DDHHS has now maintained no long waits for elective surgery for two and half years, and no long waits for specialist outpatient appointments for one year. Reaching these targets initially was a significant achievement but sustaining this performance over such a long period of time is a true testament to the commitment of our staff.

Over the past year community engagement has continued to grow, and it was with great pleasure that in October we welcomed a new community member representative onto the Toowoomba Hospital Patient Safety and Quality Committee. We also saw the establishment of the DDHHS Consumer Council in February 2016. The Consumer Council is engaging with communities, advisory groups and patients to promote respect, open communication and improve our service and the health outcomes of patients across our region. We will continue to work hard at promoting community and consumer engagement in the planning and operation of our health service.

This past year DDHHS has continued to collaborate with the new federally funded Darling Downs and West Moreton Primary Health Network. These networks were established with the key objective of increasing efficiency and effectiveness of medical services, especially for those at risk of poor health outcomes. As a key stakeholder in this Network I am pleased at their hard work in setting up across two geographically diverse areas of health and health population needs.

We have continued to invest in the refurbishment and expansion of our facilities across the region. Many of the rural facilities have had flooring replaced; helipads improved and received a painting face-lift. DDHHS is approximately half-way through the backlog maintenance of facilities funded through the Department of Health's Backlog Maintenance Remediation Program.

DDHHS remains committed to delivering excellence in rural and regional healthcare. The health service has implemented a free 'shuttle bus' service from the South Burnett to Toowoomba to enable patients to access the specialist healthcare that they need. We also celebrated 10 years of the Rural Generalist Program, which is recognised nationally as a very effective model for enhancing rural medical workforce capacity and capability.

Once again staff from DDHHS participated in the Working for Queensland annual survey. Across DDHHS there was a 43 per cent participation rate in the survey, close to the 44 per cent response rate across all of Queensland Health. The results of these surveys help senior management to improve conditions for our staff as well as receive feedback on how "things are running" since the previous year's survey.

The Executive have worked diligently through the year to achieve these results across the health service, and I thank them for their contributions. Additionally I would like to extend my gratitude to the Board, and especially to the Board Chair, Mr Mike Horan, for their support to the patients, staff and executive members of the health service.

This year's milestones

NAIDOC week

Following a week of celebrations across various facilities in the DDHHS, the NAIDOC Week Award for Excellence in Service Delivery was presented to Cherbourg Health Service Manager, Ms Tarita Fisher (left).

Primary Health Network starts operations

Darling Downs and West Moreton Primary Health Network (DDWM PHN) started on 1 July 2015. The PHN is jointly operated by the DDHHS and GP Connections.

Joint emergency preparedness exercise a success

A joint disaster exercise was held between Toowoomba Hospital and St. Vincent's Private Hospital to test staff's response to a large-scale disaster.

Rural Generalist Program turns 10

This program is recognised nationally for enhancing the rural medical workforce.

JULY

AUGUST

SEPTEMBER

Drs Roger and Jill Guard farewelled

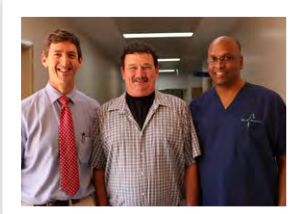
Memorial service held for Dr Roger Guard and Dr Jill Guard, respected members of the Toowoomba healthcare community who tragically lost their lives in the MH17 disaster.

Mental health nurse participates in Black Dog Ride

Baillie Henderson Hospital mental health nurse, Rob McGrigor participates in Black Dog Ride across the Red Centre to raise funds and increase mental health awareness

Highly specialised robotic ENT surgery performed

World first robotic ENT surgery performed in a regional setting on a public patient, in partnership with St Andrews Hospital Toowoomba. The surgery involved the removal of the voice box and insertion of a new speaking valve.



Goondiwindi's upgraded kitchen delivers first meals

Goondiwindi Hospital kitchen upgrade and refurbishment is completed.

Consumer representative joins committee to improve patient care

Toowoomba Hospital welcomed a new community representative member on its Patient Safety and Quality Committee.

Good news for Goondiwindi mums

Goondiwindi Hospital receives official accreditation under the national Baby Friendly Health Initiative

Legislation passes in State Parliament to implement new nurse-to-patient ratios.

Toowoomba Hospital enrolled nurse Lauren Picker travelled to Brisbane to witness the historic move.

OCTOBER

NOVEMBER

DECEMBER

New radiology services for Warwick and Goondiwindi

Expanded radiology service opens at Warwick and Goondiwindi Hospitals

Healthy Minds Expo held in Tara

Over 50 people attended the event, which focused on healthy lifestyles, chronic disease management and promotion of telehealth services.

Miles ahead in staff recognition

Miles Hospital staff members received Strategic Operational Service Unit awards for excellence in state-wide program.

New cardiac ultrasound service starts

Toowoomba Hospital announces start of full-time cardiac ultrasound service, which will mean fewer patients have to travel elsewhere to receive specialist medical treatment.

This year's milestones

Record number of medical interns start across the DDHHS

The DDHHS welcomed a total of 39 new medical graduates this year.

Alcohol and Other Drugs Service (AODS) team settle into newly refurbished office

Fountain House 1 was officially opened for the new AODS office accommodation at Toowoomba Hospital.

New theatre announced for Toowoomba Hospital

$8.1 million announced for the construction of a seventh operating theatre at Toowoomba Hospital.

Consumers engaged to improve the service

DDHHS Consumer Council established. The Council will engage with communities, advisory groups and patients to improve communication, healthcare outcomes for our patients and the service that we provide.

Closing the Gap pledge signed by the DDHHS Executive

The pledge was made on the 10th anniversary of the Closing the Gap campaign. The DDHHS is committed to improving health outcomes for its Indigenous communities.

JANUARY

Annual Employee Awards a success

Over 100 nominations received across seven categories, with the awards recognising the outstanding efforts of our dedicated staff.

FEBRUARY

New nursing graduates start

48 graduate nurses started across the DDHHS.

Patient travel set to become easier for South Burnett Patients

The DDHHS has implemented a free shuttle bus for patients in the South Burnett region that need to attend specialist appointments in Toowoomba.

MARCH

Accreditation affirms safe and quality care

DDHHS moved to a single accreditation process under the ISO: 9001 Quality Management Standard and achieved ongoing certification in March 2016.

ihca supporting excellence CERTIFICATION

AS/NZS ISO 9001:2008 QUALITY CERTIFIED ORGANISATION

New resident brings joy to aged care patients

Sammy the greyhound comes to live at Mt Lofty Heights Nursing Home and has been warmly welcomed by all residents.

Dental waiting lists slashed

The lists were slashed by over 54 per cent resulting in no patients waiting longer than clinically recommended for treatment.

Board welcomes new members

Ms Corinne Butler and Dr Ruth Terwijn joined the Board.

Long-serving staff members honoured

86 staff members honoured for 30, 35, 40 and 45 years of service with the DDHHS. Collectively the staff have clocked up 2845 years of service.

No patients have waited longer than clinically recommended for treatment

By the end of June, the DDHHS had zero patients waiting longer than clinically recommended for elective surgery, endoscopy and specialist outpatient appointments for the entire 12 month period. For elective surgery this marked 2 1/2 years in which there had been zero long wait patients.

APRIL

New SAFE Modules implemented

New tailor-made SAFE audit modules implemented to measure clinical performance and focus on safe and quality care.

MAY

Board farewells retiring member, Dr Jeff Prebble OAM

Dr Prebble, respected paediatrician with a work history spanning 37 years, retired from the Darling Downs Hospital and Health Board in May. A farewell luncheon was held in his honour.

New Health Service Chief Executive announced

The DDHHS welcomed Dr Peter Gillies to the role of HSCE in May. Dr Gillies, as the previous General Manager Toowoomba Hospital, has a strong track record in delivering efficient services and improving patient care.

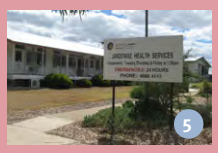
JUNE

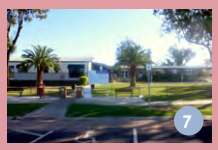
Miles Hospital welcomes new infrastructure announcement

The Board announced the allocation of $2.6 million for refurbishments at Miles Hospital. The project will include four new 2 bedroom units of accommodation and refurbishment of the community health building for the private practice clinic.

Overview

Our facilities





Legend

- Hospital
- Outpatient Clinic
- Multipurpose Health Service
- Aged Care Facility
- 10 Image reference number

Our role

The Darling Downs Hospital and Health Service (DDHHS) is an independent statutory body governed by the Darling Downs Hospital and Health Board (the Board), which reports to the Minister for Health and Minister for Ambulance Services. The DDHHS was established as a statutory authority on 1 July 2012. DDHHS's responsibilities are set out in legislation through the *Hospital and Health Boards Act 2011* and the *Financial Accountability Act 2009* and subordinate legislation.

DDHHS provides public hospital and healthcare services under a service agreement with the Department of Health. This agreement identifies the services to be provided, performance indicators and key targets that ensure outcomes are achieved. The DDHHS delivers services from 26 facilities across the region, which includes nine regional hospitals, eight rural community hospitals, six residential aged care facilities, three multipurpose health services, and five outpatient clinics.

To support the services that we provide we also have service level agreements in place with private health providers for highly specialised services and at times patients may require transportation to Brisbane for specialist services that are only provided at tertiary facilities. The DDHHS is also a provider of specialist services to residents from surrounding health services, such as the South West Hospital and Health Service.

DDHHS continues to be one of the largest employers in the region, employing more than 5,000 people in full time, part time and casual positions. In 2015-2016 DDHHS had a funded budget of $684 million.

Our region

The DDHHS covers a geographically diverse area of approximately 90,000 square kilometres. The area covers the local government areas of the Toowoomba Regional Council, Western Downs Regional Council, Southern Downs Regional Council, South Burnett Regional Council, Goondiwindi Regional Council, Cherbourg Aboriginal Shire Council and the community of Taroom in the Banana Shire Council.

The region has an estimated population of nearly 280,000 people. The region's population is expected to reach 300,000 in less than five years, an increase of 1.2 per cent annually. Aboriginal and Torres Strait Islander Australian's make up 4.2 per cent of the population in the region compared to 4.3 per cent across the State. Healthcare challenges for the region's population include ageing, obesity, diabetes and other health issues associated with low socioeconomic backgrounds.

Due to the size of the region and the need for patients to travel significant distances to receive the specialist healthcare they need this will see a continuing increase in claims administered by the DDHHS through the Patient Travel Subsidy Scheme (PTSS) which has increased by 22 per cent over the past two years, with a 14 per cent increase in the past year alone.

Our services

DDHHS provides a comprehensive range of hospital services including inpatient and outpatient services, surgical sub-specialties, medical sub-specialties, and diagnostic services.

The DDHHS also offers community and primary health services including: aged care assessment, Aboriginal and Torres Strait Islander health programs, child and maternal health services, alcohol and other drugs services, home care services, community health, sexual health service, allied health services, oral health, and other public health programs.

Our integrated mental health service provides specialist services across a number of clinical programs through Toowoomba Hospital, Baillie Henderson Hospital and throughout rural communities. DDHHS also operates six residential aged care services across the health service.

Overview

Our vision

To deliver excellence in rural and regional healthcare.

Our purpose

Delivering quality healthcare in partnership with our communities.

Our values

The DDHHS values are aligned to the public service values of customer's first, ideas into action, unleash potential, be courageous and empower people. In 2015-2016 work continued on embedding a value-based culture in our organisation. Our values guide how we work and support us to achieve our goals:

- **Caring** – We deliver care, we care for each other and we care about the service we provide.
- **Doing the right thing** – We respect the people we serve and try our best. We treat each other respectfully and we respect the law and standards.
- **Openness to learning and change** – We continually review practice and the services we provide.
- **Being safe, effective and efficient** – We will measure and own our performance and use this information to inform ways to improve our services. We will manage public resources effectively, efficiently and economically.
- **Being open and transparent** – We work for the public and we will inform and consult with our patients, clients, staff, stakeholders and community.

Our challenges

In 2015-2016 the health service faced a number of challenges in delivering healthcare services to our region. These included:

- **Financial constraints** – whilst the health service continued to perform efficiently this year there are ever increasing service demand pressures that impact on the delivery of a balanced budget and retained surplus.
- **Workforce challenges** – recruiting and retaining highly qualified staff in rural and regional areas is an ongoing challenge that the service continues to manage.
- **Service demand and expectations** – demand for public healthcare services is increasing and shaped by our changing population profile. Adaptability to change has been critical along with managing community expectations of the services that we can provide.
- **Chronic disease** –increasing incidence of chronic diseases such as diabetes, obesity and an ageing population place significant pressure on our service.
- **Outdated infrastructure** - the service has a large number of aged buildings and facilities that are becoming harder to maintain or refurbish and adapt to changing models of care.

Our strategic direction

The *DDHHS Strategic Plan 2015-19* articulates how we deliver on the Queensland Government's objectives for the community which includes strengthening the public health system, as well as creating jobs, building a diverse economy, delivering quality frontline services, protecting the environment and building safe, caring and connected communities.

The plan has four key strategic directions which focuses our efforts on delivering quality healthcare for our community:

- Deliver quality healthcare
- Ensure resources are sustainable
- Ensure processes are clear
- Ensure dedicated trained staff

Our priorities against the *DDHHS Strategic Plan 2015-19* this year included:

- Making a Closing the Gap commitment to improve Indigenous health outcomes in our region
- Implementing a free patient transfer bus for patients in the South Burnett region with confirmed medical, oral health or allied health appointments at Toowoomba Hospital
- Establishing the Darling Downs and West Moreton Primary Health Network
- Growing community engagement through the establishment of a Consumer Council and promoting consumer participation in the planning of our service.
- Supporting our staff through education and training
  - » Celebrating the 10 year anniversary of the Rural Generalist Program
  - » Increasing nominations of staff for the annual employee awards which recognises and celebrates staff achievements in demonstrating our values, vision, and purpose
  - » Improving staff training rates through the Darling Downs Learning Online (DD-LOL) training system and celebrating its first birthday
- Continued safety and quality across all services
  - » Achieving ISO:9001 accreditation
  - » Continuing the implementation of the SAFE audits
- Delivering improved local facilities including:
  - » Announcement of a seventh theatre at Toowoomba Hospital
  - » Announcement of a new magnetic resonance imaging (MRI) service for Toowoomba Hospital
  - » New accommodation for the Alcohol and Other Drugs Services
  - » New flooring across Warwick Hospital
  - » New computerised tomography (CT) scanners operational at Goondiwindi and Warwick Hospitals
  - » Upgraded helipads throughout the DDHHS
  - » Ongoing works on the Backlog Maintenance Remediation Program
- Continuing to collaborate with primary healthcare providers and other key stakeholders.

Our governance

Our Board

The Darling Downs Hospital and Health Board is comprised of nine non-executive members who are appointed by the Governor in Council on the recommendation of the Minister for Health in accordance with the *Hospital and Health Boards Act 2011*.

The Board sets the strategic direction for the health service and is accountable for its performance in delivering quality health outcomes to meet the needs of the community it serves.

Mr Mike Horan *AM*

Dr Dennis Campbell

Dr Ruth Terwijn

Ms Cheryl Dalton

Ms Marie Pietsch

Ms Corinne Butler

Dr Ross Hetherington

Ms Trish Leddington-Hill

Ms Megan O'Shannessy

Mr Mike Horan AM

Chair, Darling Downs Hospital and Health Board
Chair, Executive Committee

Mr Mike Horan was the Member for Toowoomba South in the Queensland Parliament from 1991 to 2012. During his political career Mike served as the leader of the National Party, the leader of the Opposition, Shadow Attorney-General and Shadow Minister for Police, Health and Primary Industries respectively. Mike regards his time as Minister for Health (1996-1998) as a highlight of his political career.

Mike has considerable experience in the development and construction of small and large health facilities. More than 100 health construction projects varying from rural hospitals to major metropolitan hospitals occurred under his Health Ministry. During his time as Health Minister the Surgery on Time System was established, a ten year Mental Health Plan introduced and targets for breast screening and children's immunisation were set and achieved. Thirty eight District Health Councils were put in place and the Rural Health Council was established at Roma.

Mike held the position of General Manager of The Royal Agricultural Society of Queensland (Toowoomba Showgrounds) from 1978 to 1991 and was a driving force in the sale of the old inner city Toowoomba Showgrounds and the development of the new Toowoomba Showgrounds on a 98 hectare site. Mike also served as secretary of the Darling Downs sub-chamber of Agricultural Societies, a number of Breed Societies and of the Downs Harness Racing and the Toowoomba Greyhound Racing Club.

Mike is currently Board Chair of Downs Rugby Ltd, covering rugby union from Gatton to St George and a board member of the Toowoomba Police Citizens Youth Club.

In June 2013 Mike was awarded a Member (AM) in the General Division of the Order of Australia for significant service to the Parliament of Queensland and to the community of the Darling Downs.

He is a great believer in working with the community to achieve results.

Dr Dennis Campbell *PhD, MBA, FCHSM, CHE, FAIM, GAICD*

Deputy Chair, Darling Downs Hospital and Health Board
Chair, Finance Committee
Member, Executive Committee
Chair, Audit and Risk Committee (until April 2016)
Member, Audit and Risk Committee (from May 2016)

Dr Dennis Campbell has been Chief Executive Officer in both the public and private sectors and served on numerous boards and advisory committees. He has legal and health qualifications and in 2007 was awarded an Australia Day Medallion for services to the Australian College of Health Service Executives.

Dennis has held the positions of Assistant and Acting Regional Director as well as Chief Executive Officer at St Vincent's Hospital, Toowoomba. He is currently the Deputy Chairman of the Heritage Bank Board.

Dennis served as Corporate Director with Legal Aid, Queensland for ten years as well as in other executive positions within the Department of Education and Department of Aboriginal and Islander Advancement.

Dennis has legal and health qualifications and has served on numerous boards and advisory committees, representing both public and private health sectors.

Dennis joined the Heritage Board in 2000 and is a Chairman of the Finance Committee. Dennis became Chairman of Permanent LMI Pty Ltd in January 2010. He also served as a trustee of the Queensland Museum Foundation and as Chairperson on the Management Advisory Committee of the Cobb & Co Museum, Toowoomba.

In 2008, Dennis was awarded the Gold Medal for Leadership and Achievement in Health Services Management, recognising his contribution and professional achievements in shaping healthcare policy at institutional, state and national levels.

Our governance

Dr Ruth Terwijn *RN, MNurs (Hons), PhD*

Member, Safety and Quality Committee

Dr Ruth Terwijn is a registered nurse and academic who started her nursing career at St Vincent's Hospital, Toowoomba. Ruth worked with Family Planning Queensland in clinical, educational and managerial roles for 18 years. During this time she completed her Master of Nursing (Hons) through the University of Southern Queensland (USQ).

Ruth accepted an academic role as a lecturer of nursing at USQ. Her teaching focus during this time was introducing student nurses to the profession of nursing and progressing a problem-based learning model to an online learning platform.

Ruth has worked closely with nursing students with a Permanent Humanitarian Visa. In 2015, she completed her PhD with a critical research study on the experiences of English as an additional language (EAL) and international nursing students.

Ms Cheryl Dalton

Member, Finance Committee
Member, Audit and Risk Committee (until April 2016)
Chair, Audit and Risk Committee (from May 2016)

Ms Cheryl Dalton has previously been a Councillor for the South Burnett Regional Council and has extensive local Government experience as well as a long standing membership of the Queensland Resource Operating Plan and Moratorium Panel, a Department of Natural Resources and Mines Panel.

Cheryl has been an elected member of the South Burnett Regional Council (2 terms), the Kingaroy Shire Council (3 terms) and the Local Transition Committee. In the South Burnett Regional Council she previously held the Planning and Land Management Portfolio, and Waste Management Portfolio. Cheryl is the current Chair of the South Burnett Regional Council Arts Culture and Heritage Committee.

Community involvement includes her executive position on the South Burnett JobMatch Committee (Disability Employment Service), the Voluntary Auditor for both the Wooroolin Scout Group and the Durong Guide Group, a Community Reference Panel Member for the Burnett Water Resource Plan and the former Burnett Development Reference Group, both involved in water management and planning for the Burnett region.

Her business experience includes agribusiness being a Managing Director of a medium sized stockfeed manufacturing business Goldmix Stockfeeds from 1993 to 2005 and subsequently working in a consultative role in quality assurance. She is currently a Managing Director of Dalton Agribusiness which has interests in agriculture (cattle and pigs), a tractor and dozer parts importing and wholesaling business and property development.

Ms Marie Pietsch *MAICD*

Member, Safety and Quality Committee
Member, Audit and Risk Committee (from May 2016)

Ms Marie Pietsch has extensive healthcare experience across the Darling Downs region and held positions on numerous councils and committees, including Chair of the Minister's Rural Health Advisory Council and Chair Southern Downs Health Community Council.

Marie has a professional background working in the Darling Downs region and her work on agricultural and health-related committees has given her strong exposure to local community issues.

Marie is a member of various health committees including:

- Member of Inglewood Multipurpose Health Service Management Committee
- Chair of Inglewood Community Advisory Network.

Marie's work in representing health consumers in her region earned her a 2003 Centenary Medal for distinguished service to the community as Chair of the Southern Downs District Health Council. Marie also received an Australia Day Achievement Medallion for outstanding service to Queensland Health.

Ms Corinne Butler *MPM*

Member, Finance Committee (from May 2016)
Member, Audit and Risk Committee (from May 2016)

Ms Corinne Butler is the owner of Tweak HR a local consultancy that helps other local businesses improve their productivity and profitability.

Corinne has a background in business and human resources and is the Chair of Destination Southern Downs. She is the founder of the Women of Warwick and Business Network of Warwick. Corinne was the State President of the Australian Human Resources Institute for two terms. Corinne was also the Vice President of the Queensland Rural, Regional and Remote Women's Network whose purpose is to connect rural, regional and remote women, business, and industry. Corinne is a human resources multi award winner. She is a skilled facilitator, coach, mediator and assessor.

Dr Ross Hetherington *MBBS, DRANZOG, FACCRM, PG Dip Pall Med, FAICD*

Member, Finance Committee (until May 2016)
Member, Audit and Risk Committee
Member, Executive Committee (from May 2016)
Member, Safety and Quality Committee (from May 2016)

Dr Ross Hetherington is a medical practitioner and a Designated Aviation Medical Examiner (DAME). Ross also co-founded the Central Queensland Rural Division of General Practitioners and holds a number of aviation and medical memberships.

Ross has extensive experience in rural medicine and has been in private practice as a General Practitioner (GP) in Warwick since 1996. He is a board member of Health Workforce Queensland, which supports the regional, rural and remote health workforce in Queensland. Ross is Board Chair of RHealth and a foundation member of Regional Health Board, Longreach. He has held previous Directorships with AGPN and the Australian Rural and Remote Workforce Agency Group.

Ross is a member of the Aviation Medicine Society of Australia and New Zealand and a foundation member of the Menopause Society of Australasia.

Ross has an MBBS from the University of Queensland and has a Post Graduate Diploma in palliative care.

Ms Trish Leddington-Hill *BSc, LLB, GAICD*

Member, Safety and Quality Committee (until April 2016)
Chair, Safety and Quality Committee (from May 2016)

Ms Patricia (Trish) Leddington-Hill worked for more than 10 years with RHealth, a primary healthcare organisation servicing the Darling Downs and South West Queensland.

Trish grew up on a rural property near Millmerran, Queensland, and was educated in Millmerran, Toowoomba and Brisbane. She completed a Bachelor of Science and Bachelor of Laws at the University of Queensland in 2000.

Trish worked in the rural sector in a number of roles, before joining RHealth (then known as Southern Queensland Rural Division of General Practice) in 2002 where she coordinated and managed projects across the areas of allied health, mental health, aged care, quality use of medicines, health promotion and integration.

Trish's work became focused on promoting improvements to the health and community services sectors through partnerships and workforce planning and development. She completed studies in the internationally recognised Partnership Brokering Accreditation Scheme (PBAS) and is an internationally accredited Partnership Broker. During her time on the Board of the Darling Downs Hospital and Health Service, Trish has also successfully completed governance studies and is a graduate member of the Australian Institute of Company Directors (GAICD).

Trish is a keen supporter of her local community and is heavily involved in various local committees.

Ms Megan O'Shannessy *RN*

Member, Safety and Quality Committee
Member, Audit and Risk Committee (from May 2016)
Member, Finance Committee (from May 2016)

Megan is a registered nurse and midwife. Over a 25 year rural nursing career she has been the Director of Nursing at Thargomindah, Cunnamulla, Dirranbandi, St George and Warwick Hospitals.

She was a member of the Queensland Nursing Council from 1998 to 2000. She completed a Bachelor of Nursing at the University of Southern Queensland in 1996 and is at present completing her Masters in Public Health at the James Cook University.

She is now the Director of Prevocational General Practice Program at Queensland Rural Medical Education.

Board member changes this year

Dr Jeff Prebble OAM

Dr Jeff Prebble is a respected paediatrician with extensive medical experience in public and private hospitals across Toowoomba and Brisbane. Jeff is a member of several health-related committees and professional organisations, and has published numerous papers.

Jeff held a number of key positions in the medical community. He was a consultant Paediatrician in private practice in Toowoomba and Visiting Paediatrician at Toowoomba Hospital. Previously Jeff has held positions as Senior Visiting Consultant in Department of Paediatrics, Head of Department of Paediatrics and Chairman of Division of Infants, Children and Youth at Toowoomba Hospital.

Jeff has received a number of awards including the Order of Australia Medal in 2002 for services to paediatric medicine as a practitioner, educator and advocate for clinical care and practice standards for paediatrics, and the Australian Centenary Medal in 2003 for distinguished service to the medical profession.

Jeff retired from the Board in May 2016.

Mr Terry Fleischfresser

Mr Terry Fleischfresser has been a member of a number of local and state government committees since 2000 in the Kingaroy Shire Council and South Burnett Regional Council. Terry is the past Chairman for South Burnett Jobmatch.

Terry is a local business owner and operator in the Kingaroy and South Burnett Region. He has a strong background in the public sector and in community engagement in the Darling Downs region over the past 37 years.

