Darling Downs Hospital and Health Service

ANNUAL REPORT

2017–2018

Queensland Government

Darling Downs Hospital and Health Service
Annual Report 2017-18

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 2017-18 annual report:

- Consultancy expenditure
- Overseas travel expenditure
- Results against the Queensland Language Service Policy

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

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http://www.health.qld.gov.au/darlingdowns/ or by contacting:
Office of the Chief Executive
Darling Downs Hospital and Health Service
Jofre Level 1 Baillie Henderson Hospital
PO Box 405 Toowoomba Qld 4350
DDHHS@health.qld.gov.au
Phone (07) 4699 8412

Attribution

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The State of Queensland (Darling Downs Hospital and Health Service) annual report 2017-2018.

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 telephone (07) 4699 8412 and we will arrange an interpreter to effectively communicate the report to you.

28 August 2018

The Honourable Stephen Miles MP
Minister for Health and Minister for Ambulance Services
PO Box 48
Brisbane Qld 4000

Dear Minister

I am pleased to submit for presentation to the Parliament the Annual Report 2017 – 2018 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 66 of this annual report.

Yours sincerely,

Dr Dennis Campbell
Acting Chair
Darling Downs Hospital and Health Board

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Acknowledgement of Traditional Owners

The Darling Downs Hospital and Health Service respectfully acknowledges the Traditional Owners, both past and present, of the region we serve.

Our commitment to improving health outcomes for Aboriginal and Torres Strait Islander people is one we will continue to work diligently towards in line with Australian and State Government policies including *Closing the Gap* initiatives.

I am proud to present the sixth annual report of the Darling Downs Hospital and Health Service (DDHHS).

As a health service, we are focussed on providing timely access to safe, innovative and compassionate care to patients and consumers in hospital, aged care and community settings. As a result of the hard work of our staff, we have continued to maintain our tier one status – a result of managing wait lists, prudent financial management and the quality of the work we do.

At the forefront of our achievements is the continued zero waitlist for specialist outpatients in all categories of clinical urgency. This is an important focus as it provides patients with a pathway to receive their specialist treatment, elective surgery, endoscopy and dental treatments within clinically appropriate timeframes.

I was delighted this year to celebrate BreastScreen Queensland Toowoomba Service's 25-year anniversary in July. It was a wonderful milestone of care for rural and regional women through both the Toowoomba and mobile services which have seen more than 370,000 women screened since the service's inception. The Board is very proud that the service delivered proactive care to 17,588 women at the full-time site in Toowoomba, as well as 12 rural communities.

Improving infrastructure to support healthcare delivery has also been a priority, with several key projects in progress and the completion of some important new assets. This included completion of the Matron Farr Building at Kingaroy Hospital to provide a first-class oral health training, dental clinic and community health facility for the South Burnett community. Planning also continued for the new Kingaroy Hospital. Toowoomba Hospital's new seventh theatre, central sterilising department and new kitchen were completed to support the ongoing great work of this very busy facility.

Works also started this year on Warwick Hospital's new emergency department that will make a big difference in providing patient care.

Closing the health gap for our Aboriginal and Torres Strait Islander communities was also a key focus this year. We have made individualising healthcare a priority by implementing a 'Discharge with Medical Support' process supporting patients to leave hospital earlier if they have family and cultural commitments. At the end of the year, 84% of our staff had completed the Aboriginal and Torres Strait Islander Cultural Practice Program as part of their mandatory training. This was a wonderful achievement in helping make our facilities and programs welcoming places and enabling our staff to provide culturally-appropriate care. We also improved access to telehealth services to increase the number of Aboriginal and Torres Strait Islander patients attending appointments at Toowoomba Hospital. It was also positive that NAIDOC Week was celebrated at more facilities than ever before.

A key part of the Board's role is to stay in close touch with our communities and other stakeholders to understand the local healthcare needs and priorities through a robust community engagement program. I thank all the Board members for their governance and advocacy. Board meetings are held regularly in Toowoomba and rural facilities and include opportunities to hear directly from community leaders and representatives.

I congratulate Health Service Chief Executive Dr Peter Gillies and his Executive Team on providing exceptional leadership and their dedication to patient-centred care.

Mr Mike Horan AM
Board Chair

Each year we are seeing a higher demand for our services and an increase in the complexity of the care we are required to provide to meet the needs of our communities.

As a health service region, we have some of the highest rates of obesity, diabetes and kidney disease. As our population continues to grow, we can expect a significant increase in the health needs of our communities. This is why as a health service we have been working to improve awareness of the importance of exercise and a balanced diet including low carbohydrate options. We are focussed on reducing the need for emergency treatment by empowering the community to take ownership of their healthcare and focus on their lifestyle and wellbeing.

We have also started a number of projects to support people living with chronic disease to take a multi-disciplinary approach to care. One of these projects is the award-winning 'Diabetes Model of Care' project which focussed on comprehensive planning for patients to self-manage their diabetes in their homes with collaborative support of GPs and our health service. It is projects like this one that enable us to find innovative ways of managing chronic disease by improving health literacy and access to care.

This year we investigated solutions to improve patient flow through our hospitals to improve not only the patient's journey, but also streamline our processes to gain efficiencies. This work ensured that the emergency length of stay target was met and patients stayed less than four hours in our emergency departments.

Despite the challenges of chronic disease across the region, Darling Downs Hospital and Health Service has continued to provide the highest possible care to our communities including all specialist outpatients waiting within clinically recommended timeframes and all elective surgery patients treated on time.

The strategic priority of delivering care as close as possible to home was also a key focus this year. Telehealth allows us to use telecommunications and video conferencing to provide education and specialist medical, nursing and allied health support over a distance. We've been able to make our clinicians as accessible as possible to our regional communities by providing these telehealth services. This year our telehealth target was met with a 20 per cent increase in usage across the region. This meant that telehealth services were accessed over 8,700 times, reducing the need for patient travel. This year we were also able to provide a new tele-stroke service, which allowed patients presenting to a rural emergency department to access specialist clinicians in Toowoomba to fast track stroke treatment plans.

This year also saw our health service partner with the Cognitive Institute to deliver the Safety and Reliability Program including Speaking Up for Safety training which is being provided for all staff. I believe that safety is everyone's responsibility and as an organisation we are building a culture of looking out for each other and respectfully calling attention to safety concerns. At the end of the financial year, we had trained over 50% of our staff in the program and committed to providing the safest possible care.

On behalf of the Executive Team and myself, I would like to take this opportunity to thank our staff for the work they do to provide outstanding care to our communities and I look forward to seeing what we achieve next year.

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

Darling Downs Hospital and Health Service (DDHHS) is the major provider of public hospital and health services in the Toowoomba, Western Downs, South Burnett and Southern Downs regions.

Our role

DDHHS was established as an independent statutory authority on 1 July 2012 under the *Hospital and Health Boards Act 2011*. DDHHS is governed by the Darling Downs Hospital and Health Board (the Board), which is accountable to the local community and the Queensland Minister for Health and Minister for Ambulance Services.

DDHHS is one of 16 hospital and health services that together with the system manager (the Department of Health) make up the entity known as Queensland Health.

The hospital and health services are the principal providers of public hospital and health services for the community within a defined geographical area. The Department of Health is responsible for the overall management of the Queensland public health system including statewide planning and performance monitoring of all hospital and health services.

A formal service agreement is in place between the Department of Health and DDHHS that identifies the services DDHHS will provide, funding arrangements for those services and targets and performance indicators to ensure expected health deliverables and outcomes are achieved.

To support the services we provide, DDHHS also has agreements in place with a range of private health providers for highly specialised services and at times patients may require transportation to Brisbane for specialist services only provided at tertiary facilities.

DDHHS is also a provider of specialist services to residents from surrounding areas, including south west Queensland, northern New South Wales and the Lockyer Valley regions.

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.

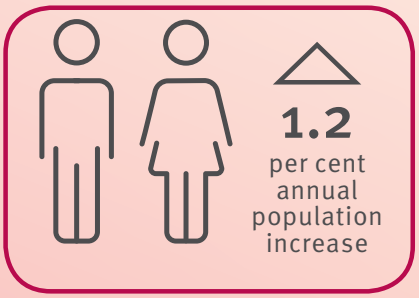
Our region

DDHHS's region is a large and diverse geographic area covering approximately 90,000 square kilometres. The area covers the local government areas of the Toowoomba, Western Downs, Southern Downs, South Burnett and Goondiwindi regional councils, Cherbourg Aboriginal Shire Council and the community of Taroom in the Banana Shire Council.

Our community

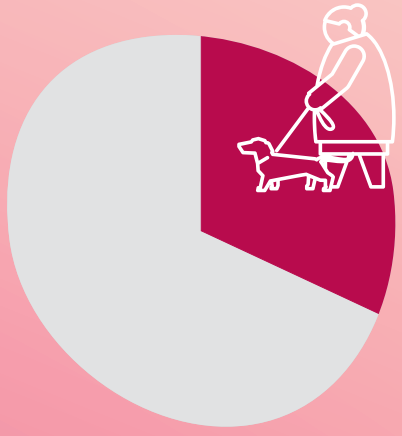
The region has a population of approximately 280,000 people, which is expected to reach 300,000 in five years - an increase of 1.2 per cent annually. Aboriginal and Torres Strait Islander Australians make up 4.9 per cent of the population compared to 4 per cent across the state.

Healthcare challenges for the region's population include health issues associated with ageing, obesity, chronic disease and low socioeconomic status.

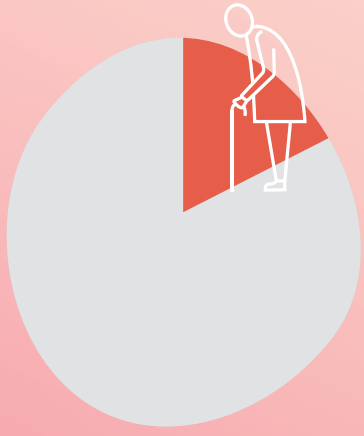


Within the DDHHS region:

30.9 per cent
of the population are in the lowest quintile for socioeconomic disadvantage



32 per cent
of the population are obese



17.5 per cent
of the population are aged 65 years or older

The leading causes

of burden of disease in DDHHS are cancer, cardiovascular disease, mental health disorders and neurological disorders.

The size of the region

and the need for some patients to travel significant distances to receive specialist healthcare continues to contribute to the numbers of claims administered by DDHHS through the Patient Travel Subsidy Scheme.

Despite these challenges,

DDHHS is well placed to provide the necessary public hospital and healthcare services to ensure all residents have access to timely, equitable and efficient healthcare that meets their needs.

Our services

As the major provider of public hospital and healthcare services in the region, DDHHS provides a wide range of specialty services from various facilities. These services are delivered in line with our Service Agreement with the Department of Health. The Service Agreement is publicly available at www.publications.qld.gov.au

In 2017-18, these services were provided from 29 facilities across the region, including one large regional referral hospital, one extended inpatient mental health service, three medium-sized regional hub hospitals, twelve rural hospitals, three multipurpose health services, three community outpatient clinics and six residential aged care facilities.

The comprehensive range of services provided by DDHHS throughout the region includes both specialist inpatient and outpatient services, such as:

- allied health
- cancer services
- cardiac medicine
- emergency medicine
- intensive care
- medical imaging
- medicine and a range of medical subspecialties
- mental health and addiction medicine
- obstetrics and gynaecology
- paediatrics
- palliative care
- rehabilitation
- surgery and a range of surgical subspecialties.

Services delivered in the community include:

- Aboriginal and Torres Strait Island health programs
- BreastScreen Queensland
- child and maternal health services
- community care services including domestic assistance
- community rehabilitation
- infectious diseases
- oral health
- public health
- residential aged care, aged care assessment and home care services
- sexual health.

Concessional parking

To help families with the cost of parking in the hospital precinct, we implemented a car parking policy and concessional parking procedure in October 2017. During the 2017-18 period, an average of 1,168 concessional parking permits per month were issued.

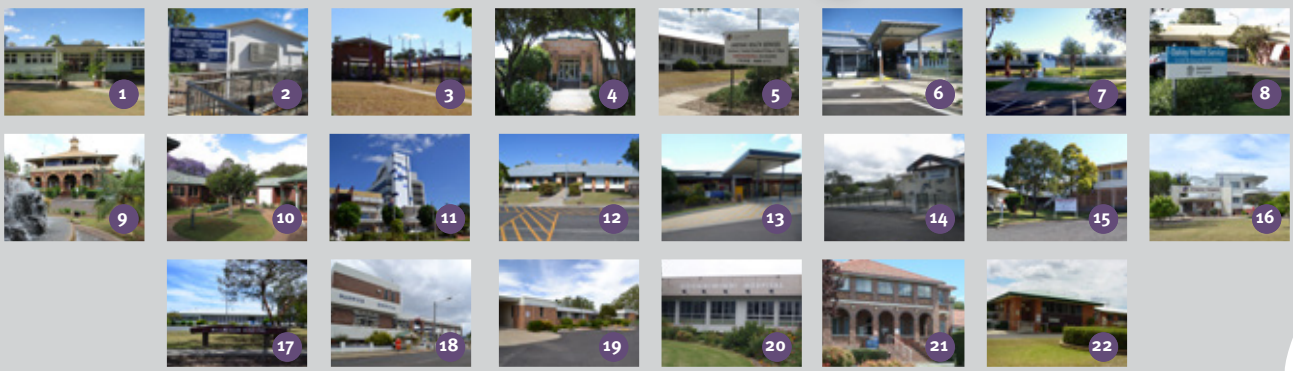
Our vision and values

In July 2017, a new vision and five key new values were launched, as below:

Our vision:

Caring for our Communities: Healthier Together

Our facilities



Our strategic direction

The DDHHS *Strategic Plan 2016-2020* was reviewed and updated in July 2017 to ensure a continuation of our objectives for the period until 30 June 2020. Our six key strategic objectives all contribute to our vision of healthier communities and guide our priorities for each year.

Each of the six strategic objectives is further defined through a number of key strategies underpinning each objective which are in turn, given effect through operational plans and engagement with the community and our healthcare partners.

Key activities undertaken throughout 2017-18 that contribute to our strategic objectives are outlined in the 'Our Performance' section of this report.

Key objectives

1	HC	Deliver quality evidence-based healthcare for our patients and clients
2	E	Engage, communicate and collaborate with our partners and communities to ensure we provide integrated, patient-centred care
3	L	Demonstrate a commitment to learning, research, innovation and education in rural and regional healthcare
4	R	Ensure sustainable resources through attentive financial and asset administration
5	P	Plan and maintain clear and focused processes to facilitate effective corporate and clinical governance
6	WF	Value, develop and engage our workforce to promote professional and personal wellbeing and to ensure dedicated delivery of services

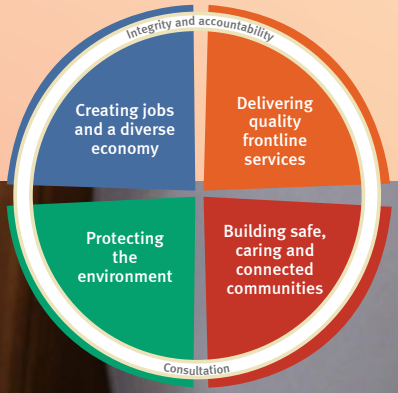
Each of the strategic objectives and their associated strategies also contribute to the Queensland Government's Objectives for the community and the principles outlined in the *'My health, Queensland's future: Advancing health 2026'*.

Objectives for the community

- creating jobs and a diverse economy
- delivering quality frontline services
- protecting the environment
- building safe, caring and connected communities.

Principles

- promoting wellbeing
- delivering healthcare
- connecting healthcare
- pursuing innovation.



Three fluffy robotic seals that provide similar benefits to patients as therapy pets were donated by the Toowoomba Hospital Foundation in February.

Our strategic risks and opportunities

Risks

Providing efficient, high-quality healthcare in an environment of limited funding and increased demand continues to be a significant challenge for the health service. An ageing population, increasing rates of chronic disease and high levels of community expectation all contribute to the high demand for services in our region.

The summary of our key strategic risks included in the 2017 update of our strategic plan are as follows:

- Increasing incidence of **chronic disease and obesity** due to an ageing population and community lifestyle choices resulting in increased service demand
- Meeting and staying abreast of changing **community expectations** due to challenges obtaining representative consumer and partner feedback required to improve excellence in service delivery
- Recruiting and retaining a qualified **workforce** to ensure we can maintain and increase service activity to meet demand. Challenges faced include an ageing workforce, remoteness of locations and workforce cultural expectations
- Continuing to deliver service at the level expected by the community, within a balanced **budget**, in the context of increasing demand
- Forecasting and managing **service demand** due to population growth and seasonal factors resulting in increased waiting times
- Aged and re-purposed **infrastructure** including Information and Communications Technology requiring significant capital investment to meet contemporary demand.

Opportunities

Despite the above risks and challenges, many opportunities have also been identified as innovative means of providing care to our patients. Key opportunities for the health service in the 2017-18 year included:

- Continually improving models of care and expanding use of emerging technologies to ensure patient-centred service and improved outcomes
- Continuing to strengthen complementary relationships with healthcare partners, consumers and the community
- Streamlining and adapting our financial management to take advantage of funding models and to ensure a balanced fiscal position
- Nurturing and growing our workforce
- Initiation of integrated electronic Medical Records (ieMR).

Our Board

The Darling Downs Hospital and Health Board (the Board) is comprised of nine non-executive members who are appointed by the Governor in Council on the recommendation of the Minister for Health and Minister for Ambulance Services, in accordance with the *Hospital and Health Boards Act 2011*. There are Board directors representing the four different regions of the hospital and health service – Southern Downs, Western Downs, South Burnett and Toowoomba.

The Board is responsible for the oversight of health services in the region and is accountable for its performance in delivering quality health outcomes to meet the needs of the community it serves.

Mr Mike Horan AM

Chair, Darling Downs Hospital and Health Board

Mike 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, 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.

Mike was the General Manager of The Royal Agricultural Society of Queensland (Toowoomba Showgrounds) from 1978-1991 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 has also served as secretary of the Darling Downs sub-chamber of Agricultural Societies, a number of Breed Societies, Downs Harness Racing and Toowoomba Greyhound Racing 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.

Mike was appointed as Chair of the Darling Downs Hospital and Health Board in May 2012 and is the Chair of the Board Executive Committee. He was the inaugural Chair of the Queensland Hospital and Health Board Chairs' Forum (HHB Chair's Forum) from 2012 to 2014. Mike is the HHB Chair's Forum representative on the Investment Review Committee.

Mike is currently Board Chair of Downs Rugby Ltd, covering rugby union from Gatton to St George and a board member of the Toowoomba Hospital Foundation. He is a former Board member of the Toowoomba Police Citizens Youth Club and former Director for Icon Cancer Care.

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

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

Deputy Chair, Darling Downs Hospital and Health Board (Toowoomba)

Dr Dennis Campbell has been a Chief Executive Officer (CEO) in both the public and private health sectors, during which time he held the positions of Assistant and Acting Regional Director in the Queensland Department of Health as well as CEO of St Vincent's Hospital, Toowoomba for ten years. He also served as Corporate Director with Legal Aid, Queensland for ten years as well as other Executive positions within the Department of Education and Department of Aboriginal and Torres Strait Islander Advancement.

In 2007, he was awarded an Australia Day Medallion for services to the Australian College of Health Service Executives. In 2008, he was awarded the Gold Medal for Leadership and Achievement in Health Services Management recognising his contribution and professional achievements in shaping healthcare policy at the institutional, state and national levels. He is involved in the colleges' mentoring program, on a number of national committees and is committed to making a contribution to the college and its members.

Dennis serves as a member of numerous Boards and Advisory Committees, representing both public and private health sectors, has legal and health qualifications and is involved in organisational health consulting. He is the Deputy Chairman of the Board of Heritage Bank, trustee of the Queensland Museum Foundation and Chairperson of the Management Advisory Committee of the Cobb & Co Museum, Toowoomba.

Dennis is Deputy Chair of the Darling Downs Hospital and Health Board, Chair of the Board Finance Committee and a member of the Board Executive and Board Audit and Risk Committees.

Ms Cheryl Dalton

Board Member, Darling Downs Hospital and Health Board (South Burnett)

Ms Cheryl Dalton has extensive governance experience gained in her sixteen years as a local government Councillor in the South Burnett, as well as through her long standing membership on the Department of Natural Resources and Mines Panel. She is currently the Chief Executive of SBcare, a not-for-profit aged care and disability service provider and works closely with and advocates for the community and social service sector. Cheryl has in excess of thirty years business management experience through her family agribusiness ventures where she is active as a Managing Director in a variety of agricultural enterprises and works primarily in the financial and quality assurance aspects of the business.

Cheryl's community involvement has and continues to encompass a wide range of interests including water planning and management, the arts, disability employment, social service and advisory committee roles to government.

Cheryl is the Chair of the Board Audit and Risk Committee and a member of the Board Finance Committee.

Dr Ross Hetherington

MBBS, DRANZOG, FACCRM, PGDipPallMed, FAICD

Board Member, Darling Downs Hospital and Health Board (Southern Downs)

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 also Board Chair of RHealth and Rural Health Workforce Australia and a member of the Department of Health's Workforce Distribution Group and the Aviation Medicine Society of Australia and New Zealand. He was a foundation member of the Regional Health Board, Longreach and the Menopause Society of Australasia. He has held previous Directorships with Australian General Practice Network (AGPN) and the Australian Rural and Remote Workforce Agency Group.

Ross is a member of the Board Executive and Board Safety and Quality Committees.

Ms Marie Pietsch MAICD

Board Member, Darling Downs Hospital and Health Board (Southern Downs)

Ms Marie Pietsch is heavily involved in local committees and is a keen advocate for the sustainability of rural and remote communities. She has extensive healthcare experience across the Darling Downs region and has held positions on numerous councils and committees, including Chair of the Minister's Rural Health Advisory Council and Chair of the 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 needs.

Marie is a member of various health committees including being a member of Inglewood Multipurpose Health Service Management Committee, a member of the Statewide Clinical Communicating for Safety Reference Group and 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. Marie also received an Australia Day Achievement Medallion for outstanding service to Queensland Health and in 2014 Marie was awarded Citizen of the Year by the Goondiwindi Regional Council for services to the community especially in health. She is a member of Australian Institute of Company Directors (AICD).

Marie is a member of the Board Finance, Board Safety & Quality, and Board Audit & Risk Committees and is a representative on the Darling Downs Hospital and Health Services Consumer Council.

Ms Trish Leddington-Hill BSc, LLB, GAICD

Board Member, Darling Downs Hospital and Health Board (Western Downs)

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, before being appointed to the Darling Downs Hospital and Health Board in November 2012.

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

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 early 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.

Trish is a keen supporter of her local community and is heavily involved in various local committees and clubs, especially in support of her school-aged children.

Trish is the Chair of the Board Safety and Quality Committee and a member of Board Audit & Risk Committees.

Ms Megan O'Shannessy RN, MPH, MAICD

Board Member, Darling Downs Hospital and Health Board (Western Downs)

Megan is a Registered Nurse and Midwife. She has extensive clinical and leadership experience in rural health as Director of Nursing in Thargomindah (1990–1992), Dirranbandi (1992–1995), St George (1995–2001) and Warwick (2001–2013). She was the District Manager of Southern Downs (2007/2008), leading the transition to the district structure. Megan was Council member of the Queensland Nursing Council (2001–2005) and member of the Queensland Health Nursing Interest Based Bargaining Implementation Group in 2006.

Megan is the Chief Operations Officer of the Griffith University Rural Health Multidisciplinary Training Program on the Darling Downs with the local not-for-profit organisation Queensland Rural Medical Education (QRME). She continues to practise clinically as a part-time Practice Nurse at the Clifton Co-Operative Health Service.

Megan is a Senior Lecturer at the Griffith University Rural Clinical School, holds a Master in Public Health (JCU) and a Bachelor of Nursing (USQ). Megan is also a Member of the Medical Board Queensland.

Megan is a member of the Board Safety & Quality Committee.

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

Board Member, Darling Downs Hospital and Health Board (Toowoomba)

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 (FPQ) in clinical, educational and managerial roles. During this time she completed an Advanced Practice Nursing in Sexual and Reproductive Health course and a Master of Nursing (Hons) through University of Southern Queensland (USQ).

After many years at FPQ, she changed her focus to become a lecturer of nursing at USQ. Her teaching priority during this time was introducing student nurses to the profession of nursing, postgraduate rural and remote nursing courses, and part of the team that introduced flexible learning through online nursing courses. Ruth worked closely with nursing students who held a Permanent Humanitarian Visa. In 2015, she completed her PhD with a critical research study of the experiences of English as an additional language (EAL) and international nursing students.

Ruth is a member of the Board Executive and Board Safety and Quality Committees.

Professor Julie Cotter
PhD, BCom(Hons), FCPA, CA, GAICD

Board Member, Darling Downs Hospital and Health Board (Toowoomba)

Professor (Emeritus) Julie Cotter is a respected academic with a wealth of experience in business and governance. She is the Director of the Australian Centre for Sustainable Business and Development, a research centre of the University of Southern Queensland (USQ). Professor Cotter's areas of expertise include finance, governance and agribusiness and she is a Chartered Accountant and a Fellow of CPA Australia.

Professor Cotter is the Chair of the Australian Institute of Company Director's (AICD) Toowoomba Regional Committee and a member of Australian Agricultural Company's (AACo) Scientific Advisory Board and an independent member of the Department of Education Audit and Risk Management Committee. Julie previously served as a member of the neighbouring West Moreton Hospital and Health Board between September 2012 and March 2015, where she also chaired the Audit and Risk Committee.

Other previous non-executive board roles include Toowoomba and Surat Basin Enterprise (TSBE), a membership-based regional development organisation. Professor Cotter's roles with the AICD, TSBE and USQ have allowed her to build strong relationships with the Toowoomba and Darling Downs business communities.

Professor Cotter has held senior management positions at the University of Southern Queensland (USQ) since 2006, including Head of School and Research Centre Director roles. In these positions she has been responsible for strategic and business management and leadership of large teams. During Julie's time at USQ she has been a member of many university-wide management boards and committees contributing to strategic and operational management of the University.

Julie is a member of the Board Finance and Board Audit & Risk Committees.

Board meetings

The Board meets monthly, with every second meeting held in a rural area. The Health Service Chief Executive (HSCE) attends as a standing invitee at each Board Meeting.

During 2017-18 rural Board meetings were held in Dalby, Goondiwindi, Kingaroy, Chinchilla and Warwick. When meeting in rural areas the Board takes the opportunity to conduct site visits of the local hospitals and community health centres in each region, as well as meeting with staff and key stakeholders in each of the communities. Toowoomba meetings took place at both Toowoomba Hospital and Baillie Henderson Hospital campuses, with Board visits conducted at various work units at each facility. Consultation luncheons were held with focus groups including the National Disability Insurance Agency and disability service providers, education stakeholders and commercial stakeholders. Official openings were held for the Baillie Henderson Hospital laundry upgrade, the Toowoomba Hospital kitchen and Place of Prayer.

A summary of Board activities for 2017-18 is provided on pages 19-20. The chair and members provide a significant contribution to the community through their participation on the Board. Remuneration acknowledges this contribution and transactions are accounted for in the financial statements on page 68. Additionally, total out of pocket expenses paid to the Board during the reporting period was $27,174.

The Darling Downs Hospital and Health Board (from left): Board Chair Mr Mike Horan AM, Dr Ross Hetherington, Ms Megan O'Shannessy, Professor Julie Cotter, Dr Dennis Campbell, Ms Marie Pietsch, Ms Cheryl Dalton, Ms Trish Leddington-Hill and Dr Ruth Terwijn.

Board committees

To support the Board in its functions the following sub-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 12-16.

Executive Committee

The purpose of the Board Executive Committee is to support the Board, working with the HSCE to progress strategic issues, setting the Board agenda and itinerary for each meeting, and ensuring accountability in the delivery of health services.

During the 2017-18 financial year eleven Executive Committee meetings were held. The HSCE and Director, Governance and Assurance attend all Executive Committee meetings.

Finance Committee

The Board Finance Committee is directly accountable to the Board for providing assurance and oversight of the financial position, operating performance and resource management strategies of the health service, in accordance with relevant legislation and regulations.

During the 2017-18 financial year eleven Finance Committee meetings were held. Also attending meetings in advisory capacities were the HSCE and Chief Finance Officer.

Audit and Risk Committee

In 2017-18 the Board Audit and Risk Committee observed the terms of its charter and operated with due regard to Queensland Treasury's *Audit Committee Guidelines*.

The Committee provides assurance and assistance to the Board on the health service's:

- Risk, control and compliance frameworks
- 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*.

The 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 DDHHS generally.

During the 2017-18 financial year five committee meetings were held. Also attending meetings in advisory capacities were the HSCE, Chief Finance Officer, Head Internal Audit and representatives of Queensland Audit Office and the health service's external auditor, KPMG.

The committee has oversight of:

- Endorsement of the internal audit plan
- Progress against the annual audit plan
- 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*.

Safety and Quality Committee

The Board Safety and Quality Committee focusses on providing leadership and promoting improvements to patient safety systems and structures to ensure the delivery of safe and effective care. The committee provides assurance and assistance to the Board on matters relating to the safety and quality of health services, monitoring of relevant indicators and strategies of the service.

During the 2017-18 financial year, meetings were held bi-monthly, with six meetings held in total. Attending these meetings in an advisory capacity are the HSCE, Executive Director Medical Services, Executive Director Nursing and Midwifery Services, Executive Director Allied Health, Executive Director Workforce, and Director Clinical 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
Mike Horan *Chair*	18.05.12 17.05.19	11	11	11	11	-	-	-	-	-	-
Dennis Campbell *Deputy Chair*	29.06.12 17.05.19	11	11	11	10	11	10	5	5	-	-
Cheryl Dalton	29.06.12 17.05.21	11	11	-	-	11	7	5	5	-	-
Julie Cotter	18.05.18 17.05.20	11	11	-	-	11	10	5	5	-	-
Marie Pietsch	26.09.12 17.05.19	11	9	-	-	11	9	5	5	6	3
Megan O'Shannessy	18.05.13 17.05.19	11	10	-	-	-	-	-	-	6	5
Ross Hetherington	29.06.12 17.05.21	11	11	11	11	-	-	-	-	6	5
Ruth Terwijn	18.05.16 17.05.20	11	10	11	10	-	-	-	-	6	5
Trish Leddington-Hill	09.11.13 17.05.21	11	11	-	-	-	-	5	5	6	6

Board engagement with the community

As part of the Board's commitment to ensuring that DDHHS is delivering services that meet the needs of our community, regular staff and community consultation sessions are held as part of each Board meeting. These sessions give the Board the opportunity to meet with key stakeholders in our region to hear about local needs and issues.

A summary of events, meetings and consultations undertaken in the past year is provided below.

Company / Organisations
Active Physio Dalby
Akooramak Care of Older Persons
Allen's Pharmacy
APP
Arrow Energy
ARUP
Aurora Training Institute
Australian Workers' Union (AWU)
Blue Care
Bush Kids Dalby
Carbal Medical Centre
CARE Goondiwindi
Cedar Centre
Centrelink
Chinchilla Christian School
Chinchilla Community, Commerce & Industry Inc. (CCCI)
Chinchilla Family Support Centre Inc
Chinchilla Medical Practice
Church of Christ
Toowoomba Clubhouse
Chinchilla Community Advisory Group
Dalby Herald
Dalby Leagues Club
Darling Downs West Moreton Primary Health Network
Darling Downs, Lutheran Church of Australia
Disability Services QLD
Downs Industry Schools Co-op (DISCO)
GasFields Commission
GDI Ministry Circle
Goondir Health Services

Company / Organisations
Goondiwindi Hospital Volunteers
Goondiwindi Medical Centre
Goondiwindi Regional Council
Griffith University
Health Workforce Queensland
Kaloma Home For The Aged
Kingaroy Chamber of Commerce & Industry Inc.
Kingaroy Consumer Advisory Group
Kingaroy Police Station
Kingaroy State High School
Lady Bjelke-Petersen Community Hospital
Lighthouse Community Centre
Lucy Walker Pharamacy
Markwell Medical
Meals on Wheels
Member for Condamine
Member for Groom
Member for Toowoomba North
Member for Toowoomba South
Mens Shed
Myall Youth and Community Network Centre Inc.
Nadine Hinchliff
National Disability Insurance Scheme LAC Partner
Oak Tree Retirement Village
Oz Care
Oz Care Warwick
Palmerin Street Medical Practice
Partners in Recovery
Peddlethorp Architects
Queenland Ambulance Service
Queensland Centre for Mental Health Learning
Queensland Health Capital and Asset Services
Queensland Police Service
Queensland Rural Medical Education Limited
Rachel Stone Podiatry
Resonate Regional Radio News
Richmond Fellowship Queensland (RFQ)
Rotary Club
RSL (Returned Services League)
Rural Sky
Saint Mary's College

Company / Organisations
South Burnett Online
South Burnett Regional Council
South Burnett Times
Southern Downs Anglican Diocese
Southern Downs Regional Council
Southern Free Times
Southern Queensland Rural Health
Specialised Property Consulting Pty Ltd
State Government
The Physiotherapy Centre
The University of Queensland
Toowoomba Catholic Diocese
Toowoomba Chamber of Commerce
Toowoomba Hospital Foundation
Toowoomba Regional Council
TSBE (Toowoomba Surat Basin Enterprise)

Company / Organisations
Uniting Care Community
Uniting Church Presbytery
University of Queensland
University of Southern Queensland
Vital Health Dalby Office
Warrina Services
Warwick Community Advisory Group
Warwick Physioworks
Warwick Police Station
Western Downs Regional Council
Western Downs Youth Hub
Wiley & Co
Yellow Bridge
Zonta Club of Dalby Area Inc
Zonta Club of Warwick

Darling Downs Hospital and Health Board member Cheryl Dalton (second from left) meets with community stakeholders at a South Burnett Board meeting.

Our Executive

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. Reporting to the HSCE, the organisation is led by a team of ten executives that are responsible for the operational and professional management of their respective divisions to achieve the organisation's strategic objectives.

Dr Peter Gillies MBChB, MBA, FRACMA, GAICD

Chief Executive Darling Downs Hospital and Health Service

Dr Peter Gillies was appointed as Health Service Chief Executive in May 2016. Dr Gillies has been with the Darling Downs Hospital and Health Service (DDHHS) since 2009 when he moved to Toowoomba to take up the role of Director Medical Services. Dr Gillies was appointed as Executive Director of Medical Services in February 2011 and subsequently General Manager Toowoomba Hospital in July 2013. In these roles he provided expert direction in improving patient care and meeting or exceeding clinical targets including timely surgery, outpatient waiting lists, and emergency department access.

Dr Gillies 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. He 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 United Kingdom (UK) in both hospital and general practice roles prior to immigrating to New Zealand in 1995.

Shirley-Anne Gardiner
BBS, BA (Hons), MMgt, MAICA

Executive Director Toowoomba Hospital

Ms Shirley-Anne Gardiner has extensive knowledge and leadership experience involving people and health service delivery models within large complex organisations with fifteen years' experience in senior and operational leadership and management positions. She has been the Executive Director for Toowoomba Hospital since August 2016. In this role Shirley-Anne provides single-point accountability for the Toowoomba Hospital, DDHHS's largest hospital and main provider of services within the region.

Shirley-Anne has previously held leadership roles including Operations Manager of Palmerston North Hospital (MidCentral Health), a 350-bed regional hospital in New Zealand and Executive Director, Population Health and Engagement for the Darling Downs South West Queensland Medicare Local. Shirley-Anne holds a Masters in Management (Health Services), Bachelor of Business Studies (Finance) and a Bachelor of Arts (Honours) in Social Anthropology. She has used these skills and experience to improve organisational performance and conduct strategic and operational service planning.

Greg Neilson

BHSc(N), MHlthM, GCertHlthEcon, PGCertForensicMentalHlthNurs, MNurs, MMHN, MAdvPracNurs, PGCertAdolescentMentalHlthNurs, FACMHN

Executive Director Mental Health

Mr Greg Neilson has over 25 years' experience in senior nursing and management positions in 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 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 University.

He is a Fellow of the Australian College of Mental Health Nurses and has been active in a number of committees. He was Chair of the College's Credentialing Committee for approximately 10 years up until 2018. Greg has been the Executive Director Mental Health since June 2016. In this role Greg is accountable for executive leadership over DDHHS mental health, and alcohol and other drugs services, which includes acute and extended inpatient and ambulatory services.

Dr Martin Byrne

BAppSc, MBBS, FRACGP, FARGP, FACRRM, FRACMA, MHM, DRANZCOG, GAICD

Executive Director Medical Services
Executive Director Rural—1 July 2017 to 29 April 2018

Dr Byrne has approximately 20 years' experience as a rural GP throughout Queensland and joined DDHHS in 2013 as the Director, Clinical Governance.

He was Medical Superintendent at Mitchell Hospital for five years, before commencing as Director of Medical Services in Roma and the Executive Director Medical Services for South West Queensland.

Dr Byrne is currently the Executive Director, Medical Services. In this role Dr Byrne is responsible for providing professional leadership for medical services across DDHHS.

Dr Byrne was also acting as the Executive Director Rural from 1 July 2017 to 29 April 2018.

Joanne Shaw

RN, MNurs, GCertCCNurs, GCertTRNSPRC, GCertCCEngage, GAICD

Executive Director Rural— from 30 April 2018

With broad experience in leadership and management roles, Joanne has extensive knowledge of the strategic and operational leadership of tertiary, rural and remote hospitals to provide high-quality, safe, sustainable, patient and family-centred care.

Joanne holds a Bachelor of Nursing and is a Registered Nurse with postgraduate qualifications including a Graduate Certificate in Critical Care Nursing, Graduate Certificate in Transfusion Practice, Graduate Certificate in Consumer and Community Engagement, and a Masters of Nursing. Other notable achievements include graduating from the Australian Institute of Company Directors, and publishing in the British Journal of Haematology.

Joanne has previously held leadership roles including, most recently, Director of Nursing Integrated Health Services at North West Hospital and Health Service. Joanne was based in Mt Isa for this role, and covered a geographic area of 300,000 square kilometres – an area greater than the state of Victoria. In this role Joanne covered 10 remote hospitals, nine community and primary healthcare departments, and was the professional practice lead for mental health, alcohol and other drugs (AODS) and the homeless team. Joanne also acted in the Executive Director Nursing, Midwifery and Clinical Services role, and the Executive Director Integrated Health Services role. Joanne currently serves as Non-Executive Director (Board of Governance) at Western Australian Aids Council.

Dr Hwee Sin Chong

MBChB, MHM, MIPH, FRACMA, GAICD, CHIA

Executive Director Queensland Rural Medical Service

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 the public and private health sector. She is a Fellow of the Royal Australasian College of Medical Administrators, and has a Masters of Health Management and Masters 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 2014, she was appointed to the role of Executive Director Medical Services for the health service, and then in 2017 was selected as the Executive Director of the then named Rural and Remote Medical Support (now known as the Queensland Rural Medical Service). In this role Dr Chong is responsible for medical professional leadership and the development of strategies to enhance the delivery of rural and remote medical workforce services across Queensland, which includes the Queensland Rural Generalist Program. She is also responsible for four other statewide vocational training pathways (basic and advanced physician, paediatrics and intensive care training) and a number of other relieving services.

Andrea Nagle

RN, RM, MHM, GCert Child & Family Health, MACN, Adjunct Assoc Professor, USQ School of Nursing and Midwifery

Executive Director Nursing and Midwifery Services— from 24 July 2017

Ms Andrea Nagle is a career nurse who has worked in the public and private health sectors as well as non-government health organisations. Ms Nagle completed her initial nursing training at Mackay Base Hospital before moving to Brisbane where she worked in Intensive Care for 6 months. In 1986 she relocated to Nambour, where she undertook midwifery training, worked in emergency nursing and became the first nurse involved in aeromedical retrievals from the Nambour Department of Emergency Medicine. During her time in Nambour Ms Nagle also completed her Bachelor of Nursing and Masters of Health Management (Health Administration). In 1997, Ms Nagle moved to Brisbane where she was employed as a Nurse Manager at the Sunnybank Private Hospital (HCoA Hospital Holdings), charged with commissioning the Acute Referral Centre. Ms Nagle worked in this position for two years before joining the Royal Flying Doctor Service of Australia as Senior Flight Nurse of the Townsville base, where she was involved in emergency evacuations and retrievals across North Queensland and was responsible for setting up primary health clinics in Pentland, Greenvale and Ravenswood. In late 2002 Ms Nagle took up the position of Clinical Nurse Manager at Wesley Emergency Centre, where she remained for seven years.

Family considerations prompted a move to Toowoomba in 2009 and Ms Nagle returned to Queensland Health, taking a temporary job as relieving NUM at Laidley before becoming Nurse Unit Manager – Emergency Department/Maternity at Dalby Hospital. Ms Nagle went on to fill relieving Director of Nursing roles in Millmerran, Jandowae and Oakey before taking up a 12-month position relieving the Nursing Director Medical at Toowoomba Hospital, and then Nurse Unit Manager of the Emergency Department, a role to which she was eventually permanently appointed. Following this appointment, she was seconded to the role of Toowoomba Hospital Nursing Director and Service Manager (Women's and Children's and Emergency Department).

Most recently, Ms Nagle was appointed as the Darling Downs Hospital and Health Service (DDHHS) Director of Nursing Rural (Western Cluster), before stepping into the DDHHS Executive Director Nursing and Midwifery Services role in July 2017. In this role Ms Nagle is the professional lead responsible for nursing and midwifery services across the DDHHS and maximising the potential of nursing to enhance health outcomes for the health service. In July 2018, following realignment processes, Community and Oral Health and Nursing Education and Training, joined Public Health sitting under the Executive Director Nursing and Midwifery Services position.

Annette Scott BPhty, GCert Mngt, GAICD

Executive Director Allied Health

Ms Annette Scott commenced her career in health as a physiotherapist. After spending her earlier career as a private practitioner in Central Queensland, she joined the Queensland public health system where she subsequently fulfilled a number of roles including direct delivery of clinical services as a senior clinician, and non-clinical roles including Telehealth Project Management, Workforce Development and Quality Improvement. In more recent years, she has focused her career on health service management and has extensive experience in managing multidisciplinary health services across a range of settings including acute inpatient, outpatient, community, and rural outreach.

Her most recent achievements include the implementation of a range of innovative Health Practitioner workforce redesign initiatives that attracted national and statewide attention for their ability to impact positively on patient flow and increase efficiency of health service delivery.

In her role as Executive Director Allied Health, Annette is the operational lead for the allied health workforce within the Toowoomba Hospital and the rural communities of the Darling Downs and South Burnett, as well as the professional lead for the Health Practitioner workforce across DDHHS. She also manages a range of commonwealth and state funded community programs including the Aged Care Assessment Service and the BreastScreen Queensland Toowoomba service.

Jane Ranger BBus (Acc), CPA, GAICD

Chief Finance Officer

Ms Jane Ranger was appointed to the Chief Finance Officer role in August 2016. In this role, Jane provides single-point accountability for the Finance Division including Financial Control and the Business Analysis and Development areas ensuring the prudent financial management of DDHHS. Jane also oversees and has responsibility for the Commercial Management Division including procurement and contract management. In 2017, the Health Information Services division, incorporating clinical information and data quality, was added to Ms Ranger's organisational structure responsibilities. Prior to being appointed to this role Jane was the Senior Finance Manager for the Toowoomba Hospital. In this role she was responsible for the oversight and sound financial management of the Toowoomba Hospital and Baillie Henderson Hospital.

Jane has extensive experience in both public and private healthcare including five years as the State Commercial Manager, Queensland, Northern Territory and New South Wales for Healthscope, the second largest private healthcare provider in Australia. Originally from the UK, Jane immigrated to Australia in 1989. Ms Ranger completed her Bachelor of Business, as dux of her class at Griffith University, Gold Coast in 1999 and attained CPA status in 2002. In 2018 Jane further extended her professional qualifications completing the Australian Institute of Company Directors course. In 2018 Ms Ranger also will complete the Queensland Health Change Leadership Program in association with KPMG and Harvard University.

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

Executive Director Infrastructure

Dr Paul Clayton joined DDHHS and came to work in the health sector in early 2016 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 DDHHS a professionally balanced and practical approach to corporate governance, project management, strategic oversight and business planning.

Paul was appointed to the Executive Director Infrastructure role in October 2016. In this role, Paul provides executive leadership over the Infrastructure Division and ensures the coordinated delivery of DDHHS infrastructure and maintenance projects. Prior to joining 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 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.

Chris Neilsen

A/Executive Director Workforce— from 17 March 2018

Chris has over 20 years' experience in senior human resources roles over a broad range of industries including construction, manufacturing, infrastructure and health in both private and public-sector organisations.

Chris joined DDHHS as Director of Human Resources in 2013, and has currently been acting as Executive Director Workforce since March 2018. Chris is responsible for leadership of the Workforce functions including Recruitment, Workplace Relations, Learning and Development, Work Health and Safety, Workforce Culture and Capability and Workforce Planning across DDHHS.

Karen Abbott RN, RM

Executive Director Nursing and Midwifery Services— until 24 July 2017

Ms Karen Abbott completed her Registered Nurse training at Royal Brisbane Hospital and her Midwifery training at Redcliffe Hospital. Karen later completed a Bachelor of Health Science (Nursing).

Karen's career took her to the rural health environment for the remainder of her career, as Director of Nursing/Facility Manager at Taroom Hospital for 17 years followed by Director of Nursing/Facility Manager at Gatton Hospital, in the Lockyer Valley. Karen was the Cluster Operations Manager for the Western Cluster in the Division of Rural Health within DDHHS for three years prior to taking up the Executive Director of Nursing and Midwifery position in August 2016. Karen retired in July 2017.

Corinne Butler

Executive Director Workforce—until 16 March 2018

Ms Corinne Butler was appointed as the Executive Director, Workforce in September 2016. In the role of Executive Director, Workforce, Corinne provided executive leadership over DDHHS workforce services to support employee engagement, safety and effective workforce planning.

Our organisation

Our divisions

DDHHS is divided into eleven 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 DDHHS:

Toowoomba Hospital

The largest of the clinical divisions, it operates the main regional hospital for DDHHS which has nearly 300 beds.

Toowoomba Hospital has five clinical services groups:

- medical
- women's and children's
- patient flow
- surgical and cancer services
- clinical support.

Mental Health Services

This division provides a comprehensive range of child and youth, adult and older persons and acute inpatient services at Toowoomba Hospital. It also provides a range of community mental health 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 division is also responsible for DDHHS's Alcohol and Other Drugs Service and Aboriginal and Torres Strait Islander Mental Health, Alcohol and Other Drugs Service.

Rural Health Services

This division operates 15 hospitals, three multipurpose health services (MPHSs), three outpatient clinics and six residential aged care facilities (RACFs).

The division is managed via a cluster model with three geographic clusters (Southern, Western and South Burnett).

Professional Divisions

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

Medical Services

This division provides professional leadership for medical staff and services across DDHHS and has responsibility for the medical workforce, medical education, human research and ethics, clinical governance and pastoral care.

Queensland Rural Medical Service

This division provides professional leadership for rural and remote medical support through Queensland Country Practice (QCP) including specialist pathways, Health Practitioner Relieving Services, the Rural Generalist Program and the Medical Education and Training program which are all delivered on a statewide basis.

Allied Health

This division provides professional and operational leadership for allied health professionals and services across DDHHS, including workforce planning and development, clinical education, research and standards. This division also includes the DDHHS Research Unit, Aged Care Assessment Team, Community Care Services and BreastScreen Queensland Toowoomba Service.

Nursing and Midwifery Services

The division provides professional leadership for nursing and midwifery services, including workforce planning, standards and education and training across DDHHS.