In 2000, Terry was elected to Local Government in the Kingaroy Shire Council in the portfolio of Environment and Health. He went on to a ministerial appointment for the South Burnett Regional Health Council and was re-elected in 2004 to the Kingaroy Shire Council Environment and Health Portfolio.

Terry's term as a Board Member came to an end in May 2016.

Mr Terry Fleischfresser, Dr Dennis Campbell, Dr Jeff Prebble and Ms Marie Pietsch visiting Warwick Hospital.

Board meetings

The Board meets monthly, with every second meeting held in a rural area. The Health Service Chief Executive (HSCE) and Director Executive Services attend as standing invitees at each Board meeting.

During 2015-2016 Board meetings were held in Wondai, Oakey, Goondiwindi, Kingaroy and Miles, as well as in Toowoomba (Toowoomba Hospital and Baillie Henderson Hospital). When meeting in the rural areas the Board takes the opportunity to visit the surrounding hospitals and community health centres, as well as meet with staff and key community stakeholders including GPs in each of the communities.

The Board travelled in excess of 30,000 km throughout the 90,000 km² of the DDHHS to attend Board meetings, community engagement events and to complete site visits throughout the year.

A summary of Board activities for 2015-2016 is provided on pages 20-22.

The chair and members provide a significant contribution to the community through their participation on the Board. Remuneration acknowledges this contribution and is detailed on page 91. In addition, total out of pocket expenses paid to the Board during the reporting period was $26,123. These expenses include domestic travel, accommodation costs, motor vehicle allowances and meals.

Board Committees

To support the Board in its functions the following committees have been established under the *Hospital and Health Boards Act 2011*:

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

Each member's committee membership is listed in their profiles on pages 13-16.

Executive Committee

The Board Executive Committee focussed on supporting the Board in its role, working with the HSCE to progress strategic issues, setting the Board agenda and ensuring accountability in the delivery of health services.

During the 2015-2016 financial year, twelve Executive Committee meetings were held. The HSCE attends all Executive Committee meetings.

Finance Committee

The Board Finance Committee provided assurance and assistance to the Board, through oversight of the financial position, performance and resource management strategies of the DDHHS in accordance with relevant legislation and regulations.

During the 2015-2016 financial year, ten Finance Committee meetings were held. Also attending meetings in advisory capacities were the HSCE and Chief Finance Officer.

Safety and Quality Committee

The Board Safety and Quality Committee provided leadership and scrutiny of patient safety systems and structures to ensure the delivery of safe and effective care. The committee provided assurance and assistance to the Board on safety, quality and clinical governance frameworks and strategies of the service.

During the 2015-2016 financial year, Safety and Quality Committee meetings were held bi-monthly. Also attending in an advisory capacity are the HSCE, Executive Director Medical Services, Executive Director Nursing and Midwifery Services, and Director Clinical Governance.

In May 2016, Ms Trish Leddington-Hill was appointed chair of the committee following the retirement of the former chair, Dr Jeff Prebble.

Our governance

Audit and Risk Committee

The Board Audit and Risk Committee operates with due regard to Queensland Treasury's *Audit Committee Guidelines*, and provided assurance and assistance to the Board on:

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

This committee has an oversight role and does not replace management's primary responsibilities for the management of risks including fraud risk, the operations of the internal audit and risk management functions, the follow up of internal and external audit findings or governance of the DDHHS generally.

During the 2015-2016 financial year, Audit and Risk Committee meetings were held quarterly, with a total of 4 meetings held. Also attending meetings in advisory capacities were the HSCE, Chief Finance Officer, Head Internal Audit and representatives of Queensland Audit Office and the DDHHS's external auditor, KPMG.

The committee oversaw:

- endorsement of the annual risk-based audit plan
- completion of fieldwork in line with the audit plan, and
- the preparation of the Annual Financial Statements including review of the Chief Finance Officer's assurance statement for the financial year regarding the continued efficient and effective operation of the organisations internal financial controls in line with Section 77(2)(b) of the *Financial Accountability Act 2009*.

Ms Cheryl Dalton was appointed chair of the committee in May 2016.

Audit and risk management

Internal audit

DDHHS's Internal Audit function operates under a Board-approved charter in accordance with the requirements of the *Financial and Performance Management Standard 2009* and consistent with relevant audit and ethical standards. The Internal Audit Charter gives due regard to Queensland Treasury's *Audit Committee Guidelines*.

The role of Internal Audit is to conduct independent assessment and evaluation of the effectiveness and efficiency of organisational systems, processes and control environment, thereby providing assurance and value to the Board and Management. Internal Audit is independent of management, and its work is carried out by in-house resources and external contracted auditors. Internal audit works independently of, but collaboratively with, the external auditors.

Internal Audit works in accordance with audit plans that are approved annually by the Board. The plans are developed using a risk-based approach that considers both strategic and operational risks.

The Head of Internal Audit reports functionally to the Audit and Risk Committee of the Board, and administratively to the HSCE. The Head of Internal Audit directs the unit's activities, provides a framework for it to operate effectively, and reports on Internal Audit activities to the Executive Management Group and the Audit and Risk Committee.

During the 2015-2016 period a total of seven internal audits were completed. The organisation is diligently working through and implementing the various recommendations provided within these audits.

Risk and compliance management

The DDHHS is committed to effectively managing risk in alignment with best practice and through a practical approach that carefully plans for and prioritises risks, and balances the costs and benefits of action.

The DDHHS *Risk Management Framework* uses an integrated risk management approach to describe how risks are identified, managed and monitored within the DDHHS.

The progression towards a fully integrated compliance program continued in 2015-2016 with the appointment of a Compliance Manager and further development of the compliance management system that will continue to provide assurance that the organisation is meeting its various obligations.

External scrutiny

DDHHS operations are subject to regular scrutiny from external oversight bodies. These include Queensland Audit Office (QAO), Crime and Corruption Commission, Office of the Health Ombudsman, Australian Council on Healthcare Standards, Aged Care Standards and Accreditation Agency, Institute of Healthy Communities Australia (IHCA), Queensland Ombudsman, and the Coroner.

Queensland Audit Office

During 2015-2016 the Auditor-General issued one report in Parliament relative to the DDHHS:

- Report 15: 2015-2016 Queensland public hospital operating theatre efficiency

Key findings identified in this report have been evaluated and will continue to be monitored by the Board and Executive in the 2016-2017 financial year.

Coronial findings

During 2015-2016 findings were handed down in relation to two inquests.

The first relates to the death of a registered nurse due to an overdose of the drug Fentanyl in her home in the context of evidence of longstanding intravenous drug use and doctor shopping.

The inquest considered the management of drug dependent health practitioners in the workplace. Seven recommendations were handed down, dealing mainly with the role of the Australian Health Practitioner Regulation Agency in the management of such cases. There was no specific recommendation that required any action on the part of the DDHHS.

The second inquest involved two separate deaths of patients one in Oakey Hospital and the other in Warwick Hospital, which were combined into a single inquest. Circumstances in both instances were around clinical deterioration of the patients and the efficacy of the use of the Queensland Adult Deterioration Detection System Tools (Q-ADDS).

It was recommended that funding be provided by Queensland Health to provide further research into the validation of Q-ADDS tools and into the socio-cultural factors that influence compliance with existing hospital care escalation systems.

It was also recommended that DDHHS consider a protocol for advising family of the deterioration of a patient immediately as staff become aware of such deterioration. The DDHHS has implemented this recommendation.

Information systems and record keeping

The *Public Records Act 2002*, Information Standard 40: Recordkeeping (IS40) and Information Standard 31: Retention and Disposal of Public Records (IS31) provides overarching governance for recordkeeping practices within the DDHHS. The Queensland State Archives provide additional guidelines relevant to retention and disposal.

Training is available to all staff regarding security, privacy and confidentiality, and records management at orientation, department inductions and through the service's Health Information Services team.

In the 2015-2016 year the health service undertook a project to assess the implementation of an electronic document records management system (eDRMS). The health service continues to work towards the implementation of this system to assist in the ongoing management of its records.

Disclosures of confidential information in the public interest

In accordance with Section 160 of the *Hospital and Health Boards Act 2011* the disclosure of confidential information is permitted if the Chief Executive of the service believes, on reasonable grounds, the disclosure is in the public interest; and the Chief Executive has, in writing, authorised the disclosure.

The table below summarises the relevant disclosures made in the 2015-2016 reporting period.

Date disclosure authorised	Nature of confidential information disclosed	Purpose for which confidential information disclosed
30 December 2015	Identification of missing patient from Child Youth Mental Health Services at the time (no mental illness disclosure)	Locate and ensure safety of child under the care of our service

Our governance

Board and committee meeting attendance

		Board		Executive Committee		Finance Committee		Audit and Risk		Safety and Quality	
Name	Term	Held	Attend	Held	Attend	Held	Attend	Held	Attend	Held	Attend
Mr Mike Horan	18.5.12 17.5.19	12	11	12	12	-	-	-	-	-	-
Dr Dennis Campbell	29.6.12 17.5.19	12	11	12	11	10	10	4	4	-	-
Dr Jeff Prebble*	19.6.12 17.5.16	12	8	12	10	-	-	-	-	6	5
Ms Cheryl Dalton	29.6.12 17.5.18	12	10	-	-	10	9	4	4	-	-
Mr Terry Fleischfresser**	29.6.12 17.5.16	12	9	-	-	10	8	4	3	-	-
Dr Ross Hetherington	29.6.12 17.5.18	12	9	-	-	10	7	4	1	-	-
Ms Marie Pietsch	29.6.12 17.5.19	12	11	-	-	-	-	-	-	6	6
Ms Trish Leddington-Hill	9.11.13 17.5.18	12	11	-	-	-	-	-	-	6	6
Ms Megan O'Shannessy	18.5.13 17.5.19	12	11	-	-	-	-	-	-	6	5
Ms Corinne Butler***	18.5.16 17.5.17	12	1	-	-	-	-	-	-	-	-
Dr Ruth Terwijn***	18.5.16 17.5.17	12	1	-	-	-	-	-	-	-	-

*Dr Jeff Prebble retired from the Board on 17 May 2016
**Terry Fleischfresser was not reappointed to the Board from 18 May 2016
***Corinne Butler and Dr Ruth Terwijn were appointed to the Board from 18 May 2016
Note: Committee memberships were realigned in May 2016 due to membership changes within the Board.

Board engagement with consumers and the community

The Board regularly meets with local staff and community representatives throughout the health service. Every second Board meeting is held in a rural area over two days to ensure ongoing community consultation and collaboration in healthcare provision.

In 2015-2016 the Board attended over 200 meetings and events travelling over 30,000 kilometres. Below is a summary of the events, meetings and consultations undertaken in the past financial year.

Meetings
7 Springs Health and Dental
Acton Health Pharmacy
Allen's Pharmacy
Alpenglow Goondiwindi Diagnostic Imaging
Army Aviation Training Centre
Blooms The Chemist Kingaroy
Blue Care
Border Rivers Chamber of Commerce
Border Rivers Christian College
Canowindra Aged Care Facility
Care Goondiwindi
Castra Nursing Home
Centrelink
Church of Christ, Kingaroy
Crawford State Primary School
Darling Downs West Moreton Primary Health Network
Dental Essentials
Downs Cardiac Clinic
Downs Rural Medical
Durong Green Frog Girl Guides
Family Circle Psychology
Forest View Residential Aged Care Facility and Wondai Hospital
Friends of McDonald
Glendon Street Medical
Good Price Pharmacy Warehouse
Goondiwindi Hospital Auxiliary

Meetings
Goondiwindi Hospital Community Consultative Advisory Committee
Goondiwindi Indigenous Advisory Network
Goondiwindi Medical Centre
Goondiwindi Physiotherapy
Goondiwindi State High School
GP Connections
GPs on Curzon
Griffith University
Integrated Solutions
Iona Medical Centre
Kaloma Home for the Aged
Kingaroy Chamber of Commerce Inc.
Kingaroy Fire Brigade
Kingaroy Hospital Auxiliary
Kingaroy Hospital Community Consultative Committee
Kingaroy Pharmacy
Kingaroy Police
Kingaroy SES
Kingaroy State High School
Lifeline Darling Downs and South West
Lucy Walker Chemmart Pharmacy
Mark Paton & Associates
Markwell Medical
Medici Medical Centre
Middle Ridge Family Practice
Miles & District Chamber of Commerce

Our governance

Meetings

- Miles District Hospital Auxiliary
- Miles Medical Centre
- Miles State High School
- Miles State School
- Mi-Mind Centre
- Murilla Community Centre Inc.
- Nadine Hinchliff Therapy Services
- New Hope Group
- Oakey Pharmacy
- Oakey State High School
- Pharmacy Essentials Kingaroy
- Physio Extra
- Platinum Health Group – Wilsonton
- Projects Queensland
- Qld Ambulance Service
- Queensland Airports Limited
- Queensland Ambulance Service
- Queensland Fire & Emergency Services
- Queensland Police Service
- Rachel Stone Podiatry
- Range Medical Centre
- South Burnett Dental Group
- South Burnett Medical
- South Burnett Physiotherapy
- South Burnett Podiatry
- South Burnett Radiology
- South Burnett Region Hospital Auxiliary
- St Andrew's Hospital
- St John's Lutheran Primary School
- St Mary's Catholic College
- St Mary's Primary School
- St Vincent's Private Hospital

Meetings

- Sunrise Way Meeting
- Taabinga State Primary School
- Taroom Shire Cancer & Palliative Care Association
- Tie up the Black Dog
- ToMnet
- Toowoomba and Surat Basin Enterprise
- Toowoomba Hospital Foundation
- Toowoomba Medical Centre
- Transport and Main Roads
- University of Queensland (UQ) Rural Clinical School
- Wandoan Health Auxiliary Inc
- West Moreton Hospital and Health Board
- Wondai Lion's Club
- Wondai Senior Citizens

Forums and Events

- 2015 Department of Health Awards for Excellence
- 2015 PLLC Research Scholarship Grants Ceremony
- 2015 Research Week Engagement Breakfast
- Australian Institute of Company Directors (AICD) Toowoomba Business Leaders Luncheon
- Big Ideas Big Night Out
- Carbal Relocation and 1st Birthday Celebration
- Clinical Leaders Engagement Forum
- Clinical Leaders Engagement Forum
- Connecting the Dots Regions Research Forum
- DDHHS Australia Day Employee Awards
- DDHHS Staff Length of Service Awards
- Department of Health Research Project for Australia and New Zealand School of Government
- Dinner and Information session on the CareComplete launch in Toowoomba
- Dr Guard's Memorial

The Darling Downs Hospital and Health Board and Health Service Chief Executive (from front left) Dr Ruth Terwijn, Ms Megan O'Shannessy, Mr Mike Horan, Ms Marie Pietsch, (back row from left) Ms Corinne Butler, Ms Cheryl Dalton, Dr Ross Hetherington, Dr Peter Gillies, Dr Dennis Campbell and Ms Trish Leddington-Hill.

Forums and Events
Ensuring Safer Patient Care Workshop
headSpace Toowoomba Official Launch
Hospital and Health Board Chairs Forums
International Nurses' Day Breakfast
NAIDOC Week Celebrations
NAIDOC Week Celebrations - Cherbourg Hospital Health Expo 2015
National Volunteer Week 2016 - Luncheon
National Volunteer Week 2016 - Luncheon
Official Launch of Toowoomba's Christmas Wonderland
Official opening - Chinchilla Community ConneXions
Official opening of the AODS new refurbished offices
Opening of Telehealth Suite - Millmerran
Partnering with Consumers Workshop
Patient Safety...first and foremost Forum 2015
Queensland Senate Clinical Forum
Re-opening of the Lady Bjelke-Petersen Community Hospital (formerly the South Burnett Private Hospital)
Rural Generalist Clinical Forum
Second Queensland Health National Disability Insurance Scheme (NDIS) Forum

Forums and Events
Toowoomba Clubhouse Community Breakfast
Toowoomba Hospital Annual Volunteer's Christmas Luncheon
Toowoomba Launch - Spirit of Anzac Centenary Experience
University of Southern Queensland (USQ) Graduations

Members of Parliament
Deputy Prime Minister
Senator for Queensland
Member for Groom
Minister for Health and Minister for Ambulance Services
Member for Toowoomba South
Member for Toowoomba North
Member for Nanango

Local Government
Goondiwindi Regional Council
South Burnett Regional Council
Toowoomba Regional Council
Western Downs Regional Council

Our organisation

Our Executives

Reporting to the Health Service Chief Executive the organisation is capably led by a team of eight executives that are responsible for managing their respective divisions within the organisation.

Chief Executive
Dr Peter Gillies

Acting General Manager
Toowoomba Hospital
Mr Brett Mendezona

General Manager Rural
Mr Michael Bishop

Acting Executive Director Mental Health
Mr Greg Neilson

Executive Director Medical Services
Dr Hwee Sin Chong

Executive Director Nursing
and Midwifery Services
Dr Robyn Henderson

Executive Director Allied Health
Ms Annette Scott

Acting Chief Finance Officer
Ms Jane Ranger

Acting Executive Director Workforce
and Infrastructure
Dr Paul Clayton

Dr Peter Gillies *MBChB, MBA, FRACMA, GAICD*

Dr Peter Gillies commenced in the role in January and, following a rigorous recruitment process, was appointed as the Darling Downs Hospital and Health Service (DDHHS) Chief Executive in May 2016.

For the previous five years Peter was Executive Director of Medical Services and General Manager Toowoomba Hospital. In these roles he provided expert direction in improving patient care and meeting or exceeding clinical targets such as timely surgery, outpatient waiting lists, and emergency department access.

Peter came to Toowoomba in 2009 to take up the role of Director Medical Services following his employment as the Director of Medical Services for Hunter New England Health in Armidale, New South Wales.

He is a Fellow of the Royal Australasian College of Medical Administrators and has a Masters of Business Administration from Otago University. He is also a Graduate of the Australian Institute of Company Directors.

Peter has a background in general management, previously working as the general manager of a health software company and as the regional manager for a not-for-profit private hospital group in Auckland, New Zealand.

He has been a doctor for nearly 25 years and has worked in South Africa and the UK in both hospital and general practice roles prior to immigrating to New Zealand in 1995.

Mr Brett Mendezona *RN*

Mr Brett Mendezona commenced his nursing career at Baillie Henderson Health Service in January 1996 as a General Registered Nurse working in a number of wards including Ridley Unit and Jofre House.

Prior to commencing his role as Acting General Manager Toowoomba Hospital, Brett fulfilled the role of Service Manager / Nursing Director Surgical Services at Toowoomba Hospital. In this role, he was responsible for the oversight and performance of all aspects of the Surgical Service operationally, clinically, and its budgetary performance. Brett in collaboration with the surgical multi-disciplinary team led the achievement of the National Elective Surgery Target (NEST) on the 31st December 2013. The NEST target has been maintained since this time.

Brett has worked at Toowoomba Hospital for 20 years in a number of positions from Registered Nurse, Nurse Unit Manager and Nursing Director specifically within Operating Theatres and the Surgical Service.

Mr Michael Bishop *BOccThy MHA*

Mr Michael Bishop is a founding member of the Mental Health Council of Australia, the National Rural Health Alliance, the Australian National Art Therapy Association, Mackay Centre for Research On Children and Community Services, The Australian College for Child and Family Protection Practitioners and Services for Australian Rural and Remote Allied Health (SARRAH).

Michael graduated with a Bachelor of Occupational Therapy from the University of Queensland in 1983 and a Masters degree in Health Services Management from the University of New South Wales in 1996. He has undertaken postgraduate study in both profession-specific areas as well as social economics.

He has worked nationally and internationally with health services aimed at improving both the scope and quality of allied health professional services. He is acknowledged as an allied health professional leader by peers (the Queensland SARRAH Network Coordinator, and Australian Chair, AHLANZ) as a result of this work.

He has a Human Rights Commendation for work in de-stigmatising mental illness. Michael was chair of the Editorial Boards of the Australian Journal of Rural Health, Communities, and Families and Children Australia and convened several Australian Rural and Remote Scientific Health Conferences.

Mr Greg Neilson *RN, FACMHN, Credentialed Mental Health Nurse*

Mr Greg Neilson has over 25 years' experience in senior nursing and manager positions in the DDHHS, Division of Mental Health, Alcohol and Other Drugs. Hospital trained in general and psychiatric nursing he completed additional post-basic qualifications in gerontic nursing, advanced psychiatric nursing and community mental health.

He has a Bachelor of Health Science (Nursing) and Masters Degrees in Nursing, Mental Health Nursing and Advanced Practice Nursing. He also has additional postgraduate qualifications in forensic mental health nursing and child and adolescent mental health nursing. Greg also has a Masters Degree in Health Service Management from the University of New England and Graduate Certificate in Health Economics from Monash.

He is a Fellow of the Australian College of Mental Health Nurses, and is Chair of the colleges Credentialing Committee. His current substantive position is Nursing Director Acute and Community Mental Health, DDHHS.

Dr Hwee Sin Chong *MBChB, MHM, MIPH, FRACMA, GAICD*

Dr Hwee Sin Chong first commenced in Toowoomba as the Deputy Director of Medical Services in 2011, bringing with her several years of experience in medical management across a range of roles in the public and private health sector.

She is a Fellow of the Royal Australasian College of Medical Administrators, and has a Master of Health Management and Master of International Public Health from the University of NSW.

Dr Chong graduated from Otago University, working for several years in New Zealand before immigrating to Australia.

In her role as Executive Director Medical Services, Dr Chong is the professional lead for medical staff across the DDHHS, and is responsible for clinical governance.

Dr Robyn Henderson

Dr Robyn Henderson was appointed as Executive Director of Nursing and Midwifery Services in December 2014. Dr Henderson carries on a proud family tradition, being a third generation nurse. Having worked as a practice nurse, charge nurse and in staff development, Dr Henderson brings extensive experience to the DDHHS. Her appointment as EDNMS marks the fifth time she has held an executive director's role, having worked in similar positions on three occasions in New Zealand and once in Ireland.

Dr Henderson studied nursing and psychology at Massey University (NZ) and has completed a PhD with her research focused on aged care. Dr Henderson has a keen interest in the integration of primary health and hospital healthcare for the benefit of patients.

Ms Annette Scott *BPhty, GCert Mngt, GAICD*

Ms Annette Scott commenced her career in health as a physiotherapist, graduating from the University of Queensland in 1983. After spending her earlier career as a private practitioner in solo practice in Central Queensland, she joined the public health system in Queensland in 1993. She has subsequently fulfilled a number of clinical, quality improvement and management roles, and has worked across a range of service settings including acute inpatient, outpatient, community and rural outreach.

Prior to taking on the role of Executive Director Allied Health, Ms Scott fulfilled the role of Allied Health Workforce Development officer in the Darling Downs. In this role she was responsible for implementing a range of innovative redesign initiatives across the Health Practitioner workforce. These initiatives have attracted national and state-wide attention for their ability to impact positively on patient flow and health service delivery.

To support the validity and effectiveness of the redesign agenda Ms Scott has undertaken training in the Calderdale Framework, a transformational workforce redesign program developed in the United Kingdom. She is now one of only 3 Calderdale Practitioners in Australia who is endorsed to train in the framework.

Ms Jane Ranger *BBus (Acc), CPA*

Ms Jane Ranger commenced with the DDHHS in 2014 as the Senior Business Analyst and later the Senior Finance Manager for Toowoomba Hospital. Ms Ranger has been acting in the position of Chief Finance Officer since May 2016.

Previously, Ms Ranger was the Group Company Accountant for the McNab Construction Group and spent five years as the State Commercial Manager, Queensland, Northern Territory and New South Wales for Healthscope, the second largest private healthcare provider in Australia.

As the Senior Finance Manager for Toowoomba Hospital, Ms Ranger was responsible for the oversight and sound financial management of the medical, surgical, women's and children's hospital services, as well as the financial management of ambulatory care and support services and facility services for Toowoomba Hospital and Baillie Henderson Hospital.

Originally from England, Ms Ranger immigrated to Australia in 1989. Ms Ranger has worked at a senior level in the banking, hospitality, public transport, manufacturing and building industries. She completed her Bachelor of Business, as dux of her class at Griffith University, Gold Coast in 1999 and attained CPA status in 2002.

Dr Paul Clayton *BSc (Hons), PhD, DipBus, MAIB*

Dr Paul Clayton joined DDHHS early in 2016 and came to work in the health sector after more than 20 years in project management and technical services delivery in the environment sector. Paul has a technical foundation in the aquatic sciences but has worked in senior management and major project oversight roles for the past decade. With a career that includes direct experience in research, government, and the private sector, Paul brings to the DDHHS a professionally balanced and practical approach to corporate governance, project management, strategic oversight and business planning.

Prior to joining the DDHHS Executive team, Paul contributed in a strategic planning role and coordinated the production of the updated DDHHS Strategic Plan 2016-2020 as well as progressing arrangements for coordinated infrastructure and asset management across the health service.

Before joining the DDHHS, Paul was General Manager for a local division of an international consultancy and contractor company working with clients on infrastructure projects for the resources, urban development, and the agricultural sectors, and for all three tiers of government in Australia. Paul has held a number of senior management roles with oversight of multidisciplinary teams and with responsibility for complex project deliverables and project budgets.

Ms Shirley Wigan

Ms Shirley Wigan has extensive experience in the delivery of mental healthcare services, having commenced her career as a Social Worker. Shirley has worked at Mackay Hospital, West Moreton, Princess Alexander Hospital, Royal Brisbane Women's Hospital and as the Executive Director of Mental Health Services at Brisbane's Bayside for seven years.

Shirley was appointed Executive Director Mental Health for the Darling Downs in 2008. Shirley left the organisation in June 2016 after a long career in the public sector.

Ms Melanie Reimann

Ms Melanie Reimann holds a double undergraduate degree with major fields of study in Accounting, Finance and Business Law from the USQ. She is a qualified CPA and holds a Master of Business Administration with a specialisation in Public Management from Deakin University.

As the Director (Financial Reporting and Budgets) at USQ, she was responsible for the budgeting, management reporting, financial reporting, financial systems, insurance, taxation and research accounting for the university.