Community Health Services and the Public Health Unit for DDHHS are also operationally aligned to this division.

Community Health Services includes:

- oral health services
- mobile women's health service
- public medicine.

Public Health Unit includes:

- environmental health
- communicable disease/immunisation.

Support Divisions

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

Finance

This division supports the health service in ensuring resources are balanced, sustainable and efficient. Finance provides DDHHS-wide support functions comprising financial control, management accounting, commercial management and health information services which are designed to optimise quality healthcare through compliant and efficient business processes.

Infrastructure

This division supports the organisation to plan for and deliver key infrastructure and maintenance programs across the health service to meet the health service's strategic objective of optimising asset use. This division manages the information and communication technology, projects, planning and property, managing and engineering and facility services portfolios.

Workforce

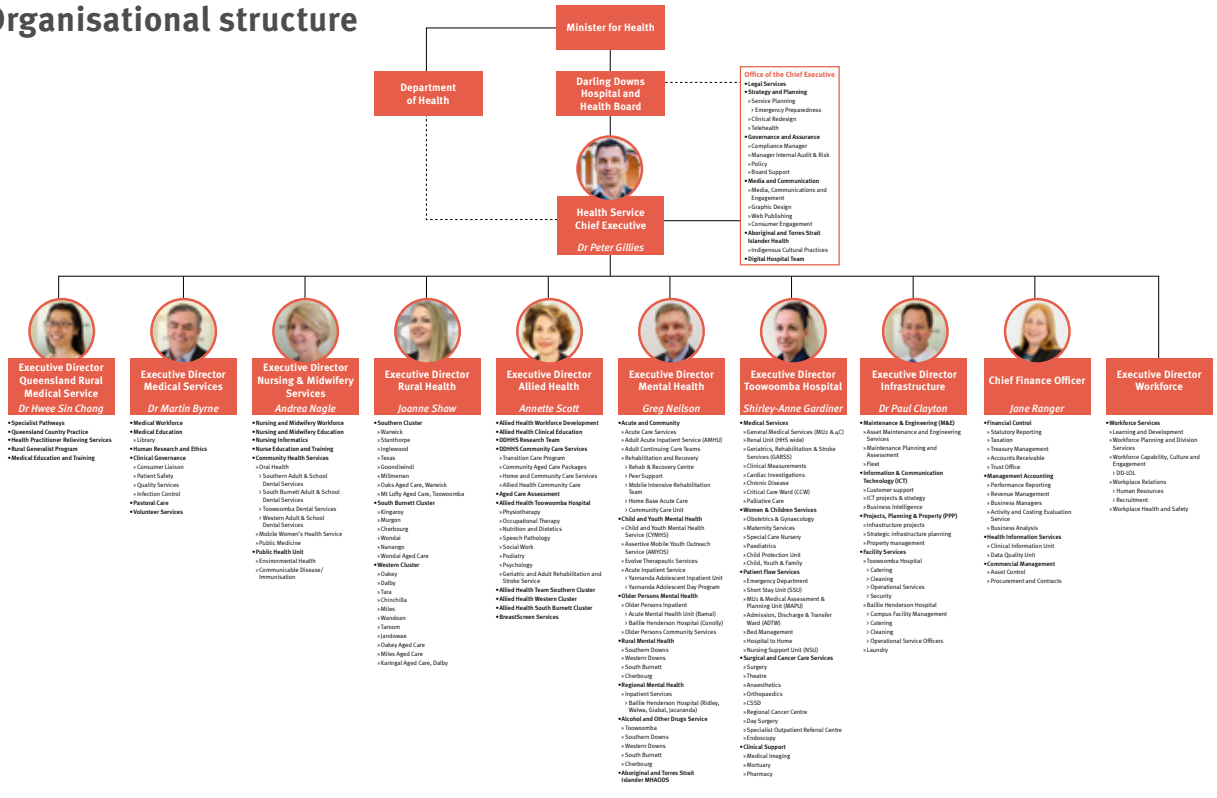
This division supports the health service to deliver on the key priority of ensuring a dedicated, trained workforce.

Workforce 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 and promoting employee health and wellbeing.

Office of the Chief Executive

This division supports the health service through legal services, strategy and planning, governance and assurance (including Board secretariat, risk and compliance management, and policy development), media and communication, Aboriginal and Torres Strait Islander Health and the Digital Hospital team.

Organisational structure

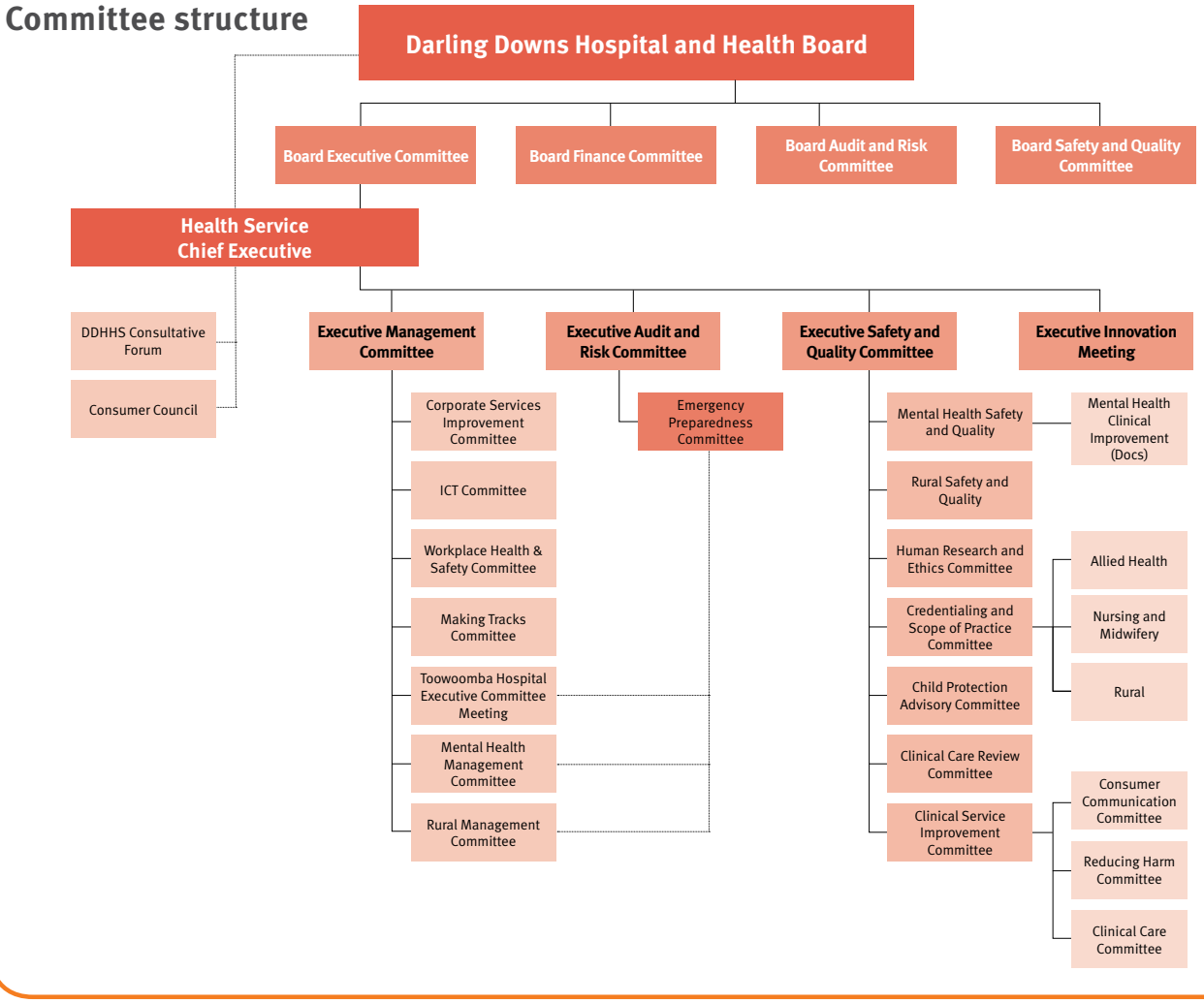


Executive committees

The DDHHS Executive committees support the Board and Executive Team to fulfil their responsibilities and assist in facilitating effective governance, management oversight, collective decision making and ensuring collaboration with the aim of achieving the strategic objectives of the organisation. The Executive committees and their purpose are outlined below:

- **Executive Management Committee**
  Leads the organisation to provide oversight of the operational functioning of the health service, including resourcing, governance and assurance functions to delivery quality, safe, patient-centred services to the community.
- **Executive Safety and Quality Committee**
  Ensures safety, quality and clinical governance processes are effective, coordinated and support the delivery of quality, safe, patient-centred services.
- **Executive Audit and Risk Committee**
  Oversight of risk management and compliance obligations of the health service. This committee also considers recommendations from internal and external audit and monitors timeliness of remediation measures to address audit findings.
- **Executive Innovation Meeting**
  Provides oversight of the strategy and innovation agenda for the health service and drives initiatives based on global horizon scanning and evidence-based research.

Committee structure



Our staff

The valued staff who undertake these functions and services are made up of the following:

4395
Total FTE

5597
Total headcount

65 years
Average retirement age

10 years
Average employment tenure

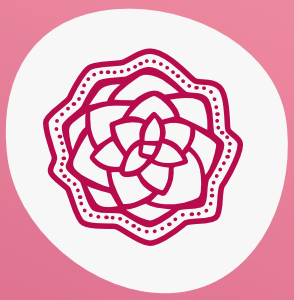
6%
Separation rate

Employment type
60% full-time
34% part-time
6% casual

Employment status
76% permanent
18% temporary
6% casual

2:1
Clinical to non-clinical ratio

Gender ratio
80% women
20% male



2.13%
Identify as Aboriginal and Torres Strait Islander

6.34%
People from non-English speaking backgrounds

2.05%
People with disabilities

DDHHS expects the highest level of conduct from its staff at all times and, as a public service agency, the five public service values and the Code of Conduct for the Queensland Public Service are applicable to all employees of the health service. Staff of DDHHS are expected to act in accordance with the principles of the Code of Conduct and to report any actions which do not meet this expected level. In this regard, staff have a responsibility to disclose any suspected wrongdoing and to ensure any disclosure is in accordance with the ethics expected within the organisation. Staff are supported in the making of Public Interest Disclosures.

To support staff in their understanding of the expectations of the organisation, mandatory training packages are available on the online training portal and ethics, integrity and accountability and fraud awareness training packages must be completed on an annual and biennial basis respectively.

DDHHS values its staff and supports staff to undertake flexible working arrangements where possible and offers full-time, part-time and casual positions throughout our facilities. DDHHS has also introduced a staff wellness program to support staff to incorporate healthy choices into daily living. More information on the wellness program and other workforce programs is available on pages 57-60 of this report.

No redundancy, early retirement or retrenchment packages were paid to staff during 2017-18.

Risk and compliance management

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 cost 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 health service.

A fully integrated compliance management framework was developed with further on-going work in progress on the compliance assurance system that will continue to ensure that the organisation is meeting its various obligations. Risk Management and Compliance Management reports are submitted to the Audit and Risk Committees of both the Board and Executive.

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*. The Internal Audit Charter gives due regard to Queensland Treasury's Audit Committee Guidelines and the Institute of Internal Auditors' International Professional Practices Framework.

The role of Internal Audit is to conduct independent assessment and evaluation of the effectiveness and efficiency of organisational systems, processes and controls, thereby providing assurance and value to the Board and Executive.

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

The 2017-18 Internal Audit plan included 11 audits covering topics such as clinical coding, pharmacy, medical recruitment, information technology strategy, cybersecurity and general controls, business continuity planning and emergency preparedness and assurance mapping.

The Internal Audit strategy this year was expanded to include a programme of 'lite' audits of the smaller rural facilities with a view to providing greater audit coverage as well as service-wide consistency of processes.

The implementation of recommendations arising from audits is monitored and reported to the Audit and Risk Committees of both the Board and the Executive.

Internal Audit work is carried out using a co-source model of both in-house resources and external contracted auditors that are engaged through a transparent procurement process. Internal Audit also works independently of, but collaboratively with, the external financial auditors.

External scrutiny

DDHHS operations are subject to regular scrutiny from external State oversight bodies such as the Auditor-General, Ombudsmen, Coroner, Queensland Audit Office and Crime and Corruption Commission.

Coronial findings

During 2017-2018 there were no findings handed down in relation to Inquests involving DDHHS services.

Queensland Audit Office

During 2017-18 DDHHS participated in one external audit. The audit was undertaken by the Queensland Audit Office and was an Organisational Structure and Accountability Review.

The audit made six recommendations for improvement to organisational structure and corporate governance all of which were accepted by management, actioned and recorded as complete.

Information systems and recordkeeping

Queensland State Archives (QSA) is the lead agency for record keeping and is responsible for the development and implementation of a whole-of-government recordkeeping policy framework. QSA was established under section 21 the *Public Records Act 2002* as the state's archives and records management authority.

DDHHS has many corporate recordkeeping systems across various functions of the health service including financial, payroll, legal and contract management. DDHHS's policies, procedures and ongoing improvement program support compliance with the *Public Records Act 2002*.

In 2017-18 DDHHS engaged Prosperity Audit Services to undertake an audit of all non-clinical records management. The audit identified areas of improvement to ensure that DDHHS is compliant with the *Public Records Act 2002*, *Information Standard 40: Recordkeeping (IS40)* and *Information Standard 31: Retention and Disposal of Public Records (IS31)*.

From this audit, a working group has been created to oversee and drive the implementation of the 14 audit recommendations. These recommendations included records management governance as well as training and standardisation of records management applications. Thirteen of these recommendations are in progress and are expected to be completed within the 2018-19 financial year. Training is available to all staff regarding the making and keeping of public records in all formats at orientation, local inductions, and through the DDHHS Health Information Services team.

DDHHS complies with the *Health Sector (Clinical Records) Retention and Disposal Schedule (QDAN 683 v.1)* and with the *General Retention and Disposal Schedule (QDAN 249 v.7)*. This compliance ensures that public records are kept for as long as they are required.

The launch of DDHHS's new vision and values in July was off to a flying start to embed them into the organisation.

Our milestones

Baillie Henderson Hospital laundry refurbishment complete

New kitchen completed at Warwick Hospital

July

NAIDOC Week celebrated at more DDHHS facilities than ever before

Breastscreen Toowoomba Service celebrates 25th anniversary of local care

DDHHS launches new Vision and Values

August

September

New stroke program launched to allow patients to be diagnosed at Warwick Hospital

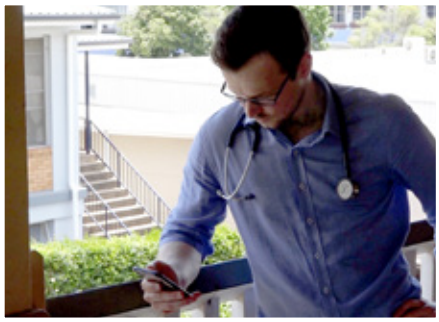
Toowoomba Hospital's central sterilising department upgrade completed

Hosted first Mental Health and Wellbeing Expo at the Baillie Henderson Hospital campus

Toowoomba Hospital's Renal Services team won a Queensland Health Award for Excellence for their project Reduce Miles Spread Smiles

First patients welcomed at new Matron Farr Building dental, training and community health clinic at Kingaroy Hospital

October



November

Medical Education team launched new mobile app to support junior doctors

Warwick Hospital staff among many across the HHS who took part in Movember to raise awareness for men's health

December

Our milestones

Staff recognised for excellence at DDHHS Employee Awards

Toowoomba Hospital new kitchen and Place of Prayer officially opened

Online interactive magazine Healthier Together first issued

New Nursing and Midwifery Code of Conduct launched

National Close the Gap Day celebrated at Cherbourg and across HHS

January

February

March

ihca
supporting excellence
CERTIFICATION

Auditors commend DDHHS on the pride, commitment, professionalism, innovation and dedication they witnessed during audit

Speaking Up for Safety program launched

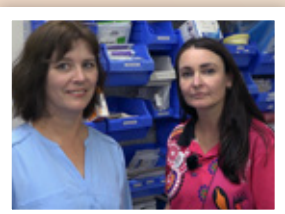
10th anniversary of the National Apology celebrated

First Health Check Pitstop for staff and emergency service partners hailed a success

International Days of the Midwife and Nurses celebrated

Thank you function held to recognise Toowoomba Hospital's seventh theatre team's achievements

World No Tobacco Day recognised



April

Diabetes Model of Care Project took out the Consumer's Choice award at Clinical Excellence Showcase

May

June

DDHHS hosted successful NDIS and Aged Care Expo

Length-of-service awards acknowledge staff

Culture Check-up staff survey shows improved results

Our performance

In August 2017 DDHHS became one of the first health services in the State to be moved to Performance Level 1 against the Queensland Health 'Delivering a High Performing Health System for Queenslanders' Framework. This is the highest level of performance attainable under the framework.

The Framework utilises Key Performance Indicators to capture information and covers aspects of performance across the following six areas of health service delivery:

- safe
- equitable
- effective
- patient-centred
- timely
- efficient.

Our service standards

DDHHS delivers services in accordance with its obligations outlined in the Service Agreement with the Department of Health and the Service Delivery Statement (SDS).

The Service Agreement identifies the health services provided by DDHHS and the funding arrangements, performance indicators and targets to ensure the achievement of outcomes. DDHHS reports against national targets as established in the *National Partnership Agreement on Improving Public Hospital Services* and documented in the SDS and Service Agreement.

Performance highlights

DDHHS continued to meet the increasing demand for services throughout 2017-18. Despite the increase in demand, DDHHS continued its high performance against targets and key performance indicators set by the Department of Health.

158,982

Emergency Department presentations

222,496

Specialist Outpatient attendance

85,320

Inpatient separations

2994

Births

11,170

Surgeries
(including elective and emergency surgeries)

100%

Specialist outpatients
waiting within clinically recommended timeframes. Specialist outpatient targets have now been met for the past three years.

4 years

Elective surgery targets met and maintained

4 years

Consecutive period
in which oral health patients have waited less than two years for treatment

Our achievements

Emergency department

Emergency Departments throughout DDHHS saw a total of 158,982 patients this financial year.

As outlined in the table below, Category 1 and 3 patients were being seen in recommended times at a slightly lower percentage than the identified target. However, results for both measures have improved from 2016-17 and both fell only two per cent short of the relevant target.

Infrastructure investments have assisted Emergency Departments to manage the continued demand for service. The refurbishment of the Toowoomba Hospital Emergency Department saw a substantial improvement in the number of treatment spaces, which increased from 21 to 30.

Further, the commencement of the $3 million redevelopment of the Warwick Hospital Emergency Department is also expected to have a positive impact on targets over the coming year, with an increase in treatment bays, short stay bays and triage bays, including an ambulance triage bay.

Performance measure	Notes	17-18 Target	17-18 Actual
Emergency Length of Stay Percentage of emergency department attendees who depart within 4 hours of their arrival in the Emergency Department (ED)	1	›80%	86%
ED patients seen in recommended times			
Category 1 (within 2 minutes)	1	100%	98%
Category 2 (within 10 minutes)	1	80%	85%
Category 3 (within 30 minutes)	1	75%	73%
Category 4 (within 60 minutes)	1	70%	86%
Category 5 (within 120 minutes)	1	70%	98%
ED median wait time (minutes)	1	20	10

Specialist outpatient appointments

Performance measure	Notes	17-18 Target	17-18 Actual
Percentage of specialist outpatients waiting within clinically recommended times			
Category 1 (30 days)	1	98%	100%
Category 2 (90 days)	1	95%	100%
Category 3 (365 days)	1	95%	100%

DDHHS had a total of 222,496 specialist outpatient attendances during 2017-18 with all patients waiting within clinically recommended timeframes. This achievement sees three years of DDHHS meeting or exceeding specialist outpatient targets.

Elective surgery

Performance measure	Notes	17-18 Target	17-18 Actual
Percentage of elective surgery patients treated within clinically recommended times			
Category 1 (30 days)	1	›98%	99%
Category 2 (90 days)	1	›95%	98%
Category 3 (365 days)	1	›95%	99%
Median wait time for elective surgery (days)	1	25	48

Since December 2013, DDHHS has met the specified targets for elective surgery patients treated within clinically recommended times for all three patient categories. Achieving these targets in conjunction with specialist outpatients waiting within clinically recommended times means the patients in our region are seen by a specialist and receive their surgery (if required) within clinically appropriate timeframes. Meeting elective surgery targets in 2017-18 was achieved despite the closing of two theatres for a number of weeks to allow for works to be undertaken to build a seventh operating theatre at Toowoomba Hospital.

The median wait time for elective surgery was above the target of 25 days. As in previous years, this is largely due to the significant proportion of elective surgery patients in the region being either Category 2 or 3 patients that require treatment within 90 or 365 days respectively and may be treated on the cusp of those timeframes.

In 2017-18, a total of 6,809 elective surgery procedures were undertaken by DDHHS, which is a six per cent increase on the 2016-17 year. With the expectation that numbers will continue to increase in 2018-19, the focus is on maintaining the current results and continuing to provide services within the clinically recommended timeframes.

Activity

Performance measure	Notes	17-18 Target	17-18 Actual
Total weighted activity units			
Acute Inpatient	2	57,878	54,894
Outpatients	2	12,583	10,877
Sub-acute	2	5,173	5,829
Emergency Department	2	17,705	18,099
Mental Health	2	9,783	8,923
Prevention and Primary Care	2	3,017	3,426

Other key performance indicators

Performance measure	Notes	17-18 Target	17-18 Actual
Service delivery statement standards			
Rate of healthcare associated staphylococcus aureus bloodstream infections/10,000 acute public hospital patient days	1	<2	0.34
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient facility	3	>65%	71%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	3	<12%	15%
Ambulatory mental health service contact duration (hours)	3	>72,612	84,630
Telehealth – number of non-admitted telehealth service events	4	8,107	8,721
Minimum Obligatory Human Resource Information (MOHRI)	5	4,315	4,395

BreastScreen Queensland's senior medical officer Dr Teena Haslam (left) and breast screening advocate Janine Hills celebrated the Toowoomba service's 25-year anniversary in July.

Oral Health

For the fourth consecutive year, 100 per cent of patients were waiting less than two years for their dental treatment. This maintenance of zero long wait patients occurred despite a significant increase in activity for the 2017-18 period, with the target for oral health weighted occasions of service (WOoS) being exceeded by 13.1per cent. This was a total of 220,766 WOoS.

There were 8484 patients on the general care waiting list at 30 June 2018, an increase of 7 per cent on 30 June 2017. Despite the increase in patients requiring care, it is envisaged that zero long waits will continue to be maintained through current strategies including wait list auditing, centralised call centre, improved coding and hub and spoke models.

Telehealth

DDHHS achieved well above the target for telehealth service events in 2017-18. A number of new telehealth initiatives commenced throughout the health service to allow patients to access specialty services without having to travel extensively to do so. For more information on telehealth projects undertaken this year, please refer to page 43.

Complaints management

A total of 1712 complaints were received in 2017-18, with 1587, or 93% resolved within 35 days, well above the target of 80%. There were significantly more compliments than complaints received in the health service, with a total of 3176 compliments received.

Compliments received

Everyone was extremely helpful, attentive and professional. I cannot thank them enough for all the care I have received while here.
Toowoomba Hospital

Somehow just saying thank you doesn't seem enough. But I hope you know how much your kindness has meant to me... I really appreciate everything that was done, the warm caring atmosphere and your kindness.
Kingaroy Hospital

No words can ever express my gratitude and that of my family for the professional caring attention you gave so freely.
Mt Lofty Heights Nursing Home

Explanatory Notes

The 2017-18 targets are as published in the 2018-19 Service Delivery Statement. While some 2017-18 estimated actuals published in the Service Delivery Statement are different to actuals included in this Annual Report, there are no significant variations.