Melanie was appointed to the Chief Finance Officer in August 2015 and oversaw the areas of financial control, management accounting and commercial management. Melanie resigned from the position of Chief Finance Officer in May 2016.

Our organisation

Our divisions

The organisation operates under the authority of the Board as legislated in the H*ospital and Health Boards Act 2011*. The Health Service Chief Executive (HSCE) is accountable to the Board for all aspects of DDHHS performance, including the overall management of human, material and financial resources and the maintenance of health service and professional performance standards.

The organisation is divided into eight divisions that work in partnership to deliver health services to our communities. The divisions are grouped into clinical, professional and support roles with each division having specific responsibilities and accountabilities for the effective performance of the organisation.

Clinical Divisions

There are three clinical divisions that lead the delivery of high quality, safe, and evidence-based patient care across the continuum and geography of DDHHS:

Toowoomba Hospital

- The largest of the clinical divisions, operates the main regional hospital for the DDHHS through four clinical services groups: Surgical; Medical; Ambulatory Care and Support Services; and Women's, Children's and Emergency Department Services.
- Facility Services for Toowoomba Hospital and Baillie Henderson Hospital are operationally aligned to this division.

Rural Health Services

- The division operates 15 hospitals, three multi-purpose health services, five outpatient clinics and six residential aged care facilities.
- The division is managed via a cluster model with three geographic clusters (Southern, Western and South Burnett) and a cluster for residential aged care services.
- Oral Health Services for the DDHHS are also operationally aligned to this division.

Mental Health Services

- The division provides child and youth, adult and older persons, acute inpatient services at Toowoomba Hospital, and community services in Toowoomba and a range of rural centres.
- Mental Health services for consumers who require extended treatment and rehabilitation are provided at the Baillie Henderson Hospital, Toowoomba.
- The Alcohol and Other Drugs Service for DDHHS is operationally aligned to this division.

Professional Divisions

Three professional divisions lead the DDHHS in promoting clinical service improvement, consumer satisfaction, clinician engagement, clinical governance, professional and clinical standards and clinical workforce planning and education:

Medical Services

- The division provides professional leadership for medical staff and services across the DDHHS and has responsibility for the medical workforce, medical education, clinical governance, rural and remote medical support, health information services, pastoral care, and public health teams.

Allied Health

- The division provides professional leadership for Allied Health professionals and services across the DDHHS (including workforce planning and development, clinical education, research and standards).
- This division also includes the DDHHS Research Unit and the Aged Care Assessment Team.

Nursing and Midwifery Services

- The division provides professional leadership for Nursing and Midwifery Services (including workforce planning, education and standards) across the DDHHS.

Support Divisions

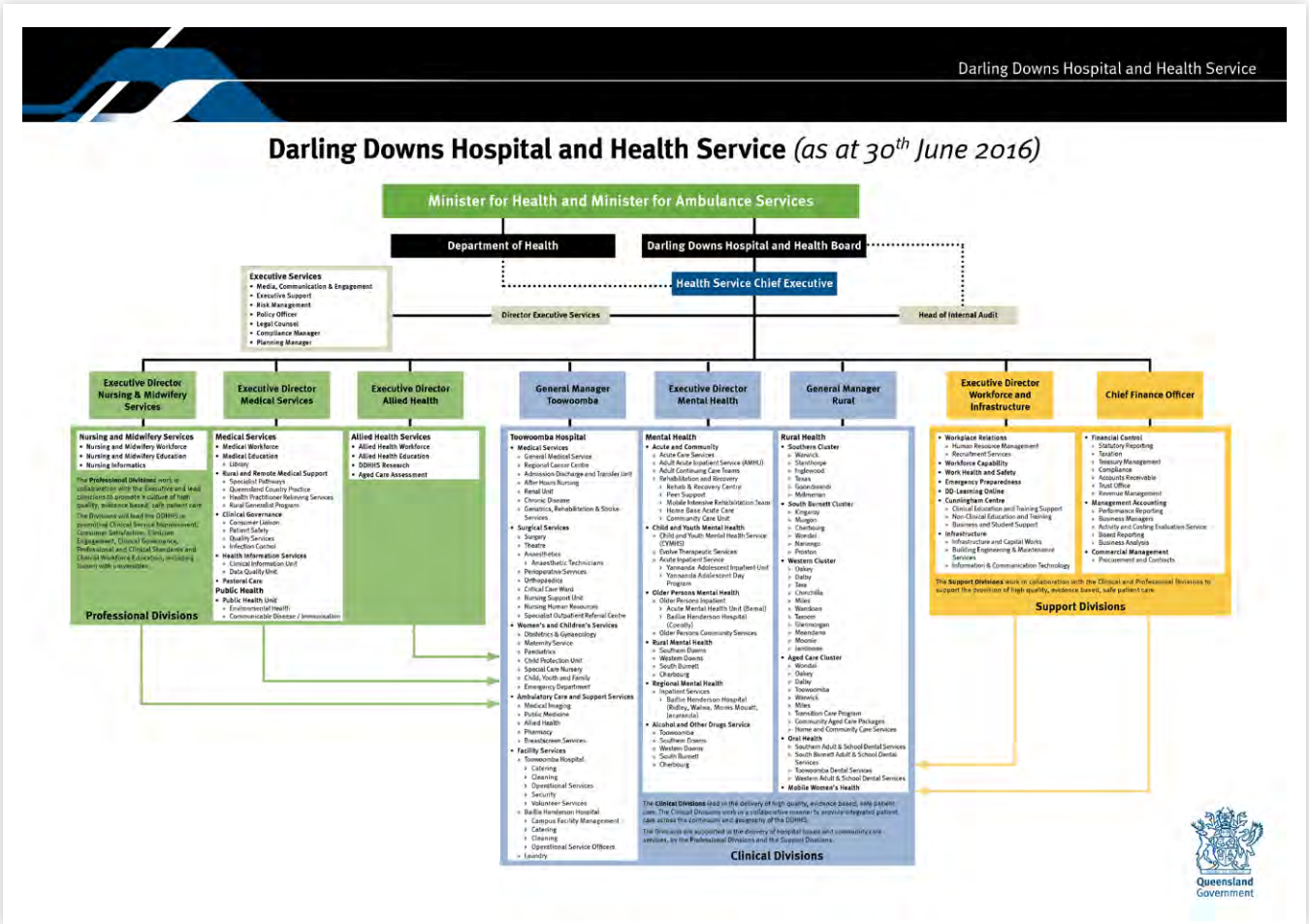
The support divisions work in collaboration with the clinical and professional divisions in supporting the provision of high quality, evidence-based, safe patient care.

Finance

- The division supports the health service in ensuring resources are balanced, sustainable, and efficient and provides DDHHS-wide support functions comprising Financial Control, Management Accounting and Commercial Management which are designed to optimise quality healthcare through compliant and efficient business processes.

Workforce and Infrastructure

- The division supports the organisation to deliver on the key priority of ensuring a dedicated trained workforce, and is responsible for supporting managers in:
  - » Embedding a values-based culture
  - » Planning, recruiting and retaining an appropriately skilled workforce
  - » Developing, educating and training the workforce
  - » Engaging employees to improve the service
  - » Promoting employee health and wellbeing.
- The division also supports the organisation to plan for, and deliver key infrastructure and maintenance programs across the health service to meet the organisations strategic objective of optimising asset use.
- This division manages the Building Engineering and Maintenance Services and the Information and Communication Technology portfolio.



Our year at a glance

Separations (discharges)

76,087

4,227 from 2014-2015

Telehealth consultations (non-admitted patients, excluding mental health)

5,128

630 from 2014-2015

Same day admissions

35,935

2,034 from 2014-2015

Surgery hours

15,732

1,954 from 2014-2015

All outpatient attendances

246,438

25,018 from 2014-2015

Births

3,067

26 from 2014-2015

Service delivery statement

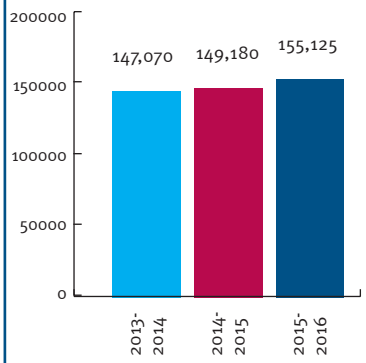
Darling Downs Hospital and Health Service	Notes	2015-16 Target / Estimate	2015-16 Actual
Effectiveness Measure			
Percentage of patients attending emergency departments seen within recommended timeframes:			
Category 1 (within 2 minutes)		100%	97%
Category 2 (within 10 minutes)		80%	88%
Category 3 (within 30 minutes)		75%	75%
Category 4 (within 60 minutes)		70%	83%
Category 5 (within 120 minutes)		70%	97%
All categories		..	88%
Percentage of emergency department attendances who depart within four hours of their arrival in the department		90%	88.9%
Median wait time for treatment in emergency departments (minutes)	1	20	25
Percentage of elective surgery patients treated within clinically recommended times:			
Category 1 (30 days)		›98%	100%
Category 2 (90 days)		›95%	100%
Category 3 (365 days)		›95%	100%
Median wait time for elective surgery (days)	2	25	43
Percentage of specialist outpatients waiting within clinically recommended times:	3		
Category 1 (30 days)		..	100%
Category 2 (90 days)		..	100%
Category 3 (365 days)		..	100%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	4	‹2.0	0.63
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit		›65%	74%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge		‹12%	11.4%
Efficiency Measure			
Average cost per weighted activity unit for Activity Based Funding facilities	5	$4,814	$4,363
Other measures			
Total weighted activity units:	6		
Acute Inpatient		45,450	48,537
Outpatients		8,637	10,443
Sub-acute		5,073	5,267
Emergency Department		15,145	17,516
Mental Health	7	23,437	56,794
Interventions and Procedures		5,801	4,788
Ambulatory mental health service contact duration (hours)		›60,500	84,632

Our performance

Service delivery statement notes:

1. There is no nationally agreed 2015-2016 target for this measure. The 2015-2016 target / estimate is based on the prior year's estimate and was indicative only in the Service Delivery Statement. Increasing numbers of category 3 presentations and limited physical capacity within emergency department's has impacted on the ability to meet this target.
2. There is no nationally agreed 2015-2016 target for this measure. The 2015-2016 target / estimate is based on the prior year's estimate and is indicative only in the Service Delivery Statement. The median wait time for the DDHHS is higher than target due to the higher proportion of category 3 (non-urgent) patients receiving surgery during this period.
3. The 2015-2016 *Service Delivery Statement* did not include a 2015-2016 target/estimate as the target was under review.
4. Staphylococcus aureus are bacteria commonly found on around 30% of people's skin and noses and often cause no adverse effects. Infections with this organism can be serious, particularly so when they infect the bloodstream. The data reported for this service standard are for bloodstream infections with staphylococcus aureus (including MRSA) and are reported as a rate of infection per 10,000 patient days. The measure aligns with the national benchmark of 2.0 cases per 10,000 acute public hospital patient days.
5. The 2015-2016 target/estimate measure for the average cost per weighted activity unit for Activity Based Funding facilities are as per reported in the *2016-2017 Queensland State Budget Service Delivery Statements*.
6. The 2015-2016 target/estimate measures for total weighted activity units are as per the *2016-2017 Queensland State Budget Service Delivery Statements*.
7. Actual mental health weighted activity units is an anomaly due to the introduction of a new care type that saw patients statistically discharged and readmitted on 1 July 2015.

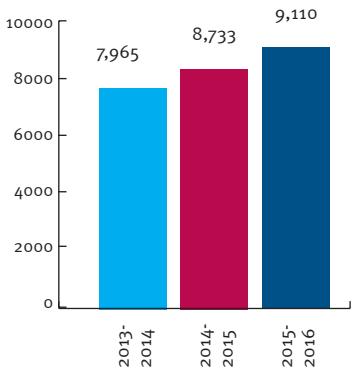
DDHHS EMERGENCY DEPARTMENT ATTENDANCES



↑ 5,945

495 more patients a month than 2014-2015 (4%)

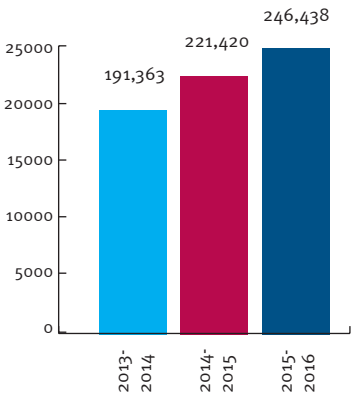
ELECTIVE SURGERIES PERFORMED DDHHS



↑ 377

31 more patients a month than 2014-2015 (4%)

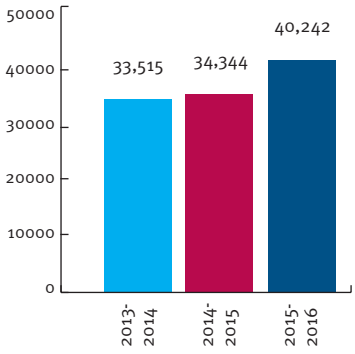
PATIENTS SEEN AT SPECIALIST OUTPATIENT CLINICS



↑ 25,018

2,048 more patients a month than 2014-2015 (11.3%)

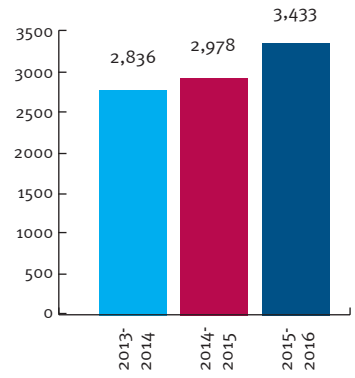
ADULT DENTAL TREATMENTS (EXPRESSED AS OCCASIONS OF SERVICE)



↑ 5,898

491 more patients a month than 2014-2015 (15%)

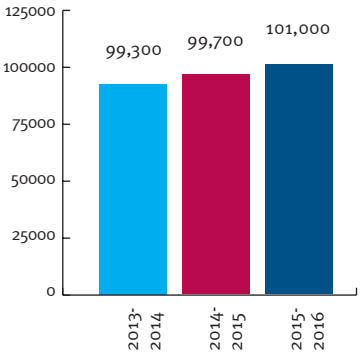
TOOWOOMBA HOSPITAL EMERGENCY (UNPLANNED) SURGERIES



↑ 455

38 more patients a month than 2014-2015 (15.2%)

AGED CARE OCCUPIED BED DAYS



↑ 1,300

108 more patients a month than 2014-2015 (1.5%)

Our performance

Toowoomba Hospital's emergency department is the busiest in the DDHHS with more than 50,000 presentations a year.

Performance against our strategic objectives

Over the past year the DDHHS has continually measured its performance against the service standards defined in the *2015-2016 Queensland State Budget Service Delivery Statements* and within our service agreement with the Department of Health.

We also measure our performance against the strategic objectives outlined in our strategic plan. Significant progress has been made this year on delivering against this plan and our priorities.

The plan has four key strategic directions which focuses our efforts on delivering quality healthcare for our community:

1. Deliver quality healthcare
2. Ensure resources are sustainable
3. Ensure processes are clear
4. Ensure dedicated trained staff

1. Deliver quality healthcare

DDHHS has, for the fourth year in a row, delivered more healthcare than contracted in our service agreement with the Department of Health. Under this service agreement, weighted activity units (WAUs) provide a common unit of comparison. Excluding mental health, there was an agreed target of 83,010 and DDHHS delivered 86,551 WAUs across the financial year. This equates to 4.3 per cent more activity than contracted.

DDHHS continues to efficiently deliver and meet the growing demands for health services in the region, consistently reducing waiting lists and improving the timeframes for patients to receive the healthcare that is needed. Most notably, the long wait list for specialist outpatients has reduced from 62 per cent of the total waiting list being long wait patients in 2014, to zero per cent in 2016.

Access to emergency department services

Increasing demand for emergency department services has stretched our resources. Toowoomba Hospital in particular has felt the greatest impact. The unit is small, in comparison to similar facilities, with only twenty treatment spaces but had over 50,000 presentations in the 2015-2016 financial year, an increase of over three per cent. The growth in presentations has primarily been in category 2 and 3 patients, which are more complex and require additional treatment time.

Despite the increasing numbers of presentations, facilities across the service have achieved 88.9 per cent against the Queensland Emergency Access Target (QEAT), which is only slightly below the 90 per cent target of patients who present to an emergency department needing to be admitted, discharged or transferred within four hours. The median wait time in emergency across the health service was 25 minutes against a target of 20 minutes.

In the next financial year $3 million has been provided to the DDHHS by the Department of Health to complete a modest refurbishment of the Toowoomba Hospital Emergency Department. The refurbishment will provide an additional nine treatment spaces, which will go a long way to improving access to timely emergency services for our community.

100% of patients seen on time for elective surgery

Once again the DDHHS has made improvements in elective surgery timeframes across the health service. The National Elective Surgery Target (NEST) of 100 per cent for urgent, 97 per cent for semi-urgent and 98 per cent for routine has been surpassed, with 100 per cent of all patients receiving their surgery within clinically recommended timeframes. This is despite a seven per cent increase in demand in services from the community resulting in a total of 9,110 surgeries completed in 2015-2016.

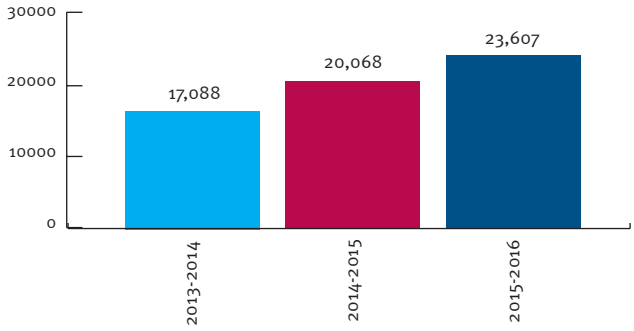
The DDHHS has now been able to maintain 100 per cent of patients receiving elective surgery on time since December 2013, a period of over two and a half years. This is a significant achievement.

	Urgent (within 30 days)	**Semi-urgent** (within 90 days)	**Routine** (within 365 days)
Target	›98%	›95%	›95%
DDHHS Actual	100%	100%	100%

Specialist outpatient waiting lists reduced to zero

The DDHHS has continued to outperform all other health services and has been able to maintain zero patients waiting longer than clinically recommended for an outpatient appointment for the entire year. This is despite having a total of 23,607 specialist outpatient referrals in 2015-2016 which is a 38 per cent increase over the past two years.

New specialist outpatient referrals

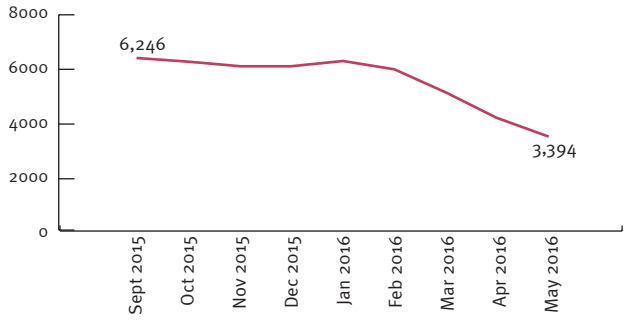


Dental waiting lists slashed

For another year DDHHS has had no patients waiting longer than the clinically recommended for routine dental treatment (less than two years).

By the end of May 2015 the number of people waiting between one to two years was slashed from 1,127 to 195 and people waiting one year or less from 5,119 to 3,199. That's a 54 per cent decrease in the numbers of patients waiting for dental treatments. The total number of adult dental treatments provided this year was 40,242, an increase of 5,898 treatments since last year.

Total numbers of patients waiting since late 2015



Our performance

Another way we have improved access to dental services for our patients is through a recent establishment of a co-operative agreement with a private provider and the Southern Cluster Oral Health Team, which has resulted in a mobile dental clinic being dispatched to Texas to provide denture services to patients unable to make the journey into Inglewood or Stanthorpe.

Birthing services continue to be busy

Across the seven designated birthing facilities, and at four non-designated birthing facilities (for babies that just couldn't wait), there were 3,067 births over the year. This is an increase of 26 births compared to last year. The DDHHS is committed to providing maternity services in regional areas which will allow women to birth closer to home.

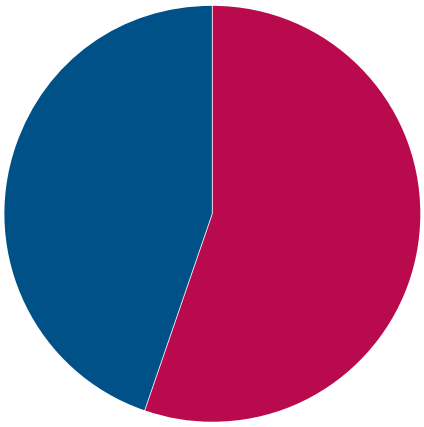
Location	Births
Toowoomba	2,038
Kingaroy	350
Warwick	204
Dalby	179
Stanthorpe	134
Goondiwindi	92
Chinchilla	65
Miles, Millmerran, Nanango, Tara (non-designated birthing facilities)	5
Total	3,067

BreastScreen

This year the BreastScreen Queensland Toowoomba Service screened a total of 17,765 women from across the region. Overall screening was down compared to target as a result of a seasonal screening cycle and the relocation of the service to a new facility, which required the clinic to close for a short period.

In July 2016, following a $1.85 million project, the service relocated to a purpose built facility in the Toowoomba CBD which has improved parking, and an extra mammography room, taking the total to three rooms which will mean the service will be able to cater for increased demand for services. The new facility also has two ultrasound rooms, two clinical exam rooms, a counselling room, dedicated screening and assessment waiting rooms and associated staff areas.

BreastScreen 2015-2016 screening split



Toowoomba site	9,824
Mobile Service	7,941

Mental health service improvements

The DDHHS's Mental Health service continues to provide vital support to consumers in the community. Mental health inpatient activity has decreased this year in line with best practice mental healthcare that sees the continued decentralisation of the extended inpatient services provided at the Baillie Henderson Hospital campus to services provided within the community.

In 2015-2016 the service transitioned 24 consumers from the Baillie Henderson Hospital campus to the new 24 bed community care unit, which is now fully operational in Kearneys Spring. A further 34 consumers are also being cared for within the home by the Mental Health Adult Mobile Outreach Team and the Home Based Acute Care Team.

The service continues to perform well against other key performance indicators with 74% of patients receiving community follow up within 1-7 days from discharge from an acute mental health unit compared to a target of 65%. The provision of ambulatory mental health services also continues to expand with the service providing 84,632 hours of care during the year which has exceeded the target by 24,132 hours.

The Mental Health division are committed to delivering best-practice mental healthcare to consumers in the Darling Downs. In the next year the division will see the implementation of the new *Mental Health Act 2016* and the roll out of the National Disability Insurance Scheme (NDIS), which will both play a significant role in the way mental health services are delivered across the region.

Allied health programs play a key role in recovery and rehabilitation

Allied health achievements

The Allied Health Team have continued to expand and improve on models of care for their patients, with the Speech Pathology Team introducing a new model of care for the Ear, Nose and Throat (ENT) Voice Clinic, which provides a comprehensive, multi-disciplinary diagnostic clinic and service to patients with voice disorders.

After an eight-month pilot, the weekend allied health service for acute stroke patients became a permanent service. The service demonstrated improvements in clinical indicators, clinical outcomes, and a substantial reduction in length of stay (average 5.7 days per patient).

Patient transport service makes accessing services easier

The DDHHS has invested in a new transport service for patients living in the South Burnett to improve access to specialist services in the region. The daily service was implemented in March 2016 and picks up patients from hospitals in the South Burnett region and takes them to their medical appointments at the Toowoomba Hospital. When patients arrive at the Toowoomba Hospital a volunteer directs them to the relevant area within the hospital for their appointment. The numbers of patients using this service is increasing each month with a current average of six patients each day.

Our performance

Closing the Gap to improve Indigenous health outcomes

On the tenth anniversary of "Closing the Gap" the DDHHS undertook a pledge to reduce the gap in Indigenous health expectancies and outcomes.

The organisational pledge was signed by the executive staff of the health service and undertook to petition the federal and state governments to:

- recommit to Close the Gap by 2030
- increase Aboriginal and Torres Strait Islander control and participation in the delivery of health services
- address the critical social issues of housing, education and self-determination that contribute to health inequality.

The Making Tracks Committee has been formed to lead this change through the organisation. The DDHHS has also committed to updating the DDHHS Strategic Plan, implementing a Cultural Capability Plan as well as Steps to a Healthy Future Plan.

The Committee provides strategic oversight for the planning and implementation of health services for Aboriginal and Torres Strait Islanders within the DDHHS. The committee is responsible for coordinating, consulting, and reporting on health initiatives, innovation and performance outcomes, including Closing the Gap targets. The Committee has established an action plan, with key performance indicators that it will continue implementing in 2016-2017.

The Board also continually monitors Closing the Gap key performance indicators at its monthly meetings.

In addition, the Indigenous Respiratory Program is conducting research to develop specific assessment tools to measure the lung capacity of healthy indigenous children. The current assessment tools used are designed for non-indigenous children and this research will examine the validity of these tools.

Accreditation with ISO:9001 affirms quality and safe care

The DDHHS underwent a full certification surveillance audit against the Australian Standard/New Zealand International Standards Organisation (ISO) 9001:2008 (Quality Management System) Standard (referred to as ISO 9001:2008) in March 2016. ISO certification highlights that the DDHHS as an organisation has good management practices in place that realises consumers' quality expectations and outcomes. This audit was undertaken again by the Institute for Healthy Communities Australia (IHCA) and assessed 13 facilities across the health service. The DDHHS achieved ongoing certification under ISO 9001:2008 for another year.

Regular Systematic Approach Facilitates Excellence (SAFE) Audits

The DDHHS is committed to providing safe and quality healthcare. Despite the delivery of a record amount of activity and services this year, the service has maintained its strong focus on clinical governance and patient safety and quality.

The SAFE clinical audit program is one example of this. The program engages management, front-line clinicians and consumers in assessing compliance with the National Standards for Safety and Quality in Healthcare, the National Mental Health Standards and Aged Care standards and supports continuous service improvement.

SAFE was initially launched in July 2014 and has been well received by clinical staff. The program consists of six modules and incorporates a Quality Improvement Plan to assist managers to address gaps identified from the SAFE audits.

A review of the SAFE program in April 2016 identified audit results consistently met the agreed benchmark of 80% compliance. SAFE version two was introduced in July 2016 and will concentrate on any areas that are still below benchmark. One of the strategies to improve compliance is the "September Safety Snapshot" where staff across the DDHHS will focus on the top 5 audit criteria that are below benchmark.

2. Ensure resources are sustainable

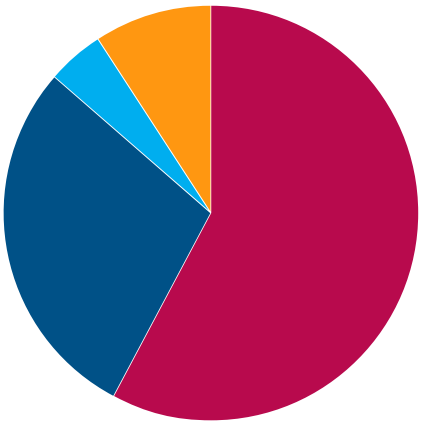
DDHHS achieved a financial result of $3.47 million surplus for the year ending 30 June 2016. This represents a half a percent surplus against a revenue base of $684 million. This is the fourth financial year the DDHHS has achieved an operating surplus while still delivering more services than we are contracted to do and improving health outcomes for our patients.

Revenue and expenses – financial year ending 30 June 2016	$(000)'s
Revenue	**$683,942**
Expenses	
Labour and employment expenses	$461,556
Non-labour expenses	$197,469
Depreciation and revaluation expense	$21,443
Total	**$680,468**
Net surplus from operations	**$3,474**

How we are funded

DDHHS's total income for the 2015-2016 financial year was $683.9 million. This was comprised of: $396.3 million from the State, $195.8 million from the Commonwealth, Special Purpose Grants worth $30.8 million, and other revenue (including self-generated) was $61.015 million.

Income

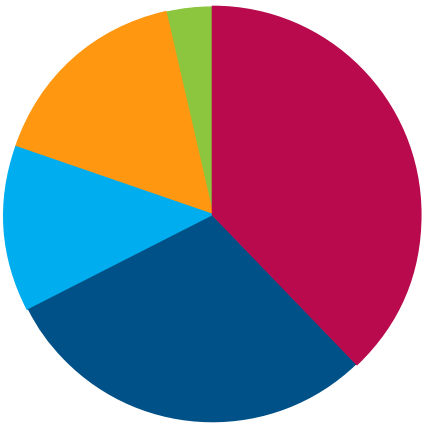


State contribution	$396.3 M
Commonwealth contribution	$195.8 M
Special Purpose Grants	$30.8 M
Other revenue (including self-generated)	$61.015 M

How the funding was distributed

DDHHS operates a complex group of healthcare services across a broad and diverse geographical area. The table below shows the proportion of the budget spent on services within the DDHHS. Total expenses for 2015-2016 were $680 million averaging $1.85 million per day spent on servicing the communities of the Darling Downs and South Burnett.

Budget allocation



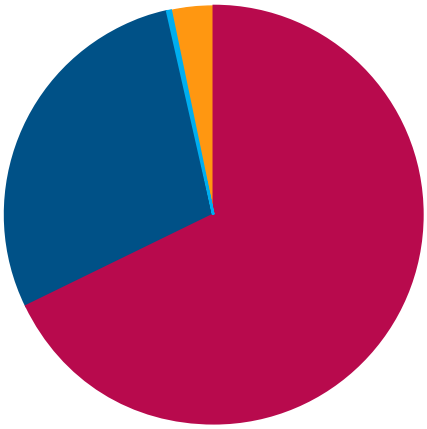
Toowoomba Hospital	38.28%
Rural Health	30%
Mental Health	11.78%
Other Professional and Support Services	16.45%
Depreciation	3.49%

Our performance

How the funding is spent

Once again the largest percentage spend is against labour costs, this amounts to 67.83 per cent of expenditure across clinical and non-clinical support staff. Non-labour expenses such as clinical and non-clinical supplies, other clinical services (such as pathology, radiology, prosthetics), catering, maintenance and utilities accounted for 28.87 per cent of expenditure.

Expenses



Employee expenses	67.83 %
Supplies and Services	28.72%
Grants and subsidies	0.15%
Depreciation expenses	3.30%

Financial outlook

In the 2016-17 financial year the service will provide public healthcare in line with the Service Agreement with the Department of Health. The DDHHS will have a total operating budget of $674.5 million, an increase of 5.8 per cent or $36.7 million from the 2015-2016 budget as outlined in the 2016-17 *Queensland State Budget Service Delivery Statements*.

Next financial year the DDHHS will focus on delivering a balanced budget however financial modelling indicates that funding is not keeping up with increasing service demand. The health service will continue to work collaboratively with the Department to ensure that we can deliver quality public healthcare to all patients within our region as efficiently as possible.

Backlog maintenance program

Work continues on our $50.6 million program of maintenance and remediation works across the health service. This year we have continued internal and external painting, flooring upgrades, air conditioning improvements, upgrades to helipads, as well as plumbing and electrical upgrades. Next year will be the final year of this very important three year program.

Infrastructure projects

In February 2016 the Board announced plans to fund the construction of a seventh operating theatre at Toowoomba Hospital as the six current theatres have been operating at capacity in order to meet demand. The $8.1 million redevelopment will also provide a new central waiting area, reception, and additional consultation rooms. Planning is underway with construction due to start next financial year.

This year the Toowoomba Hospital has had an upgrade to its power supply at a total cost of $2.48 million that will increase power capacity for the new kitchen, pathology building and future developments on site. Further expansions and improvements at Toowoomba Hospital have included the upgrade of the existing computerised tomography (CT) scanner and the installation of a second CT scanner at a total cost of $2.75 million; and the refurbishment of Fountain House 1 for the Alcohol and Other Drugs Service (AODS) at a cost of $2.86 million.

New CT scanners were installed at Goondiwindi and Warwick Hospitals in November 2015 through a partnership with a private imaging provider. The availability of CT scans for the first time in Goondiwindi means patients have local access to high-quality medical imaging, which reduces the need for patients to be transferred to Toowoomba or even Brisbane.

In June 2016, the Board announced an investment of $2.6 million at Miles Hospital for the refurbishment of the community health building to house the Miles Medical Practice and the replacement of the hospital's existing staff accommodation with four brand new two bedroom self-contained units. The Board has also committed funding to refurbish the private practice clinic at Jandowae.

TOOWOOMBA HOSPITAL MATERNITY REFURBISHMENTS FINISHED AHEAD OF TIME

Refurbishment works at Toowoomba Hospital's Birthing Suite were completed a-week-and-a-half ahead of schedule allowing a return to full clinical services in late June.

The newly refurbished maternity and birthing facilities were welcomed by staff, expectant and new mothers, and visitors.

The Harbison Maternity Unit received extensive structural and cosmetic upgrades including the widening of some bathroom doors and showers for easier movement, and the reconfiguration of ward rooms to give mothers, babies and their visitors more space.

Other works included new floor coverings, painting, new blinds and upgraded bathrooms in the ward rooms, plus new window fittings and ensuites in single rooms.

The birthing suite makeover included new flooring coverings, repairs in two bathrooms and routine maintenance.

Harbison Nurse Unit Manager Peta Zupp and Rob McHugh from Building,Engineering and Maintenance Services celebrate the early completion of the refurbishment.

Our generous supporters

Our local hospitals are important parts of each community and we are big-heartedly supported by the Toowoomba Hospital Foundation, local auxiliaries, service clubs, other groups and individuals through fundraising efforts and other generous donations.

This year the Toowoomba Hospital Foundation has supported the Toowoomba Hospital and our staff through:

- donation of a new cardiac ultrasound system, couch and chair, valued at $314,402, for the hospital's new Echocardiography Unit
- purchase of a $16,000 golf cart and $9,000 electric wheel chair to help transport frail or immobile patients to various parts of the hospital campus
- facilitation of scholarship funding through the Pure Land Learning College to support staff research initiatives
- funding of a clinical trials nurse at the Regional Cancer Centre
- donation of equipment to various wards thanks to fundraising initiatives such as annual golf days, rodeos and the annual DonateLife campaign which promotes the importance of organ donation
- various BreastScreen promotions and fundraisers including the 17th annual Walk of Hope and Pink Ribbon Day
- production of a video for children with Type 1 diabetes
- prizes for a range of staff and community initiatives including Pastoral Care Week, pressure injuries awareness, employee awards and length-of-service presentations, volunteers' lunches, special care nursery family fun day, and more.

In addition to the generosity bestowed on us by the Toowoomba Hospital Foundation, our rural facilities have been given the following generous donations:

- Friends of Dr EAF McDonald Nursing Home, New Hope Coal, and local business support to fit out a new $60,000 palliative care room at the Oakey facility
- $30,000 donation for new equipment for South Burnett palliative care services through the Rotary Club of Kingaroy, in conjunction with the Queensland Police Service. The equipment such as special mattresses, shower aids and wheel chairs will help local residents stay at home longer to receive end-of-life care
- Millmerran Hospital Auxiliary donated new curtains for the veranda to provide greater comfort for patients, residents and visitors, as well as a mobile file trolley
- Wondai Hospital Auxiliary members celebrated almost 200 years of voluntary service
- Lions Club of Nanango's donation of a $3,960 Masimo Monitor to Kingaroy Hospital
- Humpty Dumpty Foundation's donation of a $9,000 LED phototherapy system for Warwick Hospital to treat babies with jaundice
- donation of a $3,000 palliative care bed to the Texas Multipurpose Health Service through the hospital auxiliary (thanks to a kind benefactor), as well as a new table and television
- a local family's donation of a 'cuddle cot' to Goondiwindi Hospital to support families grieving after the birth of a stillborn baby
- Thiess Mining's donation of almost $5,000 to purchase new televisions at Miles Hospital
- Goondiwindi Hospital Auxiliary's donation of a portable pain relief system to allow women in labour to move around freely.

3. Ensure processes are clear

Collaboration commences with the Darling Downs and West Moreton Primary Health Network

On 1 July 2015 the Darling Downs and West Moreton Primary Health Network (DDWM PHN) commenced operations. The PHN has been established by the DDHHS, in partnership with GP Connections. The PHN is governed by its own Board and administration.

The main objective of the federally funded PHN is to ensure patients receive "the right care in the right place at the right time." The DDWM PHN provides leadership, resources and coordination of services across the primary healthcare sector throughout the region. The clinical priorities of the DDWM PHN are aged care, health workforce, digital health, mental health, Aboriginal and Torres Strait Island health and population health.

In May 2016, the DDHHS welcomed the appointment of Mr John Minz as the Board Chair and interim Chief Executive Officer Ms Sam Freeman to the DDWM PHN. The PHN and DDHHS continue to work collaboratively together to progress the integration of healthcare services across the region.

Further information regarding DDWM PHN is available on their website www.ddwmphn.com.au

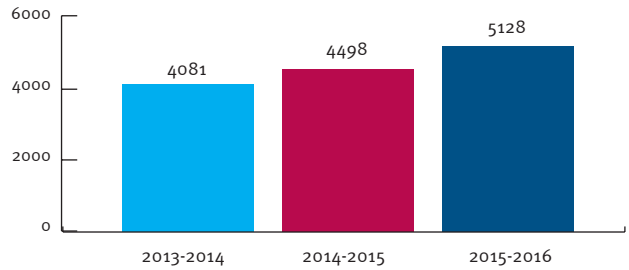
Business Planning Framework for Nursing and Midwifery Services

The DDHHS has invested in broadening the application of the Business Planning Framework for nursing and midwifery services to ensure that all clinical services and clinical support service areas delivered by nurses and midwives are resourced using this methodology. This Framework supports nurses and midwives in applying a structured business planning approach to inform optimal staffing levels aligned to demonstrated clinical need and the acuity of patients. This year 95 discrete service plans were prepared applying the BPF, doubling the number of plans prepared since the use of the BPF was ratified through *Enterprise Bargaining Agreement Number 8 - Nurses and Midwives Certified Agreement 2012*.

Telehealth delivers more care locally

Telehealth has seen significant growth over the past year with over 5,000 reported occasions of service completed for the DDHHS. Compared to 2014/15 there have been 630 more telehealth appointments completed this year.

Telehealth services (excluding mental health)



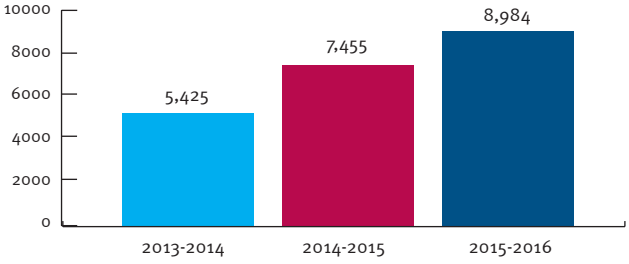
The DDHHS's geriatrician service is delivering quality videoconference consultations to private nursing home patients. Teledentistry continues to be implemented across DDHHS Aged Care facilities with this model of care being the first of its kind in the Queensland Health public sector.

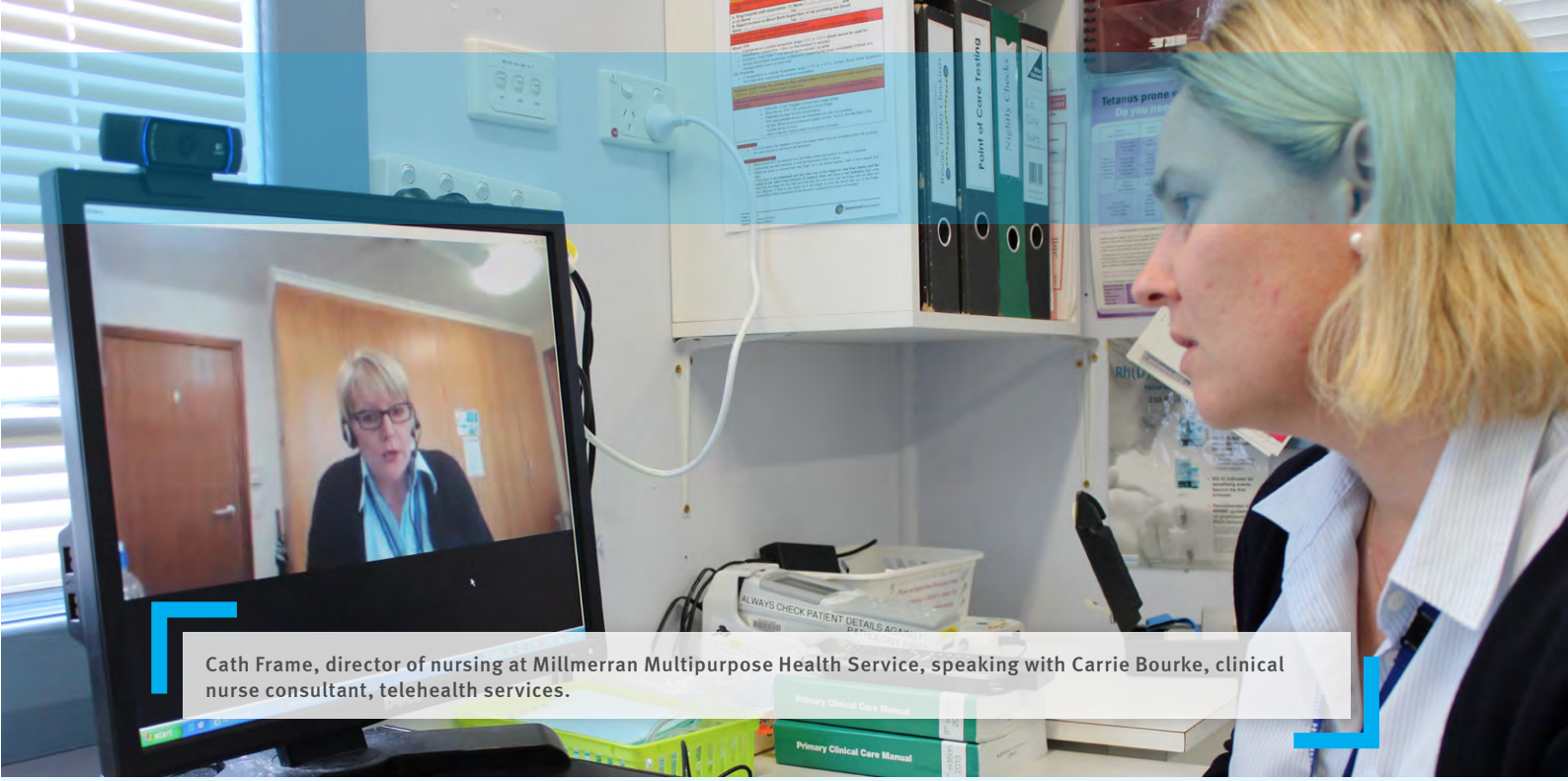
Links with the Princess Alexandra Hospital this year have seen Toowoomba Hospital nursing staff trained in joint count as part of the rheumatology telehealth clinic so that DDHHS patients can now have their appointments in Toowoomba.

The DDHHS's Allied Health service has also worked hard this year to increase telehealth services throughout the region including lymphoedema outreach services to Cherbourg, support for Oakey Hospital as a stepdown from Toowoomba Hospital's orthopaedic outpatient department, women's health outreach to Kingaroy, and paediatric speech pathology services delivered to the home.

The Mental Health telehealth service continues to grow year on year with consultations stretching across the DDHHS and the South West Hospital and Health Service.

Mental health telehealth services





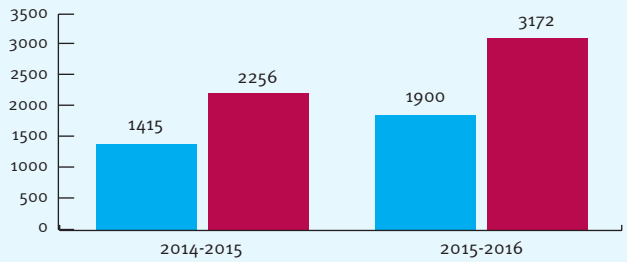
Cath Frame, director of nursing at Millmerran Multipurpose Health Service, speaking with Carrie Bourke, clinical nurse consultant, telehealth services.

Consumer feedback helps us to improve our care

The DDHHS encourages feedback from consumers and patients across the health service as this helps us to review and improve our care and the service we provide to the community.

The DDHHS strives to resolve consumer complaints within key timeframes. In 2015-2016 DDHHS acknowledged 100 per cent of consumer complaints within five days and resolved 80 per cent within 35 days. The DDHHS's Consumer Liaison Unit continues to diligently work with consumers to ensure their concerns are heard and actioned as appropriate. Throughout 2015-2016, compliments about our staff, facilities and the service we provide continued to exceed complaints and the DDHHS is very proud of this achievement.

Consumer feedback



	2014-2015	2015-2016
Total complaints	1415	1900
Total compliments	2256	3172

Consumer engagement across the health service

The DDHHS Consumer Council was established in February 2016 and holds meetings every two months, on the fourth Monday of the month. The Consumer Council's purpose is to engage with communities, existing hospital and community advisory groups, the Toowoomba Hospital Foundation, and hospital auxiliaries to promote mutual respect and facilitate forums and communication through to the Health Service Chief Executive to improve healthcare outcomes.

Toowoomba Hospital welcomed Dr Jim Madden, retired educator and academic, as its consumer representative on the Toowoomba Hospital Patient Safety and Quality Committee. Dr Madden responded to the call out to the professional community for members to contribute to better healthcare outcomes for residents accessing services from Toowoomba Hospital.

The DDHHS is committed to increasing consumer participation in planning and the delivery of its healthcare services, with more work to occur on improving consumer consultation and engagement in the next financial year.

Our performance

Telehealth Services CNC Carrie Bourke and Telehealth Business Coordinator Shayne Stenhouse at the opening.

NEW TELEHEALTH SUITE FOR MILLMERRAN MULTIPURPOSE HEALTH SERVICE

Staff members from the Millmerran Multipurpose Health Service helped open the facility's new telehealth suite in February.

The new $10,549 suite features state-of-the-art telehealth equipment which enables patients of the facility, as well as members of the community, to undergo medical consultations with specialists located in larger centres.

"The need for a fit-for-purpose, private telehealth suite was identified by the Millmerran MPHS's Community Advisory Network," Director of Nursing Cath Frame said.

"Previously the telehealth equipment was located in a multipurpose room in a busy part of the facility.

"This renovated suite is away from the main thoroughfare of the facility and enables a better experience for patients or community members accessing our services."

Aged Care Professional Breakfast

The DDHHS's Aged Care Professional Breakfast commenced with its first Breakfast held in November 2015. The Aged Care Professional Breakfast has been very well received and attended by various staff from both within the DDHHS and the non-government sector.

The Aged Care Professional Breakfast has provided a great foundation for networking as well as providing an opportunity to share ideas and information as we progress through the current aged care and community care reforms. At each breakfast two guest speakers cover various topics applicable to the community and aged care. Guest speakers have included service providers, benchmarking facilitators as well as a guest speaker from the Federal Department of Human Services.

Emergency preparedness exercises

The Ravenshoe fire disaster of 9 June 2015 reinforced the need for a high level of emergency preparedness throughout DDHHS. DDHHS staff took part in a number of emergency preparedness exercises in 2015-2016. Plans have been put in place to stage a similar exercise at Kingaroy Hospital in 2016-17.

Staff from Oakey Hospital were involved with "Exercise Bernborough" which revolved around emergency response to a flood scenario. The exercise was run by the Toowoomba Local Disaster Management Group.

Toowoomba Hospital staff were involved with "Exercise Firebug" which was based on a fire scenario, with the exercise run by the Toowoomba District Disaster Management Group.

On 6 August 2015 a large-scale exercise involving staff from Toowoomba Hospital was held in conjunction with staff from St Vincent's Private Hospital. Staff from Toowoomba Hospital came from a variety of work departments including emergency, critical care, medical imaging, surgical department, mortuary and media and communications. Emergency services personnel also participated. The scenario was based on a multi-casualty disaster and was designed to test resources, staff and services, and to ascertain how the two hospitals could work together.

Dr Peter Gillies, in his former role as Toowoomba Hospital General Manager, and St Vincent's General Manager Carl Yuile initiated the idea for a joint disaster exercise to push staff to react quickly, safely and effectively to a realistic scenario.

The exercise was designed to make participants think quickly, while ensuring patient safety and ongoing care, and to build co-operation between the two facilities. The effectiveness of the exercise was assessed by exercise evaluators, senior instructors, assistant instructors and exercise observers.

The exercise received overwhelmingly positive feedback from participants and was seen to be successful in that it highlighted the willingness of the two facilities to work together. An openness to strengthening the ties between the two hospitals was evident, which was particularly encouraging, given the limited resources available in the area to respond to a large-scale disaster.

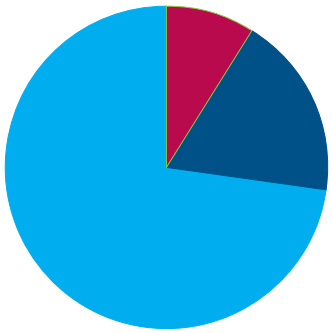
4. Ensure dedicated, trained staff

To deliver excellence in rural and regional healthcare, we value the workforce we employ and the skill and commitment that they bring to the organisation. Our workforce is our most crucial resource and employing the right people, in the right place, at the right time ensures we can achieve our vision and deliver the best patient-focussed healthcare to our communities.

Our workforce

DDHHS continues to be one of the largest employers across the Darling Downs, Southern Downs, Western Downs and South Burnett areas. Our workforce consists of over 5,000 employees, the largest cohort being clinical staff; which includes medical, nursing, allied health and a range of other professional and technical staff delivering front line services. Clinical staff are supported across the health service by a range of administrative, operational and trades staff in clinical and corporate support, operational services, infrastructure and other supporting roles.

DDHHS continues to support flexible working arrangements where appropriate, and support a healthy work-life balance for all staff.

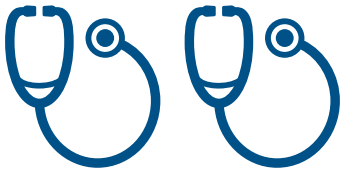


Occupational status	%
Casual	9
Temporary	18
Permanent	72

4,028

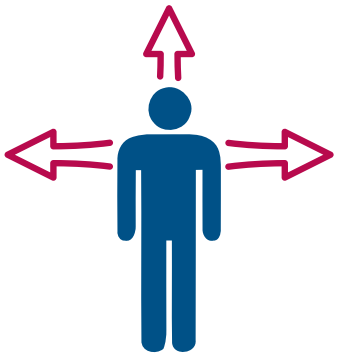
MOHRI FTE

*MOHRI – minimum obligatory human resource information



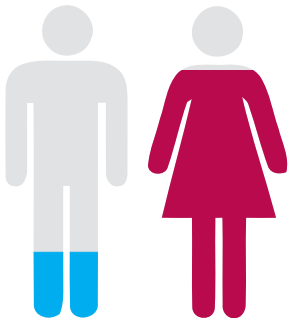
Clinical to non-clinical ratio

2:1



7.4%

Separation rate



Gender	%
Female	79
Male	21

5,122

Headcount

45

Average age

Our performance

INTERNATIONAL NURSES DAY CELEBRATED

The dedication and tireless efforts of DDHHS nurses and midwives was proudly celebrated at the International Nurses Day Breakfast held on 12 May 2016.

This year's theme: *Nurses a Force for Change: Improving Health System Resilience* highlighted the fundamental role the nursing profession plays in assuring sustainable quality healthcare availability across the world.

This year's guest speaker, the inspirational Ms Sue Ellen Kovak shared with the audience her experiences as a Red Cross volunteer during the 2014 Ebola crisis in Sierra Leone.

She spoke about the courage of nurses to be on the frontline of healthcare in many world crises.

Mr Kovack is pictured with Toowoomba Hospital registered nurse Lydia Williams.

Planning for and retaining a skilled workforce

In 2015-2016 DDHHS had a retention rate of 92.6 per cent for permanent staff with a separation rate of 7.4 per cent. These figures remain comparable with the previous two years, indicating a stable workforce ratio.