1. Source: System Performance Report (SPR). Total number of patients seen in DDHHS Emergency Departments was taken from EDIS.
2. Source: DSS. Data as at 10 August 2018. Small amounts of activity will continue to be gained while coding reviews continue throughout September.
3. Source: Mental Health Performance Report produced by Clinical Systems Collections and Performance Unit. Data sources for report include Queensland Health Admitted Patient Collection, Consumer Integrated Mental Health Application, Mental Health Activity Data Collection and Alcohol Tobacco and Other Drugs Services Information System.
4. Source: Monthly Activity Collection from HBCIS.
5. Source: DSS.

Performance against Strategic Objectives

The DDHHS *Strategic Plan 2016-2020* outlines six key strategic objectives as detailed on page 10. While all the work undertaken throughout the health service contributes to the organisation's strategic objectives, outlined below are the health service's major achievements under each of the strategic objectives for the 2017-18 period.

Strategic Objective 1 - Healthcare

DDHHS continues to provide efficient and safe healthcare to consumers within our region. This included meeting or exceeding targets for emergency care, elective surgery, specialist outpatients, oral health and telehealth. This strategic objective incorporates these healthcare priorities together with improving access and where possible, local access to services in our region and delivering support services to close the gap in Indigenous health outcomes.

Accreditation confirms high standard of care

In January 2018 DDHHS underwent full accreditation against the National Safety and Quality in Healthcare Standards (NSQHS), the National Mental Health Standards and ISO 9001:2015 re-certification. Full accreditation for three years was achieved.

A "Met with Merit" status was also achieved against NSQHS 2 – Partnering with Consumers – Consumer and/or carers are involved in the governance of the health service organisation".

Institute for Healthy Communities Australia auditors noted how much pride, commitment, professionalism, innovation and dedication they witnessed during their audit. Other areas of mention included:

- The End of Life 'Yarning app' in Goondiwindi
- The community-driven renal unit in Dalby
- Wondai's innovation in operations
- Taroom's innovation in addressing the challenges to maintain focus and skills.

Nurse navigators support patients

With 19 nurse navigator roles across the region, DDHHS has worked to streamline how patients access care. The nurse navigator positions have assisted patients with complex health conditions to manage their own healthcare and improved the accessibility of services. The nurse navigator positions significantly contribute to patient experience and their ability to access care at the right place, at the right time. This financial year saw a focus from the nurse navigators on rural, acute care, maternity, aged care and mental health.

Rural stroke pathway program

A priority for the health service is on the availability of care as close as possible to a patient's home. In August 2017, a Rural Stroke Pathway Program was established at the Warwick Hospital to rapidly diagnose and treat suspected stroke patients. This program alleviates the need for patients brought to Warwick Hospital suffering from a suspected stroke to be transferred to Toowoomba for diagnosis.

The Rural Stroke Pathway Program, the introduction of a CT scanner and a specialist emergency medicine doctor at the Warwick Hospital has increased the capability to assess, diagnose and treat stroke patients locally.

Cognitive Institute – Speaking Up for Safety

Darling Downs Hospital and Health Service became the eighth health service in the world and the first regional service to partner with the Cognitive Institute on its Safety and Reliability Improvement Program. The Cognitive Institute is an international provider of healthcare education and its 'Speaking Up for Safety' program was officially launched on 19 January 2018. This mandatory training provides staff with the tools and confidence to speak up if they have concerns about the safety of patient care. The program makes safety everyone's business and by 30 June 2018, 54 per cent of staff across the health service had completed the training.

Promoting Professional Accountability is the next stage of this important program and will commence in mid-late 2018.

Telehealth services extended to support patients

Pharmaceutical review is a key strategy in reducing patient harm. The tele-pharmacy model uses telehealth technology for medication review and assessment. Initially trialled at Dalby Hospital, the service was extended this year to be provided by a pharmacist from Warwick, Dalby, Kingaroy or Toowoomba hospitals.

Telehealth has been undertaken over previous years throughout the health service, however there were several new initiatives in telehealth during the 2017-18 year, assisting the health service to exceed its telehealth target for the year.

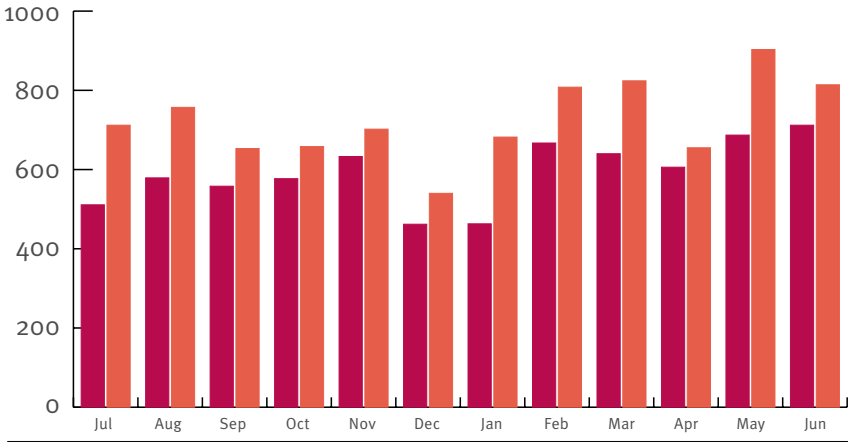
Toowoomba Hospital's Telehealth Hub welcomed its first patient in August 2017 for an appointment with a Brisbane specialist. Since then, 372 patients have used the service, saving an estimated 99,256 kilometres in travel.

The Rural Outreach Ophthalmology model has been implemented across the health service. This service benefits the community in rural areas who receive diabetic retinopathy early detection screening.

Planning continues to be undertaken for a Telehealth First model; however, even at such an early stage, outpatient departments at Toowoomba Hospital increased referrals to telehealth by 39 percent in 2016-17, with a total of 1277 new referrals converted from 'in person' to telehealth in 2017-18.

Implementation of an adhoc tele-stroke care pathway commenced in 2017-18. Where patients present to a rural emergency department, clinicians from Toowoomba Hospital can consult into the department via telehealth to discuss treatment plans and lysis of blood clots if appropriate. This program allows patients to stay locally and also reduces admissions and transfers to the Toowoomba Hospital.

Non-admitted Telehealth service events



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
2015-16	413	394	342	467	456	367	336	474	487	456	510	504
2016-17	511	579	558	577	633	462	463	667	640	606	687	712
2017-18	712	757	653	658	702	540	682	808	824	655	903	814

Joint replacement patients benefit from enhanced recovery program

Toowoomba Hospital this year developed a recovery program to improve outcomes for its elective joint replacement surgical patients. The Enhanced Recovery After Surgery (ERAS) program brings together a multi-disciplinary team of clinical nurses, orthopaedic specialists, pharmacists, dietitians, physiotherapists, occupational therapists and anaesthetists. The program has seen a decrease in the length of time for recovery from surgery for patients, improvements in post-operative care, reductions in the physical stress of the operation, and improvements in post-operative mobility.

All patients undergoing orthopaedic procedures are now considered for an ERAS plan including reductions in fasting times before surgery, non-diabetic patients undertaking carbohydrate loading pre-operation, optimising use of analgesics and earlier mobility post-surgery.

Top 10 non-admitted Telehealth specialities 2017-2018

Anaesthetics	374
Clinical Measurement	306
Haematology	670
Midwifery	518
Nephrology	1012
Obstetrics	258
Oncology	300
Orthopaedics	1306
Paediatric Medicine	618
Pre-admisson/Pre-Anaesthesia	602

Shuttle services connect care

Patients eligible for the Patient Travel Subsidy Scheme (PTSS) requiring transport to specialist services in Toowoomba are now able to access a shuttle service to better connect them with care. The Goondiwindi Meditrans and Highfields shuttle bus services established this year as part of the Goondiwindi Care Coordinator and Meditrans service pilot project is a result of collaboration between the Goondiwindi Regional Council, Darling Downs Hospital and Health Service and Darling Downs and West Moreton Primary Health Network (DDWMPHN).

Sensory room helps mental health clients

Baillie Henderson Hospital's Ridley Unit established a sensory room for its clients in early 2018 to further support mental health patients on-campus. The sensory room is a safe place for clients to feel self-regulated and grounded and uses soft lighting and relaxing imagery, music, aromatherapy, and other sensory equipment to provide stimulation of the senses. Up to four clients at a time can use the sensory room under the supervision of an occupational therapist or nurse.

More patients helped to quit smoking

The smoking cessation program achieved great results in signing up in-patients and some community-based patients to quit-smoking programs. Across the region, approximately 77 per cent of eligible patients had pathways completed each month with the target of 50 per cent consistently exceeded. Referrals from DDHHS to Quitline topped the state in January for Aboriginal and Torres Strait Islander referrals, which is a key target area to help close the health gap.

Clinical interventions were expanded to offer more nicotine replacement therapies, development of a pilot smokers' clinic to assist patients to stop smoking before hernia surgery at Toowoomba Hospital and the use of smokerlyzers to measure carbon monoxide levels in antenatal patients.

Staff education was key to the program's success with the internal training package reviewed and updated. Almost 3450 employees completed this training that is mandatory and role specific for the majority of clinicians and all Indigenous health workers.

Aged Care Accreditation

This year four of our six aged care facilities underwent accreditation through the Australian Aged Care Quality Agency (AACQA). Mt Lofty Heights Nursing Home (Toowoomba), Dr EAF McDonald Nursing Home (Oakey), Milton House (Miles) and The Oaks (Warwick) achieved accreditation. The auditors particularly commended the hen house at Miles which accommodates pet chickens used in progressive animal therapy with residents.

BreastScreen provides more outreach to women

BreastScreen Queensland's Toowoomba Service this year screened 17,588 women. This was slightly less than targeted, as a mobile service at Highfields was cancelled due to issues with a suitable venue. A bus service to Toowoomba was put in place, and the service expects to screen more Highfields women when it returns to the community in late 2018.

It is important that as a health service we continue to improve access to screening mammograms for rural and remote women. Last year, the mobile van visited 12 rural communities and for the first time, the mobile van screened at an Aboriginal Medical Service; providing on-site mammograms to Aboriginal and Torres Strait Islander women at Carbal's Women's Wellness Day. This year also saw 77 more Indigenous women screened than the previous financial year.

A new promotions partnership was started with the Toowoomba Chamber of Commerce to engage local businesses and encourage working women to be screened. The BreastScreen health promotions officer conducted 19 breast health awareness education sessions with local organisations and had representation at 10 expos and events. The BreastScreen Queensland service also held its first culturally and linguistically diverse breast health presentation in collaboration with he Darling Downs West Moreton Primary Health Network and Multicultural Development Australia. The presentation was delivered in three different languages and attended by 30 women.

Allied health rural generalist pathway

The Allied Health Rural Generalist Pathway is a key strategy to progress the sustainability and value derived from Queensland's rural and remote allied health workforce. This initiative provides funded supernumerary graduate positions for rural or remote allied health teams across Queensland Health. It aims to support early career rural and remote workforce development and to assist teams to implement rural generalist service redesign and development.

A key component of the allied health rural generalist pathway is a structured education program which supports the capability development for rural allied health practice. This year saw the commencement of the first cohort of the Allied Health Rural Generalist Program (Level 1), as well as the Graduate Diploma of Rural Generalist Practice (Level 2) in partnership with James Cook University.

Allied Health Rural Generalist Training Positions for 2017-18 were arranged across eight Hospital and Health Service areas including Darling Downs. This collaborative approach to training Allied Health Rural Generalists saw DDHHS support these students to gain skills in both social work and physiotherapy.

New Dalby renal service provides care close to home

From January 2018 residents of the Dalby area needing haemodialysis no longer needed to travel to Toowoomba for treatment. The establishment of a renal service at Dalby Hospital, comprising two haemodialysis chairs, with the capacity to treat four patients a day, saw significant improvements to the quality of life of patients accessing the service. Having the treatment closer to home means the four-hour round-trip to Toowoomba, three times a week, will no longer be required and patients are able to access the care needed at the Dalby Hospital. The investment saw almost $100,000 in infrastructure including water treatment plant, reverse osmosis units, haemodialysis machines, and specialised chairs installed to provide this local service to low-risk patients.

The Rotary Club of Dalby donated a hand-held ultrasound to Dalby Hospital's new renal service in May. The diagnostic equipment is small, portable and easy to use for tasks such as detecting the presence of fluid.

Closing the Gap

DDHHS is committed to closing the gap in health outcomes for Aboriginal and Torres Strait Islander people.

Achievements under the Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework for 2017-18 include:

- **Cultural Practice Program**
  The Cultural Practice Program develops the cultural skills of all staff, recognising that everyone plays a role in improving health outcomes for Aboriginal and Torres Strait Islander people. For the first time, DDHHS met its target of 85 per cent of staff having completed this training.
- **NAIDOC celebrations**
  23 events were held across the health service to celebrate National Aboriginal and Islander Day Observance Committee (NAIDOC) week. Over 2000 staff, patients, community members and other organisations attended these events.
- **DDHHS Aboriginal and Torres Strait Islander Health Forum**
  The DDHHS Aboriginal and Torres Strait Islander Health Forum continues to be held each quarter with attendance from both internal staff and representatives from our Aboriginal and Torres Strait Islander healthcare partners and local community members.
- **Arts project**
  A number of art projects have been undertaken to provide a welcoming environment for Aboriginal and Torres Strait Islander people. During 2017-18, art projects were undertaken at Toowoomba Hospital, Mt Lofty Heights Nursing Home and at the Floresco service. Artwork included a 30 metre healing carpet snake painting at Toowoomba Hospital.
- **Facebook page**
  The 'Darling Downs Aboriginal and Torres Strait Islander Health' Facebook page was launched in February 2018. The page aims to engage Aboriginal and Torres Strait Islander consumers and is used as a promotional tool for health programs including 'Tackle Flu' and promotes employment opportunities.

Discharge with medical support

In May 2017, a discharge with medical support process was developed to assist patients who are unable to complete their inpatient stay due to family and cultural responsibilities, transport and accommodation issues.

The process takes these issues into account and ensures the patient has the appropriate support in place for early discharge. This includes referral to the consumer's general practitioner, community nurse, allied health, Aboriginal and Torres Strait Islander community controlled health service, and Indigenous health worker or liaison officer. Patients who do not meet the requirements to discharge with medical support continue to be documented as having been discharged against medical advice.

Maternity outreach

The Midwifery Group Practice model which has been in operation since 2008 at Goondiwindi Hospital extended its services in 2017 to also provide a service from Toomelah Health Clinic. This extension of the service has enabled Aboriginal and Torres Strait Islander women living in this community to access culturally appropriate care, health education and linkages to the wider healthcare system. Data from this service was collected for the *Toomelah Boggabilla Health Action Plan Priority Outcomes 2017-18*.

A number of Aboriginal and Torres Strait Islander specific services continue to operate throughout the health service to provide culturally appropriate care including:

- Outreach Maternal and Infant Health Service
- South Burnett Indigenous Hospital Liaison Services
- Indigenous Alcohol, Tobacco and Other Drugs Youth Program, Cherbourg
- Indigenous Multi-Disciplinary Care Team, Toowoomba Hospital
- South Burnett Renal Services Expansion
- Maternal Child and Youth Health Workforce Development Program
- Cherbourg Young Parent Support Service.

The Aboriginal and Torres Strait Islander Health management structure was also reviewed and a new Director position has been established and will be recruited to in 2018. This position will drive Aboriginal and Torres Strait Islander healthcare initiatives for the health service. All current Aboriginal and Torres Strait Islander services and staff will move to a centralised model. This new health management structure will provide strategic direction, leadership and oversight to support our Aboriginal and Torres Strait Islander workforce to deliver high-quality health services and improved health outcomes for our Aboriginal and Torres Strait Islander consumers.

Strategic objective 2 - Engage

Effective community and consumer liaison was the foundation of providing patient-centred care and integrated services in 2017-18. We welcomed more consumer representatives than ever before to provide input and direction to local healthcare planning and delivery. Our Board also continued its strong focus on community engagement, meeting regularly with stakeholders from right across the health service to keep in touch with local needs and priorities. These details are included on pages 19-20.

This strategic objective also encompasses collaboration with other healthcare providers, including primary health to reduce chronic disease and provide leadership in fighting obesity.

Consumer and community representation at the heart of our care

Darling Downs Hospital and Health Service is committed to providing opportunities for communities, consumers and carers, government, and individual stakeholders to provide input on our services, and how these services can best meet their needs.

As a snapshot, we have:

- 12 community advisory groups established in 12 communities
- 36 committees with more than 72 consumer representatives and 70 community organisations involved
- 12 hospital auxiliaries across 20 communities
- Four Aboriginal and Torres Strait Islander community advisory groups.

These groups contribute to meeting NSQHS Standard 2 – Partnering with Consumers. New groups in 2017-18 included:

- Warwick Hospital Community Advisory Group reformed with their first meeting held in November 2017
- Jandowae Hospital Community Advisory Group followed up the inaugural July meeting with a quarterly October meeting
- Chinchilla Hospital Consumer Advisory Group was formed in February 2018 and held its inaugural meeting. The formation of the advisory group was well received by the community and also received positive media coverage.

Mental health expo a success

This year, DDHHS worked hard to break down the stigma in accessing mental health services by celebrating Mental Health Week with a Mental Health and Wellbeing Expo at Baillie Henderson Hospital in October 2017. More than 40 mental health service providers attended including Carbal and Goolburri Aboriginal Health Services, Ozcare, Toowoomba Clubhouse, TOMNET, Richmond Fellowship Queensland, Carers Queensland, Warrina, Lifeline and the Department of Defence. The expo provided the community with an opportunity to connect with local service providers and wellbeing programs and supported a united, collaborative approach to community mental health support.

New diabetes care program

Hundreds of local residents with diabetes benefited from Toowoomba Hospital's innovative Diabetes Model of Care project aimed at providing timely, collective access to care. Hospital staff work closely with local GPs, Queensland Ambulance Officers and community health providers to decrease hospital attendance and patient's length of stay. This model of care also focuses on comprehensive hospital discharge planning and creating better in-home, self-management of diabetes.

Almost 400 patients took part in the program with outstanding results including improvements in blood test results, significant reduction in re-admission rates in high-risk patients, and a high level of patient satisfaction with the service and their overall quality of life. The program also included education sessions with GP practices across the health service. A presentation on the project was awarded the 'Consumer's Choice Award' at Queensland Health's Clinical Excellence Showcase annual event. It has now become the benchmark in caring for diabetes patients.

Aged care and NDIS Expo

Bringing together providers to help consumers navigate their healthcare is a key strategic vision of the Darling Downs Hospital and Health Service and this year, hundreds of people attended a community information expo for aged care and the National Disability Insurance Scheme (NDIS) in June. The expo organised in conjunction with Darling Downs West Moreton Primary Health Network featured 66 information booths, NDIS and aged care displays and health and wellness stalls. These events encouraged our consumers to take ownership of their care and aimed to improve the health literacy of our region.

New mental health hub Floresco

A significant focus for the health service is to support community initiatives that reduce the need for admissions to hospital, particularly in the mental health sector. Floresco is a collaboration between support services for mental health consumers and provides a seamless experience for holistic care. The facility was established to reduce admissions to the emergency department and improve access to non-clinical services.

Floresco was made possible with $1.5 million in funding including $1.05 million from the Queensland Government Integrated Care Innovation Fund (ICIF) and $450,000 from the Darling Downs Hospital and Health Service. This demonstration project has seen clear pathways of integrated care established to help address collaboration between mental health services in our region. An evaluation will be conducted in 2018-19 to determine the full effectiveness of this service.

Health Check Pit-Stop

It is important that the Darling Downs Hospital and Health Service continues to develop ways to engage other government departments across the region to take ownership of their health and wellbeing and the health and wellbeing of their staff. This year a Health Check Pit-Stop was held for our staff as well as Emergency Services and Australian Defence Force personnel. The Pit-Stop offered simple health checks to gather health-related information to help improve wellbeing. The event was very well attended and coincided with Healthy Weight Week. Queensland Ambulance Service, Red Cross and the Stroke Foundation all contributed to the event.

Social media reaches more of our community

This year, DDHHS launched a number of social media channels to engage with the community and encourage a two-way conversation. Facebook, Instagram, Twitter, YouTube and Pinterest were created with a reach of over 687,000 people since their creation in August.

As mentioned on page 46, the ‘Darling Downs Aboriginal and Torres Strait Islander Health’ Facebook page was also launched this year to improve engagement with Aboriginal and Torres Strait Islander communities to raise awareness of health initiatives, improve sentiment and access to facilities and increase visibility of important messages including ‘Tackle Flu’. The page is also being used to promote employment opportunities within the health service to increase the representation of Aboriginal and Torres Strait Islander people within the workforce.

HealthPathways helps connect clinical care

Darling Downs HealthPathways is a web-based portal with information on referral and management pathways helping clinicians to navigate patients through the complex primary, community and acute healthcare system in our region. HealthPathways is designed to be used at the point of care by general practitioners.

Working collaboratively with Darling Downs West Moreton Primary Health Network, HealthPathways went live on 14 June 2018. In total, 30 pathways have been completed. Work will continue on this project into 2018-19 and Clinical Prioritisation Criteria will also be included. These are clinical decision support tools that will help ensure patients referred for public specialist outpatient services in Queensland are assessed in order of clinical urgency.

Hospital serves up healthier menu

The Darling Downs Hospital and Health Service is focussed on educating the community on the importance of wellbeing and the nutritional content of food and drink. This year saw the Toowoomba Hospital make changes to its in-patient menu to encourage healthier food choices and wellbeing. These changes included the removal of juice, flavoured milks and white bread to reduce the amount of added sugar patients consume while in hospital.

Palliative Care 'yarning' app

End-of-life care is an important message across the health service, particularly when it comes to starting the conversation around culturally-appropriate palliative care. This year saw the development of an innovative new palliative care app for Aboriginal and Torres Strait Islander people in Goondiwindi. The Advanced Care Yarning app is designed to assist the wider population of Indigenous communities to understand, discuss and make decisions about their palliative care.

Early stages of the app were developed with valuable input from a Goondiwindi reference group and supported by the Indigenous advisory working party. One of the key elements of the app is the use of Indigenous artwork including the bush, the river and fishing to focus on cultural storytelling to explain the concepts contained in the app. The app was further developed in partnership with a team from the Royal Brisbane and Women's Hospital, Queensland University, SAE Qantm and eHealth Queensland Digital Innovation and Strategy Unit at Brisbane's Health Hack 2017, where it won first place for best design.

Jamie Oliver Ministry of Food

Another focussed initiative to drive awareness of wellbeing was the attraction of the Jamie Oliver Ministry of Food van to provide a five-week education course on making basic, nutritious recipes to improve health awareness. Jamie's van was located at the Baillie Henderson Hospital campus and was organised as a joint initiative with the Toowoomba Hospital Foundation.

Low carbohydrate diet education

This year a key focus of the Darling Downs Hospital and Health Service has been on the education of the community in low-carb nutrition and its benefits as a lifestyle choice. This has included a presentation by Low Carb Down Under with a focus on managing chronic disease and how low-carb nutrition can be used to manage diabetes and obesity. This free session saw a number of consumers living with diabetes gaining valuable insight into managing the disease, community members were educated on how to prevent diabetes and obesity and DDHHS staff received information they are able to provide to consumers as an option for managing chronic disease.

In May 2018, principal research scientist in clinical nutrition at CSIRO Health and Biosecurity, Professor Grant Brinkworth presented a 'Low Carb Every Day' seminar in Toowoomba. The session looked at how low carbohydrate options could be included easily into diet and the science behind why low carb diets are beneficial in preventing chronic disease.

New *Healthier Together* magazine launched

This year, a new digital magazine with a complementary printed version was created to educate the community on health-related information, upcoming events and putting a spotlight on our staff and the work they do to care for our communities. This quarterly publication saw two editions created this year with a readership of over 10,000 people.

Professor Grant Brinkworth (left) was presented on the benefits of a low-carb diet at a seminar in May.

Strategic Objective 3 - Learning

One of our values is innovation - we strive to know more, learn more and do better. To help achieve this, we are committed to the establishment of research, learning and collaboration with the tertiary education sector as a core activity in all sectors of the health service, recognising that it provides the basis for safe and effective patient care.

Collaborative partnership boosts rural health training

Health education, training and research in rural south Queensland received a major boost this year with the establishment of a new University Department of Rural Health. DDHHS has joined University of Queensland, South West Hospital and Health Service and University of Southern Queensland in a successful bid for Commonwealth funding to establish Southern Queensland Rural Health. Nursing, midwifery and allied health students (physiotherapy, pharmacy, psychology, social work, occupational therapy, speech pathology, dietetics and exercise physiology), will have the opportunity of placement within the Darling Downs, South West and West Moreton regions. Research indicates that students who have been on rural placements are far more likely to return to work in rural areas once they qualify. Support for Southern Queensland Rural Health is part of a long-term strategy to attract graduates to rural and remote regions.

Research partnerships to foster innovation

DDHHS is a partner in the Darling Downs Health and Innovation Research Collaborative (DDHIRC) which aims to improve health outcomes in the Darling Downs through collective capability in healthcare, health and medical research and workforce development. Highlights for this year have included establishment of the collaborative, the drafting of a Statement of Intent and trial shared projects to assist in designing the DDHIRC framework.

Several projects receive accolades

The 2017 Queensland Health Awards for Excellence awarded the renal services team the Regional Rural and Remote Award for Outstanding Achievement. Reduce MILES, Spread SMILES is an innovative program to reduce travel requirements for rural and remote renal dialysis patients. The program resulted in 25 per cent of all chronic kidney disease patients being seen via telehealth.

This year, DDHHS presented at Queensland Health's Clinical Excellence Division – Clinical Showcase and was awarded the Consumer's Choice Award for the Diabetes Model of Care project. The project aimed to provide diabetes care for consumers within their own communities, by partnering with and using existing resources, including primary health facilities. Ultimately the program aimed to decrease length of stay and allow treatment of chronic disease to be treated in the community and avoid admittance to hospital.

Other projects presented to the Awards for Excellence included:

- The Rural Ophthalmology Outreach Model: making ROOM for equitable access to specialist eye care
- If the mountain doesn't come to you – you go to the mountain; improving Chronic Kidney Disease outcomes in an Aboriginal and Torres Strait Islander population
- Caring for communities, healthier together: how Darling Downs increased participation with alcohol and other drugs services.

Innovative ideas from staff improve processes

This year we asked staff across our health service to share their 'bright ideas' for an innovation, a creative concept, or how we could improve patient care and better deliver services.

A number of ideas were submitted by staff and investigated for implementation. One of the successful ideas resulted from an issue identified in Warwick. Staff at The Oaks Nursing Home saw the need for a cord-saving device for inpatient beds as cords are sometimes damaged when they are caught in bed rails, or run over when being moved. The cost to replace bed cords can be expensive and the 'bright idea' focussed on a flexible rod sleeve that would protect the cords. At $10 for each sleeve, the bright idea has helped save on the replacement of electric bed cords. It is innovations like this coming directly from our workforce that see improvements made to the way care is delivered across the region.

Darling Downs Hospital and Health Service Executive appointed to statewide clinical senate

This year, Executive Director for Allied Health, Annette Scott, was appointed to the Queensland Clinical Senate (QCS), Queensland Health's peak clinician advisory body. The appointment will bring an allied health perspective to planning and prioritising initiatives to be actioned through the senate. The appointment will allow DDHHS the opportunity to be involved in the strategic clinical decision-making and recommendations to Queensland Health about how to deliver the best care statewide.

Queensland know-how showcased with Japanese rural generalists

An international collaboration between Darling Downs Hospital and Health Service and Japan's developing rural generalist program provided the opportunity to contribute to international rural generalist concepts, philosophy and training. The launch of the Queensland-based training rotation for Japanese rural generalists in early 2018 enabled two Japanese doctors to be engaged into rural Queensland as observers in Stanthorpe. Japanese rural generalists receive experiential learning, providing them with first-hand exposure to the inner workings of Queensland rural general practice by accompanying rural medical staff through daily hospital and general practice routines. Feedback from the Japanese rural generalists indicated they greatly benefited from exposure to rural training in Queensland and will use these learnings to enhance their own medical practice and further develop the Japanese rural generalist program.

Junior doctors' support program launched

Queensland Country Practice worked collaboratively with the Australian College of Rural and Remote Medicine (ACRRM) to develop an education framework that will help prepare and support junior doctors for rural practice. The Prevocational Rural Medical Term (PRMT) was created and launched in 2018. Underpinning the importance of safety and supervision within rural terms, a series of five e-modules for junior doctors and a supervisor module was developed. The education framework was made available to all junior doctors participating in the Queensland Country jDocs program irrespective of their future career aspirations. Upon successful completion of the PMRT program, junior doctors receive a certification from ACRRM with the first certificate being issued in June.

Rural Generalist Leadership Program confers first associate fellowships

The Queensland Rural Generalist Program (QRGP), the Royal Australasian College of Medical Administrators (RACMA) and the two Australian general practice training colleges – the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) launched the Rural Generalist Leadership Program which focusses on and aligns to the professional leadership standards of RACMA. It also puts these in context to the rural practice domain of our rural generalists.

This program enables participants to apply for an Associate Fellowship of RACMA with 23 current rural generalists completing this program and being conferred with an Associate Fellowship.

Interns get a taste of rural practice

To increase the opportunity for interns to train and practise rurally, DDHHS through Queensland Country Practice, led a statewide partnership with other hospital and health services, regional training organisations and universities to bid for Commonwealth funding under the Rural Junior Doctor Training Innovation Fund. This application was successful with 30 interns participating in supervised rural general practice.

Early evaluation showed that these interns gained an appreciation of rural general practice and may consider entering rural practice either through the Queensland Rural Generalist Pathway or General Practice Independent Pathway. The introduction of this intern primary-care rotation in Queensland completes the integrated supply strategy from university to vocational practice.

Focus on pressure injury prevention

More than 90 participants attended the "Under pressure - small moves gets results" workshop. This year the workshop included presentations from Queensland University of Technology Professor Fiona Coyer and our own staff on topics including implementation of evidence-based practice to reduce pressure injuries in intensive care units and patient experience.

Strategic Objective 4 - Resources

The management of resources within the health service continues to be challenging with limited funding opportunities and increased demand for services combined with a changing healthcare landscape. This strategic objective has a focus on efficiency and effectiveness along with managing resources and enhancing infrastructure and information communication technology.

DDHHS achieved a balanced budget for the 2017-18 year.

Revenue and expenses – FY ending 30 June 2018	$(000)
Revenue	773,021
Expenses	
Labour and employment	530,100
Non-labour	208,998
Depreciation, impairment and revaluation	29,787
Total	768,885
Net surplus from operations	4,136

How we are funded

Income	$(000)
State contribution	438,601
Commonwealth contribution	222,176
Special Purpose Grants	42,226
Other	70,018
Total	773,021

Funding distribution

	%
Toowoomba	36.30
Rural	27.99
Mental Health	10.89
Other professional and support	20.87
Depreciation	3.94

Expenses breakdown

Expenses	$(000)	%
Employee expenses	530,100	68.94
Supplies and services	200,711	26.10
Grants and subsidies	3,208	0.42
Other expenses	5,079	0.67
Depreciation and expenses	29,787	3.87

Financial outlook

In 2018-19 DDHHS will have a budget of $801.1 million, which is an increase of $39.3 million or 5.2 per cent from the published 2017-18 operating budget of $761.7 million.

Health Technology Equipment Replacement

The Health Technology Replacement program is a statewide rolling program to replace aged and obsolete health technology. The actual spend in 2017-18 for this program was $3,689,151. Major items replaced as part of this program in 2017-18 included:

- inspiration assessment machine, Toowoomba Hospital
- mobile x-ray units for Dalby, Kingaroy, Murgon and Stanthorpe
- colonoscopes and gastroscopes, Kingaroy Hospital
- six dialysis machines, Toowooomba Hospital
- nurse call system, Texas Hospital
- ventilator, Tara Hospital.

Toowoomba Hospital Foundation and other significant donations

There are a number of valued supporters throughout our region who donate money and equipment to our local facilities and are an incredibly valued part of each local community. DDHHS greatly appreciates the support and generous donations received from these parties. Some of the generous donations received throughout 2017-18 are outlined below:

- Our largest supporter in 2017-18, as in previous years, was the Toowoomba Hospital Foundation (THF). The THF supports Toowoomba Hospital and staff by funding projects, equipment and training for our staff. Over $1 million of funding and equipment was donated by the THF in 2017-18, including $500,000 towards the seventh operating theatre.

- Dalby Hospital Auxiliary provided over $5000 of funding and equipment to Dalby Hospital and Karingal Aged Care Facility, including chairs and chair overlays. Dalby Hospital also received a $9,500 cash donation from the Rotary Club.
- Goondiwindi Hospital Auxiliary provided over $7000 worth of funding and equipment to Goondiwindi Hospital.
- Griffith University donated over $100,000 of equipment to the refurbished dental clinic at Kingaroy Hospital.
- Over $8,000 of equipment was donated by the Inglewood Hospital Auxiliary to Inglewood Hospital.
- Miles Hospital Auxiliary made cash donations to Miles Hospital of over $4,500.
- Murgon Hospital received over $25,500 in cash and donations from the Murgon Hospital Auxiliary, including a cash donation for patient chairs and vital signs monitors.
- Texas Hospital Auxiliary provided a $12,000 donation to Texas Hospital.
- A number of individual donations and bequests were also received by facilities within the health service.

Microsoft Office 365

The Office 365 project is delivering an up-to-date Microsoft Office product suite to all Queensland Health staff. It provides benefits such as access to files and applications from both Queensland Health and personal devices, guaranteed most up-to-date versions of Microsoft Office applications, ability to collaborate on files at the same time as colleagues from any place and any device, video and audio conferencing features from the desktop, workflow tools in SharePoint Online, additional means for storing personal work-related files and access within and outside the Queensland Health network through OneDrive, easier sharing of information and applications through access to OneDrive, SharePoint, Skype for Business and Yammer.

DDHHS commenced the rollout in early 2018 and achieved a major milestone in May 2018 by completing the migration of over 2500 workstations from Microsoft Office 2003 to Office 365. This involved a significant amount of preparatory work by DDHHS in identifying, analysing and remediating, where required, every key Microsoft Word, Excel, Powerpoint and Access file used throughout DDHHS. The migration included having DDHHS Champions at each site to support staff during the migrations by being the early adopters and super users in the new product suite.

ieMR

DDHHS is embracing the future of digital healthcare by implementing a fully integrated electronic medical record (ieMR) system at Toowoomba Hospital as part of a broader roll-out across health services in Queensland. The ieMR will promote clinical collaboration between colleagues and partners across the state, improve coordination of patient experiences and support best practice clinical care and research.

The real-time electronic record will consolidate a patient's medical history, allowing clinicians to instantly view information when and where they need to. This digital transformation will be driven by the commitment and teamwork of clinical and business staff and supported by a dedicated project team and change network.

Central Sterilising Department refurbishment

This year a $3.4 million Central Sterilising Department redevelopment project was funded by the Board surplus. This project commenced in January 2016 and practical completion was reached in August 2017. A complete redevelopment of the existing department was undertaken with the procurement and installation of new sterilising equipment. The redevelopment resulted in work efficiencies and also assisted compliance with Australian/New Zealand Standard 4187.

Warwick Emergency Department upgrade

The update to the Warwick Emergency Department is a major infrastructure initiative due for completion in late 2018. This $3 million project, funded through the Board surplus, commenced in April 2018 and will provide critical additional spaces for emergency patient care. Demand for services at the Warwick Emergency Department continues to increase with an average of 60 patients receiving treatment per day.

Upon completion of the upgrade, there will be an additional three treatment bays, four short stay bays and three triage bays, including an ambulance triage bay. The design of the new look Emergency Department was completed in consultation with Warwick Hospital doctors, nurses and other stakeholders to ensure work flow for the treatment of patients was optimised.

Fleet centralisation

Across the 2017-18 financial year, work continued on the establishment of a pooled motor vehicle fleet management model across DDHHS.

This model resulted in overall lease costs being maintained despite the introduction of three additional leased vehicles. Management of lease terms facilitated by a pooled fleet model has resulted in a reduction of potential excess disposal fees of $109,508. Additionally, lease adjustment and extension practices have resulted in a total saving of $88,278.23 across the life of the relevant leases, or $3,601.10 per month.

Biomedical Technology Services on-site

Biomedical Technology Services (BTS) have provided servicing and repair of clinical equipment from their centralised Brisbane location for several years, however, commenced operating from a dedicated workspace at Toowoomba Hospital in April 2018. Benefits to hosting BTS on-site include reduced costs, reduction in amount of time equipment is out of service and increased confidence in preventative maintenance and servicing processes to ensure all equipment used is functioning correctly.

Toowoomba Hospital Kitchen

The new Toowoomba Hospital kitchen was completed in October 2017 and became operational in November 2017. This project was funded by the Department of Health at an approximate cost of $9.78 million. The kitchen was designed for the preparation of patient meals, including climate controlled food preparation areas, but also includes office space and staff amenities. This important infrastructure initiative provides for improved food safety standards, work flow efficiencies and workplace safety.

Kingaroy Hospital re-development

The Minister for Health announced funding of $62 million in the 2017-18 budget towards the redevelopment of Kingaroy Hospital. This important project for the South Burnett, assisting to ensure the future needs of this growing region can be met, commenced in July 2017 and practical completion is due in late 2021.

The project includes the construction of a new hospital on the existing hospital site, refurbishing the existing inpatient unit building as an outpatient department and demolition of the existing hospital.

To date, the significantly large body of design work required for a project of this size has commenced and early works have also been completed; including, for example, demolitions, asbestos removal, storage arrangements, carpark construction and relocation of underground services.

Matron Farr Building

The Matron Farr Building redevelopment in Kingaroy was completed in December 2017 at a cost of $4.64 million. This redevelopment was funded jointly by Griffith University, Queensland Rural Medical Education Limited and Board surplus funds. This new facility houses both dental and community health services.

The redevelopment resulted in an increase in dental capacity from a four chair surgery to a ten chair surgery, as well as increasing training capacity with Griffith University. An additional benefit of the project was the centralisation of community health functions on-site creating ease of access for consumers from Kingaroy and the greater South Burnett region.

Financial System Renewal Program

The Financial System Renewal (FSR) Program is a significant technology transformation initiative providing a contemporary business, finance and logistics solution. Integration of systems and streamlining of processes is a key focus area for the health system, including staff training in change management, finance, asset management, procurement and online accounting. Training in 2017-18 was undertaken in preparation for a more focussed system-based education required in 2018-19. FSR will provide a user-friendly, intuitive and future-proof experience for a more responsive business need into the future.

Theatre 7

Toowoomba Hospital's seventh operating theatre was designed in consultation with surgical teams and constructed to allow for additional theatre capacity as the previous six operating theatres were at capacity. The $2.65 million project to repurpose an existing storage area and staff tea room has resulted in a state-of-the-art operating space and has enabled more patients to access elective surgeries at the Toowoomba Hospital. The new theatre was funded internally and included almost $500,000 from the Toowoomba Hospital Foundation for furniture, fittings and equipment.

This project commenced in July 2017 and was completed in October 2017, with the first procedure taking place on 6 November 2017.

Strategic Objective 5 - Planning

DDHHS continues to improve our planning processes to ensure we are well placed to provide efficient and effective health services into the future. Planning in our health service includes planning to meet demand for services, managing disasters and emergency management and considering the future impacts of climate change and sustainability.

Emergency Management Health Service Directive

DDHHS has developed a number of new plans to meet the requirements of the Health Service Directive 003:2017 Disasters and Emergency Incidents. These include a new:

- Disaster, Emergency and Continuity Management Plan
- Pandemic Influenza Sub-Plan
- Heatwave Sub-Plan
- Chemical, Biological and Radiological Response Sub-Plan.

These plans address routine prevention and preparedness activities, as well as the response to and recovery from any emergencies that do occur.

DDHHS has also made a number of improvements to business continuity arrangements, to ensure that critical services can continue to operate in the event of infrastructure outages, loss of building access or other business disruptions. These arrangements will continue to be developed in the 2018-19 financial year, including series of drills and exercises to validate the level of preparedness in critical areas.

Operational Planning

Following the establishment of the Strategy and Planning team in April 2017, a renewed focus on effective, integrated planning was implemented for the 2017-18 period. Divisional operational plans were prepared in consultation with the Strategy and Planning team and a DDHHS-wide operational plan was developed, with clear monitoring and reporting processes established.

Initiatives identified in the operational plans aligned with the strategic objectives of the organisation while also functioning to assist in mitigating strategic or organisational risks or contributing to the development of strategic opportunities. Quarterly Executive meetings were held to report on progress of initiatives included in the DDHHS-wide operational plan and the plan was managed as a 'live' document to ensure effective prioritisation of initiatives as the year progressed.

A total of 46 initiatives were completed over the twelve month period, contributing greatly to the realisation of our strategic objectives.

Planning for the future

As part of future planning for the healthcare needs of the Darling Downs community, drafting of the Health Service Plan 2018 – 2028 has commenced to assist with planning for the next ten years of health service delivery for the region. A number of community engagement sessions were held across the Darling Downs to hear from our consumers what services will best suit the communities' needs into the future. Staff workshops were also held at a range of facilities to hear from staff on the health services we provide and current and future challenges.

Further, the Queensland Treasury Corporation was engaged to complete an integrated business plan (including a report and forecast model) with a five year outlook, outlining predicted future activity and expenditure to support funding decisions and enable improved planning over that period. Both the Health Service Plan and the forecasting model will be utilised to undertake effective medium and long-term planning to ensure the future needs of the community can be met.

Climate Change planning

A strong commitment to investigating the potential effects of climate change on the health service and the Darling Downs community has been made in the 2017-18 period, with a view to extended planning in the community and environmental sustainability area to be undertaken over the next financial year.

This year, DDHHS contributed to the planning of the Queensland Health and Wellbeing Climate Adaptation Plan through its participation in forums held by the National Climate Change Adaptation Research Facility and Climate and Health Alliance. Further, to more clearly understand the potential impact of climate change on our ability to provide services and the potential changing needs of the community, a climate change risk assessment was undertaken and will underpin planning activities in this focus area for the 2018-19 year.

Total Asset Management Plan

DDHHS participates in the Total Asset Management Plan (TAMP) process, a whole-of-government framework that seeks to ensure assets are strategically planned to ensure optimal service delivery. This thorough infrastructure and asset management process provides for appropriate planning to ensure facilities are able to provide effective clinical services for our communities.

The 2017-18 TAMP was finalised detailing the long-term infrastructure plans for DDHHS. The TAMP identified the new Kingaroy Hospital as the highest priority for the health service. Infrastructure for all facilities were reviewed as part of the planning process and a full detailed infrastructure plan was endorsed by the Board in October 2017.

Infrastructure Condition Assessment

During 2017-18 building condition assessments were undertaken at Warwick, Goondiwindi, Inglewood, Millmerran, Stanthorpe and Texas hospitals as part of a three-year rolling program.

Identified condition-based maintenance works at those sites totalled $32,691,206. Details of these works have been included in the maintenance systems and work is continuing to identify works that can progress immediately within the existing maintenance budget and those that will be completed as part of future works. This program will continue in 2018-19 in the Toowoomba and South Burnett areas of the health service.

▲ *Planning for infrastructure improvements to deliver the best healthcare for our communities continued.*

Patient Travel Subsidy Scheme improvement initiatives

In the 2016-17 Annual Report, DDHHS reported on the Patient Travel Subsidy Scheme Service Improvement report and its 16 key recommendations. At that time, 10 of the recommendations had been completed and plans for a software solution had commenced.

In 2017-18, the final six key recommendations were completed. Central to the improvement of the management of patient travel claims is the introduction of the Patient Travel Information Management System (PTIMS). PTIMS is being rolled out across the state to streamline and enhance functionality of the scheme and DDHHS is one of the first health services in the state to commence PTIMS training.

Strategic Objective 6 - Workforce

During 2017-18, there was a renewed focus on the culture of our organisation and living our shared vision and values. Included in this strategic objective are considerations for future recruitment and challenges in our workforce and the support and development of our current managers and future leaders throughout the organisation.

Vision and Values launch

Vision

Caring for our communities: Healthier Together

Values

Compassion, Integrity, Dignity, Innovation, Courage

In July 2017, DDHHS launched its new vision and values with simultaneous events held across the health service's facilities. The launch events were the commencement of a commitment to embedding the vision and values throughout the health service. Following the launch, further activities included a 'value of the month' campaign, posters outlining guiding principles and key behaviours, tip sheets and other promotional and supporting materials. Videos featuring the Executive Team and other 'champions' across the health service discussing each value and its importance within the workplace were also created. The importance of our values has also been demonstrated through their inclusion in both recruitment and performance and development processes.

Strategic Workforce Planning

The DDHHS Strategic Workforce Plan applies the Public Service Commission's whole of government strategic workforce planning framework and four key strategies:

- Align
- Profile
- Transition
- Review.

Workforce planning within DDHHS aims to identify critical skills gaps, integrate plans and planning cycles and develop initiatives to address workforce supply and demand. It also includes the implementation of strategies to deal with diversity, talent management and planning for attraction, succession and retention.

Wellness Program

The wellness program for DDHHS was launched in May 2017 and has been developed to provide staff with an integrated healthy lifestyle and wellbeing strategy to make informed healthy lifestyle choices. The program covers a broad range of wellness topics covering physical, emotional and financial wellbeing.

Staff have a range of information and supports available to them including an internal webpage with information and resources for healthy eating and physical, emotional, financial, social, cultural and spiritual wellbeing. A staff wellness Facebook group has also been established and by joining the group, staff can access current wellness events, participate in discussions and access information on how to incorporate healthy choices into their lifestyle.

Major events for 2017-18 included:

Peak2Park

The annual Peak2Park event was held in Toowoomba on Sunday, 4 March 2018. DDHHS fully funded individual entry fees for all employees who participated in the event. Every staff member and any of their family members who also participated received a free DDHHS Wellness shirt to wear during the event.

A total of 137 staff and 52 family members participated in the event this year.

Wellness Challenge

The 'Your lifestyle, Your food, Your choice' wellness challenge was conducted between 16 April and 29 June 2018 and was open to all staff and their immediate family members. The aim of the challenge was to increase awareness of healthy eating and for participants to increase their vegetable and whole food consumption.

Staff and their families were provided with a choice of three healthy eating styles and asked to choose the one they believed would fit with their lifestyle goals and food preferences to commit to for a four week challenge. A total of 321 staff members and their families registered for the challenge. There were incentives on offer for staff including the covering of online membership costs as well as exercise trackers and wellness merchandise. Following the challenge, 95 per cent of staff who completed the evaluation indicated they intended to continue with their chosen eating style and the participants rated the program an average of 4.31 out of 5 overall. Many testimonials were received from participants who showed great appreciation for the support received to undertake the challenge and for the health service valuing staff health and well being.

Other wellness activities undertaken throughout the health service during the year included:

- incorporating movement into daily life
- general information sharing and resources on diet, exercise and other lifestyle factors
- new tennis nets at Baillie Henderson Hospital for use by patients and staff
- gyms and fitness centres offering discounts to staff
- staff holding healthy morning teas
- wellness choir at Toowoomba Hospital
- after work jogging group at Kingaroy Hospital
- Toowoomba Hospital Foundation float for the Carnival of Flowers – wellness walkers
- planking challenges
- weight loss challenge.

Graduate nurse and midwifery program

Recruitment processes in 2017-18 were focused on providing graduate nursing and midwifery appointments in Toowoomba as well as appointments in large and small connected rural facilities in the Southern Downs, Western Downs and South Burnett regions.

In March 2018, 59 nurses and eight midwives fulfilled all requirements of the 2017 Graduate Program and received their certificates. Approximately 75 per cent of these graduates were retained in the health service.

Since March 2018, DDHHS has recruited 81 graduate nurses and 18 midwives into the DDHHS Nursing and Midwifery Graduate Program.