In 2015-2016 the DDHHS welcomed 464 new employees to the service. All new staff complete an orientation and induction training package via the DDHHS's online training platform Darling Downs Learning Online (DD-LOL). The training package provides a comprehensive overview of the DDHHS, our values and performance expectations and development opportunities for our staff.

The DDHHS's strategic workforce plan is a key tool that helps the DDHHS to identify the key risks, objectives and goals that affect our workforce for the period 2016-2020. Key to this plan is the DDHHS values and embedding a workforce culture that commits to these values and the highest standards of ethical behaviour. With an increasing demand on aged care services in our region, with pressure on health expenditure, as well as State and Federal healthcare reforms, the DDHHS work environment will continue to change. The workforce plan develops an understanding of these changes and the adaptation that will need to be undertaken by the DDHHS to continue to improve performance, productivity and healthcare delivery.

During the period, one employee received a redundancy package at a cost of $202,000. No early retirement or retrenchment packages were paid during this period.

Educating and training our workforce

The DD-LOL team celebrated an exciting first year expanding their course selections to help staff keep up to date with compulsory and tailored training courses. The DD-LOL platform delivers training courses to our staff in areas such as: orientation and induction; work health and safety; cultural practice; ethics, integrity and accountability; patient centred care; and other role specific training to support the requirements of our workforce.

There has been a significant improvement in rates for training completion and the added flexibility of tailoring training to make programs available in short time frames has received positive feedback from across the health service. In 2015-2016:

- 59,315 online training courses were completed by DDHHS staff
- 4,783 staff have completed patient-centred care training

Establishing expectations

DDHHS is committed to ensuring the highest level of ethical behaviour through all areas of the health service. We uphold our responsibility to conduct and report on our business transparently and honestly while maintaining processes so that all staff are aware of these responsibilities. As a public service agency, the Code of Conduct for the Queensland Public Service is applicable to all employees of the DDHHS. All employees are expected to uphold the Code by committing to and demonstrating the intent and spirit of its principles and values.

Kingaroy Hospital registered nurses Shannon Green (left) and Rebecca Hoey joined the graduate nursing program in early 2016.

We strongly support and encourage the reporting of Public Interest Disclosures. All employees have a responsibility to disclose suspected wrong doing and to ensure any disclosure is in accordance with DDHHS ethical culture. This responsibility is reinforced by the *Public Sector Ethics Act 1994*. To support our staff in complying with their obligations under the *Public Sector Ethics Act 1994* staff are required to complete an ethics and fraud awareness training package annually through the DD-LOL platform.

Engaging our clinicians to improve the service

Our value of openness to learning and change recognises the need to continually review the service we provide. A core component of achieving this value is engaging clinicians to embed evidence-based research and practice to improve our clinical care. The DDHHS Research Team encompasses all clinical disciplines (allied health, nursing and medicine) and has worked diligently throughout the year in a variety of areas to achieve this goal. There are 27 current research projects being led by a DDHHS staff member (as a primary or chief investigator) and another 17 where a DDHHS staff member was listed as a collaborator. The team received three funding grants worth over $95,000 and have published 13 papers in peer reviewed academic journals. They have also applied for an additional eight funding grants that are still pending.

The work of the Research Team is supported by the DDHHS Research Strategic Plan and a Research Advisory Committee. The team has also recruited a Mobile Emergency Department Research Manager who commenced in September 2015. This role will support research in emergency departments across West Moreton, Gold Coast and the Darling Downs.

Allied Health Rural Generalist Trainee Program (AHRGTP)

In 2015-2016, DDHHS hosted two new graduates though Allied Health Professions Office Queensland (AHPOQ's) Allied Health Rural Generalist Trainee program (AHRGTP). The program has allowed the DDHHS to increase its rural workforce and facilitate clinical redesign as well as develop and support graduate clinicians in a rural setting. In Chinchilla, the rural generalist Occupational Therapist and the Occupational Therapy team have been improving access to services by contributing to a multi-disciplinary Allied Health paediatric clinic with telehealth service delivery. In Kingaroy, the AHRGTP role as part of the physiotherapy team has improved delegation models to an allied health assistant workforce which has resulted in an increased capacity for inpatient rehabilitation.

DDHHS Graduate Nursing Program

This year a new Nurse Educator role has been established to be responsible for driving graduate, undergraduate and vocational education and training (obtained through the Nursing Guarantee funding). This position has allowed the DDHHS to enhance its commitment to supporting the future nursing and midwifery workforce. The DDHHS new graduate program is now offering 48 dedicated graduate nurse positions, which is a 50 per cent increase from 2014-2015. This investment in graduate nurses is a key strategy in addressing forecasted workforce shortages by positioning DDHHS as an employer of choice for nurses in the region.

Nursing workforce boosted by introduction of Nurse Navigator positions and nurse-to-patient ratios

The State Government also committed to boost nursing staff levels with legislation passed in December to increase nurse-to-patient ratios. DDHHS planned for the implementation on 1 July 2016.

Five nurse navigators started as part of the State Government's commitment to allocate 19 positions to the DDHHS over two financial years. The nurse navigator roles will be valuable in coordinating care across our complex health system. The care coordination will not only be related to nursing or midwifery but will also support links to allied health and mental healthcare.

Work health and safety

We are committed to ensuring the health and safety of all staff within our workplace by having a robust governance framework and continually working towards improving our safety management system. The current hours lost (WorkCover hours) versus occupied FTE was 0.31 this year which is below the state target of 0.35.

Extensive rehabilitation support is provided to staff whether the illness or injury is work related or not, with every effort made to return staff to work as soon as it is deemed safe. This includes supporting their return on reduced hours, or days, and by reviewing workloads. The average return to work in the DDHHS after an injury is 13.39 days against the industry average of 19.73 days.

Additional bariatric equipment has also been purchased from the Board's accumulated surplus this year to support the safety of our staff in the safe movement of obese and morbidly obese patients. Extensive training and support was provided to staff to assist them in using these new resources correctly.

Occupational violence prevention

Occupational violence training has had high attendance and positive feedback. Along with a Queensland-wide awareness campaign, the DDHHS has emphasised our zero tolerance for violence against clinical staff and our staff are well trained in how to manage these incidents. All staff attend compulsory occupation violence prevention training as a part of the staff orientation package, and in-depth training is provided for staff working in high-risk areas.

2015 Annual DDHHS Employee Awards

There were 101 nominations across seven categories for the second year of the Annual DDHHS Employee Awards. This is just over double the nominations received in the inaugural year. The awards program recognises DDHHS employees for excellence in demonstrating the values, purpose and vision of the DDHHS. These awards are a public acknowledgement of our dedicated staff, gives us a moment to acclaim their great work and to applaud special achievements over the past year.

DDHHS Vision (7 nominations)

Winner: Dr RT Lewandowski, Medical Superintendent Kingaroy Hospital, Rural Division.

DDHHS Purpose (9 nominations)

Winner: Toowoomba Hospital Emergency Department Nurse Practitioners, Anthony Wollaston and Andrew See.

DDHHS Values

Caring (34 nominations)
Winner: Karen Abbott, Cluster Operations Manager Western Cluster, Rural Division.

Doing the Right Thing (13 nominations)
Winner: Rica Lacey, DDHHS Cultural Practice Coordinator, Infrastructure and Workforce Division.

Openness to Learning and Change category (18 nominations)
Winner: Dr Kathryn Wilks, Staff Specialist Infectious Diseases.

Being safe, effective and efficient (13 nominations)
Winner: Geriatric Adult Rehabilitation and Stroke Service Day Therapy team, Toowoomba Hospital.

Being Open and Transparent (7 nominations)
Winner: Dr Adam Visser, Staff Specialist, Toowoomba Hospital.

Length of service awards

Staff members who had achieved the milestones of 30, 35, 40 and 45 years of service were honoured in a special ceremony in June 2016. The Board Chair Mr Mike Horan AM paid tribute to the employees who have clocked up 2,845 years collectively.

Staff from different professions and occupations including nursing, mental health, administration and operational streams from many of the health service's 26 facilities covering the Darling Downs, Southern Downs, Western Downs and South Burnett were honoured at the ceremony.

Staff from Miles Hospital staff congratulate enrolled nurse Alison Dangerfield (centre front row) on International Women's Day for being one of DDHHS's longest-serving female employees with almost 50 years of service.

Engaging our employees - Working for Queensland survey results

Employee engagement is about creating an environment where employees are committed to their work and really care about doing a good job. The benefits of employee engagement are widely documented and include increases in employee effort, organisational commitment, productivity and retention of skills and reduction in staff turnover, absenteeism and training of new employees. One of the ways DDHHS engages with its employees is through the annual 2016 Working for Queensland (WfQ) Employee Opinion survey which was completed in May 2016. This year 2,120 employees shared their view and ensured their voice counted.

This level of participation and the survey results are making a real difference in our workplace, helping to build a better workplace and drive positive change. The 2016 WfQ results for DDHHS showed positive improvement in the areas of job empowerment, my workgroup, my manager and anti-discrimination. This year the Workforce Capability team developed a number of resources that will assist managers and staff to identify practical actions that can be put in place to help drive positive change in our workplace.

Supporting women in the workplace

DDHHS encourages flexible work arrangements, where appropriate, and is proud to have a workforce that is predominately female. The DDHHS has an almost 50 per cent gender balance on its Executive Team, with four out of the nine positions being filled by women. The DDHH Board has an even greater number of women members, with two-thirds of the members being women.

The DDHHS is committed to encouraging and supporting women in the workplace with many of our policies aligned to the government's *Queensland Women's Strategy 2016-2021*.

Glossary

Term	Meaning
Accessible	Accessible healthcare is characterised by the ability of people to obtain appropriate healthcare at the right place and right time, irrespective of income, cultural background or geography.
Accreditation	Accreditation is independent recognition that an organisation, service, program or activity meets the requirements of defined criteria or standards.
Activity Based Funding (ABF)	A management tool with the potential to enhance public accountability and drive technical efficiency in the delivery of health services by: • capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery • creating an explicit relationship between funds allocated and services provided • strengthening management's focus on outputs, outcomes and quality • encouraging clinicians and managers to identify variations in costs and practices so they can be managed at a local level in the context of improving efficiency and effectiveness • providing mechanisms to reward good practice and support quality initiatives.
Acute	Having a short and relatively severe course.
Acute care	Care in which the clinical intent or treatment goal is to: • manage labour (obstetric) • cure illness or provide definitive treatment of injury • perform surgery • relieve symptoms of illness or injury (excluding palliative care) • reduce severity of an illness or injury • protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function • perform diagnostic or therapeutic procedures.
Acute Hospital	Is generally a recognised hospital that provides acute care and excludes dental and psychiatric hospitals.
Admission	The process whereby a hospital accepts responsibility for a patient's care and/or treatment. It follows a clinical decision, based on specified criteria, that a patient requires same-day or overnight care or treatment, which can occur in hospital and/or in the patient's home (for hospital-in-the-home patients).
Aged Care and HACC Assessment Team (ACHAT)	ACHAT provides comprehensive assessments for the needs of frail older people and facilitates access to available care services appropriate to their needs.
Allied Health staff (Health Practitioners)	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; medical imaging; nuclear medicine technology; occupational therapy; orthoptics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work.
Ambulatory	Care provided to patients who are not admitted to the hospital, such as patients of emergency departments, outpatient clinics and community based (non-hospital) healthcare services.
Antenatal	Antenatal care constitutes screening for health, psychosocial and socioeconomic conditions likely to increase the possibility of specific adverse pregnancy outcomes, providing therapeutic interventions known to be effective; and educating pregnant women about planning for safe birth, emergencies during pregnancy and how to deal with them (WHO, 2011).
Bariatric equipment	Equipment and supplies that are designed for larger or obese patients.
Backlog Maintenance Remediation Program	A State Government program providing capital expenditure and maintenance funding to address high priority and critical operational maintenance, life cycle replacements and upgrades.
Block Funded	Block funding is typically applied for small public hospitals where there is an absence of economies of scale that mean some hospitals would not be financially viable under Activity Based Funding (ABF), and for community based services not within the scope of Activity Based Funding.
Breast screen	A breast screen is an x-ray of the breast that can detect small changes in breast tissue before they can be felt by a woman or her doctor. A breast screen is for women who do not have any signs or symptoms of breast cancer. It is usually done every two years for women in the targeted age range.
Cardiology	Management, assessment and treatment of cardiac (heart related) conditions. Includes monitoring of long-term patients with cardiac conditions, maintenance of pacemakers and investigative treatments.
Chronic disease	Chronic disease: Diseases which have one or more of the following characteristics: (1) is permanent, leaves residual disability; (2) is caused by non-reversible pathological alteration; (3) requires special training of the individual for rehabilitation, and/or may be expected to require a long period of supervision, observation or care.
Clinical governance	A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical practice	Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/or manage illness, together with associated professional activities for patient care.

Term	Meaning
Clinical redesign	Clinical process redesign is concerned with improving patient journeys by making them simpler and better coordinated. The redesign process is patient focused, led by clinical staff, systematic and methodical and quick with tight timeframes.
Community Care Unit	A Community Care Unit (CCU) is a residential facility for adult mental health consumers who are in recovery but require additional support and life skills rehabilitation to successfully transition to independent community living.
Community health	Community health provides a range of services to people closer to their home. Some of these services include children's therapy services, pregnancy and postnatal care, rehabilitation and intervention services, and programs that focus on the long-term management of chronic disease.
Computerised Tomography (CT)	CT is diagnostic imaging technique which uses Xrays that are rotated around a patient to demonstrate the anatomy and structure of the organs and tissues.
Consumer Advisory Networks	Groups that represents people who use health services. Consumer Advisory Networks act as a bridge between health consumers and the health service.
Department of Health	The Department of Health is responsible for the overall management of the public sector health system, and works in partnership with Hospital and Health Services to ensure the public health system delivers high quality hospital and other health services.
Ebola	Ebola virus disease (EVD) is a severe, often fatal illness in humans. The virus is transmitted to people from wild animals and spreads in the human population through human-to-human transmission.
Emergency department waiting time	Time elapsed for each patient from presentation to the emergency department to start of services by the treating clinician. It is calculated by deducting the date and time the patient presents from the date and time of the service event.
Endoscopy	Internal examination of either the upper or lower gastro intestinal tract.
Enrolled nurse	Enrolled nurse (EN) is an associate to the registered nurse (RN) who demonstrates competence in the provision of patient-centred care. EN practice requires the EN to work under the direction and supervision of a registered nurse.
Environmental Health	Environmental Health programs are related to human health issues that are affected by the physical, chemical, biological and social factors that are present in the environment.
Full-time equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
Governance	Governance is aimed at achieving organisational goals and objectives, and can be described as the set of responsibilities and practices, policies and procedures used to provide strategic direction, ensure objectives are achieved, manage risks, and use resources responsibly and with accountability.
GP (General Practitioner)	A general practitioner is a registered medical practitioner who is qualified and competent for general practice in Australia. General practitioners operate predominantly through private medical practices.
Home and Community Care (HACC)	The Commonwealth funded HACC Program provides services which support frail older people and their carers, who live in the community and whose capacity for independent living are at risk of premature or inappropriate admission to long term residential care.
Hospital	Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.
Hospital and Health Board	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to managing a complex healthcare organisation.
Hospital and Health Service	Hospital and Health Service (HHS) is a separate legal entity established by Queensland Government to deliver public hospital services.
Inpatient	A patient who is admitted to a hospital or health service for treatment that requires at least one overnight stay.
Internal Audit	Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.
Interns	A medical practitioner in the first postgraduate year, learning further medical practice under supervision.
Key Performance Indicators	Key performance indicators are metrics used to help a business define and measure progress towards achieving its objectives or critical success factors.
Long wait	A 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for an urgent (category 1) operation, more than 90 days for a semi-urgent (category 2) operation and more than 365 days for a routine (category 3) operation.
Medical practitioner	A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.

Glossary

Term	Meaning
Minimum Obligatory Human Resource Information (MOHRI)	MOHRI is a whole of Government (WoG) methodology for producing an Occupied Full Time Equivalent (FTE) and headcount value sourced from the Queensland Health payroll system data for reporting and monitoring.
Mobile Womens Health	The Mobile Womens Health service, aims to improve the health and well-being of women in rural and remote areas of Queensland. Mobile Women's Health Nurses work as sole practitioners and provide a range of preventative health services for women, including pap smears, education, information, counselling and support on a range of women's health issues.
Models of Care	Model of Care and Models of Service Delivery broadly defines the way that clinical and non-clinical services will be delivered.
Multidisciplinary team	Health professionals employed by a public health service who work together to provide treatment and care for patients. They include nurses, doctors, allied health and other health professionals.
Multipurpose Health Service (MPHS)	Provide a flexible and integrated approach to health and aged care service delivery for small rural communities. They are funded through pooling of funds from Hospital and Health Services (HHS) and the Australian Government Department of Health and Ageing.
National Emergency Access Target (NEAT)	NEAT is a National Performance Benchmark for public hospitals. NEAT commenced in January 2012, with annual increment targets over the next four years for all patients presenting to a public hospital Emergency Department (ED) to either physically leave the ED for admission to hospital, be transferred to another hospital for treatment, or be discharged, within four hours.
National Elective Surgery Target (NEST)	NEST is a National Performance Benchmark for public hospitals. The objectives of NEST are to improve patient care by: Increasing the percentage of elective surgery patients seen within the clinically recommended time, and reducing the number of patients who have waited longer than the clinically recommended time.
National Safety and Quality Healthcare Standards (NSQHS)	The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Healthcare (the Commission) in consultation and collaboration with jurisdictions, technical experts and a wide range of other organisations and individuals, including health professionals and patients. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of care provided by health service organisations.
National Standards for Mental Health Services (NSMHS)	The National Standards for Mental Health Services (NSMHS) were first introduced in 1996 to assist in the development and implementation of appropriate practices and guide continuous quality improvement in mental health services. Demonstration of the delivery of services against these standards ensures that consumers, carers and the community can be confident of what to expect from mental health services.
Occupied Bed Days	Is the occupancy of a bed or bed alternative by an admitted patient as measured at midnight of each day, for any period of up to 24 hours prior to that midnight.
Oncology	The study and treatment of cancer and malignant tumors.
Opthalmology	Consultation, assessment, review, treatment and management of conditions relating to eye disorders and vision, and services associated with surgery to the eye.
Oral-maxillofacial surgery	Specialises in treating diseases, injuries and defects in the head, neck, face, jaws and the hard and soft tissues of the Oral (mouth) and Maxillofacial (jaws and face) region.
Orthopaedics	Consultation, diagnosis, treatment and follow-up of patients suffering diseases and disorders of the musculoskeletal system and connective tissue.
Outpatient	Non-admitted health service provided or accessed by an individual at a hospital or health service facility.
Outpatient Clinic	Provides examination, consultation, treatment or other service to non-admitted non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.
Outreach	Services delivered to sites outside of the service's base to meet or complement local service needs.
Own Source Revenue	Own Source Revenue (OSR) is revenue generated by the agency, generally through the sale of goods and services. Examples of OSR include revenue generated through privately insured inpatients, private outpatients, and Medicare ineligible patients (overseas visitors).
Palliative Care	Palliative care is an approach that improves quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychological and spiritual.
Pastoral Care	Pastoral Care Services exist within a holistic approach to health, to enable patients, families and staff to respond to spiritual and emotional needs, and to the experiences of life and death, illness and injury, in the context of a faith or belief system.
Patient Travel Subsidy Scheme (PTSS)	The Patient Travel Subsidy Scheme (PTSS) provides assistance to patients, and in some cases their carers, to enable them to access specialist medical services that are not available locally.
Performance indicator	A measure that provides an 'indication' of progress towards achieving the organisation's objectives. Usually has targets that define the level of performance expected against the performance indicator.

Term	Meaning
Primary Healthcare	Primary healthcare services include health promotion and disease prevention, acute episodic care not requiring hospitalisation, continuing care of chronic diseases, education and advocacy.
Primary Health Network	Primary Health Networks (PHNs) replaced Medicare Locals from July 1 2015. PHNs are established with the key objectives of: • increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and • improving coordination of care to ensure patients receive the right care in the right place at the right time. PHNs work directly with general practitioners, other primary healthcare providers, secondary care providers and hospitals to ensure improved outcomes for patients.
Public hospital	Public hospitals offer free diagnostic services, treatment, care and inpatient accommodation to Medicare eligible patients. Patients who elect to be treated as a private patient in a public hospital, and patients who are not Medicare eligible are charged for the cost of treatment.
Public patient	A public patient is one who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.
Queensland Emergency Access Target (QEAT)	Queensland Emergency Access Target (QEAT) has been introduced to include additional Emergency Department (ED) sites across the State for all patients presenting to an ED to either physically leave the ED for admission to hospital, be transferred to another hospital for treatment, or be discharged within four hours. For DDHHS QEAT reporting facilities are Toowoomba, Warwick, Kingaroy, Chinchilla, Dalby, Goondiwindi, Stanthorpe and Oakey.
Queensland Weighted Activity Unit (QWAU)	QWAU is a standardised unit to measure healthcare services (activities) within the Queensland Activity Based Funding (ABF) model.
Registered nurse (RN)	An individual registered under national law to practice without supervision in the nursing profession as a nurse, other than as a student.
Renal Dialysis	Renal dialysis is a medical process of filtering the blood with a machine outside of the body.
Risk	The effect of uncertainty on the achievement of an organisation's objectives.
Risk management	A process of systematically identifying hazards, assessing and controlling risks, and monitoring and reviewing activities to make sure that risks are effectively managed.
Rural Generalist	A Rural Generalist is defined as a rural medical practitioner who is credentialed to serve in: • Hospital-based and community-based primary medical practice; and • Hospital-based secondary medical practice in at least one specialist medical discipline (commonly but not limited to obstetrics, anaesthetics and surgery); and without supervision by a specialist medical practitioner in the relevant disciplines.
SAFE (Systematic Approach Facilitates Excellence)	A DDHHS program to measure performance against the clinical standards to improve safety and quality.
Secondary healthcare	Medical care provided by a specialist or facility upon referral by a primary care physician. It includes services provided by hospitals and specialist medical practices
Statutory bodies / authorities	A non-departmental government body, established under an Act of Parliament.
Stroke Lysis	Treatment to dissolve blood clots in blood vessels, improve blood flow, and prevent damage to tissues and organs.
Sub-acute	Sub-acute care focuses on continuation of care and optimisation of health and functionality.
Sustainable health system	A health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs, for example, research and monitoring within available resources.
Telehealth	Delivery of health-related services and information via telecommunication technologies, including: • live, audio and/or video inter-active links for clinical consultations and educational purposes • store-and-forward Telehealth, including digital images, video, audio and clinical (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists • Telehealth services and equipment to monitor people's health in their home.
Tertiary Hospitals	Tertiary Hospitals provide care which requires highly specialized equipment and expertise.
Triage category	Urgency of a patient's need for medical and nursing care.
Ultrasound	Ultrasound imaging allows an inside view of soft tissues and body cavities without the use of invasive techniques. Ultra-sound waves can be bounced off tissues by using special devices. The echoes are then converted into a picture called a sonogram.
Visiting Medical Officer	A medical practitioner who is employed as an independent contractor or an employee to provide services on a part time, sessional basis.
Weighted activity unit	A single standard unit used to measure all activity consistently.

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/s	ARRs – section 8	i
Accessibility	• Table of contents	ARRs – section 10.1	1
	• Glossary	ARRs – section 10.1	50-53
	• Public availability	ARRs – section 10.2	Inside front cover
	• Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 10.3	Inside front cover
	• Copyright notice	*Copyright Act 1968* ARRs – section 10.4	Inside front cover
	• Information Licensing	*QGEA – Information Licensing* ARRs – section 10.5	Inside front cover
General information	• Introductory Information	ARRs – section 11.1	2, 3, 8-9
	• Agency role and main functions	ARRs – section 11.2	9
	• Operating environment	ARRs – section 11.3	9-11, 28-29
Non-financial performance	• Government's objectives for the community	ARRs – section 12.1	11
	• Other whole-of-government plans / specific initiatives	ARRs – section 12.2	48-49
	• Agency objectives and performance indicators	ARRs – section 12.3	10-11, 30-49
	• Agency service areas and service standards	ARRs – section 12.4	30-49
Financial performance	• Summary of financial performance	ARRs – section 13.1	39-40
Governance – management and structure	• Organisational structure	ARRs – section 14.1	29
	• Executive management	ARRs – section 14.2	12-19, 23-26
	• Government bodies (statutory bodies and other entities)	ARRs – section 14.3	12-18, 20, 91
	• *Public Sector Ethics Act 1994*	ARRs – section 14.4	46-47

Summary of Requirement		Basis for requirement	Annual report reference
Governance – risk management and accountability	• Risk management	ARRs – section 15.1	18
	• Audit committee	ARRs – section 15.2	18
	• Internal audit	ARRs – section 15.3	18
	• External scrutiny	ARRs – section 15.4	19
	• Information systems and recordkeeping	ARRs – section 15.5	19
Governance – human resources	• Workforce planning and performance	ARRs – section 16.1	45-49
	• Early retirement, redundancy and retrenchment	Directive No.11/12 Early Retirement, Redundancy and Retrenchment Directive No. 16/16 Early Retirement, Redundancy and Retrenchment (from May 2016) ARRs – section 16.2	46
Open Data	• Consultancies	ARRs – section 17 ARRs – section 34.1	Inside front cover
	• Overseas travel	ARRs – section 17 ARRs – section 34.2	Inside front cover
	• Queensland Language Services Policy	ARRs – section 17 ARRs – section 34.3	Inside front cover
Financial statements	• Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	98
	• Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	99-100

FAA *Financial Accountability Act 2009*
FPMS *Financial and Performance Management Standard 2009*
ARRs *Annual report requirements for Queensland Government agencies*

Darling Downs Hospital and Health Service

ABN 64 109 516 141

Consolidated Financial Statements - 30 June 2016

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Consolidated Financial Statements for the year ended 30 June 2016

Contents

General information

The Darling Downs Hospital and Health Service (DDHHS) is a Queensland Government statutory body established under the *Hospital and Health Boards Act 2011* and its registered trading name is Darling Downs Hospital and Health Service.