The structured graduate pathway model of placement was supported in 2017-18 with the implementation of Clinical Facilitator positions into rural areas.

This new initiative has provided excellent results in supporting graduates to complete requirements of the program. A Clinical Facilitator model was implemented to ensure graduate placements were rewarding for the graduates, and beneficial for the organisation. They also provided graduates with the support required while transitioning into the role of registered nurse with appropriate skills, knowledge and attitudes to work effectively with patients across the continuum of care.

Resident Guide app

Toowoomba Hospital was the first in Queensland to utilise an innovative app which is helping young doctors navigate their way through the first years of residency. The app provides a digital support and efficiency tool for junior doctors and provides them with a quick understanding of their new roles and responsibilities, handover tips, protocols and prescribing guidelines. The aim of introducing the app is to nurture and support our junior doctors through reducing stress by having information available at their fingertips, particularly during busy shifts.

Nursing & Midwifery Professional Practice model

The DDHHS Nurses and Midwives Professional Practice Model was launched at International Nurses' Day celebrations held on 10 May 2018. The Professional Practice Model, developed by DDHHS nursing and midwifery representatives, prioritises, aligns and guides the quality improvement work to be undertaken in our mission of creating positive health and wellbeing outcomes for the community.

The model symbolises and communicates the two professions' collective beliefs, values, systems and elements of practice that will enable person-centeredness. It provides nurses and midwives with the structural empowerment to collectively address and design solutions for clinical and professional issues impacting the two professions.

Alongside the launch of the Professional Practice Model was the supporting publication 'Our Commitment to Caring' which communicates the values of our nursing and midwifery staff and a philosophy of caring. The publication outlines the actions and behaviours identified by our nurses and midwives that demonstrate core values and contribute to building a reputation for professionalism and excellence.

Domestic & Family Violence information and training

An internal domestic and family violence webpage was developed to provide appropriate information and support tools for staff responding to a patient or client experiencing domestic or family violence. The webpage provides a wealth of internal information and resources as well as details for external specialised services.

The social work team also rolled out 'train the trainer' sessions as part of recommendations laid out in the 'Not Now Not Ever' report. The trainers will support frontline staff to respond appropriately to situations relating to domestic and family violence.

Employee awards

The 2017 DDHHS Employee Awards showcased the work undertaken by staff throughout the service in living the vision and values of the organisation. The 2017 awards marked the fourth year the awards have been held but the first year under the new vision and values. There were a total of 57 nominations under the vision and values, with a further eight across the research and volunteer sections. Winners are outlined below.

- Vision – Donella Swanton (Work Health and Safety Advisor, Workforce Division)
- Compassion – Amanda Hutchings (Senior Environmental Health Officer, Darling Downs Public Health Unit
- Integrity – Kerryanne Maddox (Nurse Unit Manager, Midwifery and Child Health, Goondiwindi Hospital)
- Dignity – Julie Westaway (Urogynaecology Nurse Practitioner, Toowoomba Hospital)
- Innovation – Jess Birt (Graphic Design and Publishing Officer, Media and Communications Unit)
- Courage – Feena Enfantie (Advanced Cardiac Scientist, Toowoomba Hospital)
- Research (Novice) – Dr Alex King (Emergency Department Staff Specialist)
- Research (Advanced) – Linda Furness (Occupational Therapy Clinical Education Support Officer)
- Volunteer (Quiet Achiever) – Graham Bayliss (Jehovah's Witness Hospital Liaison Officer)
- Volunteer (Commitment) – Lois Williams (Volunteer Courier Service).

Diversity and Inclusion Action Plan

The Diversity and Inclusion Action Plan provides local implementation of the Queensland Health Workforce Diversity and Inclusion Strategy 2017-22. A local diversity and inclusion community of practice has been established to be visible and vocal advocates for inclusion and diversity throughout the health service, share expertise and drive and monitor implementation of the action plan.

63.7%
Equal Employment Opportunity survey completion rate

2.13%
Aboriginal and Torres Strait Islander staff

80%
Female employees

2.05%
People with a disability

6 of 9
Board members are female. Five of the 11 Executive staff are female

6.34%
People from a non-english speaking background

Pulse survey check-in

Following the workplace culture survey conducted in February 2017, a short follow-up survey on three key questions was undertaken in 2018 to assist in determining the effectiveness of activities undertaken post the initial survey to improve the culture of the organisation.

The results of the survey indicated an upwards trend for each of the three questions. When asked whether they felt DDHHS was a 'truly great place to work', 74 per cent of staff responded in the positive, an increase of 20 per cent on the previous survey. Regarding whether staff members would recommend the organisation to a friend or family member as a good place to work, results indicated a net promotor score of +16, a substantial increase from the 2017 result of -6.0. The third question in the check-in survey asked staff whether they would recommend DDHHS as the best choice if they required the type of services provided. In this regard, the results demonstrated a significant improvement in results with an increase in net promotor score from +9.5 to +23.9.

A full staff survey will be conducted in early 2019 to gain a thorough understanding on how staff feel the organisation is progressing with culture improvement. In the interim, the Workforce Capability, Culture and Engagement team is offering positive culture workshops to highlight the benefits of positive culture, build an awareness of appropriate behaviours in line with the DDHHS vision and values, improve staff engagement and increase individual and team accountability to ensure future success.

Management and leadership development

The Management Development Program commenced in the 2016-17 financial year, with one cohort of staff undertaking the program. MDP aims to provide managers with training that will build their confidence and competence as effective managers and supports our managers to work in alignment with organisational values and to build cultures of engagement and excellence. The program had its first full year of operation in 2017-18 with 110 participants over nine cohorts. Participants in the program each have a mentor who plays a critical role in supporting and challenging the participant as they translate their learning from the program into their everyday practice.

At the completion of the program, each participant presents an innovative idea to the Executive Team. A number of these initiatives have been implemented in the health service.

In 2018-19, the Leadership Excellence Program will commence within DDHHS. This program is a nine month program created to build and enhance leadership capability within DDHHS and to address the development needs of our leaders. The content of the program is aligned with the Leadership Capability Framework and focuses on developing the participants' emotional intelligence to improve their impact, influence, leadership and resilience.

The new Management Development Program started with the first group of our staff (pictured) completing the training.

Glossary of terms

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 required 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 Assessment Team (ACAT)	ACAT 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).
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.

Glossary of terms

Term	Meaning
Block funding	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.
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.
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.
Closing the Gap	A government strategy that aims to reduce disadvantage among Aboriginal and Torres Strait Islander people with respect to life expectancy, child mortality, access to early childhood education, educational achievement, and employment outcomes
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.
Consumer Advisory Council	Formal advisory body to provide advice to DDHHS and to 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 in Queensland, and works in partnership with Hospital and Health Services to ensure the public health system delivers high-quality hospital and other health services.
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.
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.

Term	Meaning
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.
Haemodialysis	Commonly called kidney dialysis or simply dialysis, is a process of purifying the blood of a person whose kidneys are not working normally.
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.
Minimum Obligatory Human Resource Information (MOHRI)	MOHRI is a whole of Government methodology for producing an Occupied Full-time Equivalent (FTE) and headcount value sourced from the Queensland Health payroll system data for reporting and monitoring.
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.

Glossary of terms

Term	Meaning
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.
Occasion of service	Any examination, consultation, treatment or other service provided to a patient
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 tumours.
Ophthalmology	Consultation, assessment, review, treatment and management of conditions relating to eye disorders and vision, and services associated with surgery to the eye.
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 (e.g. 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.
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.

Term	Meaning
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 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.
Safety and Reliability Improvement Partners	Safety and Reliability Improvement Partners are an exclusive group of healthcare organisations, led by the Cognitive Institute, committed to a quantum leap in the delivery of safer and reliable healthcare.
Separation	The process by which an episode of care for an admitted patient ceases. A separation may be formal or statistical.
Service Delivery Statement (SDS)	Service Delivery Statements provide budgeted financial and non-financial information for the Budget year; https://www.treasury.qld.gov.au/resource/service-delivery-statements/
Statutory bodies/ authorities	A non-departmental government body, established under an Act of Parliament.
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.
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 (WAU)	A single standard unit used to measure all activity consistently.
WOOS	Weighted occasions of service.

Compliance checklist

Summary of Requirement		Basis for requirement	Annual report reference
Letter of compliance	• A letter of compliance from the accountable officer or statutory body to the relevant Minister	ARRs – section 7	1
Accessibility	• Table of contents	ARRs – section 9.1	2-3
	• Glossary	ARRs – section 9.1	61-66
	• Public availability	ARRs – section 9.2	Inside cover
	• Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 9.3	Inside cover
	• Copyright notice	*Copyright Act 1968* ARRs – section 9.4	Inside cover
	• Information licensing	*QGEA – Information licensing* ARRs – section 9.5	Inside cover
General information	• Introductory Information	ARRs – section 10.1	4-6
	• Agency role and main functions	ARRs – section 10.2	6-10
	• Machinery of Government changes	ARRs – section 31 and 32	Not applicable
	• Operating environment	ARRs – section 10.3	8, 11, 28-30
Non-financial performance	• Government objectives for the community	ARRs – section 11.1	10
	• Other whole-of-government plans/ specific initiatives	ARRs – section 11.2	10, 38, 46
	• Agency objectives and performance indicators	ARRs – section 11.3	10-11, 38-60
	• Agency service areas and service standards	ARRs – section 11.4	38-60
Financial performance	• Summary of financial performance	ARRs – section 12.1	52-53

Governance – management and structure	• Organisational structure	ARRs – section 13.1	28-29
	• Executive management	ARRs – section 13.2	12-18, 21-27, 30
	• Government bodies (statutory bodies and other entities)	ARRs – section 13.3	12-20
	• Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* ARRs – section 13.4	32
	• Queensland public service values	ARRs – section 13.5	32
Governance – risk management and accountability	• Risk management	ARRs – section 14.1	11, 18, 30, 32
	• Audit committee	ARRs – section 14.2	18
	• Internal Audit	ARRs – section 14.3	30, 32
	• External Scrutiny	ARRs – section 14.4	33
	• Information systems and recordkeeping	ARRs – section 14.5	33
Governance – human resources	• Workforce planning, and performance	ARRs – section 15.1	31-32, 57-60
	• Early retirement, redundancy and retrenchment	Directive No.11/12 *Early Retirement, Redundancy and Retrenchment* Directive No.16/16 *Early Retirement, Redundancy and Retrenchment* (from 20 May 2016) ARRs – section 15.2	32
Open Data	• Statement advising publication of information	ARRs – section 16	Inside cover
	• Consultancies	ARRs – section 33.1	https://data.qld.gov.au
	• Overseas travel	ARRs – section 33.2	https://data.qld.gov.au
	• Queensland Language Services Policy	ARRs – section 33.3	https://data.qld.gov.au
Financial statements	• Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 17.1	112
	• Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 17.2	113

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 2018

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Consolidated Financial Statements
for the year ended 30 June 2018

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 which is the ultimate parent entity.

The principal address of the Darling Downs Hospital and Health Service 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 the DDHHS 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 2018

	Notes	2018 $'000	2017 $'000
OPERATING RESULT			
Income from continuing operations			
User charges and fees	4	726,670	690,638
Grants and other contributions	5	42,226	32,200
Interest		431	346
Other revenue		2,927	2,872
Total revenue		**772,254**	**726,056**
Gains on disposal/revaluation of assets		767	43
Total income from continuing operations		**773,021**	**726,099**
Expenses from continuing operations			
Employee expenses	6	77,462	71,508
Health service employee expenses	7	452,638	425,756
Supplies and services	8	200,711	200,361
Grants and subsidies		3,208	2,992
Depreciation and amortisation	13	29,787	20,945
Impairment losses		903	618
Loss on revaluation of non-current assets		-	1,754
Other expenses	9	4,176	2,127
Total expenses from continuing operations		**768,885**	**726,061**
Operating result from continuing operations		**4,136**	**38**
OTHER COMPREHENSIVE INCOME			
Items not reclassified to operating result			
Increase/(decrease) in asset revaluation surplus		10,923	71,872
Total items not reclassified to operating result		**10,923**	**71,872**
Total other comprehensive income		**10,923**	**71,872**
TOTAL COMPREHENSIVE INCOME		**15,059**	**71,910**

The accompanying notes form part of these financial statements

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Statement of Financial Position
as at 30 June 2018

	Notes	2018 $'000	2017 $'000
Current assets			
Cash and cash equivalents	10	60,598	52,848
Receivables	11	13,365	24,682
Inventories	12	6,465	6,282
Other current assets		1,007	1,680
Total current assets		**81,435**	**85,492**
Non-current assets			
Property, plant and equipment	13	401,183	385,225
Intangible assets		435	131
Other non-current assets		41	14
Total non-current assets		**401,659**	**385,370**
Total assets		**483,094**	**470,862**
Current liabilities			
Payables	14	37,932	32,645
Accrued employee benefits		2,704	2,482
Unearned revenue		223	287
Total current liabilities		**40,859**	**35,414**
Total liabilities		**40,859**	**35,414**
Net assets		**442,235**	**435,448**
Equity			
Contributed equity	15	280,253	288,525
Accumulated surplus/(deficit)		59,720	55,584
Asset revaluation surplus	16	102,262	91,339
Total equity		**442,235**	**435,448**

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 2018

	Notes	*Contributed Equity* *$'000*	*Accumulated Surplus/ (Deficit)* *$'000*	*Asset Revaluation Surplus* *$'000*	*Total* *$'000*
Balance as at 1 July 2016		**288,060**	**55,546**	**19,467**	**363,073**
Operating result from continuing operations		-	38	-	38
Other comprehensive income					
Increase/(decrease) in asset revaluation surplus		-	-	71,872	71,872
Total comprehensive income for the year		**-**	**38**	**71,872**	**71,910**
Transactions with owners as owners					
Net assets received / (transferred) during year		15	-	-	15
Non appropriated equity injections (minor capital works)		21,395	-	-	21,395
Non appropriated equity withdrawals (depreciation funding)		(20,945)	-	-	(20,945)
Total transactions with owners as owners		**465**	**-**	**-**	**465**
Balance as at 30 June 2017		**288,525**	**55,584**	**91,339**	**435,448**
Balance as at 1 July 2017		**288,525**	**55,584**	**91,339**	**435,448**
Operating result from continuing operations		-	4,136	-	4,136
Other comprehensive income					
Increase/(decrease) in asset revaluation surplus		-	-	10,923	10,923
Total comprehensive income for the year		**-**	**4,136**	**10,923**	**15,059**
Transactions with owners as owners					
Net assets received / (transferred) during year	15	7,816	-	-	7,816
Non appropriated equity injections (minor capital works)		13,699	-	-	13,699
Non appropriated equity withdrawals (depreciation funding)		(29,787)	-	-	(29,787)
Total transactions with owners as owners		**(8,272)**	**-**	**-**	**(8,272)**
Balance as at 30 June 2018		**280,253**	**59,720**	**102,262**	**442,235**

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 2018

	Notes	2018 $'000	2017 $'000
Cash flows from operating activities			
Inflows:			
User charges and fees		709,711	660,415
Grants and other contributions		34,404	31,990
Interest receipts		431	346
GST input tax credits from ATO		11,880	11,764
GST collected from customers		497	571
Other		-	2,872
Total cash provided by operating activities		**756,923**	**707,958**
Outflows:			
Employee expenses		77,240	71,285
Health service employee expenses		451,485	423,236
Supplies and services		188,323	204,544
Grants and subsidies		3,208	2,980
GST paid to suppliers		10,983	12,736
GST remitted to ATO		550	526
Other		4,660	2,047
Total cash used in operating activities		**736,449**	**717,354**
Net cash provided by / (used in) operating activities[1]		**20,474**	**(9,396)**
Cash flows from investing activities			
Inflows:			
Sales of property, plant and equipment		61	65
Total cash provided by investing activities		**61**	**65**
Outflows:			
Payments for property, plant and equipment		26,484	37,927
Total cash used in investing activities		**26,484**	**37,927**
Net cash provided by / (used in) investing activities		**(26,423)**	**(37,862)**
Cash flows from financing activities			
Inflows:			
Proceeds from equity injections		13,699	21,395
Total cash provided by financing activities		**13,699**	**21,395**
Net cash provided by / (used in) financing activities[2]		**13,699**	**21,395**
Net increase (decrease) in cash and cash equivalents		**7,750**	**(25,863)**
Cash and cash equivalents at beginning of financial year		52,848	78,711
Cash and cash equivalents at end of financial year	10	**60,598**	**52,848**

[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*

[2] DDHHS does not have any liabilities arising from financing activities in the *Statement of Financial Position* .

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 2018

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

	2018	*2017*
	$'000	*$'000*
Operating result from continuing operations	4,136	38
Non-cash items included in operating result		
Depreciation and amortisation	29,787	20,945
Depreciation grant funding	(29,787)	(20,945)
Net gain on revaluation of non-current assets	(750)	-
Net loss on revaluation of non-current assets	-	1,754
Net (gain)/loss on disposal of non-current assets	94	36
Assets donated revenue	(230)	(19)
Change in assets and liabilities		
(Increase)/decrease in trade receivables	1,272	(1,613)
(Increase)/decrease in GST input tax credits receivable	898	(973)
(Increase)/decrease in inventories	(183)	462
(Increase)/decrease in other assets	646	(653)
(Increase)/decrease in other receivables	9,200	(7,578)
Increase/(decrease) in trade payables	1,470	(752)
Increase/(decrease) in accrued employee benefits	222	223
Increase/(decrease) in GST input tax credits payable	(53)	46
Increase/(decrease) in unearned revenue	(64)	221
Increase/(decrease) in other payables	3,816	(588)
Net cash provided by / (used in) operating activities	**20,474**	**(9,396)**

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Notes to the Financial Statements
for the year ended 30 June 2018

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DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Notes to the Financial Statements
For the year ended 30 June 2018

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. Basis of financial statement preparation

(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 with Queensland Treasury's Minimum Reporting Requirements for reporting periods beginning on or after 1 July 2017, 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, or when DDHHS does not have an unconditional right to defer settlement to beyond 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 17).

2. Basis of financial statement preparation (continued)

(d) Taxation

DDHHS is exempt from Commonwealth taxation with the exception of 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.

DDHHS, other Hospital and Health Services (HHS's) and DoH satisfy section 149-25(e) of the *A New Tax System (Goods and Services) Act 1999 (Cth)* (the GST Act). Consequently these entities are part of 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

DDHHS did not voluntarily change any of its accounting policies during the year. In addition, no Australian Accounting Standards have been early adopted in the current period.

AASB 2016-2 Amendments to Australian Accounting Standards - Disclosure Initiative: Amendments to AASB 107 became effective this current reporting period. This Standard requires additional disclosures to allow users to understand changes in liabilities arising from financing activities. DDHHS currently does not have any liabilities arising from financing activities and as such there is no impact to the notes to the Statement of Cash Flows.

The Australian Accounting Standards Board (AASB) has issued new and revised Accounting Standards and Interpretations that have mandatory application dates in future reporting periods. The expected impact of these Standards are set out below:

AASB 9 Financial Instruments and AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 *(December 2014)* will first apply to DDHHS's financial statements for 2018-19 with a 1 July 2018 date of transition. 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 introduces different criteria for whether financial assets can be measured at amortised cost or fair value.

DDHHS has reviewed the impact of AASB 9 on the classification and measurement of its financial assets, and determined:

- There will be no change to either the classification or valuation of the cash and cash equivalent item;
- Trade receivables will be classified and measured at amortised cost, similar to the current classification of loans and receivables. DDHHS will be adopting the simplified approach under AASB 9 and measure lifetime expected losses on all trade receivables using a provision matrix approach as a practical expedient to measure the impairment provision. This is consistent with the current approach utilised by the DDHHS in determining the impairment of its receivables;
- Consistent with current practice, DDHHS will not raise an additional impairment for trade receivables owing from other Government agencies due to the low credit risk (high quality credit rating) for the State of Queensland;
- Trade payables will continue to be measured at amortised cost.

DDHHS will not need to restate comparative figures for financial instruments on adopting AASB 9, however a number of new or changed disclosure requirements will apply. Assuming no change in the types of financial instruments that DDHHS enters into, the most likely ongoing disclosure impacts are expected to relate to the credit risk of financial assets subject to impairment.

AASB 1058 Income from Not-for-Profit Entities and *AASB 15 Revenue from Contracts with Customers* will first apply to DDHHS's financial statements for 2019-20. DDHHS has commenced analysing the new revenue recognition requirements under these standards but is yet to form conclusions about significant impacts. Potential future impacts identifiable at the date of this report are as follows:

- Under the new standards, other grants presently recognised as revenue upfront may be eligible to be recognised as revenue progressively as the associated performance obligations are satisfied, but only if the associated performance obligations are enforceable and sufficiently specific. DDHHS is yet to evaluate the existing grant arrangements to determine whether revenue from those grants could be deferred under the new requirements;

3. New and revised accounting standards (continued)

- Grants that are not enforceable and/or not sufficiently specific will not qualify for deferral, and continue to be recognised as revenue as soon as they are controlled. DDHHS receives several grants for which there are no sufficiently specific performance obligations, so these grants are expected to continue being recognised as revenue upfront, assuming no change to the current grant arrangements;
- Depending on the respective contractual terms, the new requirements may potentially result in a change to the timing of revenue 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 performance obligations (such amounts would be reported as a liability in the meantime). DDHHS is yet to complete its analysis of existing arrangements but at this stage does not expect a significant impact on its present accounting practices; and
- A range of new disclosures will also be required by the new standards in respect of DDHHS's revenue.

AASB 16 Leases will first apply to DDHHS's financial statements for 2019-20. 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 Leases* 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 of low value.

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, it is likely that there will be an 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 depreciation 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.

Queensland Treasury has indicated it intends to mandate a number of practical expediencies and exemptions as follows:

- DDHHS will not have to reassess whether existing contracts contain a lease. Contracts that were leases under AASB 117 will continue to be accounted for as leases under AASB 16 on transition, and contracts that were not leases will continue to not be accounted for as leases. The new criteria in AASB 16 for identifying a lease will be applied for all new leases and lease modifications from the date of initial application;
- DDHHS will not need to restate comparative figures in the 2019-20 financial statements. 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; and
- DDHHS will not need to recognise leases of low value assets where the value of the asset when new is less than AUD $10,000.

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 requirements.

Lessor accounting under AASB 16 remains largely unchanged from AASB 117. For finance leases, the lessor recognises a receivable equal to the net investment in the lease. Lease receipts from operating leases are recognised as income either on a straight-line basis or another systematic basis where appropriate.

AASB 1059 Service Concession Arrangements: Grantors will first apply to DDHHS's financial statements in 2019-20. This standard defines service concession arrangements and applies a new control concept to the recognition of service concession assets and related liabilities. DDHHS is currently reviewing its contractual arrangements to determine the applicability of this standard to those arrangements.

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

	2018	2017
	$'000	$'000
Government funding		
State	298,713	304,915
Commonwealth	222,176	192,338
Other	139,888	123,227
Hospital fees	28,068	27,692
Pharmaceutical benefits scheme reimbursement	28,466	36,195
Sales of goods and services	6,185	2,900
Outsourced service delivery	3,070	3,273
Other user charges - rental income	104	98
Total user charges and fees	**726,670**	**690,638**

User charges and fees primarily comprises DoH funding, hospital fees (private patients), reimbursement of pharmaceutical benefits, and sales of goods and services.

The DoH receives its revenue for funding from the Queensland Government (majority of funding) and the Commonwealth Government. The funding from DoH is provided predominantly for specific public health services purchased by DoH from DDHHS in accordance with a service agreement between the parties. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by DDHHS. The funding is based on the agreed number of activities per the service agreement and a state-wide price by which relevant activities are funded.

The funding from DoH is received fortnightly in advance. DDHHS recognises revenue when the agreed number of activities per the service agreement have been delivered. 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 with a sufficient degree of certainty. This involves either invoicing for related goods / services and/or the recognition of accrued revenue.

Outsourced service delivery comprises revenue received from other Queensland Government Departments which have engaged DDHHS to deliver specific services that those departments would otherwise be required to deliver.

Under the Pharmaceutical Benefits Scheme (PBS), the Australian Government subsidises the cost of a wide range of necessary prescription medicines for most medical conditions. In 2002, Queensland Health entered into an agreement with the Australian Government to allow hospital patients (who are being discharged, attending outpatient clinics or are day-admitted to receive chemotherapy treatment) access to medicines listed on the PBS at subsidised prices. Patients are invoiced at the reduced PBS rate and DDHHS pharmacies lodge monthly claims for co-payments through the PBS arrangement at which time the revenue is recognised.

5. Grants and other contributions

	2018	2017
	$'000	$'000
Nursing home grants	15,955	17,094
Home and community care grants	6,444	6,356
Other specific purpose grants	9,550	6,832
Corporate support services received from DoH	7,869	-
Other grants and donations	2,408	1,918
Total grants and other contributions	**42,226**	**32,200**

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 only recognised if the services would have been purchased had they 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.

5. Grants and other contributions (continued)

DDHHS receives corporate support 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. The fair value of these services is listed above. A corresponding expense is recognised in Supplies and Services in the Statement of Comprehensive Income.

6. Employee expenses

	2018	*2017*
	$'000	*$'000*
Wages and salaries	65,548	60,457
Annual leave levy	4,601	4,232
Employer superannuation contributions	4,916	4,602
Long service leave levy	1,428	1,333
Redundancies and termination payments	118	78
Other employee related expenses	851	806
Total employee expenses	**77,462**	**71,508**

Under section 20 of the *Hospital and Health Boards Act 2011* a Hospital and Health Service (HHS) can employ health executives and contracted senior health service employees, including Senior Medical Officers (SMO) and Visiting Medical Officers (VMO). 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 and VMO, 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 is 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:

	2018	*2017*
Number of employees (full time equivalents) as at 30 June	**179.7**	**183.9**

(a) Wages and Salaries

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.

(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.

6. Employee expenses (continued)

(d) Annual and long service leave levy (continued)

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

Post-employment benefits for superannuation are provided through defined contribution (accumulation) plans or the Queensland Government's QSuper defined benefit plan as determined by the employee's conditions of employment.

i) Defined Contribution (Accumulation) Plans

Contributions are made to eligible complying superannuation funds based on the rates specified in the relevant EBA or other conditions of employment. Contributions are expensed when they are paid or become payable following completion of the employee's service each pay period. Effective from 1 July 2017, Board Members, Visiting Medical Officers, and employees can choose their superannuation provider, and DDHHS pays contributions into complying superannuation funds.

ii) Defined Benefit Plan

The liability for defined benefits is held on a whole-of-government basis and reported in those financial statements pursuant to *AASB 1049 Whole of Government and General Government Sector Financial Reporting.* The amount of contributions for defined benefit plan obligations is based upon the rates determined by the Treasurer on the advice of the State Actuary. Contributions are paid by DDHHS to QSuper at the specified rate following completion of the employee's service each pay period. DDHHS's obligations are limited to those contributions paid.

(f) Key management personnel and remuneration

Key management personnel and remuneration disclosures are detailed in note 25. 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 and VMO, 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 4,215 full-time equivalent (FTE) persons (2017: 4,031 FTE), as calculated by reference to the minimum obligatory human resources information (MOHRI).

8. Supplies and services

	2018 $'000	2017 $'000
Clinical supplies and services	28,990	27,733
Pharmaceuticals	35,425	41,480
Consultants and contractors	15,483	17,108
Outsourced service delivery contracts (clinical services)	15,544	16,278
Repairs and maintenance	12,143	18,925
Pathology and laboratory supplies	13,970	12,951
Catering and domestic supplies	11,110	11,283
Corporate support services from DoH	7,869	-
Other health service employee related expenses	3,113	2,330
Patient travel	9,840	9,674
Computer services and communications	10,378	9,319
Inter-entity supplies (paid to DoH)	8,493	7,907
Water and utility costs	7,995	7,701
Insurance premiums (paid to DoH)	6,817	6,276
Operating lease rentals	2,566	2,633
Minor works, including plant and equipment	2,745	2,281
Other travel	2,137	1,822
Building services	1,393	1,398
Motor vehicles	718	677
Other supplies and services	3,982	2,585
Total supplies and services	**200,711**	**200,361**

(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

The audit fee of $201,650 (2017: $200,000) relates to the audit of the financial statements.

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 $25K (2017: $124K) were made during the period.

Special payments during 2017-18 include the following payments over $5,000:

- A compensation payment for out-of-pocket expenses paid to a member of the public.

10. Cash and cash equivalents

	2018 $'000	2017 $'000
Operating cash on hand and at bank	53,884	46,113
General trust at call deposits *	6,540	6,614
General trust cash at bank *	174	121
Total cash and cash equivalents	**60,598**	**52,848**

* Refer note 21 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 Whole of Government (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 2.23% and 2.89% (2017: 2.45% and 2.97%).

11. Receivables

	2018	*2017*
	$'000	*$'000*
Trade receivables	6,479	7,478
Less: Allowance for impairment loss	(2,211)	(1,938)
Total trade receivables	**4,268**	**5,540**
GST receivable	1,346	2,244
GST (payable)	(37)	(90)
Total GST receivable	**1,309**	**2,154**
Receivable from DoH	4,103	14,366
Other accrued revenue	3,684	2,610
Other	1	12
Total other receivables	**7,788**	**16,988**
Total receivables	**13,365**	**24,682**

Receivables are measured at amortised cost 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 $9.86M or 74% (2017: $18.614M or 75%) of total receivables is due from Government, including finalisation of the current 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.

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.

11. Receivables (continued)

(b) Impairment of receivables (continued)

	2018			2017		
Individually Impaired Receivables	**Gross receivables**	**Allowance for impairment**	**Carrying Amount**	**Gross receivables**	**Allowance for impairment**	**Carrying Amount**
Overdue	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Less than 30 days	179	(179)	-	46	(46)	-
30 to 60 days	130	(130)	-	85	(85)	-
60 to 90 days	133	(133)	-	70	(70)	-
Greater than 90 days	1,392	(1,392)	-	1,151	(1,151)	-
Total overdue	**1,834**	**(1,834)**	**-**	**1,352**	**(1,352)**	**-**
Not individually impaired	4,645	(377)	4,268	6,126	(586)	5,540
Total allowance for impairment	**6,479**	**(2,211)**	**4,268**	**7,478**	**(1,938)**	**5,540**

Movements in the allowance for impairment loss	*2018*	*2017*
	$'000	*$'000*
Balance at the beginning of the financial year	1,938	2,107
Amounts written off during the year in respect of bad debts	(551)	(668)
Increase/(decrease) in allowance recognised in operating result	824	499
Balance at the end of the financial year	**2,211**	**1,938**

As at 30 June 2018, trade receivables with a nominal value of $2,003K (2017: $3,047K) were past due but not impaired. Ageing of past due but not impaired trade receivables are disclosed in the following table.

Trade receivables past due but not impaired	*2018*	*2017*
	$'000	*$'000*
Less than 30 days	943	1,289
30 to 60 days	381	688
60 to 90 days	191	423
Greater than 90 days	488	647
Total past due but not impaired	**2,003**	**3,047**
Not overdue	2,265	2,493
Total trade receivables	**4,268**	**5,540**

12. Inventories

	2018	*2017*
	$'000	*$'000*
Clinical supplies and equipment	3,231	2,815
Pharmaceuticals	2,858	3,117
Catering and domestic	115	92
Other	261	258
Total inventories	**6,465**	**6,282**

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.

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	Buildings & improvements	Plant & equipment	Work in progress	Total
	at fair value	at fair value	at cost	at cost	
	$'000	$'000	$'000	$'000	$'000
Fair value / cost	36,516	1,016,812	87,361	6,994	1,147,683
Accumulated depreciation	-	(701,123)	(45,377)	-	(746,500)
Carrying amount at 30 June 2018	**36,516**	**315,689**	**41,984**	**6,994**	**401,183**
Represented by movements in carrying amount					
Carrying amount at 1 July 2017	35,811	296,001	35,700	17,713	385,225
Acquisitions	-	113	9,031	17,031	26,175
Transfers in from other Queensland Government entities	-	7,662	253	-	7,915
Donations received	-	-	230	-	230
Disposals	-	(20)	(135)	-	(155)
Transfers out to other Queensland Government entities	(45)	-	(54)	-	(99)
Transfer between asset classes	-	23,644	4,007	(27,750)	(99)
Net revaluation increments/(decrements)	750	10,923	-	-	11,673
Depreciation	-	(22,634)	(7,048)	-	(29,682)
Carrying amount at 30 June 2018	**36,516**	**315,689**	**41,984**	**6,994**	**401,183**
Fair value / cost	35,811	915,866	79,283	17,713	1,048,673
Accumulated depreciation	-	(619,865)	(43,583)	-	(663,448)
Carrying amount at 30 June 2017	**35,811**	**296,001**	**35,700**	**17,713**	**385,225**
Represented by movements in carrying amount					
Carrying amount at 1 July 2016	37,565	226,459	30,082	4,218	298,324
Acquisitions	-	394	10,702	26,699	37,795
Transfers in from other Queensland Government entities	-	-	15	-	15
Donations received	-	-	19	-	19
Disposals	-	(2)	(99)	-	(101)
Transfer between asset classes	-	11,973	1,231	(13,204)	-
Net revaluation increments/(decrements)	(1,754)	71,872	-	-	70,118
Depreciation	-	(14,695)	(6,250)	-	(20,945)
Carrying amount at 30 June 2017	**35,811**	**296,001**	**35,700**	**17,713**	**385,225**

(a) Recognition of 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 reported as Property, Plant and Equipment in the following classes. Items below these values are expensed in the year of acquisition.

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

Expenditure on property, plant and equipment is capitalised where it is probable that the expenditure will produce future service potential for DDHHS. Subsequent expenditure is only added to an asset's carrying amount if it increases the service potential or useful life of that asset. Maintenance expenditure that merely restores original service potential (lost through ordinary wear and tear) is expensed.

13. Property, plant and equipment (continued)

(a) Recognition of property plant and equipment(continued)

Complex assets comprise separately identifiable components (or groups of components) of significant value, that require replacement at regular intervals and at different times to other components comprising the complex asset. The accounting policy for depreciation of complex assets, and estimated useful lives of components, are disclosed in note 13(e).

(b) Cost of acquisition of assets

Cost is used for the initial recording of all property, plant and equipment acquisitions. Cost is determined as the fair 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 carrying amount in the books of the transferor immediately prior to the transfer.

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

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

Where assets have not been comprehensively valued in the reporting period, their previous valuations are materially kept up to date via the application of relevant indices. DDHHS ensures that the application of such indices results in a valid estimation of the assets' fair values at reporting date. The external valuer supplies the indices used. Such indices are either publicly available, or are derived from market information available to the valuer. The valuer provides assurance of their robustness, validity and appropriateness 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, and analysing the trend of changes in values over time. Through this process, which is undertaken annually, management assesses and confirms the relevance and suitability of indices provided by the valuer based on DDHHS's own particular circumstances.

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

The comprehensive valuations are based on 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 17.

13. Property, plant and equipment (continued)

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

Fair value measurement - land

DDHHS has engaged the State Valuation Service (SVS) to provide a market based valuation in accordance with a four year rolling revaluation program (with indices applied in the intervening periods). The revaluation program excludes properties which do not have an active market, for example properties under Deed of Grant (recorded at a nominal value of $1).

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.

The 2017-18 revaluation program resulted in an increment of $750K (2017: decrement of $1,754K) to the carrying amount of land, and is recognised in the Statement of Comprehensive Income as a gain on remeasurement of assets.

Fair value measurement - buildings and improvements

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

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 current replacement cost methodology. Current replacement cost is a valuation technique that reflects the amount that would be required today to replace the service capacity of an asset. Current replacement cost is calculated as replacement cost less adjustments for obsolescence.

To determine the replacement cost, the lowest cost that would be incurred today, to replace the existing building with a modern equivalent, is assessed. The valuation assumes a modern equivalent building will comply with current legislation (e.g. building code) and provide the same service function and form (shape and size) as the original building but with more contemporary design, materials, safety standards and construction approaches.

In determining the revalued amount the measurement of key quantities of certain elements includes:

- Building footprint (roof area);
- Girth of the building;
- Height of the building;
- Number of staircases; and
- Number of lift 'stops'

Key quantities are measured from drawings provided and verified on site during inspections. These measured quantities are assigned unit rates to determine a base replacement cost for each element. The unit rates are derived from recent similar projects analysed at an elemental level. 'On-costs' have been incorporated to include for:

- Contractors preliminary items (establishment, supervision, scaffolding, tower cranes, etc.);
- Project contingencies;
- Professional and statutory fees; and
- Client costs (management of the project etc).

The replacement cost of an asset is adjusted for obsolescence. There are three types of obsolescence factored into current replacement cost, functional, economic and physical obsolescence. Functional and economic obsolescence are adjustments to the gross value of the asset. This adjustment reflects the value embodied in components of a modern equivalent building that are either not present in the existing asset or that are inefficient or inadequate relative to a modern equivalent building due to technological developments or other external factors.

Physical obsolescence is time based and is therefore reflected in the calculation of accumulated depreciation. This adjustment reflects the loss in value of the building caused by factors such as wear and tear, physical stressors and other environmental factors. Physical obsolescence is calculated as straight line depreciation, that is, the replacement cost depreciated over the total useful life of the asset. The total useful life of the asset is a combination of expired useful life and an estimate of remaining useful life.

13. Property, plant and equipment (continued)

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

Fair value measurement - buildings and improvements (continued)

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 revaluation program resulted in an increment of $10,923K (2017: $71,872K) to the carrying amount of buildings.

(e) Depreciation

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

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.

Assets under construction (work-in-progress) are not depreciated until the earlier of construction being complete or the asset is ready for its intended use. These assets are then reclassified to the relevant class 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.

All asset useful lives are reviewed annually to ensure that the remaining service potential of the assets is reflected in the financial statements. 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 other circumstances and events. The depreciation charge will increase where the useful lives are less than previously estimated, or the asset becomes technically obsolete or non-strategic assets that have been abandoned or sold are written off or written down.

For DDHHS depreciable assets, the estimated amount to be received on disposal at the end of their useful life (residual value) is determined to be zero.

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

Class	Depreciation rates	
	2018	*2017*
	%	*%*
Buildings and improvements	0.75 - 10.0	0.76 -7.69
Plant and equipment	2.00 - 20.00	2.00 - 25.00

(f) Impairment of non-current assets

All property, plant and equipment is assessed for indicators of impairment on an annual basis. If an indicator of possible impairment exists, DDHHS determines the asset's recoverable amount. Recoverable amount is determined as the higher of the asset's fair value less costs to sell and current replacement cost. Any amount by which the asset's carrying amount exceeds the recoverable amount is recorded as an impairment loss.

An impairment loss is recognised immediately in the Statement of Comprehensive Income, unless the asset is carried at a revalued amount, in which case the impairment loss is offset against the asset revaluation surplus of the relevant class to the extent available. Where no asset revaluation surplus is available, in respect of the class of asset, the loss is expensed in the Statement of Comprehensive Income as a revaluation decrement.

13. Property, plant and equipment (continued)

(f) Impairment of non-current assets (continued)

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of its recoverable amount, but so that the increased carrying amount does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset in prior years. For assets measured at fair value, to the extent the original decrement was expensed through the Statement of Comprehensive Income, the reversal is recognised in income, otherwise the reversal is treated as a revaluation increase for the class of asset through the asset revaluation surplus. For assets measured at cost, impairment losses are reversed through income.

14. Payables

	2018	*2017*
	$'000	*$'000*
Payable to DoH	16,640	16,134
Accrued expenses	14,023	10,782
Trade payables	7,172	5,702
Other	97	27
Total payables	**37,932**	**32,645**

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. 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. Assets received or transferred by DDHHS are accounted for in line with the accounting policy outlined in note 13(b). Transactions with owners as owners also includes 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 received or transferred are outlined in the table below:

	2018	*2017*
	$'000	*$'000*
Transfers from DoH	7,863	-
Transfers to DoH	(45)	-
Transfers from other Queensland Government entities	52	15
Transfers to other Queensland Government entities	(54)	
Total net assets received or transferred	**7,816**	**15**

16. Asset revaluation surplus

	Land	**Buildings & improvements**	**Total**
	$'000	**$'000**	**$'000**
Balance at 1 July 2016	-	19,467	19,467
Revaluation increment/(decrement)	-	71,872	71,872
Balance at 30 June 2017	**-**	**91,339**	**91,339**
Revaluation increment/(decrement)	-	10,923	10,923
Balance at 30 June 2018	**-**	**102,262**	**102,262**

The asset revaluation surplus represents the net effect of upwards and downwards revaluations of assets to fair value.

17. 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. Observable inputs used by DDHHS include, but are not limited to, published sales data for land and 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.

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.

Details of the valuation approach as well as the observable and unobservable inputs used in deriving the fair value of non-financial assets are disclosed in note 13(d).

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.

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 valuations:

- 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.

There were no transfers of assets between fair value hierarchy levels during the period.

Categorisation of fair value of assets and liabilities measured at fair value

	Level 2		Level 3		Total	
	2018	2017	2018	2017	2018	2017
	$'000	$'000	$'000	$'000	$'000	$'000
Land	36,516	35,811	-	-	36,516	35,811
Buildings and improvements	656	698	315,033	295,303	315,689	296,001
Total	**37,172**	**36,509**	**315,033**	**295,303**	**352,205**	**331,812**

17. Fair value measurement (continued)

Reconciliation of non-financial assets categorised as Level 3:

As at 1 July 2016	225,719
Acquisitions (including upgrades)	394
Disposals	(2)
Transfer between asset classes	11,973
Net revaluation increments/(decrements) recognised in equity	71,872
Depreciation	(14,653)
As at 30 June 2017	**295,303**
Acquisitions (including upgrades)	113
Transfers in from other Queensland Government entities	7,662
Disposals	(20)
Transfer between asset classes	23,644
Net revaluation increments/(decrements)	10,923
Depreciation charge for the year	(22,592)
As at 30 June 2018	**315,033**

18. 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.

18. Financial instruments (continued)

(i) Credit risk exposure (continued)

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 (2017: $6 million) under WoG banking arrangements to manage any short term cash shortfalls. This facility has not been drawn down as at 30 June 2018 (2017: nil). The liquidity risk of financial liabilities held by DDHHS is limited to the payables balance as shown in Note 14.

(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 at-call deposits but 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.

19. Commitments for expenditure

(a) Non-cancellable operating lease commitments	*2018*	*2017*
	$'000	*$'000*
Committed at the reporting date but not recognised as liabilities:		
Within one year	73	70
One to five years	214	208
More than five years	446	480
Total non-cancellable operating leases	**733**	**758**

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.

(b) Capital and operating expenditure commitments

Capital and operating expenditure commitments at reporting date are inclusive of non-recoverable GST. DDHHS has capital and operating 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.

	2018	*2017*
	$'000	*$'000*
Committed at the reporting date but not recognised as liabilities:		
Repairs and maintenance	1,454	550
Supplies and services	2,154	255
Capital projects	7,824	6,567
Total capital and operating expenditure commitments	**11,432**	**7,372**
Committed at the reporting date but not recognised as liabilities:		
Within one year	11,432	7,372
Total capital and operating expenditure commitments	**11,432**	**7,372**

20. 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.

As at 30 June 2018, the following number of cases were filed in the courts naming the State of Queensland acting through DDHHS as defendant.

	2018 Number of	2017 Number of
Supreme Court	2	2
District Court	2	2
	4	**4**

(b) Guarantees and undertakings

As at reporting date, DDHHS held bank guarantees from third parties for capital works projects totalling $1,012K (2017: $521K). These amounts have not been recognised as assets in the financial statements.

21. 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 2018, amounts are set aside for clinical trials $146,132 (2017: $192,395); clinical research $96,388 (2017: $83,536); health research $109,320 (2017: $88,497) and other purposes $18,462 (2017: $6,714) for the specific purposes underlying the contribution.

22. 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	*2018 $'000*	*2017 $'000*
Balance at the beginning of the year	10,204	7,695
Patient fiduciary fund receipts	16,814	12,247
Patient fiduciary fund payments	(13,598)	(9,738)
Balance at the end of the year	**13,420**	**10,204**
Closing balance represented by:		
Cash at bank and on hand	1,694	980
Refundable patient fiduciary fund deposits *	11,726	9,224
Patient fiduciary fund assets closing balance 30 June	**13,420**	**10,204**

* 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.

22. 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 staff with grants for study, research, or educational purposes. Transactions and balances relating to the RoPP arrangement are outlined in the following table.

Right of Private Practice (ROPP) receipts and payments	*2018*	*2017*
	$'000	*$'000*
Receipts		
Private practice receipts	5,344	4,756
Bank interest	8	6
Total receipts	**5,352**	**4,762**
Payments		
Payments to medical officers	494	562
Payments to DDHHS for recoverable costs	4,858	4,200
Total payments	**5,352**	**4,762**
Increase in net private practice assets	**-**	**-**
Current assets		
Cash - RoPP	413	584
Total current assets	**413**	**584**
Current liabilities		
Payable to medical officers	13	25
Payable to DDHHS for recoverable costs	370	476
Payable to HHS general trust	30	83
Total current liabilities	**413**	**584**

23. Controlled entities

During the 2017-18 financial year, the Treasurer for the State of Queensland approved amendments to the constitution of the Darling Downs and West Moreton Primary Health Network Limited (DDWMPHN). As a result of the changes, DDHHS can no longer appoint the majority of the company's Board of Directors. Therefore, the DDWMPHN is no longer a controlled entity of DDHHS. There was no impact on the DDHHS financial statements since the entity was not consolidated on the basis of materiality.

During the 2017-18 financial year, Darling Downs Hospital and Health Service (DDHHS) signed a Consortium Deed with the University of Queensland (UQ), the University of Southern Queensland (USQ) and South West Hospital and Health Service (SWHHS) to establish and operate a project known as Southern Queensland Rural Health (SQRH).

The project's aim is to improve the recruitment and retention of health professionals in rural and remote Australia. SQRH is not an incorporated entity and is a jointly controlled operation. On this basis, any assets, liabilities, revenue and expenses incurred by DDHHS in relation to the project are recorded in DDHHS financial statements. No consolidation procedures are performed.

DARLING DOWNS HOSPITAL AND HEALTH SERVICE
Notes to the Financial Statements
For the year ended 30 June 2018

24. Budget to actual comparison

This section discloses DDHHS's original published budgeted figures for 2017-18 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 2018 $'000*	*Actual 2018 $'000*	*Variance* 2018 $'000*
Income from continuing operations				
User charges and fees		730,026	726,670	(3,356)
Grants and other contributions	1	29,897	42,226	12,329
Interest		387	431	44
Other revenue		1,434	2,927	1,493
Total revenue		761,744	772,254	10,510
Gains on disposal/revaluation of assets of assets		-	767	767
Total income from continuing operations		**761,744**	**773,021**	**11,277**
Expenses from continuing operations				
Employee expenses		73,104	77,462	(4,358)
Health service employee expenses	2	441,132	452,638	(11,506)
Supplies and services	3	218,081	200,711	17,370
Grants and subsidies		1,541	3,208	(1,667)
Depreciation and amortisation	4	24,557	29,787	(5,230)
Impairment losses		2,518	903	1,615
Other expenses		811	4,176	(3,365)
Total expenses from continuing operations		**761,744**	**768,885**	**(7,141)**
Operating result from continuing operations		**-**	**4,136**	**4,136**
OTHER COMPREHENSIVE INCOME				
Items not recyclable to operating result				
Increase/(decrease) in asset revaluation surplus	5	-	-	-
		-	10,923	10,923
Total items not recyclable to operating result		**-**	**10,923**	**10,923**
Total other comprehensive income		**-**	**10,923**	**10,923**
TOTAL COMPREHENSIVE INCOME		**-**	**15,059**	**15,059**

** Favourable / (Unfavourable)*

24. Budget to actual comparison (continued)

Statement of Comprehensive Income variance notes

1 Grants and other contributions exceeded the original budget by $12.3M. The variance is predominantly due to recognising the fair value of corporate support services provided at no cost to DDHHS by DoH ($7.9M) for the first time. Other factors contributing to the budget variance included the introduction of the new Rural Junior Doctor Training program ($1.3M) and donations exceeding the original budget by $1.1M due to one off donations for equipment purchases including fit out of the Toowoomba Hospital 7th operating theatre, fit out of the new dental training facility at Kingaroy and elective surgery equipment at a number of rural hospitals.