DDHHS is controlled by the State of Queensland who is the ultimate parent entity.

The principal address of the Hospital and Health Service (HHS) is:

Jofre
Baillie Henderson Hospital
Cnr Hogg & Tor Streets
Toowoomba QLD 4350

A description of the nature of the operations of DDHHS and its principal activities is included in the notes to the financial statements.

For information in relation to the financial statements of DDHHS, email DDHHS@health.qld.gov.au or visit DDHHS's website at http://www.health.qld.gov.au/darlingdowns/default.asp

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Statement of Comprehensive Income
for the year ended 30 June 2016

	Notes	*Actual 2016 $'000*	*Actual 2015 $'000*
OPERATING RESULT			
Income from continuing operations			
User charges and fees	4	649,859	608,095
Grants and other contributions	5	30,845	32,423
Interest		310	193
Other revenue		2,863	2,612
Total revenue		**683,877**	**643,323**
Gains on disposal/re-measurement of assets		65	78
Total income from continuing operations		**683,942**	**643,401**
Expenses from continuing operations			
Employee expenses	6	56,562	47,031
Health service employee expenses	7	404,994	378,830
Supplies and services	8	192,678	172,106
Grants and subsidies		1,006	1,265
Depreciation	13	21,443	20,770
Impairment losses		1,618	1,047
Net loss on revaluation of non-current assets		1,041	-
Other expenses	9	1,126	2,218
Total expenses from continuing operations		**680,468**	**623,267**
Operating result from continuing operations		**3,474**	**20,134**
OTHER COMPREHENSIVE INCOME			
Items not recyclable to operating result			
Increase/(decrease) in asset revaluation surplus	17	(330)	-
Total items not recyclable to operating result		**(330)**	**-**
Total other comprehensive income		**(330)**	**-**
TOTAL COMPREHENSIVE INCOME		**3,144**	**20,134**

The accompanying notes form part of these financial statements

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Statement of Financial Position
as at 30 June 2016

	Notes	*Actual 2016 $'000*	*Actual 2015 $'000*
Current assets			
Cash and cash equivalents	10	78,711	74,085
Receivables	11	14,564	14,113
Inventories	12	6,744	5,454
Other current assets		1,027	560
Total current assets		**101,046**	**94,212**
Non-current assets			
Property, plant and equipment	13	298,324	301,532
Other non-current assets		13	28
Total non-current assets		**298,337**	**301,560**
Total assets		**399,383**	**395,772**
Current liabilities			
Payables	14	33,985	34,560
Accrued employee benefits	15	2,259	1,190
Unearned revenue		66	155
Total current liabilities		**36,310**	**35,905**
Total liabilities		**36,310**	**35,905**
Net assets		**363,073**	**359,867**
Equity			
Contributed equity	16	288,060	287,999
Accumulated surplus/(deficit)		55,546	52,071
Asset revaluation surplus/(deficit)	17	19,467	19,797
Total equity		**363,073**	**359,867**

The accompanying notes form part of these financial statements

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Statement of Changes in Equity
for the year ended 30 June 2016

	Notes	*Accumulated Surplus/ (Deficit)* *$'000*	*Asset Revaluation Surplus/ (Deficit)* *$'000*	*Contributed Equity* *$'000*	*Total* *$'000*
Balance as at 1 July 2014		**31,938**	**19,797**	**288,219**	**339,954**
Operating result from continuing operations		20,134	-	-	20,134
Other comprehensive income		-	-	-	-
Total comprehensive income for the year		**20,134**	**-**	**-**	**20,134**
Transactions with owners as owners					
Net assets received during year		-	-	2,893	2,893
Non appropriated equity injections (minor capital works)		-	-	17,656	17,656
Non appropriated equity withdrawals (depreciation funding)		-	-	(20,770)	(20,770)
Total transactions with owners as owners		**-**	**-**	**(221)**	**(221)**
Balance as at 30 June 2015		**52,072**	**19,797**	**287,998**	**359,867**
Operating result from continuing operations		3,474	-	-	3,474
Other comprehensive income					
Increase/(decrease) in asset revaluation surplus		-	(330)	-	(330)
Total comprehensive income for the year		**3,474**	**(330)**	**-**	**3,144**
Transactions with owners as owners					
Net assets received during year		-	-	4,165	4,165
Non appropriated equity injections (minor capital works)		-	-	17,340	17,340
Non appropriated equity withdrawals (depreciation funding)		-	-	(21,443)	(21,443)
Total transactions with owners as owners		**-**	**-**	**62**	**62**
Balance as at 30 June 2016		**55,546**	**19,467**	**288,060**	**363,073**

The accompanying notes form part of these financial statements

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Statement of Cash Flows
for the year ended 30 June 2016

	Notes	*Actual 2016 $'000*	*Actual 2015 $'000*
Cash flows from operating activities			
Inflows:			
User charges and fees		626,709	581,768
Grants and other contributions		30,840	32,447
Interest receipts		310	193
GST input tax credits from ATO		9,962	10,143
GST collected from customers		572	593
Other		2,863	2,612
Total cash provided by operating activities		**671,256**	**627,756**
Outflows:			
Employee expenses		55,493	45,865
Health service employee expenses		401,869	378,392
Supplies and services		198,031	180,073
Grants and subsidies		1,208	1,063
GST paid to suppliers		10,301	10,249
GST remitted to ATO		568	541
Other		979	1,984
Total cash used in operating activities		**668,449**	**618,167**
Net cash provided by / (used in) operating activities[1]		**2,807**	**9,589**
Cash flows from investing activities			
Inflows:			
Sales of property, plant and equipment		75	91
Total cash provided by investing activities		**75**	**91**
Outflows:			
Payments for property, plant and equipment		15,596	14,188
Total cash used in investing activities		**15,596**	**14,188**
Net cash provided by / (used in) investing activities		**(15,521)**	**(14,097)**
Cash flows from financing activities			
Inflows:			
Proceeds from equity injections		17,340	17,656
Total cash provided by financing activities		**17,340**	**17,656**
Net cash provided by / (used in) financing activities		**17,340**	**17,656**
Net increase in cash and cash equivalents		**4,626**	**13,148**
Cash and cash equivalents at beginning of financial year		74,085	60,937
Cash and cash equivalents at end of financial year	10	**78,711**	**74,085**

[1] Refer to the reconciliation of operating result to net cash provided by / (used in) operating activities in the *Notes to the Statement of Cash Flows*

The accompanying notes form part of these financial statements

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Notes to the Statement of Cash Flows
for the year ended 30 June 2016

Reconciliation of operating result to net cash provided by / (used in) operating activities

	Actual 2016 $'000	*Actual 2015 $'000*
Operating result from continuing operations	3,474	20,134
Non-cash items included in operating result		
Depreciation	21,443	20,770
Depreciation grant funding	(21,443)	(20,770)
Net loss on revaluation of non-current assets	1,041	-
Net (gain)/loss on disposal of non-current assets	83	156
Assets donated revenue	(5)	-
Change in assets and liabilities		
(Increase)/decrease in trade receivables	1,520	(1,105)
(Increase)/decrease in GST input tax credits receivable	(339)	(107)
(Increase)/decrease in inventories	(1,290)	81
(Increase)/decrease in other current assets	(451)	(354)
(Increase)/decrease in accrued revenue	(1,635)	(3,570)
Increase/(decrease) in trade payables	(1,653)	(8,931)
Increase/(decrease) in accrued employee benefits	1,069	1,166
Increase/(decrease) in unearned revenue	(89)	125
Increase/(decrease) in other payables	1,082	1,994
Net cash provided by / (used in) operating activities	**2,807**	**9,589**

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Notes to the Financial Statements for the year ended 30 June 2016

Index of Notes

1. Objectives and principal activities of the Darling Downs Hospital and Health Service

Darling Downs Hospital and Health Service (DDHHS) is an independent statutory body, overseen by a local Hospital and Health Board. DDHHS provides public hospital and healthcare services as defined in the service agreement with the Department of Health (DoH).

Details of the services undertaken by DDHHS are included in the Annual Report.

2. General information

(a) Statement of compliance

These financial statements are general purpose financial statements and have been prepared on an accrual basis. The financial statements have been prepared in accordance with Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) and in compliance with section 62(1) of the *Financial Accountability Act 2009* and section 43 of the *Financial and Performance Management Standard 2009*. In addition, the financial statements comply with Queensland Treasury's Minimum Reporting Requirements for reporting periods beginning on or after 1 July 2015, and other authoritative pronouncements.

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

The financial statements are authorised for issue by the Chair of the Board and the Chief Finance Officer at the date of signing the Management Certificate.

(b) Presentation matters

Presentation matters relevant to the financial statements include the following:

- Except where stated, the historical cost convention is used;
- Amounts included in the financial statements are in Australian dollars and have been rounded to the nearest $1,000 or where that amount is $500 or less, to zero, unless disclosure of the full amount is specifically required;
- Comparative information has been restated where necessary to be consistent with disclosures in the current reporting period; and
- Assets are classified as 'current' where their carrying amount is expected to be realised within 12 months after the reporting date. Liabilities are classified as 'current' when they are due to be settled within 12 months after the reporting date. All other assets and liabilities are classified as non-current.

(c) Accounting estimates and judgements

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

Estimates and assumptions with the most significant effect on the financial statements are outlined in the following notes:

- Allowance for impairment of receivables (refer to note 11(b));
- Revaluation of non-current assets (refer to note 13(d));
- Estimation of useful lives of assets (refer to note 13(e)); and
- Fair value and hierarchy of financial instruments (refer to note 19).

2. General information (continued)

(d) Taxation

The only federal taxes that DDHHS is assessed for are Fringe Benefit Tax (FBT) and Goods and Services Tax (GST).

All FBT and GST reporting to the Commonwealth is managed centrally by DoH, with payments/receipts made on behalf of DDHHS reimbursed to/from DoH on a monthly basis. GST credits receivable from, and GST payable to the Australian Tax Office (ATO), are recognised on this basis.

Both DDHHS and DoH satisfy section 149-25(e) of the *A New Tax System (Goods and Services) Act 1999 (Cth)* (the GST Act). Consequently they were able, with other Hospital and Health Services (HHS's), to form a "group" for GST purposes under Division 149 of the GST Act. Any transactions between the members of the "group" do not attract GST.

3. New and revised accounting standards

The Australian Accounting Standards Board (AASB) has issued new and revised Accounting Standards and Interpretations that have mandatory application dates in future reporting periods. In accordance with the requirements of Queensland Treasury, DDHHS has early adopted two Australian Accounting Standards in the 2016 reporting period. These are:

AASB 2015-2 Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 101 [AASB 7, AASB 101, AASB 134 & AASB 1049]. The amendments arising from this standard seek to improve financial reporting by providing flexibility as to the ordering of notes, the identification and location of significant accounting policies and the presentation of sub-totals, and provides clarity on aggregating line items. It also emphasises only including material disclosures in the notes. DDHHS has applied this flexibility in preparing the 2015-16 financial statements, including co-locating significant accounting policies with the related breakdowns of financial statement figures in the notes.

AASB 2015-7 Amendments to Australian Accounting Standards - Fair Value Disclosures of Not-for-Profit Public Sector Entities [AASB 13]. This standard amends *AASB 13 Fair Value Measurement* to provide relief to not-for-profit public sector entities from certain disclosures about property, plant and equipment that are primarily held for its current service potential rather than to generate future net cash inflows. The relief applies to assets under *AASB 116 Property Plant and Equipment* which are measured at fair value and categorised within level 3 of the fair value hierarchy. These are disclosed in note 19.

As a result, the following disclosures are no longer required for level 3 assets and have been removed from these financial statements:

- Disaggregation of certain gains/losses on assets reflected in the operating result;
- Quantitative information about the significant unobservable inputs used in the fair value measurement; and
- A description of the sensitivity of the fair value measurement to changes in the unobservable inputs.

The following Accounting Standards and Interpretations that have mandatory application dates in future reporting periods have not been early adopted by DDHHS:

AASB 2016-2 Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 107 will become effective from reporting periods beginning on or after 1 July 2017. This Standard amends *AASB 107 Statement of Cash Flows* and requires entities preparing financial statements in accordance with Tier 1 reporting requirements to provide additional disclosures that enable users of financial statements to evaluate changes in liabilities arising from financing activities. These disclosures will include both cash flows and non-cash changes between opening and closing balances of the relevant liabilities and be disclosed by way of a reconciliation or roll forward as part of the notes to the Statement of Cash Flows. The measurement of assets, liabilities, income and expenditure in the financial statements will be unaffected. At this stage, DDHHS does not have any cash flows relating to liabilities arising from financing activities. Accordingly, this Standard is not expected to have a material impact on disclosures required by DDHHS.

Effective from reporting periods beginning on or after 1 July 2016, a revised version of AASB 124 will apply to DDHHS. AASB 124 requires disclosures about the remuneration of key management personnel KMP), transactions with related parties, and relationships between parent and controlled entities.

3. New and revised accounting standards (continued)

DDHHS already discloses detailed information about remuneration of its KMP, based on *Queensland Treasury's Financial Reporting Requirements*. Due to the additional guidance about the KMP definition in the revised AASB 124, DDHHS will be assessing whether its responsible Minister should be part of its KMP from 2016-17. DDHHS does not provide remuneration to Ministers, so figures for Ministerial remuneration will not be disclosed by DDHHS. Comparative information will continue to be disclosed in respect of KMP remuneration.

The most significant implications of AASB 124 for DDHHS are the required disclosures about transactions between DDHHS and its related parties (as defined in AASB 124). For any such transactions, from 2016-17, disclosures will include the nature of the related party relationship, as well as information about those transactions' terms/conditions and amounts, any guarantees given/received, outstanding receivables/ payables, commitments, and any receivables where collection has been assessed as being doubtful. In respect of related party transactions with other Queensland Government controlled entities, the information disclosed will be more high level, unless a transaction is individually significant. No comparative information is required in respect of related party transactions in the 2016-17 financial statements.

AASB 15 Revenue from Contracts with Customers will become effective from reporting periods beginning on or after 1 January 2018 and contains much more detailed requirements for the accounting for certain types of revenue from customers. Depending on the specific contractual terms, the new requirements may potentially result in a change to the timing of revenue from sales of DDHHS's goods and services, such that some revenue may need to be deferred to a later reporting period to the extent that DDHHS has received cash but has not met its associated obligations. These amounts would be reported as a liability (unearned revenue). DDHHS is yet to complete an analysis of current arrangements for sale of its goods and services, but at this stage does not expect a significant impact on its present accounting practices.

AASB 9 Financial Instruments and AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014) will become effective from reporting periods beginning on or after 1 January 2018. The main impacts of these standards on DDHHS are that they will change the requirements for the classification, measurement, impairment and disclosures associated with DDHHS's financial assets. AASB 9 will introduce different criteria for whether financial assets can be measured at amortised cost or fair value.

DDHHS has commenced reviewing the measurement of its financial assets against the new AASB 9 classification and measurement requirements. However, as the classification of financial assets at the date of initial application of AASB 9 will depend on the facts and circumstances at that date, DDHHS's conclusions will not be confirmed until closer to that time. At this stage, and assuming no change in the types of transactions DDHHS enters into, all of DDHHS's current receivables, are expected to remain at amortised cost.

Another impact of AASB 9 relates to calculating impairment losses for DDHHS receivables. Assuming no substantial change in the nature of DDHHS's receivables, as they don't include a significant financing component, impairment losses will be determined according to the amount of the lifetime expected credit losses. On initial adoption of AASB 9, DDHHS will need to determine the expected credit losses for its receivables comparing the credit risk at that time to the credit risk that existed when those receivables were initially recognised.

DDHHS will not need to restate comparative figures for financial instruments on adopting AASB 9, however, changed disclosure requirements will apply. A number of one-off disclosures will be required in the financial statements to explain the impact of adopting AASB 9.

AASB 16 Leases will become effective from reporting periods beginning on or after 1 January 2019. When applied, the Standard supersedes *AASB 117 Leases, AASB Interpretation 4 Determining whether an Arrangement contains a Lease, AASB Interpretation 115 Operating Leases - Incentives and AASB Interpretation 127 Evaluating the Substance of Transactions Involving the Legal Form of a Lease.*

Unlike *AASB 117 Leases*, AASB 16 introduces a single lease accounting model for lessees. Lessees will be required to recognise a right-of-use asset (representing rights to use the underlying leased asset) and a liability (representing the obligation to make lease payments) for all leases with a term of more than 12 months, unless the underlying assets are of low value.

3. New and revised accounting standards (continued)

In effect, the majority of operating leases (as defined by the current AASB 117) will be reported on the Statement of Financial Position under AASB 16. As a result, there will be a significant increase in assets and liabilities for DDHHS. The impact of the reported assets and liabilities would be largely in proportion to the scale of DDHHS's leasing activities.

The right-of-use asset will be initially recognised at cost, consisting of the initial amount of the associated lease liability, plus any lease payments made to the lessor at or before the commencement date, less any lease incentive received, the initial estimate of restoration costs and any initial direct costs incurred by the lessee. The right-of-use asset will give rise to amortisation expense.

The lease liability will be initially recognised at an amount equal to the present value of the lease payments during the lease term that are not yet paid. Current operating lease rental payments will no longer be expensed in the Statement of Comprehensive Income. They will be apportioned between a reduction in the recognised lease liability and the implicit finance charge (the effective rate of interest) in the lease. The finance cost will be recognised as an expense.

AASB 16 allows a 'cumulative approach' rather than full retrospective application to recognising existing operating leases. If a lessee chooses to apply the 'cumulative approach', it does not need to restate comparative information. Instead, the cumulative effect of applying the standard is recognised as an adjustment to the opening balance of accumulated surplus (or other component of equity, as appropriate) at the date of initial application. DDHHS will await further guidance from Queensland Treasury on the transitional accounting method to be applied.

DDHHS has not yet quantified the impact on the Statement of Comprehensive Income or the Statement of Financial Position of applying AASB 16 to its current operating leases, including the extent of additional disclosure required.

All other Australian Accounting Standards and Interpretations with new or future commencement dates are either not applicable to DDHHS's activities, or have no material impact on DDHHS.

4. User charges and fees

	2016	*2015*
	$'000	*$'000*
Government funding		
State	313,678	311,418
Commonwealth	195,815	167,039
Other	82,589	85,568
Hospital fees	27,726	25,964
Pharmaceutical benefits scheme reimbursement	24,262	12,191
Sales of goods and services	2,619	2,732
Outsourced service delivery	3,102	3,148
Other user charges - rental income	68	35
Total user charges and fees	**649,859**	**608,095**

User charges and fees primarily comprises DoH funding, patient and client fees, reimbursement of pharmaceutical benefits and sales of goods and services.

The funding from DoH is provided predominantly for specific public health services purchased by DoH from DDHHS in accordance with a service agreement between DoH and DDHHS. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by DDHHS.

The funding from DoH is received fortnightly in advance. At the end of the financial year, a financial adjustment may be required where the level of services provided is above or below the agreed level.

The service agreement between DoH and DDHHS specifies that DoH funds DDHHS depreciation charge via non-cash revenue. DoH retains the cash to fund future major capital replacements. This transaction is shown in the Statement of Changes in Equity as a non-appropriated equity withdrawal.

Other user charges and fees controlled by DDHHS are recognised as revenue when the revenue has been earned and can be measured reliably.

5. Grants and other contributions

	2016	*2015*
	$'000	*$'000*
Nursing home grants	17,035	16,243
Home and community care grants	6,271	6,446
Other specific purpose grants	6,045	6,794
Other grants and donations	1,494	2,940
Total grants and other contributions	**30,845**	**32,423**

Grants, contributions, donations and gifts that are non-reciprocal in nature are recognised as revenue in the year in which DDHHS obtains control over them. Control is generally obtained at the time of receipt. Where grants are received that are reciprocal in nature, revenue is progressively recognised as it is earned, according to the terms of the funding arrangements.

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

DDHHS receives corporate services support from DoH for no cost. Corporate services received include payroll services, accounts payable services, some taxation services, some supply services and some information technology services. As the fair value of these services is unable to be estimated reliably, no associated revenue or expense is recognised in the Statement of Comprehensive Income.

6. Employee expenses

	2016	*2015*
	$'000	*$'000*
Wages and salaries	47,617	39,914
Annual leave levy	3,442	3,409
Employer superannuation contributions	3,664	3,075
Long service leave levy	1,050	57
Redundancies and termination payments	228	155
Other employee related expenses	561	421
Total employee expenses	**56,562**	**47,031**

Under section 20 of the Hospital and Health Boards Act 2011 - a Hospital and Health Service can employ health executives and contracted senior health service employees, including Senior Medical Officers (SMO's), and Visiting Medical Officers (VMO's). Where regulation has been passed for the HHS to become a prescribed service, the HHS can also employ a person previously employed by DoH. Where a HHS has not received the status of a "prescribed service", non-executive staff working in a HHS with the exception of SMO's and VMO's legally remain employees of DoH (health service employees, refer to note 7).

DDHHS is not a "prescribed service", therefore, the number of full-time equivalent employees disclosed below reflect health executives and contracted senior health service employees only. The number of full-time equivalent staff that legally remain employees of DoH are disclosed in note 7.

The number of employees including both full-time employees and part-time employees measured on a full-time equivalent basis is:

	2016	*2015*
Number of employees (full time equivalents) as at 30 June	**147.2**	**132.8**

(a) Employee benefits

DDHHS 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*.

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

6. Employee expenses (continued)

(b) Workers compensation premium

DDHHS is insured via a direct policy with WorkCover Queensland. The policy covers health service executives, senior health service employees engaged under a contract and health service employees. A portion of the premiums paid are reported under other employee related expenses and a portion of the premiums paid are reported under other health service employee related expenses (note 8) in accordance with the underlying employment relationships.

(c) Sick leave

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 only recognised for this leave as it is taken.

(d) Annual and long service leave levy

Under the Queensland Government's Annual Leave Central Scheme and Long Service Leave Central Scheme, levies are made on DDHHS to cover the cost of employees' annual and long service 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 and long service leave are claimed from the scheme quarterly in arrears. DoH centrally manages the levy and reimbursement process on behalf of DDHHS.

(e) 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 DDHHS'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 (WoG) 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 DDHHS pays superannuation contributions into complying superannuation funds.

(f) Key management personnel and remuneration

Key management personnel and remuneration disclosures are detailed in note 27. These may include board members, executives, contracted senior health service employees and health service employees.

(g) Payroll system

Employees are currently paid under a service arrangement using DoH's payroll system. The responsibility for the efficiency and effectiveness of this system remains with DoH.

7. Health service employee expenses

DDHHS is not a prescribed service and accordingly all non-executive staff, with the exception of SMO's and VMO's, are employed by DoH. Provisions in the *Hospital and Health Boards Act 2011* enable DDHHS to perform functions and exercise powers to ensure the delivery of its operational plan.

Under this arrangement:

- DoH provides employees to perform work for DDHHS, and acknowledges and accepts its obligations as the employer of these employees;
- DDHHS is responsible for the day to day management of these employees; and
- DDHHS reimburses DoH for the salaries and on-costs of these employees.

As a result of this arrangement, DDHHS treats the reimbursements to DoH for departmental employees in these financial statements as Health service employee expenses.

DDHHS, through service arrangements with DoH, has engaged 3,881 full-time equivalent (FTE) persons (2015: 3,783 FTE), as calculated by reference to the minimum obligatory human resources information (MOHRI).

8. Supplies and services

	2016	*2015*
	$'000	*$'000*
Clinical supplies and services	28,757	23,465
Pharmaceuticals	29,811	18,297
Consultants and contractors	19,518	17,378
Outsourced service delivery contracts (clinical services)	17,642	15,029
Repairs and maintenance	16,561	19,578
Other health service employee related expenses	6,656	7,568
Pathology and laboratory supplies	11,730	11,348
Catering and domestic supplies	10,274	9,904
Patient travel	9,349	8,549
Computer services and communications	9,199	9,375
Inter-entity supplies (paid to DoH)	7,888	7,264
Water and utility costs	6,988	7,260
Insurance premiums (paid to DoH)	6,716	6,764
Operating lease rentals	2,453	2,467
Minor works, including plant and equipment	2,637	1,901
Other travel	1,991	1,706
Building services	1,401	1,331
Motor vehicles	646	630
Other	2,461	2,292
Total supplies and services	**192,678**	**172,106**

(a) Insurance premiums

DDHHS is insured under a DoH insurance policy with the Queensland Government Insurance Fund (QGIF) and pays a fee to DoH as a fee for service arrangement. QGIF covers property and general losses above a $10,000 threshold and health litigation payments above a $20,000 threshold and associated legal fees. QGIF collects an annual premium from insured agencies intended to cover the cost of claims occurring in the premium year, calculated on a risk assessment basis.

(b) Leases

Operating lease payments are representative of the pattern of benefits derived from the leased assets. Payments made under operating leases are recognised in profit or loss on a straight-line basis over the term of the lease. DDHHS has no finance lease assets as at the reporting date.

9. Other expenses

Total audit fees quoted by the Queensland Audit Office for the reporting period are $202K (2015: $194K). There are no non-audit services included in this amount.

Special payments include ex gratia expenditure and other expenditure that DDHHS is not contractually or legally obligated to make to other parties. In compliance with the *Financial and Performance Management Standard 2009*, DDHHS maintains a register setting out details of all special payments approved by DDHHS delegates. Special payments (ex-gratia payments) totaling $5K (2015: $92K) were made during the period. There were no special payments greater than $5,000 paid during the reporting period.

10. Cash and cash equivalents

	2016	*2015*
	$'000	*$'000*
Operating cash on hand and at bank	72,905	69,354
General trust at call deposits *	4,488	4,365
General trust cash at bank *	1,318	366
Total cash and cash equivalents	**78,711**	**74,085**

* Refer note 23 Restricted assets

10. Cash and cash equivalents (continued)

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 reporting date as well as deposits at call with financial institutions.

DDHHS's operating bank accounts are grouped as part of a WoG set-off arrangement with Queensland Treasury Corporation, which does not earn interest on surplus funds nor is it charged interest or fees for accessing its approved cash debit facility. Any interest earned on the WoG fund accrues to the Consolidated Fund.