2 Health service employee expenses exceeded the original budget by $11.5M. The variance is predominantly due to an increase of 82 FTE ($10M). Of this increase, 25 FTE ($3.1M) were specifically funded through service level agreement amendments with DoH for the delivery of patient services. The remaining increase of 57 FTE ($6.9M) was due to the investment of funds originally budgeted for purchasing clinical services externally being used to employ additional staff to deliver the services.

3 Supplies and services expenditure was $17.4M below the original budget level. The decrease in expenditure was predominantly due to a $15.1M decrease in pharmaceuticals due to patients completing treatment for hepatitis C and a $6.9M decrease due to the redirection of funds originally budgeted for purchasing external clinical services being used to employ additional Health service employees (refer note 2). These decreases were offset by a $7.9M increase due to recognising the fair value of corporate support services provided by DoH at no cost to DDHHS for the first time.

4 Depreciation expense exceeded the original budget by $5.2M. This is predominantly due to an increase in the value of building assets in 2016-17 as a result of a change to the revaluation methodology.

5 The Asset revaluation surplus exceeded budgeted levels by $10.9M as a result of the revaluation of inground services at Baillie Henderson Hospital that were previously unable to be reliably measured ($4.2M) and indexation of buildings throughout the HHS to reflect construction cost increases ($4.1M).

24. Budget to actual comparison (continued)

Statement of Financial Position

	Variance Note	Original Budget 2018 $'000	Actual 2018 $'000	Variance* 2018 $'000
Current assets				
Cash and cash equivalents	1	74,054	60,598	(13,456)
Receivables		15,736	13,365	(2,371)
Inventories		6,700	6,465	(235)
Other current assets		1,042	1,007	(35)
Total current assets		**97,532**	**81,435**	**(16,097)**
Non-current assets				
Property, plant and equipment	2	308,004	401,183	93,179
Intangible assets		-	435	435
Other non-current assets		-	41	41
Total non-current assets		**308,004**	**401,659**	**93,655**
Total assets		**405,536**	**483,094**	**77,558**
Current liabilities				
Payables	3	43,815	37,932	5,883
Accrued employee benefits		2,471	2,704	(233)
Unearned revenue		-	223	(223)
Total current liabilities		**46,286**	**40,859**	**5,427**
Total liabilities		**46,286**	**40,859**	**5,427**
Net assets		**359,250**	**442,235**	**82,985**
Equity				
Contributed equity		278,563	280,253	1,690
Accumulated surplus/(deficit)		55,545	59,720	4,175
Asset revaluation surplus	4	25,142	102,262	77,120
Total equity		**359,250**	**442,235**	**82,985**

** Favourable / (unfavourable)*

24. Budget to actual comparison (continued)

Statement of Financial Position variance notes

1 Cash and cash equivalents are $13.5M below budgeted levels. $11.1M of cash reserves (primarily from retained surpluses) were invested in capital acquisitions including construction of a 7th operating theatre, refurbishment of the central sterilising department and installation of medical imaging equipment at Toowoomba Hospital, upgrading the emergency department at Warwick Hospital, and upgrading patient accommodation at Baillie Henderson Hospital.

2 Property plant and equipment exceeded budgeted levels by $93.2M. $76.3m was due to asset revaluation including changes to the revaluation methodology for buildings in 2016-17. $11.1M was invested in capital acquisitions including construction of a 7th operating theatre, refurbishment of the central sterilising department and installation of medical imaging equipment at Toowoomba Hospital, upgrading the emergency department at Warwick Hospital, and upgrading patient accommodation at Baillie Henderson Hospital from retained surpluses. $1.1m in donations funded the acquisition of assets including equipment for the Toowoomba Hospital's 7th operating theatre, fit out of the new dental training facility at Kingaroy and elective surgery equipment at a number of rural hospitals. DoH funded additional capital acquisitions including electrical upgrades at Toowoomba and Baillie Henderson Hospitals and an expansion of the Toowoomba Hospital emergency department ($2.5m).

3 Payables were $5.9M below budgeted levels due to the timing of payments to suppliers.

4 The asset revaluation surplus exceeded budgeted levels by $77.1M primarily as a result of changes to the revaluation methodology for building assets in 2016-17 that occurred after development of the budget.

24. Budget to actual comparison (continued)

Statement of Cash Flows

	Variance Note	Original Budget 2018 $'000	Actual 2018 $'000	Variance* 2018 $'000
Cash flows from operating activities				
Inflows:				
User charges and fees	1	702,910	709,711	6,801
Grants and other contributions		30,297	34,404	4,107
Interest receipts		387	431	44
GST input tax credits from ATO		10,000	11,880	1,880
GST collected from customers		-	497	497
Other		1,034	-	(1,034)
Total cash provided by operating activities		**744,628**	**756,923**	**12,295**
Outflows:				
Employee expenses		73,203	77,240	(4,037)
Health service employee expenses	2	441,132	451,485	(10,353)
Supplies and services	3	215,743	188,323	27,420
Grants and subsidies		1,541	3,208	(1,667)
GST paid to suppliers		10,000	10,983	(983)
GST remitted to ATO		-	550	(550)
Other		955	4,660	(3,705)
Total cash used in operating activities		**742,574**	**736,449**	**6,125**
Net cash provided by / (used in) operating activities		**2,054**	**20,474**	**18,420**
Cash flows from investing activities				
Inflows:				
Sales of property, plant and equipment		-	61	61
Total cash provided by investing activities		**-**	**61**	**61**
Outflows:				
Payments for property, plant and equipment	4	8,002	26,484	(18,482)
Total cash used in investing activities		**8,002**	**26,484**	**(18,482)**
Net cash provided by / (used in) investing activities		**(8,002)**	**(26,423)**	**(18,421)**
Cash flows from financing activities				
Inflows:				
Proceeds from equity injections	5	8,002	13,699	5,697
Total cash provided by financing activities		**8,002**	**13,699**	**5,697**
Outflows:				
Total cash used in financing activities		**-**	**-**	**-**
Net cash provided by / (used in) financing activities		**8,002**	**13,699**	**5,697**
Net increase in cash and cash equivalents		**2,054**	**7,750**	**5,696**
Cash and cash equivalents at beginning of financial year	6	72,000	52,848	(19,152)
Cash and cash equivalents at end of financial year		**74,054**	**60,598**	**(13,456)**

* Favourable / (unfavourable)

24. Budget to actual comparison (continued)

Statement of Cash Flow variance notes

1 The movement in receipts from User charges and fees reflects the receipt of outstanding 2016-17 receivables from DoH ($14.4M), amendments to the 2017-18 service level agreement with DoH ($5.4M), and increased salary recoveries ($1.7M) offset by decreased revenue from the pharmaceutical benefits reimbursement scheme due to patients completing treatment for hepatitis C ($15.5M).

2 The movement in Health service employee expenses is consistent with the movement in Health service 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 (excluding the fair value of corporate support services provided to DDHHS by DoH at no cost).

4 Payments for property, plant and equipment exceeded the original budget by $18.5M due to the investment of $11.1M into capital acquisition programs by the DDHHS Board from retained surplus and $1.1M of donations funding capital acquisitions. Additionally $6.2M in capital acquisitions were funded through equity funding received through the DoH.

5 Proceeds from equity injections exceeded the original budget by $5.7M due to additional capital projects being funded by DoH and is consistent with additional payments for property, plant and equipment.

6 Cash and cash equivalents at the beginning of the year were $19.2M below budgeted levels primarily due to outstanding receivables with the DoH for service level agreement amendments ($14.4M) and the Board's investment of retained surpluses into capital acquisitions ($8.1M) in 2016-17.

25. 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 2017-18. Further information on these positions can be found in the body of the Annual Report under the section relating to Governing our Organisation.

Name (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 18 May 2012	Chair	Government Board B1	**2018**	80	7	87
			2017	83	9	92
Dr Dennis Campbell 29 June 2012	Deputy Chair	Government Board B1	**2018**	51	5	56
			2017	50	4	54
Cheryl Dalton 29 June 2012	Board Member	Government Board B1	**2018**	48	5	53
			2017	48	5	53
Dr Ross Hetherington 29 June 2012	Board Member	Government Board B1	**2018**	47	4	51
			2017	47	5	52
Patricia Leddington-Hill 9 November 2012	Board Member	Government Board B1	**2018**	48	5	53
			2017	45	5	50
Megan O'Shannessy 18 May 2013	Board Member	Government Board B1	**2018**	43	4	47
			2017	47	5	52
Marie Pietsch 29 June 2012	Board Member	Government Board B1	**2018**	50	5	55
			2017	46	4	50
Dr Ruth Terwijn 17 May 2016	Board Member	Government Board B1	**2018**	47	4	51
			2017	45	5	50
Professor Julie Cotter 18 May 2017	Board Member	Government Board B1	**2018**	47	4	51
			2017	5	-	5
Corinne Butler 17 May 2016 to 23 September 2016	Board Member	Government Board B1	**2018**	-	-	-
			2017	12	1	13

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*.

25. 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 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))*	**2018**	496	2	10	43	-	551
			2017	520	3	10	46	-	579
Shirley-Anne Gardiner Executive Director Toowoomba Hospital 1 August 2016	Provides single point accountability and leadership for Toowoomba Hospital.	HES 2-3 Appointed by Chief Executive (CE) under *Section 74 Hospital and Health Boards Act 2011*	**2018**	203	-	4	20	-	227
			2017	151	-	3	14	-	168
Brett Mendezona* Acting General Manager Toowoomba Hospital 14 January 2016 to 1 August 2016	Provides single point accountability and leadership for Toowoomba Hospital.	HES 2-3 Appointed by Chief Executive (CE) under *Section 74 Hospital and Health Boards Act 2011* (2017)	**2018**	-	-	-	-	-	-
			2017	36	-	1	2	-	39

*During the 2015-16 financial year the officer occupying the General Manager Toowoomba Hospital role was paid under the nursing and midwifery award classification whilst contract negotiations were finalised. This resulted in back pay to the officer in the 2016-17 financial year.

25. 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 Martin Byrne Acting Executive Director Medical Services 11 July 2016	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 Appointed by Chief Executive (CE) under *Section 67(2) Hospital and Health Boards Act 2011*	**2018**	503	1	10	32	-	546
Acting Executive Director Rural Health and Aged Care 1 April 2017 to 30 April 2018	Provides single point accountability and leadership for the Rural Division within DDHHS. This Division includes twenty hospital and health care services, including co-located residential aged care services, and Mt Lofty Heights Residential Aged Care Facility.		**2017**	464	1	9	34	-	508
Michael Bishop General Manager Rural 28 May 2012 to 28 October 2016	Provides single point accountability and leadership for the Rural Division within DDHHS. This Division includes twenty 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*	**2018**	-	-	-	-	-	-
			2017	76	-	1	4	50	131

25. 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
Malcolm Neilson Executive Director Mental Health Alcohol and Other Drug Services 27 June 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*	**2018**	207	-	4	17	-	228
			2017	202	-	4	20	-	226
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*	**2018**	-	-	-	-	-	-
			2017	19	-	-	-	7	26
Jane Ranger Chief Finance Officer 22 August 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*	**2018**	195	-	4	19	-	218
			2017	197	-	4	19	-	220
Paul Clayton Executive Director Infrastructure 14 October 2016	Provides single point accountability for the Infrastructure Division and coordinates DDHHS infrastructure projects to support high quality health care within DDHHS.	HES 2-1 Appointed by Chief Executive (CE) under *Section 74 Hospital and Health Boards Act 2011*	**2018**	196	-	4	20	-	220
			2017	183	-	4	18	-	205

25. 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
Chris Neilsen Acting Executive Director Workforce 12 March 2018	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 employee engagement, safety and productivity to meet service delivery needs.	HES 2-1 Appointed by Chief Executive (CE) under *Section 74 Hospital and Health Boards Act 2011*	**2018**	63	-	1	5	-	69
			2017	-	-	-	-	-	-
Corinne Butler Executive Director Workforce 26 September 2016 to 6 April 2018	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 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*	**2018**	150	1	3	14	61	229
			2017	148	2	3	13	-	166

25. 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 Queensland Rural Medical Service 24 July 2017	Provides executive leadership for Queensland Country Practice (QCP), including, Relieving Services, Service and Workforce Design and Medical Education Pathways which are all delivered on a State-wide basis. Provides leadership for the promotion of clinical service improvement, consumer satisfaction, clinician engagement, clinical governance, professional and clinical standards as well as clinical workforce education.	20MMOI1 Appointed by Chief Executive (CE) under *Section 67(2) Hospital and Health Boards Act 2011*	**2018**	442	1	9	32	-	484
Executive Director Medical Services 15 September 2014 to 23 July 2017	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.		**2017**	379	1	8	27	-	415

25. 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
Andrea Nagle Executive Director Nursing and Midwifery Services 24 July 2017	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	**2018**	244	-	4	24	-	272
			2017	-	-	-	-	-	-
Karen Abbott Executive Director Nursing and Midwifery Services 15 August 2016	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	**2018**	69	-	1	(1)	-	69
Acting Executive Director Rural Health and Aged Care 29 October 2016 to 31 March 2017	Provides single point accountability and leadership for the Rural Division within DDHHS. This Division includes twenty hospital and health care services, including co-located residential aged care services, and Mt Lofty Heights Residential Aged Care Facility.		**2017**	252	-	4	18	-	274

25. Key management personnel and remuneration (continued)

(b) Executive (continued)

(ii) DDHHS Executives employed by the Department of Health under Award (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
Robyn Henderson Executive Director Nursing and Midwifery Services 8 December 2014 to 14 August 2016	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	**2018**	-	-	-	-	-	-
			2017	33	-	1	3	-	37
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	**2018**	97	-	2	10	-	109
			2017	144	-	3	16	-	163

**During the 2017-18 year, Annette Scott was seconded to an external agency from 5 September 2017, retuning to the role of Executive Director Allied Health on 27 February 2018.

25. Key management personnel and remuneration (continued)

(c) KMP Remuneration Policy

As from 2016-17, the Minister for Health is identified as part of DDHHS's KMP, consistent with additional guidance included in the revised version of *AASB 124 Related Party Disclosures*.

Ministerial remuneration entitlements are outlined in the Legislative Assembly of Queensland's Members' Remuneration Handbook. DDHHS does not bear the cost of remunerating Ministers. The majority of Ministerial entitlements are paid by the Legislative Assembly, with the remaining entitlements being provided by Ministerial Services Branch within the Department of the Premier and Cabinet. As all Ministers are reported as KMP of the Queensland Government, aggregate remuneration expenses for all Ministers is disclosed in the Queensland General Government and Whole of Government Consolidated Financial Statements as from 2016-17, which are published as part of Queensland Treasury's Report on State Finances.

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*.

The remuneration policy for DDHHS's 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 executive management personnel are specified in employment contracts. In the current reporting period, the remuneration of executive management personnel increased by 2.5% (2017: 2.5%) in accordance with Government policy.

Remuneration expenses for 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 entitlements earned;
- Post employment benefits include amounts expensed in respect of employer superannuation obligations;
- Redundancy payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu on termination, regardless of the reason for termination;
- There were no performance bonuses paid in the 2017-18 financial year.

26. Related party transactions

Transactions with controlled entities

As at 30 June 2018 DDHHS does not have a controlling interest in any entity.

During the 2017-18 financial year, DDHHS agreed to provide a license to Southern Queensland Rural Health (SQRH) for exclusive use of a DDHHS building located on the Baillie Henderson Hospital Campus. No license fees, utilities or maintenance costs are charged to SQRH. In addition, DDHHS committed $250,000 towards renovations for the building.

Transactions with KMP or persons and entities related to KMP

A company controlled by a KMP member provides services to DDHHS for the purpose of supporting rural doctors, hospitals and health students to work in rural communities. Services provided include education and training, co-ordination of student research activities, maintenance, furniture and equipment at clinical education facilities in line with the training or accommodation requirements of students and co-ordination of accommodation services at rural facilities. The services are provided to DDHHS at no cost.

A company controlled by a KMP member provides services to the DoH for the purpose of providing dementia and neurodegenerative respite services to the value of $990,000 over four years. The company invoiced the DoH for a total of $331,848 excluding GST (2017: $350,943). There are no outstanding balances. A tender was submitted by the company in response to a public advertisement and was selected based on a standard procurement process.

All other transactions in the year ended 30 June 2018 between DDHHS and key management personnel including their related parties were on standard commercial terms and conditions or were immaterial in nature.

Transactions with other Queensland Government controlled entities

DDHHS is controlled by its ultimate parent entity, the State of Queensland. All State of Queensland controlled entities meet the definition of a related party in *AASB 124 Related Party Disclosures* .

The following table summarises significant transactions with Queensland Government controlled entities:

	For the year ending 30 June 2018		At 30 June 2018	
	Revenue Received	Expenditure Incurred	Asset	Liability
	$'000	$'000	$'000	$'000
Entity				
Department of Health	663,095	77,198	4,846	21,513
Queensland Treasury Corporation	421	25	18,552	2

DDHHS receives funding in accordance with a service agreement with the DoH. DoH receives the majority of its revenue from the State Government and the Commonwealth.

DDHHS is funded for eligible services through block funding, activity based funding or a combination of both. Activity based funding is based on an agreed number of activities per the service agreement and a state-wide price. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by Hospital and Health Services.

DDHHS purchases a number of supplies and services from the DoH including pharmaceuticals, pathology and laboratory services, Information and Communication Technology, aeromedical transport services, and insurance services.

DDHHS has bank accounts with the Queensland Treasury Corporation for general trust and patient fiduciary trust monies and receives interest and incurs bank fees on these bank accounts.

There are a number of other transactions which occur between DDHHS and other government related entities. These transactions include, but are not limited to, superannuation contributions made to QSuper, rent paid to the Department of Housing and Public Works, audit fees paid to the Queensland Audit Office, payments to and receipts from other Hospital and Health Services to facilitate the treatment of patients, pharmaceuticals, staff, training and other incidentals. These transactions are made in the ordinary course of DDHHS business and are on standard commercial terms and conditions.

26. Related party transactions (continued)

Other

There are no other individually significant transactions with related parties.

27. Events occurring after balance date

No other matter or circumstance has arisen since 30 June 2018 that has significantly affected, or may significantly affect DDHHS's operations, 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 2018 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.

Dr Dennis Campbell PhD MBA FCHSM FAIM GAICD

Acting Chair
Darling Downs Hospital and Health Board
29 / 08 / 2018

Jane Raigus FCPA BBus CDec

Chief Finance Officer
Darling Downs Hospital and Health Service
29 / 08 / 2018

Queensland Audit Office

Better public services

INDEPENDENT AUDITOR'S REPORT

To the Board of Darling Downs Hospital and Health Service

Report on the audit of the financial report

Opinion

I have audited the accompanying financial report of Darling Downs Hospital and Health Service. The financial report comprises the statement of financial position as at 30 June 2018, 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 summaries of significant accounting policies and other explanatory information, and the management certificate.

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2018, and its financial performance and cash flows for the year then ended

b) complies with the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2009 and Australian Accounting Standards.

Basis for opinion

I conducted my audit in accordance with the *Auditor-General of Queensland Auditing Standards*, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report.

I am independent of the entity in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Australia. I have also fulfilled my other ethical responsibilities in accordance with the Code and the *Auditor-General of Queensland Auditing Standards*.

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

Key audit matters

Key audit matters are those matters that, in my professional judgement, were of most significance in my audit of the financial report of the current period. These matters were addressed in the context of my audit of the financial report as a whole, and in forming my opinion thereon, and I do not provide a separate opinion on these matters.

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Specialised buildings valuation ($315.7 million)

Refer to Note 13 in the financial report.

Key audit matter	How my audit addressed the key audit matter

Buildings were material to Darling Downs Hospital and Health Service at balance date, and were measured at fair value using the current replacement cost method. Darling Downs Hospital and Health Service performed a comprehensive revaluation of 54% of the written down value of buildings this year, with the remaining assets being revalued using indexation.
 	
The current replacement cost method comprises:
• Gross replacement cost, less
• Adjustments for obsolescence.
 	
Darling Downs Hospital and Health Service derived the gross replacement cost of its buildings at balance date using unit prices that required significant judgements for:
• identifying the components of buildings with separately identifiable replacement costs;
• developing a unit rate for each of these components, including:
  ○ estimating the current cost for a modern substitute (including locality factors and oncosts), expressed as a rate per unit (e.g. $/square metre);
  ○ identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference.
 	
The measurement of accumulated depreciation involved significant judgements for forecasting the remaining useful lives of building components.
 	
The values used for indexation purposes are based on estimates of labour and material cost inflation adjusted for specific market conditions and as such also require judgement to appropriately determine.
 	
The significant judgements required for gross replacement cost and useful lives are also significant for calculating annual depreciation expense.
	My procedures included, but were not limited to:
	• Assessing the adequacy of management's review of the valuation process.
	• Assessing the appropriateness of the components of buildings used for measuring gross replacement costs with reference to common industry practices.
	• Assessing the competence, capabilities and objectivity of the experts used to develop the models.
	• Reviewing the scope and instructions provided to the valuer, and obtaining an understanding of the methodology used and assessing its appropriateness with reference to common industry practices;
	• For unit rates associated with buildings that were either comprehensively revalued this year:
	  ○ On a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the:
	  ▪ modern substitute (including locality factors and oncosts)
	  ▪ adjustment for excess quality or obsolescence.
	• For unit rates associated with the remaining buildings:
	  ○ Evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices;
	  ○ Recalculate the application of the indices to asset balances.
	• Evaluating useful life estimates for reasonableness by:
	  ○ Reviewing management's annual assessment of useful lives;
	  ○ For specific assets, we analysed the asset management plans for consistency between renewal budgets and the gross replacement of those assets.
	  ○ Testing that no asset has reached or exceeded its useful life;
	  ○ Enquiring of management about their plans for assets that are nearing the end of their useful life;
	  ○ Reviewing assets with inconsistent relationship between condition and remaining useful life.
	• Where changes in useful lives were identified, evaluating whether they were supported by appropriate evidence.
	• Reconciling the fair value of the buildings as determined by the valuer to the underlying accounting records and disclosures in the financial statements.

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Other Information

Other information comprises the information included in the entity's annual report for the year ended 30 June 2018, but does not include the financial report and my auditor's report thereon.

Those charged with governance are responsible for the other information.

My opinion on the financial report does not cover the other information and accordingly I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial report, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial report or my knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Responsibilities of the Board 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 the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2009 and Australian Accounting Standards, and for such internal control as the Board determines is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

The Board is also responsible for assessing the entity's ability to continue as a going concern, disclosing, as applicable, matters relating to going concern and using the going concern basis of accounting unless it is intended to abolish the entity or to otherwise cease operations.

Auditor's responsibilities for the audit of the financial report

My objectives are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

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- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for expressing an opinion on the effectiveness of the entity's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the entity.
- Conclude on the appropriateness of the entity's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. I base my conclusions on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

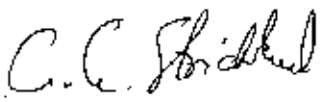
From the matters communicated with the Board, I determine those matters that were of most significance in the audit of the financial report of the current period and are therefore the key audit matters. I describe these matters in my auditor's report unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, I determine that a matter should not be communicated in my report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

Report on other legal and regulatory requirements

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2018:

a) I received all the information and explanations I required.

b) In my opinion, the prescribed requirements in relation to the establishment and keeping of accounts were complied with in all material respects.



30 August 2018

C G Strickland
as delegate of the Auditor-General of Queensland

Queensland Audit Office
Brisbane