General trust cash at bank and at call deposits do not form part of the WoG banking arrangement and incur fees as well as earn interest. Interest earned from general trust accounts is used in accordance with the terms of the trust.

General trust cash at bank and at call deposits earn interest calculated on a daily basis reflecting market movements in cash funds. Annual effective interest rates (payable monthly) achieved throughout the year range between 2.74% and 3.23% (2015: 2.81% and 3.94%).

11. Receivables

	2016	*2015*
	$'000	*$'000*
Trade receivables	6,034	6,704
Less: Allowance for impairment loss	(2,107)	(1,257)
Total trade receivables	**3,927**	**5,447**
GST input tax credits receivable	1,271	932
GST (payable)/receivable	(44)	(41)
Total GST receivable	**1,227**	**891**
Accrued revenue from DoH	5,192	6,188
Other accrued revenue	4,218	1,587
Total other receivables	**9,410**	**7,775**
Total receivables	**14,564**	**14,113**

Receivables are measured at their carrying amount less any impairment, which approximates their fair value at reporting date. Trade receivables are recognised at the amount due at the time of sale or service delivery i.e. the agreed purchase/contract price. Settlement of these amounts is generally required within 30 days from invoice date. The collectability of receivables is assessed periodically with allowance being made for impairment.

(a) Credit risk exposure of receivables

The maximum exposure to credit risk at balance date for receivables is the gross carrying amount of those assets inclusive of any allowance for impairment. Credit risk on receivables is considered minimal given that $10.371M or 71% (2015: $9.372M or 66%) of total receivables is due from Government, including finalisation of the 2015-16 service agreement with DoH, Commonwealth Pharmaceutical Benefits Scheme, insurance recoveries and transfers from fiduciary trusts.

(b) Impairment of receivables

Throughout the year, DDHHS 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 DDHHS's assessment of the credit risk associated with receivables balances and is determined based on historical rates of bad debts (by category) and management judgement. The level of allowance is assessed by taking into account the ageing of receivables, historical collection rates and specific knowledge of the individual debtor's financial position.

11. Receivables (continued)

When a trade receivable is considered uncollectible, it is written off against the allowance account. Subsequent recoveries of amounts previously written off are credited against the allowance account. Changes in the carrying amount of the allowance account are recognised in the Statement of Comprehensive Income.

As at 30 June 2016, trade receivables with a nominal value of $1,205K (2015: $647K) were individualy impaired and have been fully provided for as an allowance for impaired receivables. This represents individually impaired receivables. In addition, patient debtors and other debtors are impaired on a historical percentage basis. These general impairments of $902K (2015: $610K) are not included in the individually impaired receivables below. The sum of individually impaired assets and general impairments balance to total impairments of $2,107K (2015: $1,257K). These are disclosed as movements in the allowance for impairment loss.

	2016			2015		
Overdue	**Gross receivables $'000**	**Allowance for impairment $'000**	**Carrying Amount $'000**	**Gross receivables $'000**	**Allowance for impairment $'000**	**Carrying Amount $'000**
Less than 30 days	68	(68)	-	109	(109)	-
30 to 60 days	64	(64)	-	49	(49)	-
60 to 90 days	64	(64)	-	80	(80)	-
Greater than 90 days	1,009	(1,009)	-	409	(409)	-
Total overdue	**1,205**	**(1,205)**	**-**	**647**	**(647)**	**-**
General impairments	4,829	(902)	3,927	6,057	(610)	5,447
Total	**6,034**	**(2,107)**	**3,927**	**6,704**	**(1,257)**	**5,447**

Movements in the allowance for impairment loss	*2016 $'000*	*2015 $'000*
Balance at the beginning of the financial year	1,257	1,142
Amounts written off during the year in respect of bad debts	(652)	(868)
Increase/(decrease) in allowance recognised in operating result	1,502	983
Balance at the end of the financial year	**2,107**	**1,257**

As at 30 June 2016, receivables with a nominal value of $2,114K (2015: $1,746K) were past due but not impaired. Ageing of past due but not impaired receivables are disclosed in the following table.

Receivables past due but not impaired	*2016 $'000*	*2015 $'000*
Less than 30 days	1,318	809
30 to 60 days	484	383
60 to 90 days	102	144
Greater than 90 days	210	410
Total past due but not impaired	**2,114**	**1,746**
Not overdue	12,450	12,367
Total receivables	**14,564**	**14,113**

12. Inventories

	2016 $'000	*2015 $'000*
Clinical supplies and equipment	2,572	2,841
Pharmaceuticals	3,793	2,240
Catering and domestic	103	103
Other	276	270
Total inventories	**6,744**	**5,454**

Inventories are stated at the lower of cost and net realisable value. Cost comprises purchase and delivery costs, net of rebates and discounts received or receivable. Inventories are measured at weighted average cost, adjusted for obsolescence.

12. Inventories (continued)

Inventories consist mainly of clinical supplies and pharmaceuticals held for distribution to hospitals or residential aged care facilities within DDHHS and other HHSs. These inventories are provided to the facilities at cost. DDHHS provides a central store enabling the distribution of supplies to other HHSs and utilises store facilities managed by DoH.

Unless material, inventories do not include supplies held ready for use in the wards throughout the hospital facilities. These are expensed on issue from DDHHS's central store. Items held on consignment are not treated as inventory, but are expensed when utilised in the normal course of business.

13. Property, plant and equipment

	Land at fair value $'000	Buildings & improvements at fair value $'000	Plant & equipment at cost $'000	Work in progress at cost $'000	Total $'000
Fair value / cost	41,350	638,148	66,772	1,241	747,511
Accumulated depreciation	-	(407,815)	(38,164)	-	(445,979)
Carrying amount at 30 June 2015	**41,350**	**230,333**	**28,608**	**1,241**	**301,532**
Represented by movements in carrying amount					
Carrying amount at 1 July 2014	44,563	233,163	27,144	600	305,470
Acquisitions	-	1,962	6,949	6,150	15,061
Transfers in from other Queensland Government entities	-	10,380	8	-	10,388
Disposals	-	(24)	(223)	-	(247)
Transfers out to other Queensland Government entities	(3,213)	(5,157)	-	-	(8,370)
Transfer between asset classes	-	5,509	-	(5,509)	-
Depreciation	-	(15,500)	(5,270)	-	(20,770)
Carrying amount at 30 June 2015	**41,350**	**230,333**	**28,608**	**1,241**	**301,532**
Fair value / cost	37,565	656,045	69,519	4,218	767,347
Accumulated depreciation	-	(429,586)	(39,437)	-	(469,023)
Carrying amount at 30 June 2016	**37,565**	**226,459**	**30,082**	**4,218**	**298,324**
Represented by movements in carrying amount					
Carrying amount at 1 July 2015	41,350	230,333	28,608	1,241	301,532
Acquisitions	-	54	7,132	8,413	15,599
Transfers in from other Queensland Government entities	-	4,516	-	-	4,516
Donations received	-	-	5	-	5
Disposals	-	-	(158)	-	(158)
Transfers out to other Queensland Government entities	(350)	-	-	-	(350)
Donations made	-	-	(6)	-	(6)
Transfer between asset classes	-	5,280	157	(5,436)	1
Net revaluation increments/(decrements)	(3,435)	2,063	-	-	(1,372)
Depreciation	-	(15,787)	(5,656)	-	(21,443)
Carrying amount at 30 June 2016	**37,565**	**226,459**	**30,082**	**4,218**	**298,324**

13. Property, plant and equipment (continued)

(a) Recognition thresholds for property plant and equipment

Items of property, plant and equipment with a cost or other value equal to or in excess of the following thresholds and with a useful life of more than one year are recognised at acquisition. Items below these values are expensed in the year of acquisition.

Class	Threshold
Buildings and land improvements	$10,000
Land	$1
Plant and equipment	$5,000

Land improvements undertaken by DDHHS are included with buildings.

DDHHS has a comprehensive annual maintenance program for its major plant and equipment and built assets. Expenditure is only capitalised if it increases the service potential or useful life of the existing asset. Maintenance expenditure that merely restores the original service potential (arising from ordinary wear and tear) is expensed.

(b) Acquisition of assets

Cost is used for the initial recording of all non-current property, plant and equipment acquisitions. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use, including architects' fees and engineering design fees. However, any training costs are expensed as incurred.

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.

(c) Measurement of non-current assets

Plant and equipment is measured at cost net of accumulated depreciation and accumulated impairment losses in accordance with *Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector*. The carrying amounts for plant and equipment at cost do not materially differ from their fair value.

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

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

Separately identified components of assets are measured on the same basis as the assets to which they relate.

(d) Revaluation of non-current assets

Land, buildings and improvements classes measured at fair value, are revalued on an annual basis either by comprehensive valuations or by the use of appropriate and relevant indices provided by independent experts. Comprehensive valuations are undertaken at least once every five years. However, if a particular asset class experiences significant and volatile changes in fair value, that class is subject to specific appraisal in the reporting period, where practicable, regardless of the timing of the last specific appraisal. Assets under construction are not revalued until they are ready for use.

13. Property, plant and equipment (continued)

(d) Revaluation of non-current assets (continued)

Where assets have not been comprehensively valued in the reporting period, DDHHS uses indices to provide a valid estimation of the assets fair values at reporting date. The independent experts provide assurance of the robustness, validity and appropriateness of indices for application to the relevant assets. Indices used are also tested for reasonableness by applying the indices to a sample of assets, comparing the results to similar assets that have been valued by an independent professional valuer or quantity surveyor, and analysing the trend of changes over time. Through this annual process, management assesses and confirms the relevance and suitability of indices provided based on DDHHS's own particular circumstances.

Any revaluation increment arising on the revaluation of an asset is credited to the asset revaluation reserve of the appropriate class, except to the extent it reverses a revaluation decrement for the class previously recognised as an expense, in which case, it is recognised as income. 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.

For financial reporting purposes, the revaluation process is managed by the Finance team in DDHHS, who determine the specific revaluation practices and procedures. The DDHHS Board Audit & Risk Committee oversees the revaluation processes managed by the Finance team.

Materiality is considered in determining whether the difference between the carrying amount and the fair value of an asset warrants a revaluation.

The fair values reported by DDHHS are based on appropriate valuation techniques that maximise the use of available and relevant observable inputs and minimise the use of unobservable inputs. Details of DDHHS fair value classification of non-current assets are provided in note 19.

Land revaluation

DDHHS has engaged the State Valuation Service (SVS) to undertake land revaluation in accordance with a four year rolling revaluation program scheduled for all land holdings, excluding properties which do not have a liquid market, for example properties under Deed of Grant (recorded at a nominal value of $1).

Land is measured at fair value using independent revaluations, desktop market revaluations or indexation by the SVS within the Department of Natural Resources and Mines. Such indices are either publicly available, or are derived from market information available to SVS.

The fair value of land was based on publicly available data on sales of similar land in nearby localities prior to the date of the revaluation. In determining the values, adjustments were made to the sales data to take into account the location of the land, its size, street/road frontage and access, and any significant restrictions. The extent of the adjustments made varies in significance for each parcel of land.

Indices are based on actual market movements for the relevant local government area issued by the Valuer-General and asset category. Indices are applied to the fair value of land assets not comprehensively revalued in the reporting period.

The revaluation program resulted in an decrement of $3,435K (2015: nil) to the carrying amount of land.

Buildings and improvements revaluation

Reflecting the specialised nature of health service buildings and on hospital-site residential facilities, for which there is no active market, fair value is determined using the depreciated replacement cost methodology. Depreciated replacement cost is determined as the replacement cost less the cost to bring the asset to current standards as described below.

Buildings and improvements are measured at fair value by applying either a revised estimate of individual asset's depreciated replacement cost, or interim indices which approximate movement in market prices for labour and other key resource inputs, as well as changes in design standards as at the reporting date. These estimates are developed by independent experts.

13. Property, plant and equipment (continued)

(d) Revaluation of non-current assets (continued)

DDHHS engaged independent experts, Davis Langdon Australia Pty Ltd (now known as AECOM) to undertake building revaluations in accordance with a four year rolling revaluation program (with indices applied in the intervening periods).

In determining the replacement cost of each building, the estimated replacement cost of the asset, or the likely cost of construction including fees and on costs if tendered on the valuation date, is assessed. This is based on internal records of the original cost, adjusted for more contemporary design/construction approaches and current construction contracts. Assets are priced using Brisbane rates with published industry benchmark location indices applied. Revaluations are then compared and assessed against current construction contracts for reasonableness. The valuation assumes a replacement building will provide the same service function and form (shape and size) as the original building but built consistent with current building standards. Area estimates were compiled by measuring floor areas of Project Services e-plan room or drawings obtained from DDHHS. Refurbishment costs are derived from specific projects and are therefore indicative of actual costs.

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

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

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

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

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

Category	Condition
1	Very good condition - only normal maintenance required. Generally newly constructed assets that have no backlog maintenance issues;
2	Minor defects only - minor maintenance required or the asset is not built to the same standard as equivalent new assets (such as IT cabling, complying with regulations such as the *Disability Discrimination Act 1992*). Refurbishment is approximately 5% of replacement cost;
3	Largely still in good operational state however maintenance required to return to acceptable level of service. Significant maintenance required up to 50% of capital replacement cost;
4	Requires renewal - complete renewal of internal fit out and engineering services required (up to 70% of capital replacement cost); and
5	Asset unserviceable - complete asset replacement required. Asset's value is nil.

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

The revaluation program resulted in an increment of $2,063K (2015: nil) to the carrying amount of buildings.

13. Property, plant and equipment (continued)

(e) Depreciation

Land is not depreciated as it has an unlimited useful life.

DDHHS determines the estimated useful lives for its property, plant and equipment based on the expected period of time over which economic benefits arising from the use of the asset will be derived. Significant judgement is required to determine useful lives which could change significantly as a result of technical innovations or some other event. The depreciation charge will increase where the useful lives are less than previously estimated, or technically obsolete or non-strategic assets that have been abandoned or sold are written off or written down.

Property, plant and equipment is depreciated on a straight-line basis so as to allocate the net cost or revalued amount of each asset progressively over its estimated useful life to DDHHS. All asset useful lives are reviewed annually to ensure that the remaining service potential of the assets is reflected in the financial statements. DDHHS has assigned nil residual values to all depreciable assets.

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

Any expenditure that increases the originally assessed capacity or service potential of an asset is capitalised and depreciated over the remaining useful life of the asset. Major components purchased specifically for particular assets are capitalised and depreciated on the same basis as the asset to which they relate. A review of major components is undertaken annually and whilst components are not separately accounted for, there is no material effect on depreciation expense reported. The depreciable amount of improvements to or on leasehold land is allocated progressively over the shorter of the estimated useful lives of the improvements or the unexpired period of the lease.

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

Class	**Depreciation rates**	
	2016	*2015*
Buildings and improvements	0.76% - 7.69%	0.76% - 7.69%
Plant and equipment	2% - 25.0%	2.0% - 20.0%

(f) Impairment of non-current assets

All non-current 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, DDHHS determines the asset's recoverable amount. Any amount by which the asset's carrying amount exceeds the recoverable amount is considered an impairment loss.

The asset's recoverable amount is determined as the higher of the asset's fair value less costs to sell and depreciated replacement cost.

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.

14. Payables

	2016	*2015*
	$'000	*$'000*
Payable to DoH	14,034	16,789
Accrued expenses	13,473	12,391
Trade payables	6,454	5,178
Other	24	202
Total payables	**33,985**	**34,560**

Trade payables are recognised upon receipt of the goods or services ordered and are measured at the nominal amount i.e. agreed purchase/contract price, net of applicable trade and other discounts. Amounts owing are unsecured and generally settled in accordance with the vendor's terms and conditions but within 60 days.

15. Accrued employee benefits

	2016	*2015*
	$'000	*$'000*
Salaries and wages accrued	2,259	1,190
Total accrued employee benefits	**2,259**	**1,190**

No provision for annual leave or long service leave is recognised in DDHHS's financial statements as the liability is held on a WoG basis and reported in those financial statements pursuant to *AASB 1049 Whole of Government and General Government Sector Financial Reporting.*

16. 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*. Appropriations for equity adjustments are similarly designated.

Transactions with owners as owners include equity injections for non-current asset acquisitions and non-cash equity withdrawals to offset non-cash depreciation funding received under the Service Agreement with DoH.

Construction of major health infrastructure continues to be managed and funded by DoH. Upon practical completion of a project, assets are transferred from DoH to DDHHS by the Minister for Health as a contribution by the State through equity. The value of assets transferred by DoH to DDHHS was $4.516M (2015: $11.262M). This is offset by one-off transfers outwards of land to DoH of $0.350M (2015: $8.369M). The net assets received are $4.165M (2015: $2.893M).

17. Revaluation surplus by asset class

	Land	**Buildings & improvements**	**Total**
	$'000	**$'000**	**$'000**
Balance at 1 July 2014	2,393	17,404	19,797
Revaluation increment/(decrement)	-	-	-
Balance at 30 June 2015	**2,393**	**17,404**	**19,797**
Revaluation increment/(decrement)	(2,393)	2,063	(330)
Balance at 30 June 2016	**-**	**19,467**	**19,467**

18. Non-cash financing and investing activities

Assets and liabilities received or transferred by DDHHS are set out in the Statement of Changes in Equity and note 13(b).

19. Fair value measurement

Fair value is the price that would be received upon sale of an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date under current market conditions (i.e. an exit price) regardless of whether that price is directly derived from observable inputs or estimated using another valuation technique. Fair value measurement can be sensitive to various valuation inputs selected. Considerable judgement is required to determine what is significant to fair value.

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 general office buildings.

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 DDHHS 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.

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

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

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

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

None of DDHHS's valuations of assets or liabilities are eligible for categorisation into Level 1 of the fair value hierarchy.

Categorisation of fair value	**Level 2**		**Level 3**		**Total**	
	2016	**2015**	**2016**	**2015**	**2016**	**2015**
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Land	37,565	41,349	-	-	37,565	41,349
Buildings and improvements	740	765	225,719	229,567	226,459	230,332
Total	**38,305**	**42,114**	**225,719**	**229,567**	**264,024**	**271,681**

Reconciliation of non-financial assets categorised as Level 3:

As at 1 July 2014	227,208
Acquisitions (including upgrades)	1,962
Disposals	(24)
Transfer between asset classes	5,509
Transfers in from other Queensland Government entities	10,378
Transfers out to other Queensland Government entities	(512)
Reclassification between fair value levels	494
Depreciation	(15,448)
As at 30 June 2015	**229,567**
Acquisitions (including upgrades)	36
Transfer between asset classes	5,280
Transfers in from other Queensland Government entities	4,515
Net revaluation increments/(decrements)	2,066
Depreciation	(15,745)
As at 30 June 2016	**225,719**

20. Financial instruments

(a) Recognition

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

(b) Classification

Financial instruments are classified and measured as follows:

- Cash and cash equivalents - held at fair value through profit or loss (note 10);
- Receivables - held at amortised cost (note 11); and
- Payables - held at amortised cost (note 14).

DDHHS does not enter into transactions for speculative purposes, nor for hedging.

(c) Financial risk management objectives

Financial risk is managed in accordance with Queensland Government and DDHHS policy. These policies provide written principles for overall risk management, as well as policies covering specific areas, and aim to minimise potential adverse effects of risk events on the financial performance of DDHHS.

DDHHS's activities expose it to a variety of financial risks: credit risk, liquidity risk, and market risk.

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

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

(i) Credit risk exposure

Credit risk exposure refers to the situation where DDHHS may incur financial loss as a result of another party to a financial instrument failing to discharge their obligation.

Credit risk on cash and cash equivalents is considered minimal given all DDHHS deposits are held through the Commonwealth Bank of Australia and by the State through Queensland Treasury Corporation. The maximum exposure to credit risk is limited to the balance of cash and cash equivalents shown in note 10.

Credit risk on receivables is discussed in note 11(a).

No financial assets have had their terms renegotiated as to prevent them from being past due or impaired and are stated at the carrying amounts as indicated.

(ii) Liquidity risk

Liquidity risk refers to the situation where DDHHS may encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivering cash or another financial asset.

DDHHS has an approved debt facility of $6 million (2015: $6 million) under WoG banking arrangements to manage any short term cash shortfalls. This facility has not been drawn down as at 30 June 2016 (2015: nil). The liquidity risk of financial liabilities held by DDHHS is limited to the payables balance as shown in note 14.

20. Financial instruments (continued)

(iii) Market risk

Market risk refers to 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 three types of risk: currency risk, interest rate risk and other price risk.

DDHHS does not trade in foreign currency and is not materially exposed to commodity price changes. DDHHS is exposed to interest rate changes on 24 hour call deposits and there is no interest rate exposure on its cash and fixed rate deposits.

DDHHS does not undertake any hedging in relation to interest rate risk and manages its risk as per DDHHS liquidity risk management strategy articulated in DDHHS's Financial Management Practice Manual. Changes in interest rates have a minimal effect on the operating result of DDHHS.

21. Commitments for expenditure

(a) Non-cancellable operating lease commitments	*2016*	*2015*
	$'000	*$'000*
Committed at the reporting date but not recognised as liabilities:		
Within one year	90	84
One to five years	227	205
More than five years	537	580
Total non-cancellable operating leases	**854**	**869**

Commitments under operating leases at reporting date are inclusive of non-recoverable GST. DDHHS has non-cancellable operating leases relating predominantly to commercial accommodation. Lease payments are generally fixed, but with escalation clauses on which contingent rentals are determined. No lease arrangements contain restrictions on financing or other leasing activities.

(b) Capital expenditure commitments

Capital expenditure commitments at reporting date are inclusive of non-recoverable GST. DDHHS has capital expenditure commitments contracted for at reporting date but not recognised in the financial statements. Capital projects are included as commitments for the remaining project amounts. Each of these projects is currently at a different stage of the contractual cycle.

	2016	*2015*
	$'000	*$'000*
Committed at the reporting date but not recognised as liabilities:		
Repairs and maintenance	314	5,886
Supplies and services	50	333
Capital projects	12,798	1,708
Total capital expenditure commitments	**13,162**	**7,927**

Committed at the reporting date but not recognised as liabilities:		
Within one year	12,999	7,913
One to five years	163	14
Total capital expenditure commitments	**13,162**	**7,927**

22. Contingencies

(a) Litigation in progress

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). DDHHS's liability in this area is limited to an excess of $20,000 per insurance event (refer note 8 (a) Insurance premiums). DDHHS's legal advisers and management believe it is not possible to make a reliable estimate of the final amounts payable (if any) in respect of the litigation before the courts at this time.

22. Contingencies (continued)

(a) Litigation in progress (continued)

As at 30 June 2016, the following number of cases were filed in the courts naming the State of Queensland acting through DDHHS as defendant.

	2016 Number of cases	2015 Number of cases
Supreme Court	1	5
District Court	4	-
Tribunals, commissions and boards	-	2
	5	**7**

(b) Guarantees and undertakings

As at reporting date, DDHHS held bank guarantees from third parties for capital works projects totalling $63K (2015: $38K). These amounts have not been recognised as assets in the financial statements.

DDHHS has a controlling interest in a company limited by guarantee. The value of the guarantee is $10. This arrangement is detailed in note 25.

23. Restricted assets

DDHHS 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. These funds are retained in the Queensland Treasury Corporation Cash Fund.

As at 30 June 2016, amounts are set aside for clinical trials $194,431 (2015: $190,697); clinical research $19,869 (2015: $43,299); health research $52,001 (2015: $33,940) and other purposes $6,714 (2015: $4,768) for the specific purposes underlying the contribution.

24. Fiduciary trust transactions and balances

(a) Patient fiduciary funds

DDHHS acts in a fiduciary trust capacity in relation to patient fiduciary funds and Right of Private Practice trust accounts. Consequently, these transactions and balances are not recognised in the financial statements. Although patients funds are not controlled by DDHHS, trust activities are included in the audit performed annually by the Auditor-General of Queensland.

Patient fiduciary funds	*2016 $'000*	*2015 $'000*
Balance at the beginning of the year	3,079	710
Patient fiduciary fund receipts	13,954	10,062
Patient fiduciary fund payments	9,338	7,693
Balance at the end of the year	**7,695**	**3,079**
Closing balance represented by:		
Cash at bank and on hand	661	661
Refundable patient fiduciary fund deposits *	7,034	2,418
Patient fiduciary fund assets closing balance 30 June	**7,695**	**3,079**

* Following the introduction of new aged care agreements from 1 July 2014 by the Commonwealth Department of Health and Ageing, DDHHS is required to manage payments from residents for refundable accommodation deposits and daily accommodation payments. These funds are treated in a similar manner to patient fiduciary funds, however interest earned is offset against operating and capital costs of the facilities concerned.

24. Fiduciary trust transactions and balances (continued)

(b) Right of private practice (RoPP) scheme

A right of private practice (RoPP) arrangement is where clinicians are able to use DDHHS facilities to provide professional services to private patients. DDHHS acts as a billing agency in respect of services provided under a RoPP arrangement. Under the arrangement, DDHHS deducts from private patient fees received, a service fee (where applicable) to cover costs associated with the use of DDHHS facilities and administrative support provided to the medical officer. In addition, where applicable under the agreement, some funds are paid to the General Trust. These funds are used to provide grants for study, research, or educational purposes. Transactions and balances relating to the RoPP arrangement are outlined below:

Right of Private Practice (ROPP) receipts and payments	*2016*	*2015*
	$'000	*$'000*
Receipts		
Private practice receipts	6,249	6,793
Bank interest	9	11
Total receipts	**6,258**	**6,804**
Payments		
Payments to medical officers	593	774
Payments to DDHHS for recoverable costs	4,989	5,377
Payments to DDHHS General Trust	676	653
Total payments	**6,258**	**6,804**
Increase in net private practice assets	**-**	**-**
Current assets		
Cash - RoPP	626	649
Total current assets	**626**	**649**
Current liabilities		
Payable to medical officers	28	30
Payable to DDHHS for recoverable costs	510	514
Payable to HHS general trust	88	105
Total current liabilities	**626**	**649**

25. Controlled entities

In February 2015, DDHHS participated, with the approval of the Treasurer, in the formation of Darling Downs and West Moreton Primary Health Network Limited, and invested a 50% ownership interest in the company. Darling Downs and West Moreton Primary Health Network's registered office is in Toowoomba, Queensland, with its activities being conducted in a range of regions across the state. The company is not-for-profit, being formed solely to:

(i) increase the efficiency and effectiveness of primary healthcare services for patients in Darling Downs and West Moreton, particularly those at risk of poor health outcomes; and
(ii) improve co-ordination of care to ensure people receive the right care in the right place at the right time.

DDHHS controls the Darling Downs and West Moreton Primary Health Network Limited through the appointment of 5 out of the 9 positions on the company's Board of Directors (as per the company's constitution). The company's directors are charged with the responsibility for ensuring the functions conducted by the company's staff and contractors are in accordance with the broad requirements of DDHHS.

The remaining (non-controlling) ownership interest (50%) in the company is held by Toowoomba and District Division of General Practice Limited trading as GP Connections. GP Connections occupies the 4 remaining positions on the Board of Directors of Darling Downs and West Moreton Primary Health Network Limited.

25. Controlled entities (continued)

The Company is incorporated under the *Corporations Act 2001* and is a company limited by Guarantee. If the Company is wound up, the constitution states that each member is required to contribute a maximum of $10.00 each towards meeting any outstanding obligations of the company. Given the activities of the company, no dividends or other financial returns are received by DDHHS or GP Connections. All funding received by the company is principally used to fulfil its objectives.

The auditor of the company is the Queensland Audit Office. Total external audit fees payable relating to the audit of the financial statements are quoted to be $37,760 (2015: $3,000). There are no non-audit services in this amount.

As the amount of the investment and the transactions of Darling Downs and West Moreton Primary Health Network are not considered material, the entity is not consolidated with DDHHS's financial statements.

Summary financial information about Darling Downs and West Moreton Primary Health Network Limited is as follows:

	2016	*2015*
	$'000	*$'000*
Total income	9,947	110
Total expenses	9,942	110
Operating result	**5**	**-**
Total comprehensive income	**5**	**-**
Total current assets	7,566	1,090
Total assets	**7,566**	**1,090**
Total current liabilities	7,547	1,090
Total non-current liabilities	14	-
Total liabilities	**7,561**	**1,090**
Net assets	**5**	**-**
Net cash increase over the reporting period	**6,382**	**1,068**

26. Budget to actual comparison

This section discloses DDHHS's original published budgeted figures for 2015-16 compared to actual results, with explanations of major variances, in respect of the DDHHS's Statement of Comprehensive Income, Statement of Financial Position and Statement of Cash Flows.

The original budget has been reclassified to be consistent with the presentation and classification adopted in the financial statements.

Statement of Comprehensive Income

	Variance Note	Original Budget 2016 $'000	Actual 2016 $'000	Budget Variance* 2016 $'000	Budget Variance* 2016 %
Income from continuing operations					
User charges and fees	1	604,359	649,859	45,500	8%
Grants and other contributions		29,724	30,845	1,121	4%
Interest		111	310	199	179%
Other revenue		3,568	2,863	(705)	(20%)
Total revenue		637,762	683,877	46,115	7%
Gains on disposal/re-measurement of assets		-	65	65	100%
Total income from continuing operations		**637,762**	**683,942**	**46,180**	**7%**
Expenses from continuing operations					
Employee expenses	2	49,019	56,562	(7,543)	(15%)
Health service employee expenses		393,208	404,994	(11,786)	(3%)
Supplies and services	3	167,106	192,678	(25,572)	(15%)
Grants and subsidies		1,645	1,006	639	39%
Depreciation		23,840	21,443	2,397	10%
Impairment losses		1,273	1,618	(345)	(27%)
Other expenses		1,671	1,126	545	33%
Net loss on revaluation of non-current assets		-	1,041	(1,041)	100%
Total expenses from continuing operations		**637,762**	**680,468**	**(42,706)**	**(7%)**
Operating result from continuing operations		**-**	**3,474**	**3,474**	**100%**
OTHER COMPREHENSIVE INCOME					
Items not recyclable to operating result					
Increase/(decrease) in asset revaluation surplus		-	(330)	(330)	100%
Total items not recyclable to operating result		**-**	**(330)**	**(330)**	**100%**
Total other comprehensive income		**-**	**(330)**	**(330)**	**100%**
TOTAL COMPREHENSIVE INCOME		**-**	**3,144**	**3,144**	**100%**

** Favourable / (Unfavourable)*

26. Budget to actual comparison (continued)

Statement of Comprehensive Income variance notes

1 User charges and fees revenue increased $45.5M over the original budget. Of this $31.1M was due to amendments to the service agreement between DDHHS and DoH. These amendments included $10.1M for surgical outpatient reduction strategies, $11.6M for the delivery of public patient activity above baseline levels, $9.4M for enterprise bargaining agreements, $4M for increased activity in dental and community mental health programs and $2.1M for the reclassification of revenue for the multipurpose health services program from Grants and other contributions. These increases were offset by a $5M reduction due to changes to the model of care for long stay mental health programs. DDHHS had significant growth in revenue associated with the pharmaceutical benefits reimbursement scheme primarily due to the introduction of a new pharmaceutical regime for the treatment of hepatitis C and increases in oncology programs ($12.7M). This increase in revenue is offset by increased pharmaceutical expenditure in supplies and services.

2 Employee expenses exceeded the original budget by $7.5M. This increase was predominantly due to an increase in full time equivalent (FTE) staff numbers during the period. The increase of 18 FTE included changes to the model of care in a number of rural facilities including increasing from one to two doctors to ensure the sustainability of services, and increases in FTE at Toowoomba Hospital to meet demand including meeting both elective surgery targets and emergency department access targets.

3 Supplies and services expenditure exceeded the original budget by $25.6M. The increase in expenditure was due to a $10M increase in Pharmaceuticals due to the introduction of a new treatment for hepatitis C and additional expenditure on treatments for oncology patients (note this has been offset by increases in revenue), $8.1M for Outsourced service delivery to address waitlists and improve clinical services across a number of specialties including ophthalmology, dental services and radiology reporting services, $4.8M for external contractors to assist in meeting demand for clinical services and $1.7M for the devolution of management of blood products from the DoH to DDHHS.

26. Budget to actual comparison (continued)

Statement of Financial Position

	Variance Note	Original Budget 2016 $'000	Actual 2016 $'000	Budget Variance* 2016 $'000	Budget Variance* 2016 %
Current assets					
Cash and cash equivalents	1	56,888	78,711	21,823	38%
Receivables	2	10,930	14,564	3,634	33%
Inventories		5,645	6,744	1,099	19%
Other current assets		502	1,027	525	105%
Total current assets		**73,965**	**101,046**	**27,081**	**37%**
Non-current assets					
Property, plant and equipment		299,756	298,324	(1,432)	(0%)
Other non-current assets		-	13	13	100%
Total non-current assets		**299,756**	**298,337**	**(1,419)**	**(0%)**
Total assets		**373,721**	**399,383**	**25,662**	**7%**
Current liabilities					
Payables		33,788	33,985	(197)	(1%)
Accrued employee benefits		1,196	2,259	(1,063)	(89%)
Unearned revenue		-	66	(66)	100%
Total current liabilities		**34,984**	**36,310**	**(1,326)**	**(4%)**
Total liabilities		**34,984**	**36,310**	**(1,326)**	**(4%)**
Net assets		**338,737**	**363,073**	**24,336**	**7%**
Equity					
Contributed equity	3	263,350	288,060	24,710	9%
Accumulated surplus/(deficit)	4	48,940	55,546	6,606	13%
Asset revaluation surplus/(deficit)	5	26,447	19,467	(6,980)	(26%)
Total equity		**338,737**	**363,073**	**24,336**	**7%**

** Favourable / (unfavourable)*

26. Budget to actual comparison (continued)

Statement of Financial Position variance notes

1 Cash and cash equivalents increased $21.8M over the original budget. The significant increase is largely represented by the increase in the opening balance for cash and cash equivalents as a result of the prior year operating surplus ($20.1M).

2 Receivables have increased $3.6M above budgeted levels. This is primarily due to end of year accruals with DoH ($5.2M). These accruals represent outstanding amounts due to DDHHS for amendments to the service agreement and include amounts for additional public patient activity above baseline levels. These increases have been offset by an increase in the provision for impairment of trade receivables reflecting DDHHS's assessment of outstanding accounts at balance date ($0.9M).

3 Contributed equity has increased $24.7M above budgeted levels. Of this variance $14.7M represents funding received by DDHHS for capital works programs including minor capital, the Backlog Maintenance Remediation Program and the installation of a MRI machine at Toowoomba Hospital. $4.6M represents capital works projects including the telecommunications infrastructure replacement program, and upgrading fire safety systems in nursing homes. $2M was provided under the Health Technology Equipment Replacement program for the replacement of medical equipment.

4 The Accumulated surplus has increased $6.6M reflecting the current year operating surplus of $3.5M and the prior year surplus exceeding original forecast levels by $3.5M.

5 The Asset revaluation surplus is $7M below budgeted levels. DDHHS budgeted for increases in the fair value of assets, consistent with Queensland Treasury guidelines. However there was a material devaluation of land assets in the Western Downs region as a result of a down turn in the resource and energy sectors ($3.4M) . Overall there was in increase in building valuations, however this was not to the extent budgeted ($3.6M).

26. Budget to actual comparison (continued)

Statement of Cash Flows

	Variance Note	Original Budget 2016 $'000	Actual 2016 $'000	Budget Variance* 2016 $'000	Budget Variance* 2016 %
Cash flows from operating activities					
Inflows:					
User charges and fees	1	580,262	626,709	46,447	8%
Grants and other contributions		29,724	30,840	1,116	4%
Interest receipts		111	310	199	179%
GST input tax credits from ATO		7,485	9,962	2,477	33%
GST collected from customers		-	572	572	100%
Other		3,568	2,863	(705)	(20%)
Total cash provided by operating activities		**621,150**	**671,256**	**50,106**	**8%**
Outflows:					
Employee expenses	2	48,807	55,493	(6,686)	(14%)
Health service employee expenses		393,208	401,869	(8,661)	(2%)
Supplies and services	3	165,675	198,031	(32,356)	(20%)
Grants and subsidies		1,645	1,208	437	27%
GST paid to suppliers		7,440	10,301	(2,861)	(38%)
GST remitted to ATO		-	568	(568)	100%
Other		1,188	979	209	18%
Total cash used in operating activities		**617,963**	**668,449**	**(50,486)**	**(8%)**
Net cash provided by / (used in) operating activities[1]		**3,187**	**2,807**	**(380)**	**(12%)**
Cash flows from investing activities					
Inflows:					
Sales of property, plant and equipment		-	75	75	100%
Total cash provided by investing activities		**-**	**75**	**75**	**100%**
Outflows:					
Payments for property, plant and equipment	4	12,134	15,596	(3,462)	(29%)
Total cash used in investing activities		**12,134**	**15,596**	**(3,462)**	**(29%)**
Net cash provided by / (used in) investing activities		**(12,134)**	**(15,521)**	**(3,387)**	**(28%)**
Cash flows from financing activities					
Inflows:					
Proceeds from equity injections	5	6,107	17,340	11,233	184%
Total cash provided by financing activities		**6,107**	**17,340 -**	**11,233**	**184%**
Net cash provided by / (used in) financing activities		**6,107**	**17,340**	**11,233**	**184%**
Net increase in cash and cash equivalents		**(2,840)**	**4,626**	**7,466**	**263%**
Cash and cash equivalents at beginning of financial year		59,728	74,085	14,357	24%
Cash and cash equivalents at end of financial year		**56,888**	**78,711**	**21,823**	**38%**

* Favourable / (unfavourable)

26. Budget to actual comparison (continued)

Statement of Cash Flow variance notes

1 The movement in receipts for User charges and fees is consistent with the movement in User charges and fees in the Statement of Comprehensive Income.

2 The movement in Employee expenses is consistent with the movement in Employee expenses in the Statement of Comprehensive Income.

3 The movement in Supplies and services is consistent with the movement in Supplies and services in the Statement of Comprehensive Income.

4 Payments for property, plant and equipment exceeded the original budget due to the investment of $1.7M into capital acquisition programs by the DDHHS Board from retained surpluses and the expenditure of $1.6M associated with equity injections received for the Backlog Maintenance Remediation Program.

5 The increase in proceeds from equity injections is due to the receipt of capital funding from the DoH for the installation of a MRI machine at Toowoomba Hospital ($9.1M) and the Backlog Maintenance Remediation Program ($2.1M).

27. Key management personnel and remuneration

(a) Board members

The following details for Board members include those positions that had authority and responsibility for planning, directing and controlling the activities of DDHHS during 2015-16. Further information on these positions can be found in the body of the Annual Report under the section relating to Governing our Organisation.

Name and position (date appointed and date resigned if applicable)	Responsibilities	Contract classification and appointment authority	Year	Short-term Employee Expenses $,000	Post-Employment Expenses $,000	Total Remuneration $,000
Mike Horan AM	Chair	Government Board B1	**2016**	77	7	84
18 May 2012			**2015**	80	8	88
Dr Dennis Campbell	Deputy Chair	Government Board B1	**2016**	49	5	54
29 June 2012			**2015**	51	5	56
Corinne Butler	Board Member	Government Board B1	**2016**	5	1	6
17 May 2016			**2015**	-	-	-
Cheryl Dalton	Board Member	Government Board B1	**2016**	44	4	48
29 June 2012			**2015**	46	4	50
Dr Ross Hetherington	Board Member	Government Board B1	**2016**	44	4	48
29 June 2012			**2015**	46	4	50
Patricia Leddington-Hill	Board Member	Government Board B1	**2016**	41	4	45
9 November 2012			**2015**	43	4	47
Megan O'Shannessy	Board Member	Government Board B1	**2016**	41	4	45
18 May 2013			**2015**	43	3	46
Marie Pietsch	Board Member	Government Board B1	**2016**	43	5	48
29 June 2012			**2015**	43	4	47
Dr Ruth Terwijn	Board Member	Government Board B1	**2016**	3	-	3
17 May 2016			**2015**	-	-	-
Terry Fleischfresser	Board Member	Government Board B1	**2016**	41	4	45
29 June 2012 to 17 May 2016			**2015**	46	4	50
Dr Jeffrey Prebble OAM	Board Member	Government Board B1	**2016**	42	4	46
29 June 2012 to 17 May 2016			**2015**	47	4	51
Dr Ian Keys	Board Member	Government Board B1	**2016**	-	-	-
29 June 2012 to 17 May 2015			**2015**	39	4	43

The date of appointment shown for Board members is the original date of appointment. From time to time, Board members are re-appointed in accordance with *Hospital and Health Boards Act 2011.*

The Governor in Council approves the remuneration arrangements for Hospital and Health Board Chair, Deputy Chair and Members. The Chair, Deputy Chair and Members are paid an annual salary consistent with the Government policy titled: *Remuneration of Part-time Chairs and Members of Government Boards, Committees and Statutory Authorities.*

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Notes to the Financial Statements for the year ended 30 June 2016

27. Key management personnel and remuneration (continued)

(b) Executive

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

(i) DDHHS Executives (employed by DDHHS)

Name and position (date appointed and date resigned if applicable)	Responsibilities	Contract classification and appointment authority	Year	Short-term Employee Expenses		Long-Term Employee Expenses	Post-Employment Expenses	Termination Benefits	Total Remuneration
				Base $,000	Non-Monetary Benefits $,000	$,000	$,000	$,000	$,000
Dr Peter Bristow Health Service Chief Executive 6 August 2012 to 17 January 2016	Responsible for the overall management of DDHHS through major functional areas to ensure the delivery of key government objectives in improving the health and well-being of all Darling Downs Residents.	s24 & s70 Appointed by Board under *Hospital and Health Boards Act 2011 (Section 7(3))*	**2016**	219	8	4	20		251
			2015	480	11	9	49	-	549
Dr Peter Gillies Health Service Chief Executive 18 January 2016	Responsible for the overall management of DDHHS through major functional areas to ensure the delivery of key government objectives in improving the health and well-being of all Darling Downs Residents.	s24 & s70 Appointed by Board under *Hospital and Health Boards Act 2011 (Section 7(3))*	**2016**	337	-	7	18		362
			2015	-	-	-	-	-	-
Dr Peter Gillies General Manager Toowoomba Hospital 8 July 2013 to 17 January 2016	Provides single point accountability and leadership for Toowoomba Hospital.	20MMOI2-03 Appointed by Chief Executive (CE) under *Section 67(2) Hospital and Health Boards Act 2011*	**2016**	212	2	3	16		233
			2015	499	1	10	33	-	543
Melanie Reimann Chief Finance Officer 24 August 2015 to 10 June 2016	Provides single point accountability for the Finance Division and coordinates DDHHS's financial management consistent with the relevant legislation and policy directions to support high quality health care within DDHHS.	HES 2-3 Appointed by Chief Executive (CE) under *Section 74 Hospital and Health Boards Act 2011*	**2016**	156	-	3	16	-	175
			2015	-	-	-	-	-	-

27. Key management personnel and remuneration (continued)

(b) Executive (continued)

(i) DDHHS Executives (employed by DDHHS) (continued)

Name and position (date appointed and date resigned if applicable)	Responsibilities	Contract classification and appointment authority	Year	Short-term Employee Expenses		Long-Term Employee Expenses	Post-Employment Expenses	Termination Benefits	Total Remuneration
				Base $,000	Non-Monetary Benefits $,000	$,000	$,000	$,000	$,000
Scott McConnel Chief Finance Officer 12 December 2011 to 6 April 2015	Provides single point accountability for the Finance Division and coordinates DDHHS's financial management consistent with the relevant legislation and policy directions to support high quality health care within DDHHS.	HES 2-3 Appointed by Chief Executive (CE) under *Section 74 Hospital and Health Boards Act 2011*	**2016**	-	-	-	-	-	-
			2015	148	1	2	12	152	315
Tracie Faulkner Acting Chief Finance Officer 30 March 2015 to 23 August 2015	Provides single point accountability for the Finance Division and coordinates DDHHS's financial management consistent with the relevant legislation and policy directions to support high quality health care within DDHHS.	HES 2-3 Appointed by Chief Executive (CE) under *Section 74 Hospital and Health Boards Act 2011*	**2016**	37	-	1	2	-	40
			2015	50	-	1	4	-	55
Michael Metcalfe Executive Director Workforce 19 January 2015 to 1 May 2016	Provides executive leadership for workforce services of DDHHS. The position leads Human Resources, People and Culture, Work Health and Safety and Emergency Preparedness functions to support and lead the development and implementation of strategies that will ensure maximum employee engagement, safety and productivity to meet service delivery needs.	HES 2-2 Appointed by Chief Executive (CE) under *Section 74 Hospital and Health Boards Act 2011*	**2016**	145	-	3	14	-	162
			2015	84	-	2	8	-	94

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Notes to the Financial Statements for the year ended 30 June 2016

27. Key management personnel and remuneration (continued)

(b) Executive (continued)

(i) DDHHS Executives (employed by DDHHS) (continued)

Name and position (date appointed and date resigned if applicable)	Responsibilities	Contract classification and appointment authority	Year	Short-term Employee Expenses		Long-Term Employee Expenses	Post-Employment Expenses	Termination Benefits	Total Remuneration
				Base $,000	Non-Monetary Benefits $,000	$,000	$,000	$,000	$,000
Dr Hwee Sin Chong Executive Director Medical Services 15 September 2014	Provides professional leadership for the medical services of DDHHS. Leads the development and implementation of strategies that will ensure the medical workforce is aligned with identified service delivery needs, and an appropriately qualified, competent and credentialed workforce is maintained. In addition, the position oversees Medical Research and Clinical governance, including patient safety and quality.	20MMOI1-04 Appointed by Chief Executive (CE) under *Section 67(2) Hospital and Health Boards Act 2011*	**2016**	430	1	8	30	-	469
			2015	387	1	8	28	-	424
Michael Bishop General Manager Rural 28 May 2012	Provides single point accountability and leadership for the Rural Division within DDHHS. This Division includes 20 hospital and health care services, including co-located residential aged care services, and Mt Lofty Heights Residential Aged Care Facility.	HES 2-3 Appointed by Chief Executive (CE) under *Section 74 Hospital and Health Boards Act 2011*	**2016**	211	-	4	21		236
			2015	199	1	4	20	-	224
Shirley Wigan Executive Director Mental Health 22 November 2012 to 29 July 2016	Provides single point accountability and leadership for DDHHS Mental Health, Alcohol and Other Drugs services, including acute in-patient services at Toowoomba Hospital, extended in-patient services at Baillie Henderson Hospital and ambulatory care services located throughout DDHHS.	HES 2-3 Appointed by Chief Executive (CE) under *Section 74 Hospital and Health Boards Act 2011*	**2016**	184	-	3	18	202	407
			2015	181	-	3	18	-	202

27. Key management personnel and remuneration (continued)

(b) Executive (continued)

(ii) DDHHS Executives employed by the Department of Health under Award

Name and position (date appointed and date resigned if applicable)	Responsibilities	Contract classification and appointment authority	Year	Short-term Employee Expenses		Long-Term Employee Expenses	Post-Employment Expenses	Termination Benefits	Total Remuneration
				Base $,000	Non-Monetary Benefits $,000	$,000	$,000	$,000	$,000
Brett Mendezona Acting General Manager Toowoomba Hospital 14 January 2016	Provides single point accountability and leadership for Toowoomba Hospital.	Nursing and Midwifery - NRG 9-3	**2016**	160	-	3	17	-	180
			2015	-	-	-	-	-	-
Robyn Henderson Executive Director Nursing and Midwifery Services 8 December 2014	Provides professional leadership for the nursing services of DDHHS. The position leads the development of strategies that will ensure the nursing and midwifery workforce is aligned with service delivery needs.	Nursing and Midwifery - NRG 12-1	**2016**	225	-	4	22	-	251
			2015	123	-	2	12	-	137
Judy March Executive Director Nursing and Midwifery Services 22 May 2012 to 22 August 2014	Provides professional leadership for the nursing services of DDHHS. The position leads the development of strategies that will ensure the nursing and midwifery workforce is aligned with service delivery needs.	Nursing and Midwifery - NRG 12-1	**2016**	-	-	-	-	-	-
			2015	44	-	1	1	1	47
Karen Abbott Acting Executive Director Nursing and Midwifery Services 25 August 2014 to 31 January 2015	Provides professional leadership for the nursing services of DDHHS. The position leads the development of strategies that will ensure the nursing and midwifery workforce is aligned with service delivery needs.	Nursing and Midwifery - NRG 12-1	**2016**	-	-	-	-	-	-
			2015	101	-	2	8	-	111
Annette Scott Executive Director Allied Health 4 August 2014	Provides single point accountability and leadership, strategic planning, delivery and evaluation of the Allied Health Professional functions, and Commonwealth Programs, within DDHHS, to optimise quality health care and business outcomes.	Health Practitioner - HP7-2	**2016**	162	-	3	18	-	183
			2015	152	-	3	14	-	169

27. Key management personnel and remuneration (continued)

(b) Executive (continued)

Remuneration - Executive

Remuneration policy for DDHHS's key Executive personnel is set by the Director-General, Department of Health, as provided for under the Hospital and Health Boards Act 2011. The remuneration and other terms of employment for the key executive management personnel are specified in employment contracts. In the current reporting period, the remuneration of key executive management personnel increased by 2.5% (2015: 2.2%) in accordance with Government policy.

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

- Short-term employee expenses which include:
  - (i) Base – consisting of base salary, allowances and leave entitlements earned and expensed for the entire year or for that part of the year during which the employee was key management personnel. Amounts disclosed equal the amount expensed in the Statement of Comprehensive Income; and
  - (ii) Non-monetary benefits – consisting of provision of vehicle and expense payments together with fringe benefits tax applicable to the benefit. Amounts disclosed equal the taxable value of motor vehicles provided to key management personnel including any fringe benefit tax payable;
- Long term employee expenses include long service leave entitlement earned;
- Post employment benefits include amounts expensed in respect of 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 on termination, regardless of the reason for termination;
- There were no performance bonuses paid in the 2015-16 financial year.

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.

28. Events occurring after balance date

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 Hospital and Health Service. As a result, some Hospital and Health Services became prescribed employers by regulation.

DDHHS is not a prescribed service and accordingly all non-executive staff, with the exception of SMO's and VMO's, are employed by DoH.

Government policy concerning prescribed employer arrangements is currently being reviewed. Pending the outcome of the review, DDHHS may become a prescribed employer.

Once a Hospital and Health Service becomes prescribed, all existing and future staff working for the Hospital and Health Service become its employees. The Hospital and Health Service, not the Department of Health, will recognise employee expenses in respect of these staff. The Department of Health, will continue to be responsible for setting terms and conditions of employment, including remuneration and classification structures, and for negotiating enterprise agreements.

No other matter or circumstance has arisen since 30 June 2016 that has significantly affected, or may significantly affect DDHHS's operation, the results of those operations, or DDHHS's state of affairs in future financial years.

Management Certificate of Darling Downs Hospital and Health Service

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

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

b) the financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Darling Downs Hospital and Health Service for the financial year ended 30 June 2016 and of the financial position of the Darling Downs Hospital and Health Service at the end of that year; and

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

Mike Horan AM

Chair
Darling Downs Hospital and Health Board
30 / 8 / 16

Jane Ranger CPA BBus CDec

Acting Chief Finance Officer
Darling Downs Hospital and Health Service
30 / 8 / 16

INDEPENDENT AUDITOR'S REPORT

To the Board of Darling Downs Hospital and Health Service

Report on the Financial Report

I have audited the accompanying financial report of Darling Downs Hospital and Health Service, which comprises the statement of financial position as at 30 June 2016, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including significant accounting policies and other explanatory information, and certificates given by the Chair and Acting Chief Finance Officer.

The Board's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

Independence

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

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

Opinion

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

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

(b) in my opinion –

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

(ii) the financial report presents a true and fair view, in accordance with the prescribed accounting standards, of the transactions of the Darling Downs Hospital and Health Service for the financial year 1 July 2015 to 30 June 2016 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.

D J OLIVE FCPA
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane