Annual Report 2013–2014

Great state. Great opportunity.

Queensland Government

ISSN: 2202-6258

Accessibility

Public Availability

Where possible, readers are encouraged to download the report online at: www.health.qld.gov.au/metronorth

Where this is not possible, printed copies are available using one of the contact options below:

Physical Address: Level 14, Block 7, RBWH Campus HERSTON Qld 4029
Postal Address: PO Box 150 RBWH Post Office HERSTON Qld 4029
General Phone: 07 3646 8111
General Fax: 07 3647 9708
Office Hours: 9.00am to 5.00pm, Monday to Friday
General E-mail: MetroNorth-Design@health.qld.gov.au

Interpreter Services Statement

Metro North Hospital and Health Service is committed to providing accessible services to the community from culturally and linguistically diverse backgrounds.

If you have difficulty in understanding the Annual Report, please contact us on 07 3646 8111 and we will arrange an interpreter to communicate the report to you effectively.

Information Security

This document has been security classified using the Queensland Government Information.

Security Classification Framework (QGISCF) as UNCLASSIFIED – FINAL VERSION and will be managed according to the requirements of the QGISCF.

Letter of Compliance

Queensland Government

Office of the
Metro North Hospital and Health Board

Level 14, Block 7
Royal Brisbane and Women's Hospital
Herston Queensland 4029
www.health.qld.gov.au/metronorth

27 August 2014

Hon. Lawrence Springborg
Minister for Health
GPO Box 48
Brisbane Qld 4001

Dear Minister

I am pleased to present the Annual Report 2013-14 and financial statements for Metro North 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 accessed via the Metro North Hospital and Health Service website www.health.qld.gov.au/metronorth

Yours sincerely

Dr Paul Alexander AO
Chair
Metro North Hospital and Health Board

Table of contents

Metro North Hospital and Health Service

Metro North Hospital and Health Service (MNHHS) provides the full range of health services including rural, regional and tertiary teaching hospitals. It covers an area of 4,157 square kilometres and extends from the Brisbane River to north of Kilcoy.

MNHHS provides services to patients throughout Queensland, northern New South Wales and the Northern Territory, incorporating all major health specialties including medicine, surgery, psychiatry, oncology, women's and newborn, trauma and more than 30 sub-specialties.

An overview of our organisational profile for 2013–14 is provided in the table below.

Staff	12,685 (FTE)
Investment in care	$2,155,269,907
Sites	5 hospitals, 11 community health centres, oral & mental health facilities and 5 subacute sites totalling over 2,200 available beds
Hospital admissions	206,478 people admitted
Ambulance arrivals	86,567 ambulance arrivals handled by our emergency departments
Emergency	254,768 attendances
Outpatient services	821,760 people received care as outpatients at 1,939 clinics
Surgical operations	9,007 emergency and 27,646 elective operations performed
Children	22,235 children under age 19 were admitted to MNHHS children's wards and neonatal units
Births	8,017 babies born at our facilities
Mental health	232,557 client contacts
Community health	258,569 hours of direct primary care
X-ray and ultrasound	260,120 x-ray and ultrasound attendances
Dental	729,805 weighted occasions of service
Breastscreens	41,120 breastscreens performed
Pharmacy	79,623 number of pharmaceutical items dispensed

2013 – 2014 Fast facts

A reduction in ELECTIVE SURGERY LONG WAITS

July 2013	June 2014
1,429	30

NO MORE LONG WAIT DENTAL LISTS

July 2013	June 2014
6,394	0

Higher proportion of people admitted or treated and discharged within four hours of presentation to an emergency department

July 2013	June 2014
70%	74%

AN INCREASE IN AMBULANCE ARRIVALS

2013–14
85,567

2012–13
80,941

2013–14
206,478

2012–13
200,060

MORE HOSPITAL ADMISSIONS

Increased number of ATTENDANCES TO EMERGENCY DEPARTMENTS

2013–14	2012–13
254,768	235,864

1.0 General Information

1.1 Message from the Board Chair and Chief Executive

For the Metro North Hospital and Health Service (MNHHS) the patient is central to everything we do. Since our establishment on 1 July 2012 we have seen significant improvements in access to services for our community with the move to a more integrated and connected service focused on patient centred care. Our results demonstrate our commitment to providing high quality healthcare, whilst also recognising the importance of sustainability to meet the increased demand for health services in the future.

During 2013–14 we have continued to focus on compassionate, innovative and high quality healthcare for our patients. We have built on the success of last year by providing more health services than previous years whilst achieving a modest surplus. The surplus is to be reinvested during 2014–15 with the implementation of further surgical and outpatient initiatives to ensure access is improved to high quality and affordable healthcare for our community.

We consider our workforce to be our most valuable asset, and their commitment and dedication is demonstrated by the many achievements over the past year. Achievement highlights include significant improvements in elective surgery and dental care long waits. Since introducing strategies in February 2013 over 2,000 elective surgery long wait patients have been treated – this is greater than a 98% reduction and 14,500 patients on long term dental care wait lists were offered care.

Consistent with National Health Reform and the Blueprint for better healthcare in Queensland we have engaged with our communities, stakeholders and workforce to identify our key priorities and inform our way forward as a Hospital and Health Service. We are continuing to refine our Health Service Strategy to ensure that it remains relevant to the changing demands and needs of the community. We will continue to focus and build service design and delivery around the patient, their journey and experience.

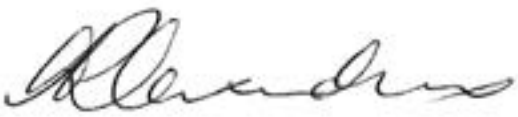
We believe that patient centred care improves the patient experience and creates public value for our services. We have established the Community Board Advisory Group in addition to hosting a number of Board Community forums, these collaborations have provided quality contributions to better understand and respond to our community's needs. We look forward to continuing to work with our health and community partners in developing our approaches to patient centred care. Partnerships with our patients, clinicians and community are essential as we continue to plan for the impacts of burden of diseases, population growth and an ageing population.

Each year in MNHHS we invest in an innovation program – Support, Explore, Excel and Deliver (SEED) – to further improve 'what' and 'how' we deliver our services. The program for 2013–14 engaged consumer representatives to seek feedback on what is important to them with regards to health services and used this as part of the short listing process for applications. We empower our staff to innovate and collaborate and have had a number of initiatives and improvements for patient flow and access during 2013–14 such as the Central Patient Intake Service providing a single point of entry and contact for primary care referrals for outpatient services which has resulted in improved access and better patient outcomes.

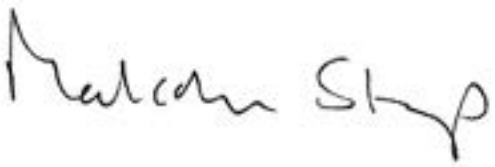
Each day over 4,000 patients access Metro North services, placing their trust in us to care for and treat them as best we possibly can. As provided in our Quality Improvement Strategy all patients diagnosed, treated and cared for at Metro North will receive the safest, highest quality care, personalised to their needs. Care will be provided in hospital and community facilities that compares well with the best in the world with a strong academic and evidence based approach to improving quality supported by patient experiences and feedback.

As we continue to evolve as a statutory body with progressive autonomy we will continue to deliver results as a patient centric, quality focused and sustainable health service. We would like to acknowledge the tremendous efforts, enthusiasm and dedication of the staff, Executive, Board and all our partners during 2013–14 to deliver outstanding outcomes for our patients and community.

"We look forward to continuing to work with our health and community partners in developing our approaches to patient centred care. Partnerships with our patients, clinicians and community are essential as we continue to plan for the impacts of burden of diseases, population growth and an ageing population."



Dr Paul Alexander AO
Chair
Metro North Hospital and Health Board



Mr Malcolm Stamp CBE
Chief Executive
Metro North Hospital and Health Service

1.2 Role of Metro North Hospital and Health Service (MNHHS)

On 1 July 2012, the MNHHS commenced operation as an independent statutory body overseen by a local Hospital and Health Board. The MNHHS is responsible for the delivery of public hospital and health services including medical, surgical, emergency, obstetrics, paediatrics, specialist outpatient clinics, mental health, critical care and clinical support services.

MNHHS's main function is to engage with our community to deliver hospital and health services, teaching, research and other services as stated in the Service Agreement.

The MNHHS Service Agreement is negotiated annually with the Department of Health and is publicly available at: https://publications.qld.gov.au/dataset/metro-north-hhs-service-agreements

MNHHS also has the following functions:

- To ensure the operations of MNHHS are carried out efficiently, effectively and economically
- To comply with the health service directives that apply to MNHHS
- To contribute to, and implement, statewide service plans that apply to MNHHS and undertake further service planning that aligns with the statewide plans
- To monitor and improve the quality of health services delivered by MNHHS, including implementation of the National Safety and Quality Health Service Standards
- To develop local clinical governance arrangements for MNHHS
- To undertake minor capital works, and major capital works approved by the Department of Health Chief Executive, in the health service area
- To maintain land, buildings and other assets owned by MNHHS
- To cooperate with other providers of health services — including other Hospital and Health Services, the department and providers of primary healthcare — in planning for, and delivering health services
- To cooperate with local primary healthcare organisations
- To arrange for the provision of health services to public patients in private health facilities
- To manage the performance of MNHHS against the performance measures stated in the Service Agreement

The Prince Charles Hospital: Australia's best performer for infection rates

A report released by the National Health Performance Authority in March 2014 has highlighted The Prince Charles Hospital as being the nation's best performer in achieving low infection rates among patients.

- To provide performance data and other data to the Department of Health Chief Executive
- To consult with health professionals working in MNHHS, health consumers and members of the community about the provision of health services.

MNHHS Clinical Service Profile

The clinical service profile within MNHHS ranges from tertiary referral to general hospital and includes subacute as well as community based services. Major health specialties provided within MNHHS include Medicine, Surgery, Psychiatry, Oncology, Women's and Newborn and Trauma Services. Sub-specialties include:

- **Surgical**: Burns, Cardiothoracic, ENT, Ophthalmology, General Surgery, Neurosurgery, Oral and Maxillofacial, Orthopaedic, Plastics and Reconstructive, Transplants – Heart and Lung, Vascular, Thoracic and Urology.
- **Medical**: Cardiology, Clinical Immunology and Allergies, Endocrinology, Gastroenterology and Hepatology, Dermatology, Geriatric Medicine, Infectious Diseases, Internal Medicine and Aged Care, Neurology, Pharmacy and Clinical Pharmacology, Nuclear Medicine, Paediatrics, QLD PET Service, Renal Medicine, Rheumatology, Thoracic Medicine, Palliative Care Services.
- **Women's and Newborn**: Gynaecology, Maternity Services, Paediatric Services, Neonatology, Neonatal Intensive Care Unit, Special Care Nursery, Foetal Diagnosis and Treatment, Breast Health, Maternal Foetal Medicine, Gynaecological Oncology and Retrieval Service for Northern NSW and Pacific Rim.
- **Cancer Care**: Radiation Oncology, Medical Oncology and Bone Marrow Transplant/Haematology.
- **Critical Care**: Emergency Medicine, Intensive Care Medicine and the Multidisciplinary Pain Centre.
- **Subacute Services**: Palliative Care, Rehabilitation, Transition Care, Hospital in the Home, Residential Aged Care, Psychogeriatric, Geriatric Evaluation and Management, Acquired Brain Injury, Intellectual and Physical Disability, Sexual Health and HIV Services.
- **Mental Health Services**: Perinatal, Child and Adolescent Psychiatry, Alcohol, Tobacco and Other Drug Services, Community Forensic Mental Health Services, Geriatric Psychiatry and Community Mental Health Services.
- **Oral Health Services**: General Practice Oral Health, Child and Adult Specialist Oral Health Services.

This is the second consecutive year that The Prince Charles Hospital (TPCH) has achieved the nation's lowest infection rate among major hospitals.

The report rates the performance of 115 Australian hospitals in relation to health care associated *Staphylococcus aureus* blood stream infections.

Staphylococcus aureus is a common blood stream infection that patients sometimes develop through the course of medical treatment provided by hospitals.

TPCH was reported as having the nation's lowest rate of infection among major hospitals with most vulnerable patients.

It recorded just 10 cases and a rate of 0.53 cases per 10,000 bed days, two and half times lower than the nation's average.

The National Healthcare Agreement signed in 2011 set a target for no more than two cases per 10,000 bed days for each state and territory.

TPCH's Executive Director, Professor Darren Walters, said that hand hygiene is a major factor in helping to reduce infections like *Staphylococcus aureus*.

"We regularly monitor and evaluate staff in both clinical and non-clinical areas to ensure good hand hygiene practices, and identify areas in need of improvement," Professor Walters said.

"Achieving low infection rates is also about diligent clinical practice and staff training, particularly when caring for patients who are at greater risk of infection.

"There needs to be a strong level of support from senior management to ensure that safety and quality remains a priority for the organisation.

"This is an excellent achievement which positions TPCH as a leader in safety and quality within Australia," Professor Walters said.

Pictured: Supporting safe patient care practices – Members of TPCH's Infection Management Service and Patient Safety Team.

2.0 Non-financial performance

2.1 Government objectives for the community

The *Metro North Hospital and Health Service (MNHHS) Strategic Plan 2014–2018* objectives and performance indicators align with the *Getting Queensland Back on Track* pledges of:

- Grow a four pillar economy
- Lower the cost of living
- Invest in better infrastructure and better planning
- Revitalise front-line services
- Restore accountability in government.

FAST FACT

ELECTIVE SURGERY LONG WAITS

were reduced from 1,429 in July 2013 to 30 in June 2014

2.2 Other whole-of-government plans/specific initiatives

In February 2013 the Department of Health released the *Blueprint for better healthcare in Queensland*, and this is publicly available at: http://www.health.qld.gov.au/blueprint/default.asp.

The blueprint has guided the development of the *MNHHS Strategic Plan 2014–2018* as it outlines structural and cultural improvements to establish Queensland as the leader in Australian healthcare.

The Blueprint focuses on four principal themes:

1. Health services focused on patients and people
2. Empowering the community and our health workforce
3. Providing Queenslanders with value in health services
4. Investing, innovating and planning for the future.

Redcliffe Paediatric Ward voted best in Brisbane

Brisbane Kids website has lavished praise on the Redcliffe Hospital Paediatric Ward in a vote to find Brisbane's best children's ward.

The website, which boasts nearly 100,000 subscribers, was approached by New South Wales Company Kili Tingatinga Art wanting to buy advertising on the site.

Brisbane Kids suggested the company donate a painting in lieu of payment for the advertising. The website asked its subscribers to vote for their favourite paediatric ward and overwhelmingly Redcliffe carried the day and won the award.

Acting Nurse Unit Manager (NUM) Robine Roser, was over the moon as were all the staff in paediatrics when they were presented with the original painting by a traditional African artist.

"Here is the painting where it now belongs," said a spokesperson on the website. "Can you just imagine the possibility that a Brisbane kid has looked at this painting and perhaps, just for a moment, felt a little less sick or even forgotten altogether that they are ill, even for a moment? That's a pretty great thought."

(L–R) Amy Dawes, Jacalyn Hall, Shaun Mahon, Robine Roser, Paula Herczegh and Heather McCloy.

Patients benefit as Metro North Hospital and Health Service reduces elective surgery long waits

Elective surgery patients accessing Metro North Hospital and Health Service (MNHHS) are experiencing shorter wait times than they did a year ago.

In 2013–2014 there has been a significant reduction in the number of elective surgery patients waiting beyond clinically recommended time frames. The biggest improvement has been for patients requiring surgery within 90 days. In June 2014, 98.8 per cent of our patients requiring surgery within 90 days had been seen on time.

We have been able to achieve better outcomes for our patients in relation to waiting lists through the targeted reinvestment of savings we have made combined with increased government funding.

This achievement marks a key deliverable for MNHHS, in its second year of operation, towards achieving Queensland's commitment to the National Healthcare Agreement.

Since introducing strategies in February 2013, over 2,000 patients have been treated – a reduction of over 98.8 per cent.

These results were well within the Service's 2 per cent key performance indicator and were made possible through efficiencies created by MNHHS in the 2012–13 financial year which allowed a $10M contribution, that was combined with a Department of Health contribution, and jointly reinvested into elective surgery as a key priority.

This investment means more people requiring elective surgery will be treated in time, which is a great outcome for the community. The reduction in waiting lists has been a win for patient care and for the long term sustainability of this vital hospital service. It has been achieved by the dedication of our staff with the common goal of achieving better healthcare outcomes for patients.This includes such targets as the use of funding to increase surgical activity and support services, unity amongst the HHS facilities to achieve equality in wait times, and overall process improvements extending across clinical areas including post-acute and community services that assist patient flow.

2.3 Agency objectives and strategic priorities (MNHHS)

MNHHS will deliver the priorities of the Government's *Blueprint for better healthcare in Queensland* through its transformation process in 2014–15. This mechanism will enable:

- Patients to be connected to high-quality integrated services
- Community and workforce to be engaged within sustainable models
- One HHS that will provide sustainable, effective and efficient service provision; and
- World class in health care delivery, research and education.

By investing in these priorities, MNHHS will be contributing to the Government's Statement of Objectives for the community – to grow a four pillar economy, lower the cost of living for families by cutting waste, deliver better infrastructure and better planning, revitalise front-line services for families and restore accountability in government.

Priority areas for 2014–15 include:

- Service delivery redesign – engaged with clinicians, community and primary health care. Joint investment with the Department of Health.
- Improving outpatient access – joint investment with the Department of Health.
- Information Technology (IT) investment delivering strategic initiatives in a modernised and mobile patient centred care environment.
- Improve value for services through initiatives including procurement strategies, and opportunities to drive efficient and effective services through partnership and contestability arrangements.
- Asset utilisation review.

Massive dent in oral care wait lists

Since February 2013, more than 14,500 people on long-term wait lists have been offered dental care across MNHHS last year, including all patients who had been waiting two or more years.

Executive Director, Oral Health Services, Dr Mark Brown attributed the drop to additional state government funding, which allowed for more efficient use of resources and the outsourcing of some services to the private sector via the dental voucher scheme.

"Thanks to this additional funding we have seen the MNHHS issue 16,942 vouchers over the period of 15 February 2013 to 31 December 2013," Dr Brown said.

"They were mainly sent to people who had been on public dental waiting lists for long periods, but also went to those requiring urgent dental care.

"Overall, MNHHS reported a 57 per cent decrease in patients awaiting dental care, going from 20,616 on wait lists in February 2013 to 8,874 at the end of the year."

Dr Brown said there had been an improvement in public dental waiting times right across the board.

"This improvement has seen Queensland Health exceed the Commonwealth performance target, resulting in a $30 million reward payment," he said.

"The reward payment will reimburse the Queensland Department of Health the money it had provided to hospital and health services to treat patients waiting on dental lists."

Dr Brown said he acknowledged that, in some cases, people had waited too long to receive the general oral health care they required.

"We've worked hard to address these waiting times, and the commitment and dedication of our oral health staff made this achievement possible," he said.

"We'll continue to work hard to make sure the people across the north Brisbane and Moreton Bay catchments are able to access oral health services when and where they need it most."

2.4 Agency service areas, service standards and other measures

MNHHS is responsible for the direct management of the facilities within its geographical boundaries including Royal Brisbane and Women's Hospital, The Prince Charles Hospital, Redcliffe Hospital, Caboolture Hospital, Kilcoy Hospital and Brighton Health Campus and Services.

In 2013–14 MNHHS facilities underwent the following Australian Council on Healthcare Standards (ACHS):

1. RBWH and Oral Health Services – Periodic Review Survey (May 2014).
2. Redcliffe, Caboolture and Kilcoy Hospitals – Self Assessment Survey (May 2014).
3. TPCH and Community – Self Assessment Survey (August 2013.)

We have also maintained and achieved Aged Care Accreditation.

MNHHS has successfully met the criteria set by the Department of Health for the transfer of ownership and has received a $4M incentive payment for achieving activity targets in 2013–14 (144 maintenance projects). MNHHS is set to get the best out of its built environment when the Department of Health transfers the ownership of buildings and land to the Service in July 2014.

$50M worth of building and maintenance projects were undertaken in 2013–14 ensuring patients received services in the best built environment. This included upgrades to wards and theatres, roads, car parks, plant and equipment in facilities across MNHHS. Systems and processes are in place to support the best use of our assets. A similar program of works is scheduled for the financial year 2014–15 with a focus on improving patient access and patient flow ($16.2M).

FAST FACT

100%

of Category 1 patients attending emergency departments are seen within the recommended timeframe of two minutes

Prosthesis music to little girl's ears

11-year-old Chloe Crust is now able to fulfil her dreams of playing the cello, thanks to the work from the RBWH Engineering Centre.

Chloe was born with a short arm and felt discouraged to play instruments at school, but after receiving her prosthetic cello adaptor, the keen musician said she feels thrilled with her new skills.

"My plucking device has helped me progress in my cello grades. It helps me move my arm faster and quicker to get the plucking right for the speed of the song," Chloe said.

After building the confidence to play the violin, Chloe dreamed of playing the cello.

She was referred to the RBWH Rehabilitation Engineering Centre (REC) where professional engineers clinically assess, design and manufacture custom solutions for clients with complex needs.

Chloe and her family met with Rehabilitation Engineer, Oliver Mason to discuss the need to create a custom prosthesis adaptor to hold a bow of a cello, with the ability for her left side to pluck the string while her right hand holds the note.

Oliver said the prosthesis adaptor is custom built using original designs for Chloe's need. "I didn't have any previous designs to work from. Prosthetic pick holders do exist but they don't have the folding capability, nor are they designed to use with a cello," Oliver said.

"I had to design and make a solution to hold the plectrum to the cello bow allowing Chloe to pluck strings when necessary, and then flip the device out of the way quickly during songs so that she could play the strings normally with the bow as well.

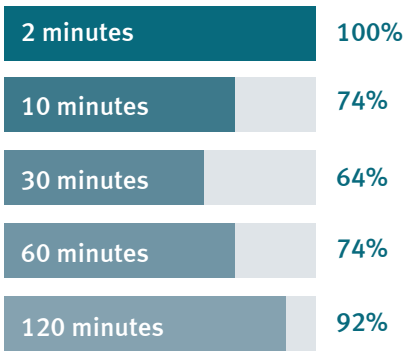
It took a few days to make, but when the family returned for the first time, it worked straight away. I am ecstatic that I was able to help Chloe."

Chloe Crust has her dream fulfilled thanks to RBWH Rehabilitation Engineer Oliver Mason and (inset) the components of Chloe's new prosthetic arm.

2.5 Non-financial performance: An overview

The following is an overview of MNHHS's non-financial performance, with a comparison of target to actual for the financial year.

WAIT TIME IN EMERGENCY DEPT



Service standards Percentage of patients attending emergency departments seen within recommended timeframes:	Notes	2012–13 Actual	2013–14 Target	2013–14 Actual
– Category 1 (within 2 minutes)		100%	100%	100%
– Category 2 (within 10 minutes)		76%	80%	74%
– Category 3 (within 30 minutes)		64%	75%	64%
– Category 4 (within 60 minutes)		71%	70%	74%
– Category 5 (within 120 minutes)		91%	70%	92%

TWENTY-SEVEN DAYS

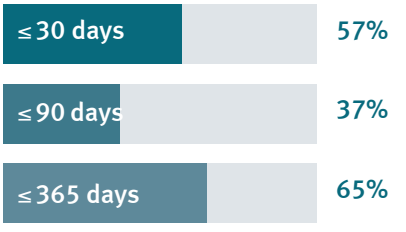
Median wait time for elective surgery

Percentage of elective surgery patients treated within clinically recommended timeframes in 2013–14

Percentage of emergency department attendances who depart within four hours of their arrival in the department		70%	83%	74%
Median wait time for treatment in emergency departments (minutes)		18		18
Median wait time for elective surgery (days)		26		27

Percentage of elective surgery patients treated within clinically recommended times:				
– Category 1 (30 days)		95%	100%	94%
– Category 2 (90 days)		72%	94%	81%
– Category 3 (365 days)		81%	97%	87%

Specialist outpatients waiting within clinically recommended timeframes in 2013–14



Percentage of specialist outpatients waiting within clinically recommended timeframes:				
– Category 1 (within 30 days)		56%	95%	57%
– Category 2 (within 90 days)		39%	90%	37%
– Category 3 (within 365 days)		62%	90%	65%

Patients admitted through MNHHS emergency departments in 2013–14

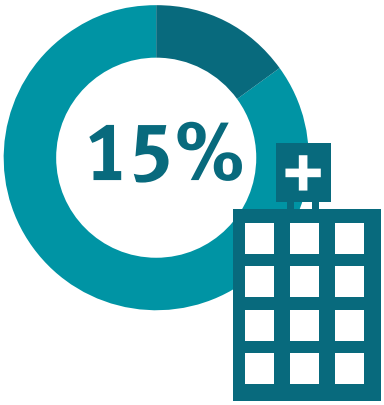
31,718

EMERGENCY DEPARTMENT ADMISSIONS

Average cost per weighted activity unit for Activity Based Funding facilities

$4,847

Percentage re-admitted to an acute mental health inpatient unit within 28 days of discharge in 2013–14



	Notes	2012–13 Actual	2013–14 Target	2013–14 Actual
Total weighted activity units:				
– Acute Inpatients		184,815	181,323	191,882
– Outpatients		37,707	38,445	39,625
– Subacute		20,824	19,841	18,879
– Emergency Department		29,249	28,811	31,718
– Mental Health		18,150	25,212	20,698
– Interventions and Procedures		32,435	35,714	35,720
Average cost per weighted activity unit for Activity Based Funding facilities		$5,113	$4,660	$4,847
Rate of healthcare associated *Staphylococcus aureus* (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	1	1.3	Less than or equal to 2/10,000	1.48
Number of in-home visits, families with newborns		9,673	13,262	10,171
Rate of community follow-up within 1–7 days following discharge from an acute mental health inpatient unit		62%	60%	62%
Proportion of re-admissions to an acute mental health inpatient unit within 28 days of discharge		16.7%	12%	15%
Ambulatory mental health service contact duration		108,654	100%	85.5%

1. *Staphylococcus aureus* are bacteria commonly found on around 30% of people's skin and noses and often cause no adverse effects. Infections with this organism can be serious, particularly so when they infect the bloodstream. The data reported for this service standard are for bloodstream infections with *Staphylococcus aureus* (including MRSA) and are reported as a rate of infection per 10,000 patient days aggregated to HHS level.

3.0 Financial Performance

3.1 Summary of financial performance

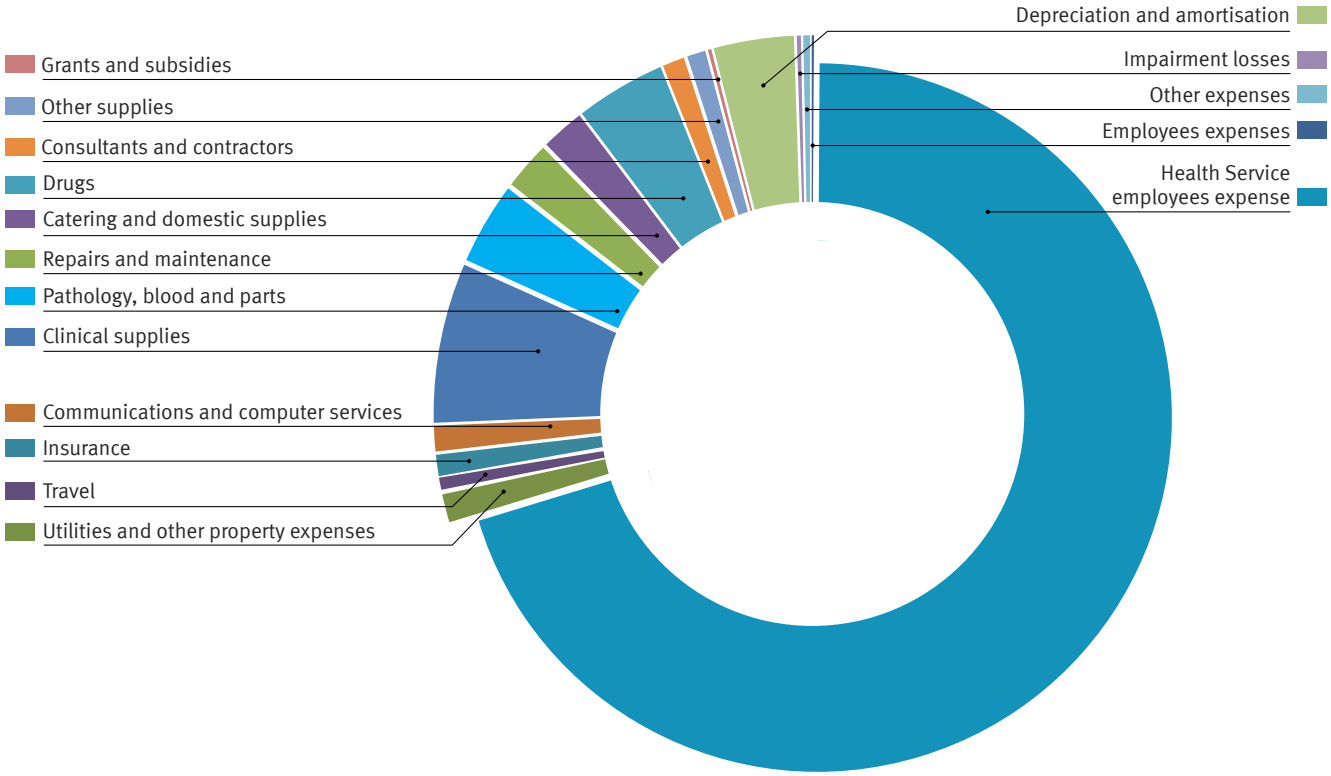
High Level Profit and Loss

	2014 $'000	2013 $'000
Revenue		
User charges and fees	172,927	140,888
Funding for the provision of public health services	1,915,732	1,926,335
Grants and other contributions	32,025	34,732
Other revenue	34,607	31,494
Total Revenue	**2,155,291**	**2,133,449**
Expenses		
Employee expenses	2,251	3,529
Supplies and services	2,012,516	2,019,096
Depreciation and amortisation	73,226	69,578
Other expenses	13,522	19,177
Total Expenses	**2,101,515**	**2,111,380**
Operating result from continuing operations	**53,776**	**22,069**

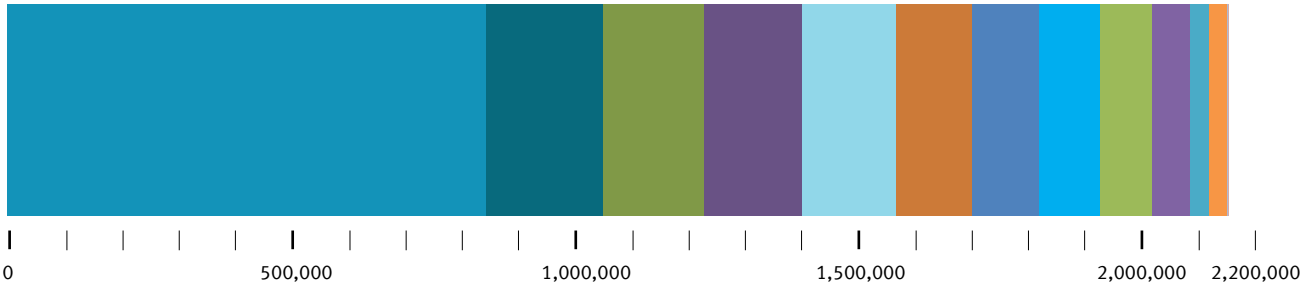
High level balance sheet

Assets		
Cash	167,698	101,889
Receivables	57,874	66,707
Property, plant and equipment	1,259,391	1,259,855
Other	19,255	19,823
Total Assets	**1,504,218**	**1,448,274**
Liabilities		
Payables	151,386	134,899
Other	1,939	1,369
Total Liabilities	**153,325**	**136,268**
Net assets	**1,350,893**	**1,312,006**

Expenses from continuing operations



Income from continuing operations



- Inpatient funding
- Other funding for the provision of public health services
- Outpatient funding
- User charges
- Interventions and Procedures funding
- Emergency department funding
- Mental Health funding
- Other ABF funding
- Subacute funding
- State managed block funding
- Other revenue
- Grants and other contributions
- Revaluation increment on property, plant and equipment
- Gains on disposal/remeasurement of assets

MNHHS launches Central Patient Intake (CPI)

Metro North Hospital and Health Service (MNHHS) launched a Central Patient Intake (CPI) service on 28 January 2014 to provide a one-stop-shop for patient handover to specialty services, with the exception of Mental Health and Oral Health Services.

Metro North Hospital and Health Board Chair, Dr Paul Alexander AO and CPI Project Officer Nicole Payne cut the ribbon at the launch.

Executive Director Medical Services MNHHS, Dr Donna O'Sullivan, said the CPI will make it easier for GPs to refer and improve patients' access to specialty services.

"The CPI gives GPs one central referral location for specialty services across MNHHS. This means no wrong door for referrals as well as streamlined processing."

"Extra features have been added to allow referrals to be processed through specialty hubs so patients will have equitable access to our services and queues will be reduced as waitlists are equalised across specialty areas."

"Gastroenterology (GE) will pilot the first specialty hub and are working with the CPI Program team to develop the model."

"We welcomed the launch of this important service that will help us work with our referrers to provide better connected care for our patients", Dr O'Sullivan said.

CPI has been launched with one central fax and phone number and one postal address. A supporting website provides GPs with comprehensive information on all specialty services across MNHHS.

Referrals received through Metro North CPI are placed on a new referral tracking system and GPs will only need to call one number to follow up.

MNHHS CPI administration and clinical staff assess each referral and work with GPs to make sure each referral contains the all necessary information to meet specialty service guidelines.

CPI staff also redirect any referrals that are addressed to a facility that does not offer the service requested to a facility that does and advise the GP of the redirection details.

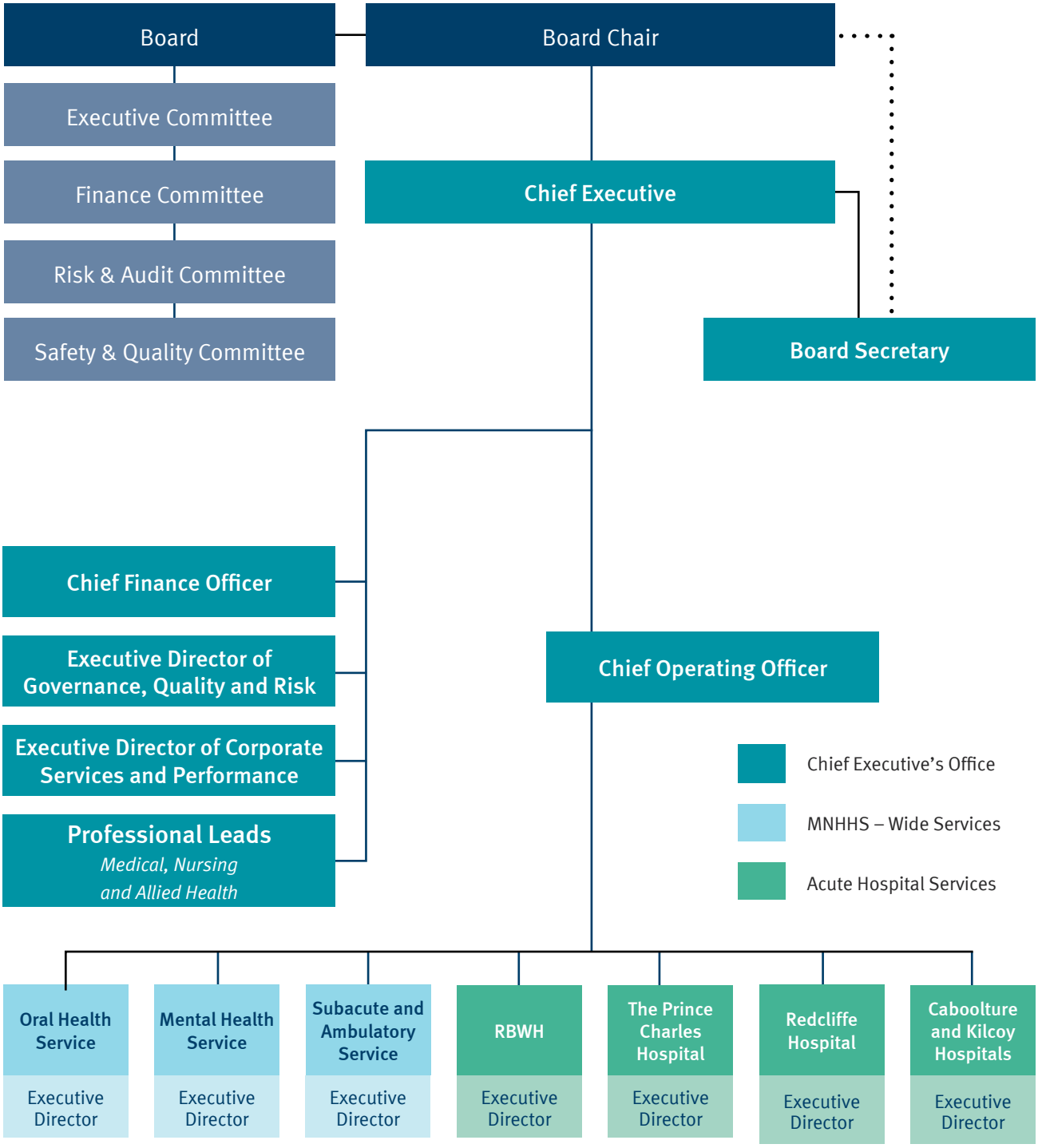
The CPI initiative is being implemented by the MNHHS Program Management Office in collaboration with specialty areas across MNHHS and Metro North Brisbane Medicare Local (MNBML).

The implementation is being carefully staged to enable a seamless transition to the new model.

The CPI Program Team is working with the MNBML to encourage GPs to use the CPI from the launch date. However, existing referral processes will run in parallel during the first phases of implementation, with outpatient staff passing referral details onto the CPI for central tracking.

4.0 Governance – Management and Structure

4.1 Organisational structure



Research on ‘good bugs’ during pregnancy

Researchers are conducting an important study at Redcliffe Hospital, in conjunction with the Royal Brisbane and Women’s Hospital and the Mater Mother’s Hospital, called ‘Probiotics to prevent gestational diabetes’.

(L–R) Site coordinator Meredith Shallcross, Research Lead Dr Alka Kothari and Research Nurse/Midwife Sharney Grant.

The research will try to determine if women taking tablets with ‘good bugs’ (probiotics) from early in pregnancy can decrease their risk of developing Gestational Diabetes Mellitus (GDM).

GDM is a form of diabetes that may occur during pregnancy, as the placenta produces hormones which can inhibit the normal function of insulin. Increased blood sugar levels in the mother create higher blood levels in the baby leading to an increase in birth weight.

Gestational diabetes is usually treated with diet or with insulin to keep blood sugar levels normal. Women with a BMI of more than 25 have an increased risk of GDM.

A study in Finland has shown probiotics to have been effective in a study of pregnant women with a BMI of less than 25. The probiotics were shown to have improved their blood sugars to the extent that 62 per cent fewer women receiving probiotics developed diabetes during their pregnancy than the control group.

Women who are less than 15 weeks pregnant with a BMI more than 25 are being invited to take part in this study. Research lead for the project is Dr Alka Kothari, Meredith Shallcross is site coordinator and Sharney Grant is the research nurse/midwife.

Sharney and Meredith say eligible staff as well as eligible patients booked to have their baby at Redcliffe Hospital are welcome to take part in the research. It involves some extra pathology tests at the 16th and 28th week of pregnancy and after delivery of the baby, as well as scheduled telephone contact.

Women are randomised to the group taking daily probiotics, or the group taking a placebo. The tablet is taken once daily from 16 weeks gestation until the birth of the baby.

4.2 The Board

The Board is appointed by the Governor in Council on the recommendation of the State Minister for Health and is responsible for the governance activities of the organisation, deriving its authority from the *Hospital and Health Boards Act 2011* and the *Hospital and Health Boards Regulation 2012*.

The functions of the Board include:

- Developing the strategic direction and priorities for the operation of MNHHS
- Monitoring compliance and performance
- Ensuring safety and quality systems are in place which are focused on the patient experience, quality outcomes, evidence-based practice, education and research
- Developing plans, strategies and budgets to ensure the accountable provision of health services
- Ensuring risk management systems are in place and overseeing the operation of systems for compliance and risk management reporting to stakeholders
- Establishing and maintaining effective systems to ensure that the health services meet the needs of the community.

The Board are all independent members who reside in the local catchment area, strengthening local decision making and accountability for health policies, programs and services within MNHHS. Each of the Board Members brings a wealth of experience and knowledge in public, private and not-for-profit sector with a range of clinical, health and business experience.

The following committees support the functions of the Board, each operates with a terms of reference describing the purpose, role, responsibilities, composition, structure and membership.

FAST FACT

94%

of Category 1 elective surgery patients are seen within the recommended timeframe of 30 days

Executive Committee

The role of the Executive Committee is to support the Board by working with the Chief Executive to progress strategic issues and ensure accountability in the delivery of services within MNHHS. The committee oversees the development of the Strategic Plan and monitors performance; the development of the clinician, consumer and community engagement strategies and the primary healthcare protocol; and works with the Chief Executive in responding to critical and emergent issues.

Finance Committee

The role of the Finance Committee is to oversee the financial performance, systems, risk and requirements of MNHHS. The committee reviews the financial strategy, financial policies, annual operating plans and capital budgets, cash flows and business plans to ensure alignment with key strategic priorities and performance objectives.

Risk and Audit Committee

The role of the Risk and Audit Committee is to oversee the internal and external audit function and matters relating to risk and compliance for financial, accounting and legislative requirements. The committee provides independent assurance and assistance to the Board on the risk, control and compliance frameworks and external accountability responsibilities as prescribed in the *Financial Accountability Act 2009, Auditor-General Act 2009, Financial Accountability Regulation 2009* and *Financial and Performance Management Standard 2009*.

Safety and Quality Committee

The role of the Safety and Quality Committee is to provide strategic leadership in relation to clinical governance. The committee oversees the safety, quality and effectiveness of health services and monitors compliance with plans and strategies, while promoting improvement and innovation for the safety and quality of services within MNHHS.

Computer game technology gets patients moving

(L–R): Finbar Mills (patient involved in the pilot study); The Hon. Lawrence Springborg MP, Minister for Health; Dr Robyn Grote, QMAC Director; The Hon. Campbell Newman MP, Premier of Queensland; and Dr Paul Alexander AO, Metro North Hospital and Health Board Chair.

A Royal Brisbane and Women's Hospital (RBWH) researcher has introduced an innovative assessment of people's gait using technology developed by the computer gaming industry and the creative world of special effects, to help improve outcomes for patients with movement disorders.

The cutting-edge, 3D gait analysis was launched in February 2014 as the first 'across the life-span' service at the Queensland Motion Analysis Centre (QMAC) led by Dr Robyn Grote, Principal Research Fellow with MNHHS.

Using reflective markers and electromygraphic sensors attached to the body, force plates embedded in a specially designed portable walkway and state-of-the-art 3D modelling, researchers are able to conduct an engineering analysis developing the most detailed and precise profile of a patient's gait and movement.

Burns patients, stroke victims, patients with acquired neurological disorders, babies and those with other complex gait and mobility problems now have access to this world class technology to improve diagnosis, treatment planning and monitoring.

This innovative facility, located at RBWH was officially opened by The Honourable Campbell Newman MP, Premier of Queensland and The Honourable Lawrence Springborg MP, Minister for Health at a ceremony that highlighted the valuable research being conducted.

The clinical laboratory was established with grants from MNHHS, sponsorship from international design and construction firm Robert Bird Group and a donation from world leading developer of motion capture products, Vicon.

Cadel Evans pedals into the heart of medical research

(L–R): Helen Seale, Clinical Consultant Physiotherapist, Cardiothoracic Program, The Prince Charles Hospital; Cadel Evans; Wendy Strugnell, Director of MRI Services, The Prince Charles Hospital; Norm Morris, Professor of Physiotherapy, Griffith University

Evans pedalled into the heart of The Prince Charles Hospital (TPCH) last month when he launched some world leading cardiopulmonary research being undertaken at TPCH at a major media event.

As an ambassador for Siemens, Cadel pedalled inside the Medical Imaging Department's Siemens MAGNETOM Aera MRI scanner to highlight the world first research which combines MRI with a purpose-built bicycle ergometer.

While pedalling inside the MRI machine, Cadel showed the research team how the heart and lungs of an elite athlete operate under exercise conditions, providing a benchmark for researchers.

Cadel said: "Through my work with Siemens, if I can raise awareness about how technology can better understand heart and lung disease and lead to improved treatments, then I know I'm helping reduce the strain on our hospitals for a more sustainable healthcare system."

The Richard Slaughter Centre of Excellence in Cardiovascular MRI, through its research collaboration with Siemens, is one of the first MRI centres in the world to have the advanced technology required to capture ultra-fast images of the heart during exercise.

The Exercise-MRI research program, led by Dr Fiona Kermeen (Thoracic and Transplant Physician) and Dr Richard Slaughter (Radiologist) aims to better understand how the heart and lungs operate under exercise conditions, which the researchers believe will lead to improved treatment for patients with heart and lung disease.

"The research is likely to change the way we treat people with heart and lung disease. Exercise-MRI scans will help inform us when the patient may need open heart surgery, a heart or lung transplant, or whether their current medications are working," said Dr Fiona Kermeen.

A multidisciplinary team, including key personnel Helen Seale (Senior Physiotherapist) and Wendy Strugnell (Director of MRI Services) is working with Professor Norm Morris (Professor of Physiotherapy at Griffith University) to undertake research on patients with pulmonary hypertension.

Director of MRI Services Wendy Strugnell said, "It was fascinating to have Cadel Evans test the new technology and show us the absolute limits of what could be achieved with these ultrafast imaging techniques. However, for our hospital community, the major beneficiaries of the technology will be sick patients who are unable to hold their breath long enough for us to take clear pictures of their beating hearts. Up until now, we have not been able to acquire images of the heart during exercise in these people."

Siemens Vice President Imaging and Clinical Products, Mr David Brown said that TPCH is the only hospital in Australia with the combination of advanced technological capability and clinical and research expertise in the cardiopulmonary arena.

"Through our research partnership, the hospital is using the latest Siemens software which delivers high speed imaging – similar to using a camera in 'sports-mode'. The patient friendly design of our MRI scanner means there is enough room for a patient to pedal while being scanned," Mr Brown said.

The event was also attended by Associate Professor Andre La Gerche (St Vincent's Hospital, Melbourne), whose international cardiac research is centred on athletes. He said that using elite athletes like Cadel Evans for exercise-MRI research will allow special insights into how the heart and lungs work.

"By understanding how the heart and lungs operate when they are working really well in athletes, we can then understand what's not working correctly in patients with heart and lung disease," Dr La Gerche said.

Dr Paul Alexander AO
Board Chair

Dr Paul Alexander has had an extensive career in the Australian Defence Force. He is an experienced senior medical officer with 30 years experience across clinical executive posts, and has held board positions in military, private practice, commercial and not-for-profit organisations. In addition to the role of Board Chair and his philanthropic interests, Paul is the Independent Health Advisor for the Department of Immigration and Border Protection, Chair of UQ Healthcare Board, medico-legal consultant and general practitioner.

Paul joined the Army in 1976 and completed his medical training at the University of Melbourne in 1978. He has undertaken a varied number of command, management and clinical positions within Defence including postgraduate medical training in the UK in Sports Medicine and Tropical Medicine, commanding both Field medical units and Military Hospitals, served as Australian Exchange Officer to the US Army Health Department for three years, and was the Senior Health Advisor at Enoggera Brisbane. He deployed with the initial peacekeeping force to Bougainville on Op BEL ISI and subsequently deployed as a member of the UN Peace Keeping Force in East Timor. Paul has also served as the RMO for the Special Air Service Regiment in Perth where he successfully completed SAS selection training.

In 2000, Paul transferred to the Army Reserve and worked for seven years in full-time clinical practice in Brisbane as a partner in a large group medical practice where he undertook the role of Managing Partner. Paul was promoted to Brigadier in January 2004 and assumed the position of Assistant Surgeon General Australian Defence Force – Army. He recommenced full time service with the Army in March 2008 when he was promoted to the rank of Major General. In 2011, Paul was made an Officer in the Military Division of the Order of Australia for distinguished service to Defence in the field of health. Paul completed his tenure as Commander Joint Health and Surgeon General Australian Defence Force in 2012, where he was responsible for the provision of healthcare to the Australian Defence Force.

Paul is a Fellow of the Royal Australasian College of Medical Administrators, a Fellow of the Australasian College of Legal Medicine and a Fellow of the Australasian College of Tropical Medicine.

Mr Vaughan Howell
Deputy Board Chair
Chair, Finance Committee

Mr Vaughan Howell has a career spanning more than 30 years working in the health service industry, managing organisations in the public, private and not-for profit sectors in Australia and the UK. His key success has been leading organisations through difficult and critical periods focusing on strategy and implementing major service redesign that has produced effective, efficient and economic, patient focused services.

His leadership and commitment to excellence has been recognised by organisations such as the Australian Quality Council, The Australian Human Resources Institute, and the Australian Institute of Marketing, Australian Private Hospitals' Association and Baxter Healthcare.

Vaughan is an experienced Board Member having served on health and welfare Boards in Australia and the UK. Vaughan is a graduate of the University of Queensland with major interests apart from health service redesign incorporating the innovative use of technologies, in bio-ethics, research ethics, knowledge and skills transference. He has served on committees and taskforces that have considered the impacts of bio-ethics on the philosophy of service delivery. He currently undertakes interesting esoteric management consulting assignments.

Mr Leonard (Len) Scanlan
Chair, Risk and Audit Committee

Mr Lenard (Len) Scanlan is a former Auditor-General of Queensland and has been appointed a National Fellow of the Institute of Public Administration Australia for his outstanding contribution to the practice of public administration. Len is a graduate of the Queensland Institute (now University) of Technology, with a Bachelor of Business (Accy), and the University of Queensland with a Bachelor of Arts (Government) and a Masters of Public Administration.

Len now operates a consultancy business focusing on audit committees, governance and boards for both the private and public sectors and is an adjunct professor at the University of Queensland. Among his business interests Len is a non-executive director of Queensland Urban Utilities and Chairman of Ganes Ltd. He chairs the Brisbane City Council's Audit Committee, as well as Metro North's Risk and Audit Committee. He is a non-executive director of the Medical Benevolent Association of Queensland Ltd and chairs the Audit Committee for the Royal National Association. He has received a number of awards, including the Centenary Medal Award.

Associate Professor Cliff Pollard
Chair, Safety and Quality Committee

Associate Professor Cliff Pollard is a qualified general surgeon, he undertook his surgical training in Queensland and obtained post Fellowship experience in the United Kingdom. Cliff has been the staff surgeon and visiting medical officer at Redcliffe Hospital, prior to moving to the Royal Brisbane and Women's Hospital in 2008 as the inaugural Director of the Trauma Service, retiring in 2012. As a member of the Royal Australian Army Medical Corps, he deployed to Bougainville and East Timor.

Cliff has a major interest in all aspects of trauma management in both pre-hospital and hospital environments and he has presented widely on the topic both nationally and internationally. More recently Cliff has been appointed Chair of the Ministerial Clinical Advisory Council and is Chair of the Statewide Trauma Clinical Network. Cliff has been an examiner in general surgery for the Royal Australasian College of Surgeons and currently teaches anatomy in the Advanced Surgical Anatomy Course. Cliff holds an Adjunct Associate Professor's position in the School of Medicine, University of Queensland.

Professor Helen Edwards OAM
Member

Professor Helen Edwards is Assistant Dean (International and Engagement), Faculty of Health, Queensland University of Technology (QUT) in Brisbane and a member of the Institute of Health and Biomedical Innovation. Helen is a Program Leader for the Wound Management Innovation Cooperative Research Centre and was involved in establishing this $110M centre which is the largest wound research initiative globally. It focuses on development of cost-effective and practical wound therapies, diagnostics and interventions.

Helen is also internationally recognised for her work in ageing and chronic disease. Her research is focused on evaluating models of care for people with chronic wounds and self-management of chronic disease. She leads the wound management research team in the Faculty of Health at QUT and works with multi-disciplinary teams and in partnership with industry. Professor Edwards is also a Board Member of the Australian Nursing and Midwifery Accreditation Council.

Professor Nicholas Fisk
Member

Professor Nicholas Fisk is Executive Dean of the Faculty of Medicine and Biomedical Sciences at the University of Queensland, with responsibility across population health, preclinical and clinical medicine and four hospital-based research centres. He practices as a maternal-fetal specialist at Royal Brisbane and Women's Hospital.

Nicholas was Director of the University of Queensland's Centre for Clinical Research (UQCCR), before becoming Executive Dean in 2010. From 1992 to 2007, he was Professor of Obstetrics and Gynaecology at Imperial College and Hammersmith Hospitals, London. His research interests lie in stem cell biology, multiple pregnancy and clinical obstetrics and he has published over 400 papers, reviews and editorials, including in prestigious periodicals such as Lancet, BMJ, JAMA and PLOS Medicine.

Nicholas is a member of editorial boards including PLOS Medicine and Stem Cells Translational Medicine, and holds a visiting professorship at the National University of Singapore. His current professional affiliations include Council Member, Queensland Institute of Medical Research and Board Member, Diamantina Health Partners.

Dr Kim Forrester
Member

Dr Kim Forrester is a registered nurse and barrister at law, her clinical background includes intensive and coronary care nursing. She is a member of the Australian College of Nursing. Kim established the Masters in Emergency Nursing program at Griffith University and was a foundation academic in the School of Medicine. She currently holds an academic appointment as Associate Professor in the Faculty of Health Sciences and Medicine at Bond University.

Kim's areas of legal practice include coroner's inquests, professional regulation and child protection. She held the position of Assistant Commissioner (legal) on the Queensland Health Quality and Complaints Commission from 2006 to 2009 and is a member of the Queensland Law Society's Elder Law and Health and Disability Law Committees. Kim publishes extensively in the area of health law. She is editor of the Nursing Column in the *'Journal of Law and Medicine'*, and co-author of the texts, *'Essentials of Law for Health Professionals'*, *'Australian Pharmacy Law and Practice'* and *'Essentials of Law for Medical Practitioners'*.

Ms Melinda McGrath
Member

Ms Melinda McGrath has held senior positions in healthcare organisations for the past 26 years, the last 18 years as a Chief Executive. She has led the strategic and operational performance of healthcare organisations and consistently obtained improved financial performance while ensuring clinical quality and patient outcomes are enhanced. As CEO of QML Pathology and of three private hospitals, Melinda ensured quality patient service and safety and improved efficiency in an environment of great strategic, competitive and funding changes, and developed and implemented multimillion dollar facility master plans to improve patient service and operational efficiency.

Melinda has qualifications in exercise physiology, psychology and business. Her board memberships have included Uniting Church Superannuation Plan, St Andrew's Heart Institute and Private Hospitals' Association of Queensland. Melinda is currently a member of the UQ Healthcare Board.

Melinda has received numerous awards over her career, including: National Winner Clinical Services Leadership Award 2005—St Andrews War Memorial Hospital; National Winner Australian Private Hospitals Association 2002 Award—Sunshine Coast Private Hospital; National Winner Australian Private Hospitals Association 2001 Team Excellence Award—St Stephens Private Hospital.

Dr Margaret Steinberg AM
Member

Dr Margaret Steinberg AM has expertise in governance and ethical decision making, as well as experience as a clinician, health administrator, academic and director of public, private and third sector organisations. Margaret is a former Commissioner of the Criminal Justice and Crime and Misconduct Commissions and Chair of their Audit and Governance Committees. She was Foundation Deputy President of the Guardianship and Administration Tribunal, Assistant Commissioner of the Health Quality and Complaints Commission and Chair of its Consumer Advisory Committee.

Margaret has special interest in governance, public and community health and currently sits on a number of professional disciplinary and regulatory Tribunals as well as being Patron, Governor or Director of third sector organisations. Margaret has a PhD (Child Health and Education) and Masters of Physiotherapy. Her awards include a Churchill Fellowship (disability), NHMRC/ PHRDC Travelling Fellowship (telemedicine) and WHO study (HIV/AIDS).

Margaret was made a Member of the Order of Australia in 2003 in recognition of her service to public health and welfare policy through research in the areas of ageing, disability and social justice.

RBWH receives US Military recognition

Royal Brisbane and Women's Hospital (RBWH) has been presented with a framed US Flag in recognition of the largest deployment of medical staff to Afghanistan from any single hospital in Australia.

Lieutenant Colonel Michael Reade made the presentation on behalf of the Commander of the NATO Role 3 Medical Hospital in Kandahar, Afghanistan, US Navy Captain Barth Merrill, to RBWH Executive Director Professor Kesh Baboolal.

The flag was flown over the US run trauma hospital in Kandahar on 8 November 2013 in recognition of the contribution of RBWH medical specialists who work at the Kandahar hospital and are also Australian Defence Force officers.

The officers were Commander Anthony Holley, Lieutenant Colonel Reade, Wing Commander Alexandra Douglas, Wing Commander Kylie Douglas, Wing Commander David Cooksley and Squadron Leader Michael Rudd. The inscription on the plaque highlights the 'shared ideals of service, professionalism, compassion and equal treatment for all'.

The presentation was made at the annual Metro North Hospital and Health Service (MNHHS) Military Dinner held on Saturday, 8 February 2014 at the United Service Club in Brisbane.

The evening also included a promotion ceremony for Wing Commander Kylie Hall, Anaesthetist and Wing Commander David Cooksley, Emergency Physician, both on the Military Surgical Team at RBWH.

Major General Paul Alexander AO, Chair, Metro North Hospital and Health Board gave the after dinner speech, reflecting on the unique experiences of health staff in the defence force and the importance of maintaining clinical skills and development through partnerships like the one with MNHHS.

The dinner, which is open to military and healthcare personnel, celebrates the collaboration between the Australian Defence.

Professor Kesh Baboolal, Executive Director RBWH was presented a framed US flag in recognition of the largest deployment of medical staff to Afghanistan from any hospital in Australia.

4.3 Executive management

The Board appoints the Health Service Chief Executive (HSCE) and delegates the administrative function of MNHHS to the HSCE and those officers to whom management is delegated. The HSCE responsibilities are:

- Managing the performance and activity outcomes for MNHHS
- Providing strategic leadership and direction for the delivery of public sector health services in the HHS
- Promoting the effective and efficient use of available resources in the delivery of public sector health services in the HHS
- Developing service plans, workforce plans and capital works plans
- Managing the reporting processes for performance review by the Board
- Liaising with the executive team and receiving committee reports as they apply to established development objectives
- The HSCE may delegate the Chief Executive's functions under the *Hospital and Health Boards Act 2011* to an appropriately qualified health executive or employee.

Health Service Chief Executive

Mr Malcolm Stamp CBE

Prior to joining MNHHS, Malcolm had over 40 years experience in the UK National Health Service (NHS). His Chief Executive posts have included Mid Essex Hospitals, Cambridge University Hospitals, Norfolk and Norwich University Hospital, Royal Liverpool University Hospital, Liverpool Health Authority, Crewe Health Authority and the provider agency for NHS London. He has also worked in New Zealand as the Chief Executive of Waikato District Health Board.

Malcolm received a CBE in 2002 in recognition of his service to the development of health services. During his career he has secured the largest (at the time) public/private sector funding agreement to develop the new Norfolk and Norwich University Hospital and was part of a team that achieved the first new Medical School for 30 years in England at the University of East Anglia.

Malcolm led Cambridge University Hospitals to become one of the first Foundation Trusts in England and was a prime mover in developing the Foundation Trust movement in England. Malcolm has held a number of national positions in the UK, including appointments to the Independent Reconfiguration Panel, National Review of Research and Development, Founding member of the Foundation Trust Network, and the Advisory Committee on Clinical Excellence Awards.

The following positions form the Executive Leadership Team to support the HSCE in the development and execution of the MNHHS strategy as approved by the Board.

Chief Operating Officer
Ms Kerrie Mahon

Chief Finance Officer
Mr Robert Dubery

Executive Director of Governance, Quality and Risk
Mr Keith Love

Executive Director of Corporate Services and Performance
Mr Scott McMullen

Professional Leads – Medical, Nursing and Allied Health
Dr Donna O'Sullivan (Medical)
Adj Assoc Prof Lesley Fleming (Nursing)
Mr Mark Butterworth (Allied Health)

Executive Directors

Executive Director RBWH
Professor Keshwar Baboolal
Adj Assoc Prof Lesley Fleming

Executive Director TPCH
Associate Professor Darren Walters

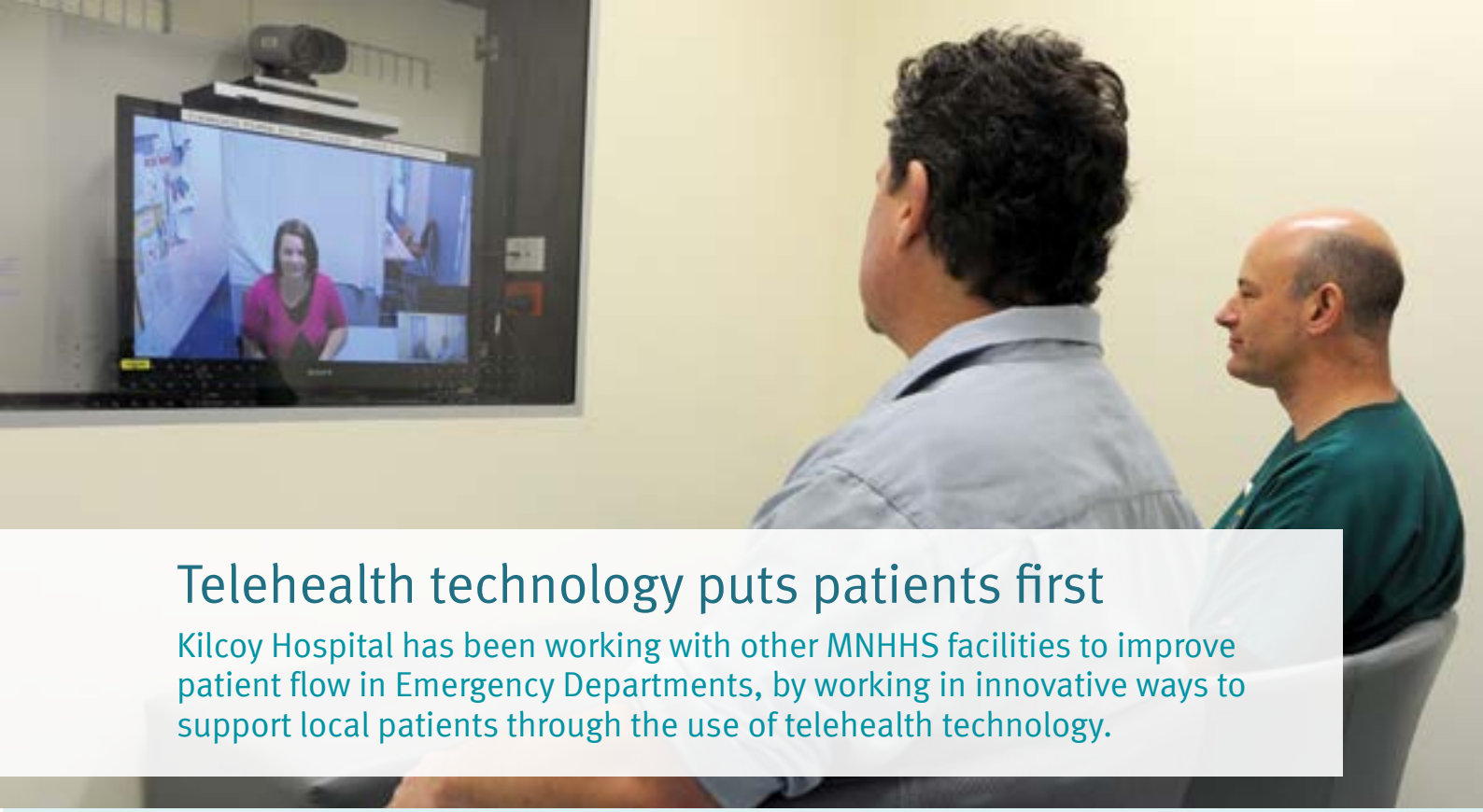
Executive Director Redcliffe Hospital
Ms Lexie Spehr

Executive Director Caboolture/Kilcoy Hospitals
Ms Caroline Weaver
Dr Stephen Ayre
Mr Keith Love

Executive Director Subacute and Ambulatory Services
Dr Cameron Bennett
Ms Mary Slattery

Executive Director Mental Health
Professor Brett Emmerson

Executive Director Oral Health
Dr Mark Brown



Telehealth technology puts patients first

Kilcoy Hospital has been working with other MNHHS facilities to improve patient flow in Emergency Departments, by working in innovative ways to support local patients through the use of telehealth technology.

Telehealth services give patients living in rural, remote and outer metropolitan locations greater access to a range of specialist consultations. By bridging the gap—and eradicating the inconvenience caused by geographical distance, a patient's personal commitments and family or childcare arrangements—telehealth delivers real-time health consultations online by providing specialist healthcare via video link up.

In today's world of rapidly increasing technological changes, embracing the use of telehealth provides a service back to the community, allowing patients to make choices as to whether they have to travel potentially hundreds of kilometres for a half hour appointment.

The innovative approaches of staff show that the team at Kilcoy Hospital are driving their telehealth initiative with energy and commitment, increasing the hospital's capacity to offer Outpatient sessions to the community of Kilcoy and surrounds for specialist appointments that occur in Brisbane, Redcliffe and Caboolture.

Director of Nursing and Facility Manager at Kilcoy Hospital, Lyndie Best said telehealth was very patient-centred.

"With the redevelopment of our old buildings, here at Kilcoy, we are creating a very warm and welcoming space which will be dedicated to Outpatient appointments".

The telehealth team have found that it is through the continued support of the Specialist Outpatient clinics across MNHHS that this vision will become a reality.

"Kilcoy Hospital can provide blood tests prior to session, which are then made accessible to the Specialist and plain x-rays can also be performed if required by nursing operators at Kilcoy. Most beneficially, this type of preparation means that any pre-workup can be achieved prior to the telehealth session", Ms Best said.

Kilcoy Hospital also holds a separate mobile telehealth unit which is able to connect to the Fracture Clinic appointments at Redcliffe for the patients who are non-weight bearing for a period of time, and are able to travel home. X-rays can also be performed prior to these scheduled sessions and any other information such as physiotherapy updates can be provided.

"It is the support of the Specialist Outpatients department and the Consultants that is key to the process. A prime example of putting patients at the centre of care, telehealth prevents a rather long and sometimes uncomfortable trip, for some, from Kilcoy to Redcliffe Hospital.

"Other uses that we are exploring with telehealth extend to working with other disciplines such as Physiotherapists, Occupational Therapists and Psychologists over distance. And this is an area we are enthusiastic to pursue with the Director of Allied Health across Kid Check and the diagnosis of behaviours where possible", says Ms Best.

Meanwhile, the timely consultation with Nurse Wound Consultants continues to be facilitated via telehealth at the facility, with patients able to describe how the wound feels while staff identify areas for the consultant to zoom in on and view in real-time.

The telehealth team at Kilcoy hospital are not stopping there however.

"Telehealth also needs to have the support of the local GPs so that they do not 'tick' the box that says no telehealth available on the Patient Travel Forms and we are looking to develop a pamphlet for the patients to take with them to their appointments to ask if they can have telehealth appointments scheduled for future appointments", says Ms Best.

4.4 Public Sector Ethics Act 1994

MNHHS is committed to upholding the values and standards outlined in the Code of Conduct for the Queensland Public Service, which was developed in accordance with the four core principles contained in the *Public Sector Ethics Act 1994*: Integrity and impartiality; Promoting the public good; Commitment to the system of government; Accountability and transparency.

Each principle is strengthened by a set of values and standards of conduct, describing behaviour that will demonstrate that principle.

All staff employed in MNHHS are required to undertake training in the Code of Conduct for the Queensland Public Service during their orientation, and re-familiarise themselves with the Code at regular intervals. During 2013–14, MNHHS fraud policy, procedures and guidelines were developed and are the standard of practice that underpins the Code of Conduct for the Queensland Public Service. The fraud standards of practice are contained in an updated orientation program.

The MNHHS Fraud policy, procedures and guidelines have been published on the MNHHS intranet, and all staff communication conducted. Communications relating to the standard of practice will be repeated every six months.

4.5 Queensland Public Service Values

Consistent with the Queensland Public Sector Values values the MNHHS Strategic Plan 2014–2018 recognises the values of:

- Customers first
- Ideas into action
- Unleash potential
- Be courageous
- Empower people.

The Prince Charles Hospital makes mark in trauma education

Participants at the skills rotation session.

The Prince Charles Hospital (TPCH) has made a mark in the medical education arena by hosting the prestigious Emergency Management of Severe Trauma (EMST) for the first time.

Considered a flagship course by the Royal Australian College of Surgeons (RACS), the EMST course is an accredited intensive course in the management of acute life threatening injuries in trauma patients.

The internationally recognised course is adapted from the Advanced Life Support course of the America College of Surgeons. Participation in the EMST course is a mandatory requirement in the ongoing professional development of medical officers who wish to/are specialising in acute trauma management, including surgery, anaesthetics, emergency department, rural, general practice and orthopaedics.

TPCH Course Director, Dr Rob Franz said the EMST course provided a great educational opportunity for doctors to up-skill in the area of severe trauma management.

"It educates participants about best practice techniques and gives them the chance to practically manage and respond to real life patient situations," Dr Franz said.

"The combination of theoretical and practical learning gives participants an extremely thorough knowledge and skills base in severe trauma.

"It is excellent that TPCH was given the opportunity to host."

5.0 Governance – Risk Management and Accountability

5.1 Risk management and audit

Risk within MNHHS is managed according to an integrated risk management policy and procedure which has been developed by management based on Australian Standards for Risk Management and endorsed by the Board.

Following internal audit of the risk management systems in 2013–14, the policy and procedure has been revised with more explicit articulation of the Board risk tolerance as well as the escalation and reporting requirements for significant risks. Key strategic risks are considered as part of the development of the *MNHHS Strategic Plan* and are articulated in the 2013–2017 plan:

- **Rapidly increasing demand for health services** – as a result of population growth and ageing, increasing incidence of chronic disease, high consumer expectations and the impact of technology.
- **Pressure on existing physical infrastructure** – many of our existing buildings, equipment, and Information and Communications Technology (ICT) infrastructure were not designed with the flexibility to adapt to new models of service delivery and/or are, in many cases, nearing the end of their useful life.
- **Maintaining a skilled and committed workforce** – rapid and ongoing change places significant pressure on staff, impacting on recruitment and retention. Effective service redesign requires system-wide, systematic and simultaneous changes to service models and work practices putting additional demands on staff to respond.
- **Managing cost pressures** – the cost of health care is rising at a rate in excess of any health funder's ability to respond. A major challenge for MNHHS will be to achieve the price and activity benchmarks set by Queensland Department of Health as the system funder, and the national funding price set by the Commonwealth.

During 2013–14 clinical councils across MNHHS identified the key clinical risks that they face and these have been incorporated into the service planning that has occurred. Risk registers are held by each facility and service and risk is a key agenda item on facility and service management committees.

Risks that are rated as 'very high' are reviewed by the Executive Leadership Team on a monthly basis and are also provided to the Board Risk and Audit Committee to ensure that appropriate risk mitigation and management plans are in place.

5.2 External scrutiny

In May 2014, the Royal Brisbane and Women's Hospital (RBWH) and the Oral Health Service underwent an independent, external accreditation survey by a team from the Australian Council on Healthcare Standards (ACHS). This external review was against the requirements outlined in the National Safety and Quality Health Service Standards as well as the ACHS Evaluation and Quality Improvement Program (EQuIP) National Standards. Of the 111 core and mandatory standards externally assessed, the RBWH and the Oral Health Service met all the requirements, with 26 of the 111 'Met with Merit'. 'Met with Merit' is the highest achievement level the survey team are able to allocate. This is a very significant achievement and provides confidence to the community that these services meet or exceed contemporary health service standards.

5.3 Internal Audit

The Internal Audit function provides an independent and objective assurance and consulting service to management and the Board. The audits undertaken are risk based and are designed to evaluate and improve the effectiveness of risk management, control and governance processes. Internal Audit operates with due regard to Treasury's Audit Committee Guidelines, a Board approved Charter and contemporary internal audit standards.

Annual and Strategic Audit Plans are developed in consideration of the Board's risk management and governance processes, designed and maintained by management. Following consultation with management and members of the Board Risk and Audit Committee, the audit plans are approved by the Board.

The delivery of audits is assisted through a Co-Source partnership arrangement with an accounting firm and engagement of subject matter experts as required. Although the function liaises regularly with the Queensland Audit Office (QAO) it remains independent of the QAO.

Key achievements of Internal Audit during the 2013–14 year included a review of:

- Theatre utilisation
- Activity based funding
- Risk management
- IT – User access and password security
- General ledger reconciliations
- Various payroll audits including leave management and rostering practices
- Credentialing
- Pharmacy and medication management.

Hospital in the Home services expanded

Metro North Hospital and Health Service (MNHHS) and Silver Chain have implemented Queensland's first community-based Public Private Partnership to expand the Hospital in the Home (HITH) program.

Silver Chain—a not-for-profit health and community care organisation—will work with MNHHS to allow more patients to receive health care in their own home, instead of being admitted to hospital.

HITH Nursing Director, Jacinta Thompson said, to date, 36 patients had received HITH services within the first month.

"The service operates at North Lakes, with a pilot program to be delivered over the next four years."

"Silver Chain will commence providing treatment for a range of conditions including cellulitis, urinary tract infection, respiratory infection, deep vein thrombosis and pulmonary embolism.

"We will also explore other areas that may be suitable for HITH treatment from the four acute hospitals in MNHHS. This will substantially increase the range of acute health care that can be safely delivered in the patient's home.

"There are currently 50 HITH funded beds across Metro North, with plans to expand the service by an additional 28 beds." Ms Thompson said.

The MNHHS team includes medical consultants, registrars and clinical nurse consultants working across each hospital and in the community with the HITH team.

"MNHHS initially commenced the HITH program in 2005 with a small number of HITH beds at Redcliffe and Caboolture Hospital. Since then the service has gradually expanded to include the Royal Brisbane and Women's Hospital and The Prince Charles Hospital." Ms Thompson said.

In December 2013, the State Government announced $28 million for the pilot program to increase HITH services through the implementation of Public Private Partnership arrangements.

5.4 Public Sector Renewal Program

MNHHS has embraced the key principles of the Queensland Public Sector Renewal Program through consideration of the principles as part of the environmental analysis for the *MNHHS Strategic Plan 2014–18*. The renewal program principles have sharpened the MNHHS focus on the key areas of:

1. Customer focus
2. Innovation
3. Contestability, commissioning and core services
4. Excellence, agility and productivity
5. Governance and accountability.

5.5 Information systems and record keeping

Section 160 of the *Hospitals and Health Board Act 2011* requires that any confidential information disclosures made in the public interest by a Service are outlined in the Annual Report for that Service. There were no disclosures of confidential information by MNHHS under this provision in 2013–14.

The Office of the Chief Executive is implementing an electronic record management system for key correspondence to and from the office and this system will be evaluated during 2014–15 for wider implementation across MNHHS.

MNHHS maintains its clinical records in accordance with a retention and disposal system which is in accordance with the Queensland State Archives Health Sector (Clinical Records) Retention and Disposal Schedule (QDAN683 v.1). Compliance with these requirements is externally assessed as part of the ACHS EQuIP National Standards accreditation requirements.

FAST FACT

12,841

Elective operations were performed within MNHHS in 2013–14

Integrating food service and clinical domains in MNHHS: A successful recipe

In 2013 Corporate Services commenced the challenging process of becoming a HHS-wide service. Food Services and Dietetics came together to produce a management model that would best meet the needs of patients and the organisation.

(L–R): Philip Juffs, Dr Merrilyn Banks, Zoe Walsh, Bianca Neaves, Tracy Knowlman, Michelle Suter, Rebecca McMullen and Brooke Starkey-Luke.

This led to a more integrated model where existing Dietitian Team Leaders assumed accountability for operational management of Patient Food Services at each site. This was new for RBWH, TPCH, and SaAS, and was already in place at Redcliffe and Caboolture.

The Dietitian Team Leaders Food Service has been working closely with all food service staff as a cohesive team to deliver outcomes based on clinical parameters, budget management, and efficient use of HR resources to improve the patient experience.

A focus on evidence and contestability are a cornerstone of the integrated model. Sites are at various stages of electronic menu implementation.

These systems improve patient safety and realise extra time for clinical support activities.

The Dietitians and Site Coordinators have been working hard to improve compliance with the Queensland Health Standards for Meals and Menus, along with the Food Safety Directive.

A high degree of menu standardisation across the Service has been achieved, allowing economies of scale in menu design and purchasing. Training and Quality Assurance processes are being reviewed and standardised across the Service. More sites are now conducting regular ward based Meal Quality Audits using a standardised tool. More trayed meals are being checked for accuracy than ever before. For example, multiallergy meals destined for the Royal Children's Hospital (RCH) no longer travel down the RBWH plating line. The feedback from the RCH has been universally positive with a massive reduction in errors and risk of cross contamination for this critical diet.

KPIs, benchmarking and budget integrity have been a focus area for the team. Aligning purchasing practices for mashed potato alone will realise savings of around $50,000 pa for MNHHS. A switch from bottled water at two of the sites to water jugs will realise another $50,000 annually per site.

Importantly, patient food service satisfaction continues to rate highly.

Redcliffe Integrated Chronic Disease Model of Care

The Redcliffe Integrated Chronic Disease model of care commenced in February 2014 and has been designed to provide improved access to community-based health care for chronic disease patients who are deemed high users of health services at Redcliffe Hospital.

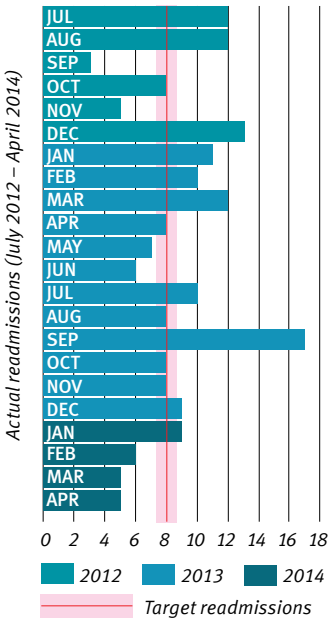
The models pillars consist of improved primary care capacity, integration of health services through development of communication and case management across the acute, primary, public and private health services and evidenced based service redesign to build sustainability.

The outcome is to have a functional evidenced supported model that can be transferrable across the MNHHS.

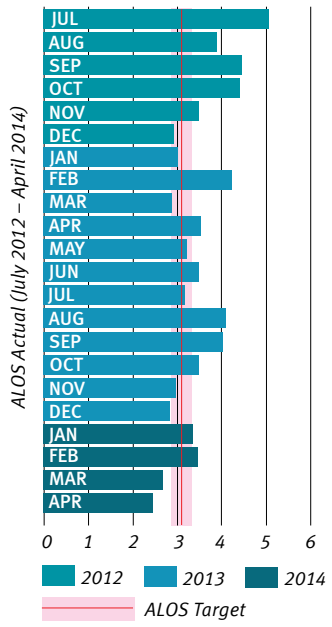
The key clinical service providers engaged in the model include Metro North Brisbane Medicare Local (NBML) Team Care Coordinators, Redcliffe Hospital (the demographic of this area reflects the largest percentage population of most disadvantaged with associated chronic disease in MNHHS), Subacute and Ambulatory Services (SaAS), General Practitioners (GPs) and private health providers.

Successes achieved through this project to date include:

- Achievement of a successful four week pilot in February 2014 showing significant satisfaction of consumers with the model
- The recruitment of 48 patients to the model
- Successful collaboration of key clinical service providers in the creation of patient continuum pathways
- Creation of new communication pathways between SaAS, MNBML, Redcliffe Hospital and GPs
- A new case management structure
- Team Care Coordination and Chronic Disease Nurse roles formalised and functioning well
- Shared Care Plans finalised and in place at the patients home
- Initiation of the first case conferencing between SaAS, MNBML, Redcliffe Hospital Chronic Disease Team regarding planning for the management of complex chronic disease patients
- Early trends with KPIs have shown a decreased length of stay for COPD patients (60 per cent per cent of cohort) from 3.6 to 2.7 days and readmission rates ranging from 9 on average per month prior to the model to 5.5 per month from Feb–May 2014 post implementation.



COPD Readmissions by Financial Year and Month



COPD ALOS by Financial Year and Month

6.0 Governance – Human Resources

6.1 Workforce planning, attraction and retention and performance

MNHHS currently employ 12,685 full time staff to deliver services at multiple sites, this has remained steady since 2012–13. The tables below show the number of staff providing and supporting services across MNHHS by employment stream and work location.

Professional stream		
MNHHS Workforce profile	**June 2014**	**% of total**
Managerial and clerical	2,063	16.3%
Medical including VMOs	1,671	13.2%
Nursing	5,489	43.2%
Operational	1,565	12.3%
Trade and artisans	110	0.9%
Professional and technical	1,786	14.1%
Total MOHRI Occupied FTE	**12,685**	

Division facility		
	June 2014	**% of total**
The Prince Charles Hospital	2,753	21.7%
Caboolture Hospital	901	7.1%
Kilcoy Hospital	31	0.2%
Redcliffe Hospital	1,283	10.1%
The Royal Brisbane and Women's Hospital	5,679	44.8%
Metro North H&Hs Other	2,038	16.1%
Total MOHRI Occupied FTE	**12,685**	

As Queensland's largest health care provider, MNHHS has established strong partnerships with universities and research bodies to support the attraction and retention of leading health care professionals and clinicians. A new MNHHS leadership framework is currently being established to support the development of current and future business leaders. This framework will align with technical development requirements for each stream to support the establishment of career paths within MNHHS.

The MNHHS workforce plan encompasses a balance of activities including strategies to:

- Identify and retain key labour for the future ensuring a sustainable, flexible and diverse workforce.
- Develop and utilise the competencies of the current workforce based on the identification of the workforce needs.
- Identification of the gap between demand and supply for staff – workforce numbers, job roles and skills – and the resultant degree of business risk.

Workforce Health and Safety Compliance

Several health and safety external and internal compliance activities were undertaken during 2013–14. External consultants Deloitte conducted an independent Health and Safety audit in February 2014, the audit was conducted across MNHHS and was based on the *Australian Standard 4801/4:2001*. MNHHS performed convincingly in this audit obtaining a full compliance rating against all audit criteria.

Workforce Key Performance Indicators

Along with achieving a strong safety focus, the provision of an effective and timely injury management service is vital to the positive workers compensation and return to work outcomes in MNHHS. The performance indicators below demonstrate ongoing improvements in the provision of our injury management services. These improvements are attributed to enhancements of the Rehabilitation Pathways, a case management model applied across all facilities within MNHHS.

Hours lost (WorkCover Vs Occupied FTE) – 0.35% (Target 0.35%)

This result is a 21.4% reduction of injured employees from 2012–13. Rehabilitation process enhancements and an increased focus on early return to work have resulted in the significant reductions.

Sick leave – 3.48% (Target 3.0%)

Sick leave performance has also improved in the past 12 months with a 16% improvement from 2012–13. The contributors to the reduction include:

- Statutory claims: MNHHS currently reporting 3% below the industry standard
- Lower average days to first return to work – MNHHS is 2.14 days below the industry average
- Average days paid per approved WorkCover claim – MNHHS remains below the industry standard by 1.51 days.

Corporate HR Review

As a result of Queensland Government Health Reform announced in September 2012, most of the HR functions and responsibilities previously held with Department of Health were transferred to MNHHS in 2013. At this time a comprehensive review of the corporate HR function within MNHHS was conducted.

A key outcome of the review was to take a more holistic view of the HR function to ensure MNHHS HR had the right capability to meet the needs of the new HHS environment and to successfully deliver the significant business –critical HR initiatives due for completion in 2014:

- Prescribed Employer
- Medical Contracts and Senior Contracts projects

The review also considered the current HR service offering against what capabilities would be required to meet the business challenges ahead. A focus on opportunities for improvement has resulted in considerable structural change in order to create alignment with broader MNHHS changes.

The review was completed in early 2014 and the following key activities have been identified:

- Restructure of HR department with a number of key appointments made
- Development of HR Strategy and Operational Plan and new Service model
- Implementation of HR Process Review Project to standardise, streamline and where possible automate all relevant HR related processes across MNHHS.

Springboard – Online Recruitment

In our quest to provide more streamlined and efficient HR Services, in February 2014 MNHHS launched 'Springboard' a new online recruitment system. Implementation of the system commenced in the Corporate Services and Performance areas, and is to be rolled-out with a phased approach over the coming months. Springboard has been warmly received by end users, who are enjoying the automation and functionality of the system.

The pilot was implemented in three phases:

1. Request to Hire online form – this form replaces numerous existing paper-based forms. The online form is intuitive for hiring managers with an online approval process for approvers/delegates.
2. Hiring Manager Access/Hiring Manager Review – this area of Springboard is designed to allow Hiring Managers to manage their candidates online. They can view applications as they come in and shortlist candidates accordingly. Candidates can also be sent to the Panel for online review.
3. Selection Report – the final stage in the Springboard program enables the Panel Chair to complete the selection process through adding assessment notes for candidates considered for further assessment, ranking these candidates and ultimately making the job offer online.

Industrial Relations

During the 2013–14 financial year changes to the Industrial Relations legislation have produced significant change to the Industrial Relations landscape providing MNHHS with opportunities to apply greater flexibility in making decisions regarding:

- how, when and by whom services are provided
- tightening of Right of Entry provisions
- ability to outsource services if required and requirement to consult with Industrial Unions prior to making these decisions made has been removed.

These legislative changes have made it possible for a significant level of organisational change to occur.

MNHHS has managed the transition with minimal Industrial disputation reaching the Queensland Industrial Commission. MNHHS continues to operate within an Industrial framework of consultative forums. The Metro North Consultative Forum is the peak forum for hospitals within the Hospital and Health Service and is accompanied by a Local Consultative forum to manage local issues.

As of the 1 July 2014 MNHHS will be prescribed by regulation as the employer of all current and future MNHHS staff. This status has been granted by Ministerial approval during 2013–14 as a result of providing evidence of the MNHHS capability to perform the required Human Resource functions and to effectively manage its workforce within a complex Industrial environment.

Kid Check Project Leader Dr Hsien-Jin Teoh.

‘Kid Check’ Paediatric Psychology

Kid Check is a paediatric psychology service that utilises postgraduate psychology students to assist with offering services to children and families via hospital paediatric out-patient clinics. Through this service model, a large number of CAT 3 long wait list children may be attended to in a short period of time.

Kid Check attends to children with:

- Attention Deficit Hyperactivity Disorder
- Oppositional Defiant Disorder (non-Compliance)
- Autism Spectrum Disorder
- Learning Disabilities
- Developmental and Intellectual Delay
- Behavioural and adjustment issues
- Emotional issues.

Offering assessments in the following areas:

- Cognitive assessments
- Developmental assessments
- Behavioural assessments
- Emotional assessments
- Social skills, social support and parenting assessments
- Learning style and academic ability assessments.

Offering brief therapies and assistance in the following areas:

- Child behaviour modification
- Advice to schools on child behaviour management, and attention focussing
- Cognitive Behaviour Therapy for Anxiety and low self esteem
- Referral to community agencies for on-going care.

Kid Check is made up postgraduate psychology interns who are provisional registered by the Psychology Board of Australia. These students are undergoing Masters and Doctoral programs in universities that have an agreement with Metro North’s Acute Psychology CIPPER project. All students are supervised by a Registered Psychologist with Clinical Endorsement, and who is also a Registered Supervisor with the Psychology Board of Australia.

At present Kid Check operates out of two sites:

- Redcliffe Hospital: Paediatric Out-patient’s Clinic
- Caboolture Hospital: Children’s Out-patient Clinic (as part of the AHPOSILS team).

Drug free technology to bring safer diagnosis for heart patients

Interventional Cardiologist, Dr Alex Incani shows a pressure wire used with the IFR technique to patient, John Forrest.

In an Australian first, The Prince Charles Hospital (TPCH) is trialling a new drug free diagnosis system to assess whether obstructions in a patient's coronary arteries may be potentially fatal.

The new Instantaneous Wave Free Ratio or iFR technique is used on patients with coronary artery disease to determine whether lesions or obstructions in their heart's (coronary) arteries are causing blockages to blood flow.

Importantly, iFR is drug-free, making it better tolerated by the patient compared with other methods used to diagnose cardiac problems.

TPCH Cardiologist, Dr Alex Incani said that a person with severe coronary artery disease may have several narrowings in their arteries, which block blood flow to the heart. "If left untreated, this condition can result in a heart attack and potentially be fatal.

"iFR may help us determine whether narrowings in a patient's coronary artery are actually causing significant blockages to blood flow.

"Not all patients with narrowed arteries necessarily experience problems with blood flow to their heart, so it's vital that diagnosis is accurate.

"The iFR method uses a pressure wire and a novel software algorithm that targets a very specific point in a person's cardiac cycle called the 'wave free period.

"The pressure wire is introduced through a catheter inserted into the coronary artery via the patient's groin or wrist.

"By determining the 'wave free period' in a person's cardiac cycle, the iFR can tell us whether the narrowings are causing blockages to the heart's blood flow.

"Knowing if a patient's coronary narrowings are causing blockages to blood flow, will determine what form of treatment is best.

"For example, some narrowings in a patient's coronary artery may be able to be treated by drug therapy.

"However more severe narrowings which are causing reduction to blood flow, may require the patient to have a coronary balloon and stent, which will physically open up the artery.

"Through this trial, we are aiming to validate that iFR can provide equally accurate results as other current methods for diagnosis, without the need for drug therapy.

"If we can do this, this may lead to iFR becoming a standard clinical practice in treating patients with coronary artery disease.

"It will give us an effective diagnostic tool for diagnosing and treating coronary artery disease and mean safer and more comfortable treatment for our patients," Dr Incani said.

The trial will involve approximately 100 patients over a 12 month period.

Achievements

A concentrated focus on long term employee suspensions has resulted in a 90 per centy reduction in the length of suspensions which correlates to an 89 per cent reduction in costs. Improvements have also been made in resolving employee complaints with an average of 57 cases resolved each month since the commencement of a co-ordinated HR Service for MNHHS.

6.2 Early retirement, redundancy and retrenchment

During 2013–14 a total of 499 employees received redundancy packages at a cost of $43,117,439. Employees who did not accept an offer of a redundancy were offered case management for a set period of time, where reasonable attempts were made to find alternative employment placements. At the conclusion of this period, and where it was deemed that continued attempts of ongoing placement were no longer appropriate, employees yet to be placed were terminated and paid a retrenchment package, with four employees receiving retrenchment packages at a cost of $585,546.

FAST FACT

18 minutes

is the median wait time for treatment in MNHHS emergency departments

New midwifery care model first in Brisbane

Women's and Newborn Services celebrate the launch of the Eligible Private Practice Midwives Model of Care.

An exciting new midwifery model was launched this month giving more choice to north side families.

Women who are booked to give birth at Royal Brisbane and Women's Hospital (RBWH) are now able to choose to see an accredited private midwife for their antenatal and postnatal care.

This agreement is the first of its kind for public hospitals in Brisbane. RBWH Nursing and Midwifery Director for Women's and Newborn Services Tami Photinos is pleased to be able to offer this model of care to Brisbane mums to- be.

"We have been working for many years to get this model of care up and running for women wanting to see their own private midwife," Ms Photinos said.

"This first phase will allow women to see an accredited private midwife in the community during the pregnancy and after the birth, but attend at the RBWH for birth as a public patient under the care of our staff. Women can also access specialist appointments from RBWH as required.

"At first a small number of private midwives have been accredited to provide this service in collaboration with RBWH. And we have continued to expand this number throughout in 2014."

The midwives will follow referral guidelines to ensure any issues that arise during the pregnancy are referred to RBWH for specialist treatment.

The collaboration also allows for Medicare rebates as the midwives are notated by the Nursing and Midwifery Board of Australia as an 'Eligible Midwife'.

"In the future we intend to transition to full continuity of care where midwives have visiting access to attend their private patients for birthing," Ms Photinos said.

7.0 Financial Statements 2013–14

7.1 General information

The Metro North Hospital and Health Service is a Queensland Government statutory body established under the *Hospital and Health Boards Act 2011* and its registered name is "Metro North Hospital and Health Service".

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

The head office and principal place of business of the Metro North Hospital and Health Service is:

Level 14, Block 7
Royal Brisbane and Women's Hospital
Herston QLD 4029

A description of the nature of the operations and principal activities of the Metro North Hospital and Health Service is included in the notes to the financial statements.

For information in relation to the health service's financial statement please call 07 3647 9704, email MD16-MetroNorthHHS@health.qld.gov.au or visit the Queensland Department of Health's internet site http://www.health.qld.gov.au/metronorth/

Statement of Comprehensive Income
For the year ended 30 June 2014

	Notes	2014 $'000	2013 $'000
Income from continuing operations			
User charges and fees	3	172,927	140,888
Funding for the provision of public health services	4	1,915,732	1,926,335
Grants and other contributions	5	32,025	34,732
Other revenue	6	34,607	31,494
Total revenue		**2,155,291**	**2,133,449**
Revaluation increment on property, plant and equipment	7	1,814	–
Gain on disposal/re-measurement of assets	8	256	132
Total income from continuing operations		**2,157,361**	**2,133,581**
Expenses from continuing operations			
Employee expenses	9	2,251	3,529
Supplies and services	10	2,012,516	2,019,096
Grants and subsidies	11	3,143	4,621
Depreciation and amortisation	12	73,226	69,578
Impairment losses	13	3,807	5,321
Other expenses	14	6,572	6,219
Revaluation decrement on property, plant and equipment	20	–	3,016
Total expenses from continuing operations		**2,101,515**	**2,111,380**
Operating result from continuing operations		**55,846**	**22,201**
Other comprehensive income			
Items that will not be reclassified subsequent to operating result:			
Increase/(decrease) in asset revaluation surplus	24	17,401	–
Total other comprehensive income		**17,401**	**–**
Total comprehensive income		**73,247**	**22,201**

The accompanying notes form part of these statements.

Statement of Financial Position
As at 30 June 2014

	Notes	2014 $'000	2013 $'000
Current assets			
Cash and cash equivalents	15	167,698	101,889
Receivables	16	57,874	66,707
Inventories	17	14,329	15,864
Other assets	18	3,023	3,387
Total current assets		**242,924**	**187,847**
Non–current assets			
Property, plant and equipment	20	1,259,391	1,259,855
Intangible assets	19	1,813	368
Other assets	18	90	204
Total non–current assets		**1,261,294**	**1,260,427**
Total assets		**1,504,218**	**1,448,274**
Current liabilities			
Payables	21	151,386	134,899
Accrued employee benefits	22	74	134
Unearned revenue	23	1,865	1,085
Total current liabilities		**153,325**	**136,118**
Non–current liabilities			
Unearned revenue	23	–	150
Total non–current liabilities		**–**	150
Total liabilities		**153,325**	**136,268**
Net assets		**1,350,893**	**1,312,006**
Equity			
Contributed equity		1,255,445	1,289,805
Accumulated surplus		78,047	22,201
Asset revaluation surplus	24	17,401	–
Total equity		**1,350,893**	**1,312,006**

The accompanying notes form part of these statements.

Statement of Changes in Equity
For the year ended 30 June 2014

	Notes	Accumulated Surplus/ (deficit)	Asset Revaluation Surplus	Contributed Equity	Total Equity
		$'000	$'000	$'000	$'000
Balance at 1 July 2013		**22,201**	**–**	**1,289,805**	**1,312,006**
Operating result from continuing operations		55,846	–	–	55,846
Other comprehensive income					
Increase in asset revaluation surplus		–	17,401	–	17,401
Total comprehensive income for the year		**55,846**	**17,401**	**–**	**73,247**
Transactions with owners as owners					
Equity injections – Minor Capital Funding		–	–	31,684	31,684
Equity withdrawals – depreciation and amortisation	2(k)	–	–	(72,848)	(72,848)
Non–appropriated equity asset transfers		–	–	6,804	6,804
Net transactions with owners as owners		**–**	**–**	**(34,360)**	**(34,360)**
Balance as at 30 June 2014		**78,047**	**17,401**	**1,255,445**	**1,350,893**

	Notes	Accumulated Surplus/ (deficit)	Asset Revaluation Surplus	Contributed Equity	Total Equity
		$'000	$'000	$'000	$'000
Balance at 1 July 2012		**–**	**–**	**–**	**–**
Operating result from continuing operations		22,201	–	–	22,201
Total comprehensive income for the year		**22,201**	**–**	**–**	**22,201**
Transactions with owners as owners					
Net assets received (transferred pursuant to the *Hospital and Health Board Act 2011*)*		–	–	1,249,134	1,249,134
Equity injections – Minor Capital Funding		–	–	27,085	27,085
Equity withdrawals – Depreciation and amortisation	2(k)	–	–	(69,578)	(69,578)
Non–appropriated equity asset transfers		–	–	83,164	83,164
Net transactions with owners as owners		**–**	**–**	**1,289,805**	**1,289,805**
Balance as at 30 June 2013		**22,201**	**–**	**1,289,805**	**1,312,006**

**Net assets transferred from the Department of Health pursuant to the Hospital and Health Board Act 2011.*

The accompanying notes form part of these statements.

Statement of Cash Flows
For the year ended 30 June 2014

	Notes	2014 $'000	2013 $'000
Cash flows from operating activities			
Inflows			
User charges		155,352	141,567
Funding for the provision of public health services		1,872,478	1,824,206
Grants and other contributions		31,875	34,731
Interest received		686	908
Other revenue		32,506	30,583
GST collected from customers		(3,970)	3,995
GST input tax credits from Australian Taxation Office*		21,714	3,376
Outflows			
Employee expenses		(2,831)	(3,529)
Supplies and services		(2,023,144)	(1,911,729)
Grants and subsidies		(3,642)	(4,690)
Other expenses		2,071	–
GST paid to suppliers		22,691	(22,187)
GST remitted to Australian Taxation Office*		(41,427)	(19,656)
Net cash provided by (used in) operating activities	**25**	**64,359**	**77,575**
Cash flows from investing activities			
Inflows			
Sales of property, plant and equipment		680	–
Outflows			
Payments for property, plant and equipment		(29,275)	4,261
Payments for intangible assets		(1,639)	–
Net cash provided by (used in) investing activities		**(30,234)**	**4,261**
Cash flows from financing activities			
Inflows			
Equity transferred – 1 July 2012**		–	20,053
Equity transferred		31,684	–
Net cash provided by (used in) financing activities		**31,684**	**20,053**
Net increase/(decrease) in cash and cash equivalents		**65,809**	**101,889**
Cash and cash equivalents at the beginning of the financial year		**101,889**	**–**
Cash and cash equivalents at the end of the financial year	**15**	**167,698**	**101,889**

The accompanying notes form part of these statements.

* *The GST transactions with the Australian Taxation Office are managed and lodged via the Department of Health under a GST Grouping as per the Division 48, A New Tax System (Goods and Services Tax) Act 1999. See Note 2(y).*

** *Cash assets transferred from the Department of Health pursuant to the Hospital and Health Board Act 2011.*

Index to notes to the financial statements

1 Objectives and strategic priorities of the Metro North Hospital and Health Service

The Metro North Hospital and Health Service is an independent statutory body, overseen by a local Hospital and Health Board, and provides a full range of health services including rural, regional and tertiary teaching hospitals. The Metro North Hospital and Health Service covers an area of 4,157 square kilometres and extends from the Brisbane River to north of Kilcoy.

The Metro North Hospital and Health Service provides public hospital and healthcare services as defined in the service agreement with the Department of Health as manager of the public hospital system.

The Metro North Hospital and Health Board is responsible for the oversight of health services within the Metro North Hospital and Health Service's graphical boundaries which includes hospitals, multipurpose health services, community and primary care facilities, aged care facilities and mental health services. The Hospital and Health Service provides a comprehensive range of community and primary health services, including aged care assessment; Aboriginal and Torres Strait Islander health programs; alcohol, tobacco and other drug services; mental health services; home care services; community health nursing; sexual health services; allied health services; oral health; and health promotion programs.

These services reflect the Metro North Hospital and Health Service's planning priorities as articulated in Metro North Hospital and Health Service Strategic Plan 2014-2018.

These strategic directions are set by the Metro North Hospital and Health Board, and the Metro North Hospital and Health Service implement and develop initiatives in accordance with these strategic directions.

The Metro North Hospital and Health Service purpose is to deliver quality healthcare in partnership with the community as a trusted leader in metropolitan healthcare.

2 Summary of significant accounting policies

(a) Statement of compliance

The Metro North Hospital and Health Service has prepared these financial statements in compliance with section 43 of the *Financial and Performance Management Standard 2009* (QLD).

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

With respect to compliance with Australian Accounting Standards and Interpretations, the Metro North Hospital and Health Service has applied those requirements applicable to a not-for profit entity, as the Metro North Hospital and Health Service is a not-for-profit entity. Except where stated, a historical cost convention is used.

(b) The reporting entity

The financial statements include the value of all income, expenses, assets, liabilities and equity of the Metro North Hospital and Health Service. The Metro North Hospital and Health Service does not have any controlled entities. The major activities of Metro North Hospital and Health Service are disclosed in Note 1.

(c) Trust transactions and balances

The Metro North Hospital and Health Service acts only in a fiduciary trust capacity in relation to patient trust accounts. Consequently, these transactions and balances are not recognised in the financial statements of the Metro North Hospital and Health Service, but are disclosed in 30(b). Although patient funds are not controlled by the Metro North Hospital and Health Service, trust activities are included in the audit performed annually by the Auditor-General of Queensland.

Metro North Hospital and Health Service also acts in an agency role in respect of the transactions and balances of the Right of Private Practice (RoPP) bank accounts. The Right of Private Practice bank accounts are not controlled by the Metro North Hospital and Health Service but the activities are included in the annual audit performed by the Auditor-General of Queensland and disclosed in Note 30(a).

(d) User charges and fees

User charges and fees are controlled by the Metro North Hospital and Health Service when they can be deployed for the achievement of the Metro North Hospital and Health Service's objectives. User charges and fees controlled by the Metro North Hospital and Health Service are recognised as revenues 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.

User charges and fees primarily comprises of hospital fees, reimbursement of pharmaceutical benefits and sales of goods and services.

(e) Funding for the provision of health services

The funding from Department of Health is provided predominantly for specific public health services purchased by the Department from the Metro North Hospital and Health Service in accordance with a service agreement between the Department and Metro North Hospital and Health Service. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by the Metro North Hospital and Health Service.

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

(f) Grants and other contributions

Grants, contributions, donations and gifts that are non-reciprocal in nature are recognised as revenue in the year in which the Metro North Hospital and Health Service obtains control over them.

(f) Grants and other contributions (continued)

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

There has been a change in the recognition of Department of Health funding from grants and other contributions in 2012–13 to user charges and fees this year, refer Note 2(e) and 2(cc) for details.

(g) Special payments

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

(h) Cash and cash equivalents

For the purpose of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques receipted but not banked as at 30 June as well as deposits at call with financial institutions.

(i) Receivables

Trade debtors are recognised at the amounts due at the time of sale or service delivery i.e. the agreed purchase/ contract price. Trade receivables are generally settled within 60-120 days, while some other trade receivables may take longer than twelve months to settle.

The collectability of receivables is assessed periodically with provision being made for impairment. All known bad debts are written off when identified. Increases in the allowance for impairment are based on loss events as disclosed in Notes 16 and 33(c).

(j) Inventories

Inventories consist mainly of medical supplies and equipment, drugs and other pharmaceuticals held for distribution to, and consumption by, hospitals.

Inventories are measured at the lower of cost and net realisable value. The cost of inventories is measured at their weighted average cost; including expenditure incurred in acquiring them and bringing them to their existing location and condition and is adjusted for loss of service potential. These supplies are expensed on issue from the Metro North Hospital and Health Service's main storage facilities.

Supplies may also be held on site under arrangements with external suppliers. The terms of consumption of these goods are outlined in the agreement with the relevant supplier. The goods do not form part of the inventory holding of the Metro North Hospital and Health Service and are not included in the financial statements. The value of these goods is charged and expensed by the Metro North Hospital and Health Service in the period they are consumed.

(k) Property, plant and equipment

Items of property, plant and equipment with a cost or other value equal to or in excess of the following thresholds and with a useful life of more than one year are recognised for financial reporting purposes in the year of acquisition. Items with a lesser value are expensed in the year of acquisition.

Class	Threshold
Buildings*	$10,000
Land	$1
Plant and Equipment	$5,000

* *Land improvements undertaken by the Metro North Hospital and Health Service are included with Buildings.*

Initial measurement

Actual cost is used for the initial recording of all non-current physical and intangible asset acquisitions. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use, including architect's fees and engineering design fees. However, any training costs are expensed as incurred.

Where assets are received free of charge from another Queensland department (whether as a result of a machinery-of-Government change or other involuntary transfer), the acquisition cost is recognised as the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation.

Assets acquired at no cost or for nominal consideration, other than from an involuntary transfer from another Queensland Government entity, are recognised at their fair value at date of acquisition in accordance with AASB 116 *Property, Plant and Equipment*.

Subsequent costs

Subsequent expenditure is only capitalised when it is probable that future economic benefits associated with the expenditure will flow to the Metro North Hospital and Health Service. Ongoing repairs and maintenance are expensed as incurred.

Subsequent measurement

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

Land and buildings are measured at 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 impairment losses where applicable.

(k) Property, plant and equipment (continued)

In respect of the abovementioned asset classes, the cost of items acquired during the financial year has been judged by management of the Metro North Hospital and Health Service to materially represent their fair value at the end of the reporting period.

To ensure the carrying amounts of the land and buildings asset classes reflect their fair value, land and buildings asset classes are revalued on an annual basis. The concept of materiality contained in AASB 1031 *Materiality* is considered in determining whether only those material assets within the class, rather than all assets of the class, are revalued. In applying the concept of materiality to asset revaluations, the Metro North Hospital and Health Service has an appropriately robust policy for identifying those assets to be included or excluded as part of the revaluation process.

The annual valuation process for a class of land or buildings carried at fair value may incorporate either one or both of the following revaluation methodologies:

- Appraisals undertaken by independent professional valuer or internal expert; or
- Use of appropriate and relevant indices.

Revaluations using independent professional valuers are undertaken with sufficient regularity to ensure assets are carried at fair value. However, if a class of asset experiences significant and volatile changes in fair value (i.e. where indicators such as property market and construction cost movements suggest that the value of the class of asset may have changed by 20% or more from one reporting period to the next), it is subject to such revaluations in the reporting period.

The fair values reported by the Metro North Hospital and Health Service are based on appropriate valuation techniques that maximise the use of available and relevant observable inputs and minimise the use of unobservable inputs (refer to Note 2(o)).

Land

In 2013–14 land was fair valued by the State Valuation Service (SVS) using the following methodology:

- Desktop indexation on 100% of the Metro North Hospital and Health Service land portfolio.

The State Valuation Service provides an individual factor change per property derived from the review of market transactions (observable market data). These market movements are determined having regard to the review of land values undertaken for each local government area issued by the Valuer-General Department of Natural Resources and Mines.

The results of the desktop indexation indicated there were material indexation movements for three properties. These three properties were subsequently subject to a desktop valuation conducted by State Valuation Service.

The desktop valuations were carried out in accordance with the Australian Property Institute's Restricted Valuation Supporting Memorandum, on the fair value basis in accordance with the requirements of the Australian and International Valuation Standards and Australian Accounting Standard AASB13 *Fair Value Measurement* and Queensland Treasury and Trade's *Non-current Asset Policies for the Queensland Public Sector*. All valuations comply with the fair value definition which is the price that would be received to sell an asset in an orderly transaction between market participants at the measurement date under current market condition (i.e. an exit price) regardless of whether that price is directly derived from observable inputs or estimated using another valuation technique.

Both valuation methodologies take into consideration specific valuation indicators such as location, size, zoning regulations and recent market data.

The revaluation program for land resulted in an increment of $41,328 (2013: decrement of $1.52 million) to the carrying amount of land (See Note 20).

Buildings

Buildings are measured at fair value utilising either independent revaluation or applying an interim revaluation methodology developed by external quantity surveyors Davis Langdon. The methodology used by Davis Langdon takes into account the specialised nature of health service buildings and the fair value is determined by using the depreciated replacement cost method. Depreciated replacement cost is determined as the replacement cost less the cost to bring to current standards. This is in accordance with Queensland Treasury and Trade's *Non-Current Asset Policy (NCAP)* 3 – *Valuation of Assets*.

In determining the replacement cost of each building, a cost model developed by Davis Langdon is used and provides an elemental cost plan (cost estimate) of the asset through the determination of key cost drivers such as;

- Asset type (clinical building, administration, clinic etc.)
- Gross floor area (where high-set residences have been inspected, only the main upper floor has been measured)
- Number of floors
- Girth of the building
- Height of the building
- Number of lifts
- Location.

Estimates of each floor area were obtained by measuring quantities (floor areas etc.) using drawings obtained through the e-Plan room, obtained from the Metro North Hospital and Health Service and verified on site or by completing a site measurement.

(k) Property, plant and equipment (continued)

The 'cost to bring to current standards' is the estimated cost of refurbishing the asset to bring it to current standards and a new condition. In order to calculate the cost to bring the buildings to current standard a condition rating is applied based upon;

- Visual inspection of the asset;
- Asset condition data and other information provided by Metro North Hospital and Health Service; and
- Previous reports and inspection photographs if available (to show the change in condition over time).

The rating system is from the International Infrastructure Management Manual (IIMM) and the criteria for assessing the building condition is shown below –

Category	Condition	Comments
1	Very good condition	Only normal maintenance required.
2	Minor defects only	Minor maintenance required (up to 5 per cent of capital replacement cost).
3	Maintenance required to return to accepted level of service	Significant maintenance required (up to 50 per cent of capital replacement cost).
4	Requires renewal	Complete renewal of the internal fit out and engineering services required (up to 70 per cent of capital replacement cost).
5	Assets unserviceable	Complete asset replacement required.

Where indices are used in the revaluation process, the application of such indices result in a valid estimation of the asset's fair value at reporting date. The Metro North Hospital and Health Service ensures there is sufficient evidence that the index used is robust, valid and appropriate to the assets to which it is being applied. This process includes, but is not limited to:

- obtaining a Metro North Hospital and Health Service specific index from a qualified property valuer, which includes key considerations such as construction cost escalation and changes to building design requirement specific to health care assets,
- assessing the reasonableness of the indices,
- questioning the underlying assumptions used to derive the indices; and
- analysing the trend of change in values over time.

Annually, management assess the relevance and suitability of indices used, based on the Metro North Hospital and Health Service's own particular circumstances.

Revaluation increments are credited to the asset revaluation surplus of the appropriate class, except to the extent they reverse a revaluation decrement for the class previously recognised as an expense. A decrease in the carrying amount on revaluation is charged as an expense, to the extent it exceeds the balance, if any, in the revaluation surplus relating to that asset class.

On revaluation, accumulated depreciation is restated proportionately with the change in the carrying amount of the asset and any significant change in the estimate of remaining useful lives.

Materiality concepts under AASB 1031 *Materiality* are considered in determining whether the difference between the carrying amount and the fair value of an asset is material.

The revaluation program for buildings resulted in a increment of $19,173,632 (2013: decrement of $1.5 million) to the carrying amount of buildings (See Note 20.)

Depreciation

Property, plant and equipment are depreciated on a straight-line basis so as to allocate the net cost or revalued amount of each asset, less its estimated residual value, progressively over its estimated useful life to the Metro North Hospital and Health Service. Annual depreciation is based on fair value and Metro North Hospital and Health Service's assessments of the remaining useful life of individual assets. Land is not depreciated as it has an unlimited useful life.

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

Any expenditure that increases the originally assessed capacity or service potential of an asset is capitalised and the new depreciable amount is depreciated over the remaining useful life of the asset.

The depreciable amount of improvements to or on leasehold land is allocated progressively over the estimated useful lives of the improvements or the unexpired period of the lease, whichever is the shorter. The unexpired period of a lease includes any option period where exercise of the option is probable.

The estimated useful lives of the assets are reviewed annually and where necessary, are adjusted to better reflect the pattern of consumption of the asset. In reviewing the useful life of each asset, factors such as asset usage and the rate of technical obsolescence are considered. Metro North Hospital and Health Service will be engaging a third party to undertake a comprehensive review of the useful life of plant and equipment in 2014–15 to ensure that the useful life is accurate and based on both historical data and current equipment standards.

(k) Property, plant and equipment (continued)

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

Class	Depreciation rates
Buildings	2.5% – 3.33%
Plant and Equipment	5.0% – 20.0%

The service agreement between the Department of Health and the Metro North Hospital and Health Service dictates that depreciation and amortisation charges that are incurred by the Metro North Hospital and Health Service are funded by the Department of Health via non-cash grant revenue. This transaction is shown in the Statement of Changes in Equity as a non-appropriated equity withdrawal.

(l) Leases

A distinction is made in the financial statements between finance leases that effectively transfer from the lessor to the lessee substantially all risks and benefits incidental to ownership, and operating leases, under which the lessor retains substantially all risks and benefits.

Operating leases

Assets subject to operating leases are not recognised as non-current assets in the Statement of Financial Position. Operating lease payments are recognised in the Statement of Comprehensive Income on a straight-line basis over the term of the lease. Any lease incentives received are recognised as an integral part of the total lease expense, over the term of the lease.

Finance leases

The Metro North Hospital and Health Service had no finance lease assets as at the reporting dates.

(m) Intangible assets

Intangible assets with a cost or other value equal to or greater than $100,000 are recognised in the financial statements. Items with a lesser value are expensed. Each intangible asset, less any anticipated residual value, is amortised over its estimated useful life to the Metro North Hospital and Health Service. The residual value is zero for all the Metro North Hospital and Health Service's intangible assets.

It has been determined that there is not an active market for any of Metro North Hospital and Health Service's intangible assets. As such, the assets are recognised and carried at cost less accumulated amortisation and accumulated impairment losses.

Internally generated software and purchased software

Intangible assets comprise capitalised internally generated software and purchased software, which are measured at cost (if equal or greater than $100,000) less accumulated amortisation and accumulated impairment losses. Expenditure on research activities relating to internally generated software is recognised as an expense in the period in which it is incurred.

Costs associated with the development of computer software are capitalised only if they can be reliably measured, the software is technically and commercially feasible, future economic benefits are probable and Metro North Hospital and Health Service intends to and has sufficient resources to complete development of the product with intent to use or sell the asset. Expenditure capitalised includes the costs of materials, direct labour and overhead costs that are directly attributable to preparing the asset for its intended use. All other development costs are expensed as incurred.

Subsequent expenditure

Subsequent expenditure is capitalised only when it increases the future economic benefits embodied in the specific asset to which it relates. All other expenditure is expensed as incurred.

Amortisation

All intangible assets have finite lives and are amortised on a straight-line basis over their estimated useful life. The estimated useful life and amortisation method are reviewed periodically, with the effect of any changes in estimates being accounted for.

Software is amortised from the time of acquisition or, in respect of internally developed software, from the time the asset is available for use. The amortisation rates for Metro North Hospital and Health Service's software is 20 per cent per annum.

(n) Impairment of non-current assets

All non-current physical and intangible assets are assessed for indicators of impairment on an annual basis in accordance with AASB 136 *Impairment of Assets*. If an indicator of possible impairment exists, the Metro North Hospital and Health Service determines the asset's recoverable amount. Any amount by which the asset's carrying amount exceeds the recoverable amount is recorded as an impairment loss.

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

An impairment loss is recognised immediately in the Statement of Comprehensive Income, unless the asset is carried at a revalued amount, in which case the impairment loss is offset against the asset revaluation surplus (recognised in equity) of the relevant class to the extent available.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of its recoverable amount, but only to the extent that the increased carrying amount does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset in prior years. A reversal of an impairment loss is recognised as income, unless the asset is carried at a revalued amount, in which case the reversal of the impairment loss is treated as a revaluation increase.

(o) Fair value measurement

Fair value is the price that would be received to sell an asset in an orderly transaction between market participants at the measurement data 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.

Observable inputs are publicly available data that are relevant to the characteristics of the assets being valued. Observable inputs used by the Metro North Hospital and Health Service include, but are not limited to, published sales data for land and residential dwellings.

Unobservable inputs are data, assumptions and judgements that are not available publicly, but are relevant to the characteristics of the assets being valued. Significant unobservable inputs used by Metro North Hospital and Health Service 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 estimated 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.

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

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

- Level 1 – represents fair value measurement that reflect unadjusted quoted market prices in active markets for identical assets;
- 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 Metro North Hospital and Health Service's valuation of assets are eligible for categorisation into level 1 of the fair value hierarchy. As 2013–2014 is the first year of application of AASB 13 *Fair Value Measurement* by Metro North Hospital and Health Service, there were no transfers of assets between fair value hierarchy levels during the period.

More specific fair value information about Metro North Hospital and Health service's property, plant and equipment is disclosed in Notes 2(k) and 20.

(p) Service concession arrangements

The Queensland Government's Department of Health has entered into three contractual arrangements with private sector entities for the operation of public infrastructure facilities which are located on land controlled by the Metro North Hospital and Health Service. After an agreed period of time, ownership of the facilities will pass to the Metro North Hospital and Health Service. Arrangements of this type are known as Public Private Partnerships. Refer to Note 31.

Although the land on which the facilities have been constructed remains an asset of the Metro North Hospital and Health Service, it does not control the facilities associated with these arrangements. Therefore these facilities are not recorded as assets by the Metro North Hospital and Health Service; however it does receive rights and incurs obligations under these arrangements, including:

- rights to receive the facility at the end of the contractual terms; and
- rights and obligations to receive and pay cash flows in accordance with the respective contractual arrangements, other than those which are received by the respective Hospital Foundations under a Deed of Assignment.

(q) Collocation arrangements

The Queensland Government's Department of Health has entered into a number of contractual arrangements with private sector entities for the operation of private health facilities for a period of time on land controlled by the Metro North Hospital and Health Service. After an agreed period of twenty-five years, ownership of the facilities will pass to the Metro North Hospital and Health Service.

As with Public Private Partnership type agreements, the Metro North Hospital and Health Service does not control these facilities and does not recognise the assets. Consequently, Metro North Hospital and Health Service has not recognised any rights or obligations that may attach to those agreements, other than those recognised under generally accepted accounting principles. Current collocation agreements in operation are listed in Note 32.

(r) Financial instruments

A financial instrument is any contract that gives rise to both a financial asset of one entity and a financial liability or equity instrument of another entity. The Metro North Hospital and Health Service does not enter into transactions for speculative purposes, or for hedging. Financial assets and financial liabilities are recognised in the Statement of Financial Position when the Metro North Hospital and Health Service becomes a party to the contractual provisions of the financial instrument. Financial assets and liabilities are offset and the net amount presented in the Statement of Financial Position when, and only when, the Metro North Hospital and Health Service has a legal right to offset the amounts and the Metro North Hospital and Health Service intends either to settle on a net basis or to realise the asset and settle the liability.

The Metro North Hospital and Health Service holds financial instruments in the form of cash and cash equivalents and receivables and payables. Financial instruments are classified and measured as follows:

(r) Financial instruments (continued)

- cash and cash equivalents – held at fair value;
- receivables – held at amortised cost; and
- payables – held at amortised cost.

Receivables

Receivables comprise trade receivables, GST input tax credits receivables and grants receivable.

Receivables are recognised initially at fair value on the date they are originated.

The recoverability of trade receivables is reviewed on an ongoing basis at an operating unit level. Any allowance for impairment is based on loss events disclosed in Note 33. All known bad debts are written off when identified.

Receivables are initially recognised at fair value plus directly attributable transaction costs. They are subsequently recorded at amortised cost, using the effective interest method, net of any allowance for impairment. The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of a financial instrument (or, when appropriate, a shorter period) to the net carrying amount of that instrument.

Financial assets, other than those held at fair value through the Statement of Comprehensive Income, are assessed for indicators of impairment at the end of each reporting period. For trade receivables, assets that are assessed not to be impaired individually are additionally assessed for impairment on a collective basis.

For financial assets carried at amortised cost, the amount of the impairment loss recognised is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the financial asset's original effective interest rate. When a trade receivable is considered uncollectible, it is written off to the Statement of Comprehensive Income as a bad debt. Subsequent recoveries of amounts previously written off are credited against an other revenue account. Changes in the carrying amount of the impairment allowance account are recognised in the Statement of Comprehensive Income.

Other disclosures relating to the measurement and financial risk management of other financial instruments are included in Note 33.

(s) Payables

Payables are recognised upon receipt of the goods or services ordered and are measured at the nominal amount i.e. agreed purchase/contract price, gross of applicable trade and other discounts. Amounts owing are unsecured and are generally settled within the creditor's normal payment terms.

(t) Prepayments

Prepayments are payments made to external parties for services to be received from them in the future. The nature of prepayments represents mainly prepaid expenses for future repair and maintenance service contracts. Prepayments are recognised as assets on the Statement of Financial Position because they represent existing rights to receive services.

(u) Employee benefits

Under section 20 of the *Hospital and Health Board Act 2011* (HHBA) a Hospital and Health Service can employ board members, a Health Service Chief Executive and health executives, and (where regulation has been passed for the Hospital and Health Service to become a prescribed service) a person employed previously by the Department of Health, as a health service employee. Where a Hospital and Health Service has not received the status of a "prescribed service", non-executive staff working in a Hospital and Health Service remain employees of the Department of Health.

Health Service Employees

In accordance with HHBA section 67, the employees of the Department of Health are referred to as health service employees. Pursuant to section 80 of the HHBA they remain employees of the Department of Health and are taken to be employed by Metro North Hospital and Health Service on the same terms, conditions and entitlements.

Under this arrangement:

- The Department of Health provides employees to perform work for the Metro North Hospital and Health Service, and the Department of Health acknowledges and accepts its obligations as the employer of these Department of Health employees;
- Metro North Hospital and Health Service is responsible for the day to day management of the Department of Health employees; and
- Metro North Hospital and Health Service reimburses the Department of Health for the salaries and on-costs of these employees.

As a result of this arrangement, the Metro North Hospital and Health Service classifies the reimbursements to the Department of Health for departmental employees in these financial statements as Department of Health – Health Service Employees. These reimbursements are shown under Note 10.

Employer superannuation contributions, annual leave levies and long service leave levies are regarded as employee benefits.

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

Health Executives

In addition to the Department of Health employees, the Metro North Hospital and Health Service has engaged employees directly. The information detailed below relates specifically to the directly engaged employees.

Wages, Salaries and Sick Leave

Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at current salary rates.

(u) Employee benefits (continued)

As Metro North Hospital and Health Service expects such liabilities to be wholly settled within 12 months of reporting date, the liabilities are recognised at undiscounted amounts.

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

As sick leave is non-vesting, an expense is recognised for this leave as it is taken.

Annual Leave

The Queensland Government's Annual Leave Central Scheme (ALCS) became operational on 30 June 2008 for departments, commercialised business units and shared service providers. Under this scheme, a levy is made on the Metro North Hospital and Health Service to cover the cost of employees' annual leave (including leave loading and on-costs). The levies are expensed in the period in which they are payable. Amounts paid to employees for annual leave are claimed from the scheme quarterly in arrears.

No provision for annual leave is recognised in the Metro North Hospital and Health Service's financial statements as the liability is held on a whole-of government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*.

Long Service Leave

Under the Queensland Government's Long Service Leave Scheme, a levy is made on the Metro North Hospital and Health Service to cover the cost of employees' long service leave. The levies are expensed in the period in which they are payable. Amounts paid to employees for long service leave are claimed from the scheme quarterly in arrears.

No provision for long service leave is recognised in the Metro North Hospital and Health Service's financial statements, the liability being held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 W*hole of Government and General Government Sector Financial Reporting*.

Superannuation

Employer superannuation contributions are paid to QSuper for the Metro North Hospital and Health Service executives and to a number of self-managed superannuation funds for Board members. QSuper is the superannuation scheme for Queensland Government employees, and the rates are determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are paid or payable and the Metro North Hospital and Health Service's obligation is limited to its contribution to QSuper and the self-managed superannuation funds.

The QSuper scheme has defined benefit and defined contribution categories. The liability for defined benefits is held on a Whole-of-Government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*.

Key Management Personnel and Remuneration

Key management personnel and remuneration disclosures are made in accordance with section 5 of the Financial Reporting Requirements for Queensland Government Agencies issued by Queensland Treasury. Refer to Note 34 for the disclosures on key management personnel and remuneration.

(v) Insurance

The Metro North Hospital and Health Service's non-current physical assets and other risks are insured through the Queensland Government Insurance Fund (QGIF), premiums being paid on a risk assessment basis. In addition, the Metro North Hospital and Health Service pays premiums to WorkCover Queensland in respect of its obligations for employee compensation. The Metro North Hospital and Health Service's Board of Directors and certain executives are also covered with Directors and Officers indemnity insurance.

QGIF covers property and general losses above a $10,000 threshold and health litigation payments above a $20,000 threshold and associated legal fees. Premiums are calculated by QGIF on a risk assessment basis.

(w) Services Received Free of Charge or for Nominal Value

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

The Metro North Hospital and Health Service receives corporate services support from the Department of Health for no cost. Corporate services include accounts payable services, payroll services, taxation services, some supply services and information system support services. As the fair value of these services is unable to be estimated reliably, no associated revenue and expense is recognised in the Financial Statements of the Metro North Hospital and Health Service.

(x) Contributed equity

Non-reciprocal transfers of assets and liabilities between wholly-owned Queensland State Public Sector 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.

(y) Taxation

The Metro North Hospital and Health Service is a State body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). FBT and GST are the only Commonwealth taxes recognised by the Metro North Hospital and Health Service.

Both the Metro North Hospital and Health Service and the Department of Health satisfy section 149-25(e) of the *A New Tax System (Goods and Services) Act 1999 (Cth) (the GST Act)* and were able, with other Hospital and Health Services, to form a "group" for GST purposes under Division 149 of the *GST Act*. This means that any transactions between the members of the "group" do not attract GST. However, all entities are responsible for the payment or receipt of any GST for their own transactions. As such, GST credits receivable from and payable to the Australian Taxation Office (ATO) are recognised and accrued. Refer Note 16.

(z) Issuance of financial statements

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

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

The preparation of financial statements necessarily requires the determination and use of certain critical accounting estimates, assumptions and management judgements 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.

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

- The measurement of receivables and the estimation of impairments – Note 33(c)
- Key assumptions used in the revaluation of property, plant and equipment – Note 2(k)
- Key assumptions used in performing estimates of useful life of property, plant and equipment and subsequent impact on depreciation – Notes 2(k) and 20

(bb) Rounding and comparatives

Amounts included in the financial statements are in Australian dollars and have been rounded to the nearest $1,000 or, where the amount is $500 or less, to zero unless the disclosure of the full amount is specifically required.

(cc) Voluntary change in accounting policy

The Metro North Hospital and Health Service has changed the classification of State Government funding received from the Department of Health from 'Grants and contributions' to 'User charges' applying Queensland Treasury and Trade's guideline *Distinction between Grants and Service Procurement Payments January 2014*.

This re-classification of revenue is also to ensure consistency in classification between the Department of Health and Metro North Hospital and Health Service in regards to the purchase of health service activity from the Metro North Hospital and Health Service. The effective date of this change is the 30th June 2014.

The comparative information has been restated where necessary to be consistent with disclosures in the current reporting period and to improve transparency across the years. Refer Note 3 and Note 4. This revision does not affect the actual timing of revenue or expense recognition and has no impact on the treatment of GST.

(dd) New and revised accounting standards

The only Australian Accounting Standard changes applicable for the first time as from 2013–14 that has had significant impact on the Metro North Hospital and Health Service's financial statements are those arising from AASB 13 *Fair Value Measurement*, as explained below.

AASB 13 *Fair Value Measurement* became effective from reporting periods beginning on or after 1 January 2013. AASB 13 sets out a new definition of 'fair value' as well as new principles to be applied when determining the fair value of assets and liabilities. The new requirements apply to all of the Metro North Hospital and Health Service's assets and liabilities (excluding leases) that are measured and/or disclosed at fair value or another measurement based on fair value. The impacts of AASB 13 relate to the fair value measurement methodologies used and financial statement disclosures made in respect of such assets. The Metro North Hospital and Health Service reviewed its fair value methodologies (including instructions to valuers, data used and assumptions made) for all items of property, plant and equipment measured at fair value to assess whether those methodologies comply with AASB 13. To the extent that the previous methodologies were not in compliance with AASB 13, valuation methodologies were revised accordingly to be in line with AASB 13. The revised valuation methodologies have not resulted in material differences from the previous methodologies.

(dd) New and revised accounting standards (continued)

AASB 13 has required an increased amount of information to be disclosed in relation to fair value measurements for both assets and liabilities. For those fair value measurements of assets or liabilities that substantially are based on data that is not 'observable' (i.e. accessible outside the Metro North Hospital and Health Service), the amount of information disclosed has significantly increased. Note 2(o) explains some of the principles underpinning the additional fair value information disclosed. Most of this additional information is set out in Note 20 Property, plant and equipment and Note 2(k) and 2(o).

A revised version of AASB 119 *Employee Benefits* became effective for reporting periods beginning on or after 1 January 2013. As the Metro North Hospital and Health Service does not directly recognise any employee benefit liabilities (refer to Note 2(u)), the only implications for the Metro North Hospital and Health Service were the revised concept of 'termination benefits' and the revised recognition criteria for termination benefit liabilities. If termination benefits meet the AASB 119 timeframe criterion for 'short-term employee benefits', they will be measured according to the AASB 119 requirements for 'short term employee benefits'. Otherwise, termination benefits need to be measured according to the AASB 119 requirements for 'other long-term employee benefits'. Under the revised standard, the recognition and measurement of 'other long-term employee benefits' are accounted for according to most of the requirements for defined benefit plans.

The revised AASB 119 includes changed criteria for accounting for employee benefits as 'short-term employee benefits'. However, as the Metro North Hospital and Health Service is a member of the Queensland Government central schemes for annual leave and long service leave, this change in criteria has no impact on the Metro North Hospital and Health Service's financial statements as the employer liability is held by the central scheme. The revised AASB 119 also includes changed requirements for the measurement of employer liabilities/assets arising from defined benefit plans, and the measurement and presentation of changes in such liabilities/assets. The Metro North Hospital and Health Service makes employer superannuation contributions only to the QSuper defined benefit plan, and the corresponding QSuper employer benefit obligation is held by the State. Therefore, those changes to AASB 119 will have no impact on the Metro North Hospital and Health Service.

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

Pursuant to AASB 1053, public sector entities like the Metro North Hospital and Health Service may adopt Tier 2 requirements for their general purpose financial statements. However, AASB 1053 acknowledges the power of a regulator to require application of the Tier 1 requirements. In the case of the Metro North Hospital and Health Service, Queensland Treasury and Trade is the regulator. Queensland Treasury and Trade has advised that its policy decision is to require adoption of Tier 1 reporting by all Queensland Government departments and statutory bodies (including the Metro North Hospital and Health Service) that are consolidated into the whole-of-Government financial statements.

Therefore, the release of AASB 1053 and associated amending standards has had no impact on the Metro North Hospital and Health Service.

The Metro North Hospital and Health Service is not permitted to early adopt a new or amended accounting standard ahead of the specified commencement date unless approval is obtained from Queensland Treasury and Trade. Consequently, the Metro North Hospital and Health Service has not applied any Australian Accounting Standards and Interpretations that have been issued but are not yet effective. The health service applies standards and interpretations in accordance with their respective commencement dates.

At the date of authorisation of the financial statements the following Australian Accounting Standards have been issued with future commencement dates:

AASB 1055 *Budgetary Reporting* applies from reporting periods beginning on or after 1 July 2014. The Metro North Hospital and Health Service will need to include in it 2014–15 financial statements the original budgeted figures from the Income Statement, Balance Sheet, Statement of Change in Equity, and Cash Flow Statement as published in the 2014–2015 Queensland Government's Service Delivery Statements. The budgeted figures will need to be presented consistently with the corresponding (actuals) financial statements, and will be accompanied by explanations of major variances between the actual amounts and the corresponding original budgeted figures.

(dd) New and revised accounting standards (continued)

AASB 1031 *Materiality* will be effectively withdrawn from reporting periods beginning on or after 1 January 2014. Consequently the only guidance about materiality available in accounting pronouncements will be AASB 101, AASB 108 and the *Framework for the Preparation and Presentation of Financial Statements*. Queensland Treasury will determine whether the guidance left in accounting pronouncements is sufficient and will include guidance as required in the 2014–15 Financial Reporting Requirements.

The following new and revised standards apply as from reporting periods beginning on or after 1 January 2014 –

- AASB 10 *Consolidated Financial Statements;*
- AASB 11 *Joint Arrangements;*
- AASB 12 *Disclosure of Interests in Other Entities;*
- AASB 127 (revised) *Separate Financial Statements;*
- AASB 128 (revised) *Investments in Associates and Joint Ventures;*
- AASB 2011–7 *Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards* [AASB 1, 2, 3, 5, 7, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 139, 1023 & 1038 and Interpretations 5, 9, 16 & 17]; and
- AASB 2013–8 *Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities – Control and Structured Entities.*

AASB 10 redefines and clarifies the concept of control of another entity, and is the basis for determining which entities should be consolidated into an entity's financial statements. AASB 2013–8 applies the various principles in AASB 10 for determining whether a not-for-profit entity controls another entity. On the basis of those accounting standards, Metro North Hospital and Health Service has reviewed the nature of its relationships with entities that Metro North Hospital and health Service is connected with to determine the impact of AASB 2013–8. Currently Metro North Hospital and Health Service does not have control over any other entities.

AASB 11 deals with the concept of joint control and sets out new principles for determining the type of joint arrangement that exist, which in turn dictates the accounting treatment. The new categories of joint arrangements under AASB 11 are more aligned to the actual rights and obligations of the parties to the arrangement. Metro North Hospital and Health Service has assessed its arrangements with other entities to determine whether a joint arrangement exists in terms of AASB 11. Based on present arrangements, no joint arrangements exist. However, if a joint arrangement does arise in future, Metro North Hospital and Health Service will need to follow the relevant accounting treatment specified in either AASB 11 or the revised AASB 128, depending on the nature of the joint arrangement.

AASB 9 *Financial Instruments* and AASB 2010–7 *Amendments to Australian Accounting Standards* arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and interpretations 2, 5, 10, 12, 19 & 127] will become effective for reporting periods beginning on or after 1 January 2017. The main impacts of these standards on Metro North Hospital and Health Service are that they will change the requirements for the classification, measurement and disclosures associated with Metro North Hospital and Health Service's financial assets. Under the new requirements, financial assets will be more simply classified according to whether they are measured at amortised cost or fair value. Pursuant to AASB 9, financial assets can only be measured at amortised cost if two conditions are met. One of these conditions is that the asset must be held within a business model whose objective is to hold assets in order to collect contractual cash flows.

The other condition is that the contractual terms of the asset give rise on specified dates to cash flows that are solely payments of principal and interest on the principal amount outstanding.

The only financial asset currently disclosed at amortised cost is receivables and as they are short term in nature, the carrying amount is expected to be a reasonable approximate of fair value so the impact of this standard is minimal. For financial liabilities which are designated as at fair value through profit or loss, the amount of change in fair value that is attributable to changes in the liability's credit risk will be recognised in other comprehensive income.

All other Australian Accounting Standards and interpretations with future commencement dates are either not applicable to Metro North Hospital and Health Service's activities, or have no material impact on Metro North Hospital and Health Service.

3 User charges and fees

	2014 $'000	2013 $'000
Hospital fees	97,882	91,222
Sale of goods and services	75,045	49,666
	172,927	**140,888**

4 Funding for the provision of public health services

Activity based funding	1,642,921	1,474,754
Block funding	65,802	196,419
Other*	207,009	255,162
	1,915,732	**1,926,335**

** Other consists of $128,832,548 in State System Manager grant funding for items not covered by the National Health Reform Agreement including such items as: Primary Health Care; Prevention, Promotion and Protection. (2013: $152,952,937)*

5 Grants and other contributions

Australian Government grants		
Grants – Nursing home	6,353	10,947
Other specific purpose recurrent grants	9,945	20,513
Other specific purpose capital grants	1,275	1,458
Total Australian Government grants	**17,573**	**32,918**
Donations other*	13,160	322
Other grants	1,292	1,492
	32,025	**34,732**

**Donations other includes a donation consisting of the Moreton Bay Integrated Care Centre's land and buildings which were received from the Redcliffe Hospital Foundation. The fair value of the donation received was $13,056,919. See notes 2(f) and 2(k).*

6 Other revenue

Interest	686	908
Health service employees expense recoveries*	15,154	12,668
Rental income	1,647	1,630
Recoveries**	12,314	11,975
Sale proceeds of non capital assets***	3	3
Other	4,803	4,310
	34,607	**31,494**

** Health service employee expenses are recovered for services provided to external parties not including the Department of Health or other Hospital and Health Services.*

*** Recoveries consist of non labour oncharges to other Hospital and Health Service's and the Department of Health.*

**** Non capital assets are those items acquired that do not meet the asset value recognition threshold of $5,000.*

7 Revaluation increment on property, plant and equipment

	2014 $'000	2013 $'000
Revaluation increment on buildings*	1,773	–
Revaluation increment on land*	41	–
	1,814	**–**

** Reversal of prior year decrement in accordance with AASB 116.*

8 Gain on disposal of assets

Gain on sale of property, plant and equipment	256	132
	256	**132**

9 Employee expenses*

Employee benefits		
Wages and salaries	1,891	2,314
Employer superannuation contributions	215	249
Annual leave levy/expense	106	360
Long service leave levy/ expense	–	354
Termination benefits	–	159
Employee related expenses		
Workers' compensation premium	21	28
Payroll tax	18	32
Other employee related expenses	–	33
	2,251	**3,529**
	30 June 2014	**30 June 2013**
Number of employees**		
Department of Health – Health service employees	12,671	12,696
Metro North Hospital and Health Service employees	14	10
	12,685	**12,706**

** The employee expenses note refers only to Health Service Board Members, Health Service Chief Executive and Health Service Executive employees. Refer to note 2(u).*

*** The number of employees includes full-time employees and part-time employees measured on a full-time equivalent (FTE) basis. It does not include Board Members.*

10 Supplies and services

	2014 $'000	2013 $'000
Department of Health – Health service employees*	1,475,222	1,504,693
Consultants and contractors	21,614	19,657
Electricity and other energy	20,072	16,820
Patient travel	9,570	10,089
Other travel	3,528	2,998
Water	3,202	3,037
Building services	3,605	3,063
Computer services	10,552	10,062
Insurance**	20,452	17,211
Motor vehicles	981	1,083
Communications	14,337	15,235
Repairs and maintenance	46,285	29,760
Expenses relating to capital works	2,788	1,763
Operating lease rentals	5,271	6,396
Drugs	89,189	90,070
Clinical supplies and services	154,444	150,991
Catering and domestic supplies	42,514	41,498
Pathology, blood and parts	79,773	85,380
Other	9,117	9,290
	2,012,516	**2,019,096**

**refer to note 2(u).*

***refer to note 2(v).*

11 Grants and subsidies

	2014 $'000	2013 $'000
Medical research program	2,279	2,549
Home, community and rural health services	–	190
Capital grants	–	1,880
Other	864	2
	3,143	**4,621**

12 Depreciation and amortisation

	2014 $'000	2013 $'000
Buildings and land improvements	45,342	40,810
Plant and equipment	27,690	28,695
Software purchased	122	50
Software developed	72	23
	73,226	**69,578**

13 Impairment losses

	2014 $'000	2013 $'000
Impairment losses on receivables*	2,184	2,125
Bad debts written off	1,623	2,922
Impairment losses on property, plant and equipment	–	274
	3,807	**5,321**

** Refer Note 16 and 33(c).*

14 Other expenses

	2014 $'000	2013 $'000
External audit fees*	359	362
Other audit fees	415	182
Bank fees	90	97
Insurance**	35	50
Inventory written off	112	283
Losses from the disposal of non–current assets	1,358	1,856
Losses		
Public monies	–	2
Special payments		
Donations/gifts	–	1
Ex–gratia payments***	67	67
Other legal costs	572	697
Journals and subscriptions	699	451
Advertising	477	336
Interpreter fees	1,427	1,241
Sponsorships	39	–
Other	922	594
	6,572	**6,219**

* *Total audit fees paid to the Queensland Audit Office relating to the 2013–2014 financial year are $355,000 (2013: $362,000). There are no non–audit services included in this amount.*

** *Insurance included in other expense is for motor vehicle insurance and directors and officers liability insurance.*

*** *Ex–gratia payments consist of six reportable payments totalling $42,296 and a number of smaller non reportable payments in 2013–14. In 2012–13 payments consisted of five reportable payments totalling $40,054 and a number of smaller non reportable payments. These payments relate to specific medical claims, personal property damage/loss and other minor claims.*

	2014 $'000	2013 $'000
15 Cash and cash equivalents		
Cash at bank and on hand	150,430	82,072
Cash on deposit	17,268	19,817
	167,698	**101,889**

Metro North Hospital and Health Service's bank accounts are grouped within the Whole-of-Government set-off arrangement with the Queensland Treasury Corporation. Metro North Hospital and Health Service does not earn interest on its operating accounts and is not charged interest or fees for accessing its approved cash overdraft facility as it is part of the Whole-of-Government banking arrangements. Metro North Hospital and Health Service only receives interest on its QTC and general trust bank accounts.

Cash deposited at call with the Queensland Treasury Corporation earns interest at a rate of 3.38%

16 Receivables		
Current		
Trade debtors	58,552	37,464
Payroll receivables	(23)	(21)
Less: Allowance for impairment	(7,388)	(5,204)
	51,111	**32,239**
GST input tax credits receivable	3,508	2,531
GST payable	(604)	(619)
Net receivable	**2,904**	**1,912**
Advances	4	4
Other – Funding receivable	3,855	32,552
	3,859	**32,556**
	57,874	**66,707**

Refer to Note 33(c) Financial Instruments (Credit Risk Exposure) for an analysis of movements in the allowance for impairment loss.

	2014 $'000	2013 $'000
17 Inventories		
Inventories held for distribution:		
Medical supplies and equipment	14,125	15,554
Catering and domestic	274	280
	14,399	**15,834**
Less: Loss of service potential	(127)	(120)
	14,272	**15,714**
Engineering	–	1
Other	57	149
	14,329	**15,864**

18 Other assets		
Current		
Prepayments	3,023	3,387
	3,023	**3,387**
Non-current		
Prepayments	90	204
	90	**204**

	2014 $'000	2013 $'000
19 Intangible assets		
Software purchased		
At cost	2,188	895
Less: Accumulated amortisation	(662)	(852)
	1,526	**43**
Software internally generated		
At cost	1,976	1,727
Less: Accumulated amortisation	(1,723)	(1,651)
	253	**76**
Software work in progress		
At cost	34	249
	34	**249**
Total	**1,813**	**368**

Intangible assets reconciliation

	Software purchased		Software internally generated		Software work in progress		Total	
	2014 $'000	2013 $'000	2014 $'000	2013 $'000	2014 $'000	2013 $'000	2014 $'000	2013 $'000
Carrying amount at 1 July	**43**	**–**	**76**	**–**	**249**	**–**	**368**	**–**
Acquisitions	1,606	–	–	–	34	80	1,640	80
Transfers in from other Queensland Government entities	–	92	249	99	(249)	169	–	360
Acquisitions through internal development	–	–	–	–	–	–	–	–
Disposals	–	–	–	–	–	–	–	–
Transfers out to other Queensland Government entities	–	–	–	–	–	–	–	–
Amortisation charge for the year*	(122)	(49)	(72)	(23)	–	–	(194)	(72)
Carrying amount at 30 June	**1,526**	**43**	**253**	**76**	**34**	**249**	**1,813**	**368**

** Amortisation of intangibles is included in the line item 'Depreciation and Amortisation' in the Statement of Comprehensive Income.*

	2014 $'000	2013 $'000
20 Property, plant and equipment		
Land		
At fair value	318,079	319,962
	318,079	**319,962**
Buildings		
At fair value	1,068,865	1,539,537
Less: Accumulated depreciation	(263,323)	(731,692)
	805,542	**807,845**
Plant and equipment		
At cost	309,758	299,203
Less: Accumulated depreciation	(176,372)	(173,456)
	133,386	**125,747**
Capital works in progress		
At cost	2,384	6,301
	2,384	**6,301**
Total property, plant and equipment	**1,259,391**	**1,259,855**

Land

Land has been measured at fair value in the 2013–14 financial year (effective date 30th June 2014) by the State Valuation Service (SVS) using the following methodologies:

- Desktop indexation on thirty-six properties (representing 100% of the land portfolio).
- Desktop valuations on three properties where the indexation indicated material movements.

Both valuation methodologies take into consideration specific valuation indicators such as location, size, zoning regulations and recent market data.

The land valuation program for 2013–14 resulted in an increment of $41,328 (2013: decrement of $1.5 million) to the carrying amount of land.

Buildings

An independent valuation of 100% of the gross value of the building portfolio was performed during 2013–14 (effective date 30th June 2014).

The buildings comprehensive valuation program for 2013–14 resulted in a net increment to the health service's building portfolio of $19.17 million (2013: decrement of $2.4 million). This is an increase of 2.3 % to the building portfolio as at 30 June 2014.

	Land*	Buildings**	Buildings**	Plant and equipment	Work in progress	Total
	2014 $'000 Level 2	2014 $'000 Level 3	2014 $'000 Level 2	2014 $'000	2014 $'000	2014 $'000
Carrying amount at 1 July 2013	**319,962**	**807,339**	**506**	**125,747**	**6,301**	**1,259,855**
Acquisitions	–	1,487	–	34,005	298	**35,790**
Transfers in from other Queensland Government entities***	–	10,145	–	3,105	–	**13,250**
Donations received	800	12,234	–	–	–	**13,034**
Disposals	–	–	–	(1,446)	–	**(1,446)**
Transfers out to other Queensland Government entities	(2,725)	–	–	–	(4,215)	**(6,940)**
Revaluation increments/(decrements)	41	19,118	56	–	–	**19,215**
Donations made	–	–	–	(336)	–	**(336)**
Depreciation charge for the year	–	(45,320)	(22)	(27,689)	–	**(73,031)**
Carrying amount at 30 June 2014	**318,078**	**805,003**	**540**	**133,386**	**2,384**	**1,259,391**

** Level 2 land assets are land with an active market.*

*** Building level 3 assets are special purpose built buildings with no active market. Level 2 assets are buildings with an active market.*

**** Transfers in includes transfer of assets due to transfer of services from the Department of Health and commissioning of work in progress assets managed by the Department of Health as part of Queensland Health's Capital Acquisition Plan.*

Included in the valuation of buildings are 23 heritage buildings held at a carrying value of $4.761 million.

20 Property, plant and equipment (continued)

	Land	Buildings	Plant and equipment	Work in progress	Total
	2013	2013	2013	2013	2013
	$'000	$'000	$'000	$'000	$'000
Carrying amount at 1 July 2012	–	–	–	–	–
Assets received (transferred pursuant to the *Hospital and Health Board Act 2011*) – 1 July 2012	320,802	778,095	126,070	3,805	1,228,772
Acquisitions	–	–	19,902	2,842	22,744
Disposals	–	–	(1,831)	–	(1,831)
Transfers between asset classes	–	333	–	(333)	–
Transfers in	678	72,000	10,301	–	82,979
Revaluation increments/ (decrements)	(1,518)	(1,498)	–	–	(3,016)
Impairment decrement	–	(274)	–	(13)	(287)
Depreciation charge for the year	–	(40,811)	(28,695)	–	(69,506)
Carrying amount at 30 June 2013	**319,962**	**807,845**	**125,747**	**6,301**	**1,259,855**

20 Property, plant and equipment (continued)

Level 3 significant valuation inputs and relationship to fair value

The fair value of health service site buildings is computed by quantity surveyors. The methodology is known as the Depreciated Replacement Cost valuation technique. The following table highlights the key unobservable (Level 3) inputs assessed during the valuation process and the relationship to the estimated fair value.

Description	Significant unobservable inputs	Unobservable inputs quantitative measures Ranges used in valuation	Unobservable inputs – general effect on fair value measurement
Buildings – health service sites (fair value $805M)	Replacement cost estimates	Health assets $220,000 to $431,760,000 Other assets $18,000 to $71,540,000	Replacement cost is based on tender pricing and historical building cost data. An increase in the estimated replacement cost would increase the fair value of the assets. A decrease in the estimated replacement cost would reduce the fair value of the assets.
	Remaining lives estimates	Nil years to 35 years	The remaining useful lives are based on industry benchmarks. An increase in the estimated remaining useful lives would increase the fair value of the assets. A decrease in the estimated remaining useful lives would reduce the fair value of the assets.
	Costs to bring to current standards	Health assets $ Nil to $127,850,000 Other assets $ Nil to $25,190,000	Costs to bring to current standards are based on tender pricing and historical building cost data. An increase in the estimated costs to bring to current standards would reduce the fair value of the assets. A decrease in the estimated costs to bring to current standards would increase the fair value of the assets.
	Condition rating	1 to 5	The condition rating is based on the physical state of the assets. An improvement in the condition rating (possible high of 1) would increase the fair value of the assets. A decline in the condition rating (possible low of 5) would reduce the fair value of the assets.

For further information on Condition Ratings refer to Note 2(k).

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

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

There are no other direct or significant relationships between the unobservable inputs which materially impact fair value.

	2014 $'000	2013 $'000
21 Payables		
Trade creditors	109,048	48,014
Health service employees – accrued labour expenses	29,186	80,041
Other creditors	13,152	6,844
	151,386	**134,899**
22 Accrued employee benefits		
Salaries and wages accrued	66	117
Other employee entitlements payable	8	17
	74	**134**
23 Unearned revenue*		
Current		
Unearned revenue	1,865	1,085
	1,865	**1,085**
Non–current		
Unearned revenue	–	150
	–	**150**

* *Unearned revenue represents revenue received in advance for services yet to be delivered at year end.*

	2014 $'000	2013 $'000
24 Asset revaluation by class		
Land		
Balance at the beginning of the financial year	–	–
Reversal of prior year decrement	41	–
Revaluation increment	–	–
Balance at end of financial year	**41**	**–**
Buildings		
Balance at the beginning of the financial year	–	–
Reversal of prior year decrement	1,773	–
Revaluation increment	17,401	–
Balance at end of financial year	**19,174**	**–**

		2014 $'000	2013 $'000
25	**Reconciliation of operating surplus to net cash flows from operating activities**		
	Operating result from continuing operations	55,846	22,201
	Non–cash items:		
	Non cash equity withdrawal – depreciation funding	(72,848)	(69,578)
	Depreciation and amortisation expense	73,226	69,578
	Property, plant and equipment impairment losses	–	274
	Property, plant and equipment revaluation (increment)/decrement	(1,814)	3,016
	Increase/(decrease) in trade receivables impairment losses	2,184	2,125
	Increase/(decrease) in inventory provision	–	184
	Capital works in progress impairment losses	–	13
	Loss on sale of property, plant and equipment	1,102	1,842
	Assets transferred – non–cash	(19,057)	(132)
	Changes in assets and liabilities:		
	(Increase)/decrease in trade receivables	7,642	7,547
	(Increase)/decrease GST receivables	(992)	–
	(Increase)/decrease in grants receivables	–	(32,552)
	(Increase)/decrease in other receivables	–	(86)
	(Increase)/decrease in inventories	1,535	1,654
	(Increase)/decrease in recurrent prepayments	478	(829)
	Increase/(decrease) in unearned revenue	–	980
	(Increase)/decrease in accrued salaries and wages	(51)	80
	(Increase)/decrease in other employee benefits	(9)	–
	Increase/(decrease) in trade payables	16,487	71,408
	Increase/(decrease) in other payables	630	(150)
	Net cash generated by operating activities	**64,359**	**77,575**

26 Non-cash financing and investing activities

Assets and liabilities received or transferred by the Metro North Hospital and Health Service are set out in the Statement of Changes in Equity.

27 Commitments for expenditure

(a) Non-cancellable operating leases*

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

	2014 $'000	2013 $'000
Not later than one year	1,456	–
Later than one year and not later than five years	2,383	–
Later than five years	546	–
Total	**4,385**	**–**

* *Metro North Hospital and Health Service has non-cancellable operating leases relating predominantly to office, car park and clinical services accommodation and medical equipment. Lease payments are generally fixed, but with escalation clauses on which contingent rentals are determined. No lease arrangements create restrictions on financing or other leasing activities.*

(b) Capital expenditure and other expenditure commitments

Material classes of capital and other expenditure commitments inclusive of anticipated GST, contracted for at reporting date but not recognised in the accounts are payable as follows:

	2014 $'000	2013 $'000
Capital – Property, plant and equipment	–	750
Capital – Software	4,847	–
Services	1,527	–
Employment	2,732	
	9,106	**750**
Not later than one year	7,264	750
Later than one year and not later than five years	1,842	–
Later than five years	–	–
	9,106	**750**

(c) Grants and other contributions

Grants and contribution commitments inclusive of anticipated GST, committed to provide at reporting date, but not recognised in the accounts are payable as follows:

	2014 $'000	2013 $'000
Not later than one year	1,621	726
Later than one year and not later than five years	2,649	493
	4,270	**1,219**

28 Contingencies

Litigation in progress

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

	2014	2013
Court	**No. of cases**	**No. of cases**
Supreme Court	5	3
District Court	1	1
Tribunals, commissions, board	8	6
	14	10

It is not possible to make a reliable estimate of the final amount payable, if any, in respect of litigation before the courts at this time.

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). The Metro North Hospital and Health Service's liability is limited to an excess per insurance event. Refer Note 2(v). The Metro North Hospital and Health Service's legal advisers and management consider it would be misleading to estimate the final amounts payable (if any) in respect of the litigation before the courts at this time.

All Metro North Hospital and Health Service indemnified claims are managed by QGIF. As of 30 June 2014, Metro North HHS has 77 claims (2013: 61 claims) currently managed by QGIF, some of which may never be litigated or result in payments to claims. Tribunals, commissions and board figures represent the matters that have been referred to QGIF for management. The maximum exposure to the Metro North Hospital and Health Service under this policy is $20,000 (2013: $20,000) for each insurable event.

29 Restricted assets

The Metro North Hospital and Health Services receives cash contributions primarily from private practice clinicians (See Note 30) and from external entities providing 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. At 30 June 2014, an amount of $17.39 million (2013: $20.57 million) in General Trust is set aside for specified purposes defined by the contribution.

30 Agency and fiduciary trust transactions and balances

The Metro North Hospital and Health Service acts in an agency role in respect of a number of Right of Private Practice bank accounts and in a fiduciary capacity in relation to a number of Patient Trust bank accounts.

(a) Right of Private Practice Bank Accounts

The Metro North Hospital and Health Service has a Right of Private Practice (ROPP) arrangement in place. The Right of Private Practice arrangement covers Option A Senior Medical Officers, Option B Senior Medical Officers and Option R Senior Medical Officers (Radiologists).

ROPP Option A – Upon appointment, Senior Medical Officers are offered a supplementary benefit/right to private practice. If the Senior Medical Officer choses to accept the offer of an Option A contract the Senior Medical Officers assigns all their Medicare billing rights to the Metro North Hospital and Health Service and the Senior Medical Officer receives an Option A allowance.

ROPP Option B – Upon appointment, Senior Medical Officers are offered a supplementary benefit/right to private practice. If the Senior Medical Officer choses to accept the offer of an Option B contract the Senior Medical Officer is able to provide medical services to private patients. The specialist, in turn, provides the Metro North Hospital and Health Service with the right to render accounts in the Senior Medical Officer's name and collect all medical fee revenue.

The Option B Senior Medical Officers are entitled to the net amount remaining after the deductions for administration and facility fees and charges and any GST payable up to the threshold amount. Once this threshold has been achieved, the participating specialists can retain $1 out of every $3 of net private earnings above this threshold, after the deduction of administration and facility fees and charges and any GST payable. The remainder of net private earnings is credited to the private practice Study, Education and Research Trust account (SERTA). Refer to Note 29.

ROPP Option R – Only specialists in radiology may elect to participate in the Option R private practice scheme. Option R is a variation of the Option B contract arrangements. Option R operates under the same provisions as those of Option B, with the exception of the application of administration and facility fees and charges. Option R participants receive a discount of 50% in relation to administration fees and facility charges.

All monies received for Right of Private Practice (Option A, B and R) are deposited into separate bank accounts that are administered by the Metro North Hospital and Health Service on behalf of the Right of Private Practice Senior Medical Officers. These accounts are not reported in the Metro North Hospital and Health Service Statement of Financial Position.

All Option A receipts, Option B and R administration and facility fees and charges (and applicable GST) and any SERTA contributions are included as revenue in the Statement of Comprehensive Income of the Metro North Hospital and Health Service on an accrual basis. The funds are then subsequently transferred from the Right of Private Practice bank accounts into the Metro North Hospital and Health Service operating account and general trust bank account (for the SERTA portion).

	2014 $'000	2013 $'000
Right of Private Practice Trust Account Revenue and Expenses		
Revenue		
Doctor's billing	55,965	53,459
Interest on trust funds	86	121
Other revenue	142	407
Total Revenue	**56,193**	**53,987**
Expenses		
Payments to Doctors	19,472	34,673
Payments to Metro North Hospital and Health Service for recoverable costs*	28,977	14,507
Payments to Study, Education and Research Trust account	3,943	4,617
Other payments	136	321
Total Expenses	**52,528**	**54,118**
Right of Private Practice Assets and Liabilities		
Current assets		
Cash	6,647	2,982
Current liabilities		
Payable to Doctors	1,447	970
Payable to Metro North Hospital and Health Service	4,051	1,517
Payable to Study, Education and Research Trust account	1,149	495

* *These Right of Private Practice payments are recognised as hospital fee income – Refer Note 3.*

30 Agency and fiduciary trust transactions and balances (continued)

(b) Patient Trust Bank Accounts

The Metro North Hospital and Health Service acts in a custodial role in respect of these transactions and balances. As such, they are not recognised in the financial statements, but are disclosed below for information purposes.

	2014 $'000	2013 $'000
Fiduciary trust receipts and payments		
Receipts		
Patient trust receipts	5,305	7,003
Total receipts	**5,305**	**7,003**
Payments		
Patient trust related payments	5,586	7,393
Total payments	**5,586**	**7,393**
Increase/(decrease) in net patient trust assets	(281)	(390)
Fiduciary trust assets		
Current assets		
Cash		
Patient trust deposits	340	621
Total current assets	**340**	**621**

31 Service Concession Arrangements

Public Private Partnership (PPP) arrangements are a contractual obligation between the Department of Health and the counterparty listed below. (Refer Note 2(p)). These arrangements are located on land that is recognised as an asset in the financial statements of the Metro North Hospital and Health Service (subject to an operating lease with the Department of Health). Public Private Partnership (PPP) arrangements operating for all or part of the financial year are as follows.

Note that all of the following are Build-Own-Operate-Transfer (BOOT) arrangements.

Facility	Counterparty	Term of Agreement	Commence-ment Date
Butterfield Street Car Park	International Parking Group Pty Limited	25 years	January 1998
The Prince Charles Hospital Car Park	International Parking Group Pty Limited	22 years	November 2000
The Prince Charles Hospital Early Education Centre	Queensland Child Care Services Pty Ltd	20 years	April 2007

Butterfield Street Car Park

A $2.5 million up-front payment for rental of land on which the car park has been built was received at the commencement of car park operations in January 1998. This amount was transferred to the Royal Brisbane and Women's Hospital Foundation via a Deed of Assignment in June 1998. Rental income of $0.3 million plus CPI per annum to January 2019 increasing to $0.6 million plus CPI per annum for the remainder of the lease period, as well as other payments when gross car park receipts exceeds particular targets have also been assigned under the same Deed of Assignment to Royal Brisbane and Women's Hospital Foundation. Metro North Hospital and Health Service does not incur any revenue or expenses relating to this car park. Under the agreement, the Department of Health and the Metro North Hospital and Health Service's staff are entitled to concessional rates when using the car park.

The Prince Charles Hospital Car Park

A $1.0 million up-front payment for rental of land on which the car park has been built was received at the commencement of car park operations in November 2000. This amount was transferred to The Prince Charles Hospital Foundation via a Deed of Assignment. Rental of $0.05 million per annum has also been assigned under the same Deed of Assignment to The Prince Charles Hospital Foundation. Under the agreement, the Department of Health and the Metro North Hospital and Health Service's staff are entitled to concessional rates when using the car park.

The Prince Charles Hospital Early Education Centre

The developer constructed a 150 place early education centre in April 2007 on site at the hospital. The developer operates and maintains the facility at its sole cost and risk. Under the agreement, staff on site are given priority access to child care. Rental of $0.1 million per annum is charged for the land and is adjusted for CPI annually. From the 1st July 2014, the rights to the inflows from this arrangement transfer from the Department of Health to the Metro North Hospital and Health Service due to the legal title transfer of land and buildings (See note 35). The estimated future cashflows are shown below.

Estimated Cash Flows

	2014 $'000
Inflows:	
Not later than 1 year	90
Later than 1 year but not later than 5 years	388
Later than 5 years but not later than 10 years	554
Later than 10 years	374
Outflows:	
Not later than 1 year	–
Later than 1 year but not later than 5 years	–
Later than 5 years but not later than 10 years	–
Later than 10 years	–
Estimated Net Cash Flow	**1,406**

32 Collocation arrangements

Collocation arrangements are a contractual obligation between the Department of Health and the counterparty listed below. These arrangements are located on land that is recognised as an asset in the financial statements of the Metro North Hospital and Health Service (subject to an operating lease with the Department of Health). Collocation arrangements operating for all or part of the financial year are as follows.*

Facility	Counterparty	Term of Agreement	Commencement Date
Caboolture Private Hospital	Affinity Health Ltd	25 years	September 1997
Holy Spirit Northside Private Hospital	The Holy Spirit Northside Private Hospital Limited	25 years	July 2001

** Refer Note 2(q).*

33 Financial instruments

(a) Categorisation of financial instruments

The Metro North Hospital and Health Service has the following categories of financial assets and financial liabilities:

	2014 $'000	2013 $'000
Financial assets		
Cash and cash equivalents	167,698	101,889
Receivables	57,874	66,707
	225,572	**168,596**
Financial liabilities		
Payables measured at cost	151,386	134,899
	151,386	**134,899**

(b) Financial risk management

Metro North Hospital and Health Service's activities expose it to a variety of financial risks – credit risk, liquidity risk and market risk.

Financial risk is managed in accordance with Queensland Government and the Metro North Hospital and Health Service policies. The Metro North Hospital and Health Service's policies provide written principles for overall risk management and aim to minimise potential adverse effects of risk events on the financial performance of the health service.

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

(c) Credit risk exposure

Credit risk exposure refers to the situation where the Metro North Hospital and Health Service may incur financial loss as a result of another party to a financial instrument failing to discharge their obligations. The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any allowance for impairment. The carrying amount of receivables represents the maximum exposure to credit risk. As such, receivables are not included in the disclosure below. Refer Note 16 for further information.

Credit risk is considered minimal given all the Metro North Hospital and Health Service deposits are held by the State through Queensland Treasury Corporation. The following table represents Metro North Hospital and Health Service's maximum exposure to credit risk based on contractual amounts net of any allowances:

	2014 $'000	2013 $'000
Maximum exposure to credit risk		
Cash at bank	150,430	82,072
Cash on deposit	17,268	19,817
	167,698	**101,889**

33 Financial instruments (continued)

Impairment of financial assets

At the end of each reporting period, the Metro North Hospital and Health Service's 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 60 days.

The allowance for impairment reflects Metro North Hospital and Health Service's assessment of the credit risk associated with receivables balances and is determined based on consideration of objective evidence of impairment, past experience and management judgement. The majority of the "more than 90 days" impairment relates to Medicare ineligible patients who are treated in Metro North Hospital and Health Service facilities. Metro North Hospital and Health service undertakes debt recovery in accordance with its policies and procedures and where appropriate external agencies, including an international debt collection firm, are engaged to assist in the recovery of debt.

Impairment loss expense for the current year is $2.184 million. This is an increase of $59,000 from 2013 and is due to a number of loss events.

Receivables of $29.642 million are not due and payable as at the 30th June 2014. The ageing of past due but not impaired receivables as well as impaired financial assets are disclosed in the following tables:

Financial assets past due but not impaired 2013–14

	Overdue $'000				
	Less than 30 days	30-60 days	61-90 days	More than 90 days	Total
Receivables	8,083	4,418	3,639	12,091	28,231
Total	**8,083**	**4,418**	**3,639**	**12,091**	**28,231**

Individually impaired financial assets 2013–14

	Overdue $'000				
	Less than 30 days	30-60 days	61-90 days	More than 90 days	Total
Receivables (gross)	206	240	155	6,787	**7,388**
Allowance for impairment	(206)	(240)	(155)	(6,787)	**(7,388)**
Total	**–**	**–**	**–**	**–**	**–**

Financial assets past due but not impaired 2012–13

	Overdue $'000				
	Less than 30 days	30-60 days	61-90 days	More than 90 days	Total
Receivables	57,789	3,658	2,637	7,828	**71,912**
Total	**57,789**	**3,658**	**2,637**	**7,828**	**71,912**

Individually impaired financial assets 2012–13

	Overdue $'000				
	Less than 30 days	30-60 days	61-90 days	More than 90 days	Total
Receivables (gross)	348	417	177	4,262	**5,204**
Allowance for impairment	(348)	(417)	(177)	(4,262)	**(5,204)**
Total	**–**	**–**	**–**	**–**	**–**

	2014 $'000	2013 $'000
Movements in Allowance for Impairment		
Balance at 1 July	**5,204**	**–**
Balance on transfer of net assets (1 July 2012)	–	3,079
Increase/(decrease) in allowance recognised in operating result	2,184	2,125
Amounts written–off during the year	–	–
Balance at 30 June	**7,388**	**5,204**

33 Financial instruments (continued)

(d) Liquidity risk

Liquidity risk is the risk that the Metro North Hospital and Health Service will not have the resources required at a particular time to meet its obligations to settle its financial liabilities.

The Metro North Hospital and Health Service is exposed to liquidity risk through its trading in the normal course of business. The health service aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times. The Metro North Hospital and Health Service has an approved overdraft facility of $23 million under Whole-of-Government banking arrangements to manage any short term cash shortfalls.

The following table sets out the liquidity risk of financial liabilities held by the Metro North Hospital and Health Service. It represents the contractual maturity of financial liabilities, calculated based on undiscounted cash flows relating to liabilities at reporting date. The undiscounted cash flows in these tables differ to the amounts included in the Statement of Financial Position that are based on discounted cash flows.

		2014 Payable in			Total
		< 1 year	1–5 years	> 5 years	
	Note	$'000	$'000	$'000	$'000
Financial liabilities					
Payables		151,460			151,460
Other current liabilities		1,865			1,865
		153,325			**153,325**

		2013 Payable in			Total
		< 1 year	1–5 years	> 5 years	
	Note	$'000	$'000	$'000	$'000
Financial liabilities					
Payables		135,033			135,033
Other current liabilities		1,085	150		1,235
		136,118	**150**		**136,268**

(e) Market risk

The Metro North Hospital and Health Service does not trade in foreign currency and is therefore not materially exposed to commodity price changes. The Metro North Hospital and Health Service is exposed to interest rate risk through its 24 hour call deposits with Queensland Treasury Corporation and its General Trust account which is held with the Commonwealth Bank of Australia Limited. There is no interest rate exposure on its operating cash accounts. The Metro North Hospital and Health Service does not undertake any hedging in relation to interest rate risk and manages its risk as per the Metro North Hospital and Health Service's Financial Management Practice Manual.

(f) Fair Value

Apart from cash and cash equivalents, the Metro North Hospital and Health Service does not recognise any financial assets at fair value in the Statement of Financial Position.

The fair value of trade receivables and payables is assumed to approximate the value of the original transaction, less any allowance for impairment.

34 Key Management Personnel and Remuneration Expense

(a) Key Management Personnel

The following details for key management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of the Metro North Hospital and Health Service during 2013–14. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Board Members

Position and Name	Responsibilities	Current Incumbents	
		Contract classification and appointment authority	Date appointed to position (Date resigned from position)
Board Chair Dr Paul Alexander AO	Board Chair of the Metro North Hospital and Health Service. *Committee memberships:* Chair of the Board Executive committee Member of the Board Safety and Quality committee	Chairperson *Hospital and Health Boards Act 2011 Section 25 (1) (a)*	1/7/2012
Deputy Board Chair Mr Vaughan Howell	Deputy Board Chair of the Metro North Hospital and Health Service *Committee memberships:* Chair of the Board Finance committee Member of the Board Executive committee Member of the Board Risk and Audit committee	Deputy Chairperson *Hospital and Health Boards Act 2011 Section 25 (1) (b)*	1/7/2012
Board Member Mr Leonard Scanlan	Board member of the Metro North Hospital and Health Service *Committee memberships:* Chair of the Board Risk and Audit committee Member of the Board Executive committee Member of the Board Finance committee	Board Member *Hospital and Health Boards Act 2011 Section 23 (1)*	7/9/2012
Board Member Ms Melinda McGrath	Board member of the Metro North Hospital and Health Service *Committee memberships:* Member of the Board Risk and Audit committee Member of the Board Finance committee	Board Member *Hospital and Health Boards Act 2011 Section 23 (1)*	7/9/2012 (17/5/2014)
Board Member Associate Professor Clifford Pollard	Board member of the Metro North Hospital and Health Service *Committee memberships:* Chair of the Board Safety and Quality committee Member of the Board Executive committee	Board Member *Hospital and Health Boards Act 2011 Section 23 (1)*	7/9/2012
Board Member Dr Margaret Steinberg AM	Board member of the Metro North Hospital and Health Service *Committee memberships:* Member of the Board Safety and Quality committee Member of the Board Risk and Audit committee Member of the Board Finance committee	Board Member *Hospital and Health Boards Act 2011 Section 23 (1)*	1/7/2012
Board Member Professor Helen Edwards OAM	Board member of the Metro North Hospital and Health Service *Committee memberships:* Member of the Board Safety and Quality committee	Board Member *Hospital and Health Boards Act 2011 Section 23 (1)*	7/9/2012
Board Member Professor Nicholas Fisk	Board member of the Metro North Hospital and Health Service *Committee memberships:* Member of the Board Safety and Quality committee	Board Member *Hospital and Health Boards Act 2011 Section 23 (1)*	7/9/2012
Board Member Dr Kim Forrester	Board member of the Metro North Hospital and Health Service *Committee memberships:* Member of the Board Safety and Quality committee	Board Member *Hospital and Health Boards Act 2011 Section 23 (1)*	18/5/2013

34 Key Management Personnel and Remuneration Expense (continued)

Key Management Personnel

Position and Name	Responsibilities	Current Incumbents	
		Contract classification and appointment authority	Date appointed to position
Chief Executive Officer Mr Malcolm Stamp CBE	The Health Service Chief Executive is responsible for the strategic direction and the efficient, effective and economic administration of the health service.	10S24/S70 01 *Hospital and Health Boards Act 2011*	8/7/2013
Chief Operating Officer Ms Kerrie Mahon	Provide operational leadership, direction and day to day management of the Metro North Hospital and Health Service's to optimise quality health care and business outcomes.	HES2 *Hospital and Health Boards Act 2011*	1/7/2012
Chief Finance Officer Mr Robert Dubery	Responsibility for developing, implementing, managing and monitoring the financial framework, corporate financial systems, controls and budget administration of the health service.	HES3 *Hospital and Health Boards Act 2011*	13/3/2013
Executive Director, Governance, Quality and Risk Mr Keith Love*	Provide strategic leadership, direction and day to day management of the Metro North Hospital and Health Service's governance, quality and risk functions to optimise quality health care, statutory and policy compliance and continuously improving business outcomes.	HES2 *Hospital and Health Boards Act 2011*	5/11/2013
Acting Executive Director, Royal Brisbane and Women's Hospital Associate Professor Keshwar Baboolal	The Executive Director is responsible for the management of the efficient, effective and economic administration of the operations of the Royal Brisbane and Women's Hospital.	S24/S70 01 *Hospital and Health Boards Act 2011*	1/2/2013
Acting Executive Director, The Prince Charles Hospital Associate Professor Darren Walters	The Executive Director is responsible for the management of the efficient, effective and economic administration of the operations of the Prince Charles Hospital.	Medical Officers' (Queensland Health) Certified Agreement (No.3) 2012 MMOI4 01	1/2/2013
Acting Executive Director, Redcliffe Hospital Ms Lexi Spehr	The Executive Director is responsible for the management of the efficient, effective and economic administration of the operations of the Redcliffe Hospital.	Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012 NRG11-4 01	1/3/2013
Acting Executive Director, Caboolture and Kilcoy Hospitals Mr Keith Love*	The Executive Director is responsible for the management of the efficient, effective and economic administration of the operations of the Caboolture and Kilcoy Hospitals.	HES2 *Hospital and Health Boards Act 2011*	5/3/2014
Executive Director, Oral Health Services Dr Mark Brown	Responsible for providing sustainable and appropriate oral health care across the health service through efficient, effective and economic administration.	District Health Services Employees Award – State 2012 DS 1	1/12/2012
Executive Director, Mental Health Services Associate Professor Brett Emmerson	Responsible for providing sustainable and appropriate mental healthcare across the health service through efficient, effective and economic administration.	Medical Officers' (Queensland Health) Certified Agreement (No.3) 2012 MMOI4 01	15/5/2013
Executive Manager and Director of Nursing, Subacute and Ambulatory Services Ms Mary Slattery	The Executive Manager and Director of Nursing, Subacute and Ambulatory Services is responsible for the management of the efficient, effective and economic administration of the operations of Primary Health, Community Health and Aged Care within the Health Service.	Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012 NRG 11-4 01	9/8/2013

34 Key Management Personnel and Remuneration Expense (continued)

Key Management Personnel (continued)

Position and Name	Responsibilities	Current Incumbents	
		Contract classification and appointment authority	Date appointed to position (Date resigned from position)
Executive Director, Nursing Services Adjunct Associate Professor Lesley Fleming	The Executive Director, Nursing Services is responsible for the strategic direction, professional development and quality of Nursing Services within the Health Service.	Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012 NRG 12-1 01	2/2/2013
Executive Director, Medical Services Dr Donna O'Sullivan	The Executive Director, Medical Services is responsible for the strategic direction, professional development and quality of Medical Services within the Health Service.	Medical Officers' (Queensland Health) Certified Agreement (No.3) 2012 MMOI3 01	2/2/2013
Executive Director, Allied Health Services Mr Mark Butterworth	The Executive Director, Allied Health Services is responsible for the strategic direction, professional development and quality of Allied Health Services within the Health Service.	Health Practitioners' (Queensland Health) Certified Agreement (No. 2) 2011 HP8-2 01	2/2/2013
Executive Director, Corporate Services and Performance Mr Scott McMullen	Responsibility for developing, implementing, managing and monitoring the corporate services which include food, cleaning, porterage, retail, building and engineering, procurement and asset management services. The position is also responsible for the human resource, communication and performance functions.	HES2 *Hospital and Health Boards Act 2011*	1/4/2013

* *Mr Keith Love was acting in the role of Executive Director, Governance, Quality and Risk, from the 8th July 2013 before being appointed to the role on the 5th November 2013. He has also been the Acting Executive Director, Caboolture and Kilcoy Hospitals from the 5th March 2014.*

(b) Remuneration Expenses

Remuneration policy for the Service's key management personnel is set by direct engagement common law employment contracts for those employed as Metro North Hospital and Health Service employees. The remuneration and other terms of employment for the key management personnel who are employed by Metro North Hospital and Health Service are also addressed by these common law employment contracts. The contracts provide for the provision of some benefits including motor vehicles.

The remuneration policy for key management personnel who are Health Service employees (See note 2(u)) is dictated by various Industrial Awards and Agreements. These Industrial Awards and Agreements also dictate the remuneration and other terms of employment for all Health Service employees.

The following disclosures focus on the expenses incurred by the Metro North Hospital and Health Service during the respective reporting periods, that are attributable to key management positions. Therefore, the amounts disclosed reflect expenses recognised in the Statement of Comprehensive Income.

Remuneration expenses for key management personnel comprises the following components:

- Short-term employee expense which include:
  - salaries, allowances and leave entitlements earned and expensed for the entire year or for that part of the year during which the employee occupied the specified position.
  - Non-monetary benefits – consisting of provision of vehicle together with fringe benefits tax applicable to the benefit.
- Long term employee expenses include amounts expensed in respect of long service leave entitlements earned.
- Post-employment expenses include amounts expensed in respect of employer superannuation obligations.
- Termination benefits are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu of notice on termination.
- Performance bonuses are not paid under the contracts in place.

34 Key Management Personnel and Remuneration Expense (continued)

(b) Remuneration Expenses (continued)

The details of this remuneration is shown in the table below.

1 July 2013 – 30 June 2014

	Short term benefits $'000					
	Base Salary $'000	Non-monetary benefits $'000	Long term benefits $'000	Post-employment benefits $'000	Termination benefits $'000	Total Remuneration $'000
Board Members						
Board Chair – Dr Paul Alexander	75	–	–	6	–	81
Deputy Chair – Mr Vaughan Howell	37	–	–	3	–	40
Mr Leonard Scanlan	37	–	–	3	–	40
Ms Melinda McGrath	30	–	–	3	–	33
Associate Professor Clifford Pollard	37	–	–	2	–	39
Dr Margaret Steinberg	37	–	–	3	–	40
Professor Helen Edwards	36	–	–	3	–	39
Professor Nicholas Fisk	36	–	–	3	–	39
Dr Kim Forrester	36	–	–	3	–	39
Total Remuneration	**361**	**–**	**–**	**29**	**–**	**390**

	Short term benefits $'000					
	Base Salary $'000	Non-monetary benefits $'000	Long term benefits $'000	Post-employment benefits $'000	Termination benefits $'000	Total Remuneration $'000
Key Management Personnel						
Chief Executive (from 8/7/2013 to current)	398	14	8	32	0	452
Chief Finance Officer (from 1/7/2013 to current)	219	0	5	23	0	247
Chief Operating Officer (from 8/7/2013 to current)	190	17	4	27	0	238
Executive Director, Governance, Quality and Risk (from 8/7/2013 to 4/3/2014)	114	9	3	13	0	139
Executive Director, Workforce and Organisational Development* (from 1/7/2013 to 1/11/2013)	61	6	1	6	0	74
Acting Executive Directors, Royal Brisbane and Women's Hospital (from 1/7/2013 to current)	384	5	8	4	0	438
Acting Executive Director, The Prince Charles Hospital (from 1/7/2013 to current)	412	0	5	41	0	458
Acting Executive Director, Redcliffe Hospital (from 1/7/2013 to current)	175	0	4	18	0	197

34 Key Management Personnel and Remuneration Expense (continued)

(b) Remuneration Expenses (continued)

1 July 2013 – 30 June 2014

	Short term benefits $'000					
	Base Salary $'000	Non-monetary benefits $'000	Long term benefits $'000	Post-employment benefits $'000	Termination benefits $'000	Total Remuneration $'000
Key Management Personnel (continued)						
Executive Director, Caboolture and Kilcoy Hospitals (from 1/7/2013 to 1/12/2013)	83	7	2	8	0	100
Acting Executive Directors, Caboolture and Kilcoy Hospitals (from 2/12/2014 to current)	184	9	2	15	0	210
Executive Director, Mental Health Services (from 1/7/2013 to current)	433	0	5	33	0	471
Executive Director, Subacute and Ambulatory Services (from 1/7/2013 to 9/8/2013)	54	1	1	4	0	60
Acting Executive Manager and Director of Nursing, Subacute and Ambulatory Services (from 10/8/2013 to current)	155	0	3	16	0	174
Executive Director, Oral Health Services (from 1/7/2013 to current)	168	14	4	18	0	204
Executive Director, Nursing Services (from 1/7/2013 to 6/12/2013 & 6/1/2014 to current)	209	16	4	21	0	250
Executive Director, Medical Services (from 1/7/2013 to current)	428	17	5	34	0	484
Executive Director, Allied Health Services (from 1/7/2013 to current)	166	21	4	20	0	211
Executive Director, Corporate Services and Performance (from 1/7/2013 to current)	195	17	4	19	0	235
Total Remuneration	**4,028**	**153**	**72**	**389**	**–**	**4,642**

** The role of the Executive Director, Workforce and Organisational Development was not replaced in November 2013. The responsibilities previously held by that position were assumed by the Executive Director, Corporate Services and Performance.*

34 Key Management Personnel and Remuneration Expense (continued)

(b) Remuneration Expenses (continued)

1 July 2012 – 30 June 2013

	Short term benefits $'000					
	Base Salary $'000	Non-monetary benefits $'000	Long term benefits $'000	Post-employment benefits $'000	Termination benefits $'000	Total Remuneration $'000
Board Members						
Board Chair – Dr Paul Alexander	76	–	–	7	–	83
Deputy Chair – Mr Vaughan Howell	33	–	–	3	–	36
Mr Leonard Scanlan	26	–	–	2	–	28
Mr Michael Denton	31	–	–	3	–	34
Ms Melinda McGrath	26	–	–	2	–	28
Associate Professor Clifford Pollard	26	–	–	2	–	28
Dr Margaret Steinberg	33	–	–	3	–	36
Professor Helen Edwards	26	–	–	2	–	28
Professor Nicholas Fisk	26	–	–	2	–	28
Dr Kim Forrester	2	–	–	–	–	2
Total Remuneration	**305**	**–**	**–**	**26**	**–**	**331**

	Short term benefits $'000					
	Base Salary $'000	Non-monetary benefits $'000	Long term benefits $'000	Post-employment benefits $'000	Termination benefits $'000	Total Remuneration $'000
Key Management Personnel						
Chief Executive (from 6/8/2012 to 1/2/2013)	549	9	0	19	5	582
Interim Chief Executives (from 1/7/2012 to 5/8/2012 & 4/2/2013 to 30/6/2013)	103	8	2	9	0	122
Chief Finance Officer (from 6/8/2012 to 11/3/2013)	131	10	3	14	0	158
Interim Chief Finance Officer (from 1/7/2012 to 5/8/2012 & 12/3/2013 to 30/6/2013)	70	2	1	8	0	81
Chief Operating Officer (from 1/7/2012 to 3/2/2013)	127	10	3	11	0	151
Interim Chief Operating Officer (from 4/2/2013 to 30/6/2013)	61	7	1	6	0	75
Executive Director, Workforce and Organisational Development (from 1/7/2013 to 30/6/2013)	166	27	3	16	0	212

34 Key Management Personnel and Remuneration Expense (continued)

(b) Remuneration Expenses (continued)

1 July 2012 – 30 June 2013

	Short term benefits $'000					
	Base Salary $'000	Non-monetary benefits $'000	Long term benefits $'000	Post-employment benefits $'000	Termination benefits $'000	Total Remuneration $'000
Key Management Personnel (continued)						
Executive Director, Royal Brisbane and Women's Hospital (from 1/7/2012 to 22/2/2013)	335	1	0	27	4	367
Acting Executive Director, Royal Brisbane and Women's Hospital (from 01/2/2013 to 30/6/2013)	142	7	3	15	0	167
Executive Director, The Prince Charles Hospital (from 1/7/2012 to 31/3/2013)	250	21	0	15	41	327
Acting Executive Director, The Prince Charles Hospital (from 01/2/2013 to 30/6/2013)	119	0	2	10	0	131
Executive Director, Redcliffe Hospital (from 1/7/2012 to 1/3/2013)	262	12	3	19	0	296
Acting Executive Director, Redcliffe Hospital (from 2/3/2013 to 30/6/2013)	45	0	1	5	0	51
Executive Director, Caboolture and Kilcoy Hospitals (from 1/7/2012 to 30/6/2013)	166	24	3	16	0	209
Executive Director, Primary and Community Health Services (from 1/7/2012 to 12/12/2012)	56	0	0	5	185	246
Executive Director, Aged Care & Residential (from 1/7/2012 to 1/9/2012)	27	2	1	3	0	33
Executive Director, Subacute and Ambulatory Services (from 1/7/2012 to 30/6/2013)	319	15	4	24	0	362
Executive Director, Oral Health Services (from 1/7/2012 to 30/6/2013)	108	15	4	13	0	140
Interim Executive Director, Oral Health Services (from 1/12/2012 to 30/6/2013)	92	9	2	9	0	112
Total Remuneration	**3,128**	**179**	**36**	**244**	**235**	**3,822**

35 Events after the reporting period

There has been a number of events occur after the reporting period that may materially affect the operation of the Metro North Hospital and Health Service in financial years, and/or the results of those operations in future financial years, and/or the state of affairs of the Metro North Hospital and Health Service in future financial years.

Prescribed employer status

In June 2012, amendments were made to the *Hospital and Health Boards Act 2011*, giving Hospital and Health Boards more autonomy by allowing them to become the employer of staff working for their Hospital and Health Service (HHS). HHSs are prescribed as employers by regulation, which is why this process is called the prescribed employer process.

Currently, all staff, except the Metro North Hospital and Health Service Chief Executive and Metro North Hospital and Health Service's health executive service (HES) employees are employed by the Director-General, Department of Health. In June 2012, amendments were made to the *Hospital and Health Boards Act 2011*, giving the Metro North Hospital and Health Board more autonomy by allowing them to become the employer of staff working for the health service.

As of 1 July 2014, the Metro North Hospital and Health Service has become a prescribed employer by regulation and all existing and future staff working for the Metro North Hospital and Health Service become its employees.

The Metro North Hospital and Health Service, not the Department of Health, will recognise employee expenses in respect of all staff from the 1 July 2014. The Director-General, Department of Health however will continue to be responsible for setting terms and conditions of employment, including remuneration and classification structures, and for negotiating enterprise agreements.

Senior Medical Officer and Visiting Medical Officer Contracts

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

Individual contracts mean senior doctors will have a direct employment relationship with the Metro North Hospital and Health Service and employment terms and conditions tailored to individual or medical specialty circumstances (within a consistent state-wide framework).

As a direct employment relationship will be established between contracted medical officers and the Metro North Hospital and Health Service, employee-related costs for contracted Senior Medical Officers and Visiting Medical Officers will be recognised by the Metro North Hospital and Health Service (not the Department of Health as it is currently) from the date the contracts are effective. Non-contracted Senior Medical Officers and Visiting Medical Officers will remain employed under current award arrangements however the employer will also be the Metro North Hospital and Health Service.

Transfer of land and building legal title to the Metro North Hospital and Health Service

The Metro North Hospital and Health Service was granted operational control of health service land and buildings on the 1st July 2012 via a Deed of Lease arrangement with the Department of Health. This arrangement confirmed that the Metro North Hospital and Health Service had all the rights of ownership without the legal title (including the right to recognise the assets in the Metro North Hospital and Health Service financial statements).

In 2013–14 a Land and Building Transfer Project (LBTP) was established by the Department of Health to work in collaboration with the Metro North Hospital and Health Service to transfer the legal ownership of land and building assets from the Department of Health to the Metro North Hospital and Health Service. The Project has worked in partnership with the Metro North Hospital and Health Service to:

- collaboratively assess HHSs capability to sustainably manage their land and building assets;
- identify and resolve potential impediments to transfer;
- identify any risks associated with transfer for the department and the HHSs and manage risks specific to delivery of the project; and
- facilitate the timely transfer of legal ownership.

Commencing 1 July 2014, the legal title of the Metro North Hospital and Health Service's land and buildings will transfer from the Department of Health. As the Metro North Hospital and Health Service currently controls these assets there will be no material impact to the financial statements of the Metro North Hospital and Health Service.

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

35 Events after the reporting period (continued)

Royal Children's Hospital – Surrender of Lease

The transitioning of the Royal Children's Hospital to the new Lady Cilento Children's Hospital ("LCCH") will result in Children's Health Queensland vacating the Royal Children's Hospital and other associated buildings at the Herston site (referred to as "RCH buildings") on 30 June 2015 (current termination date of the Deed of Lease) or until such time as the lease is surrendered.

Children's Health Queensland currently controls the RCH buildings under a deed of lease arrangement with the Metro North Hospital and Health Service. Metro North was prescribed as the legal owner of the RCH land and buildings effective from 1 July 2014. Under the terms of the Deed of Lease, Metro North Hospital and Health Service is the lessor while Children's Health Queensland is the lessee of the RCH buildings. Children's Health Queensland is currently responsible for managing and maintaining the buildings during the deed of lease. At the time the lease is surrendered, control of the RCH buildings will transfer at fair value to the Metro North Hospital and Health Service.

The restoration and redevelopment of the Herston Hospital Site

On the 29th May 2014, the Cabinet Budget Review Committee (CBRC) approved the establishment of a Taskforce to oversee master-planning for the progressive re-development of the Herston site, which included the RCH buildings. The Taskforce is accountable to the Minister for Health and reports to both the Minister for Health and the Treasurer. CBRC determined that an Expression of Interest (EOI) be undertaken immediately for a health related development, including a private hospital and associated commercial activities, to be located on the Herston site at no net cost to the State. The assessment of bids, including on-site location options, will have regard to advice from the Taskforce in relation to the master-planning process. Projects Queensland, within Queensland Treasury and Trade, is responsible for leading the EOI process, and any subsequent bidding phases. The Taskforce will be required to submit a preliminary report to CBRC in November 2014 that will include preferred master-planning options and preliminary advice on the feasibility of these options consistent with the Vision for the Herston Health Precinct. The final master-plan is due to be submitted to CBRC in the first quarter of 2015.

On the 1st August 2014, the Queensland Government publicly announced that it would be undertaking the EOI process that will see industry present preliminary ideas in relation to the restoration and redevelopment of the Herston site. There are a number of Metro North Hospital and Health Service's heritage listed buildings also earmarked for redevelopment, namely the Edith Cavell building and the Lady Lamington buildings (comprising the original Nurses Home and the North and South Towers).

As at the time of signing of these financial statements, no decision has been made by the Government in respect of the development of the Herston site. As such, and until such time as a determination is made as to the future use of the Herston site, the current realisable value as at 30 June 2014 in relation to the Metro North Hospital and Health Services land and buildings in relation to the redevelopment site will be carried at fair value based on the current usage of these buildings.

7.2 Certification of the Metro North 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 requirement for establishing and keeping the accounts have been complied with in all material respects; and

(b) the statements have been drawn up to present a true and fair view, in accordance with the prescribed accounting standards, of the transactions of Metro North Hospital and Health Service for the financial year ended 30 June 2014 and of the financial position of the Health Service at the end of the 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 Paul Alexander AO
MBBS, FRACMA, FACLM
Board Chair

Date: 27th August 2014

Mr Malcolm Stamp CBE
Chief Executive

Date: 27th August 2014

Mr Robert Dubery
FCPA, FCMA, CGMA, GAICD
Chief Finance Officer

Date: 27th August 2014

7.3 Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT

To the Board of Metro North Hospital and Health Service

Report on the Financial Report

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

The Board's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

Independence

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

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

Opinion

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

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

(b) in my opinion –

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

(ii) the financial report presents a true and fair view, in accordance with the prescribed accounting standards, of the transactions of the Metro North Hospital and Health Service for the financial year 1 July 2013 to 30 June 2014 and of the financial position as at the end of that year.

Other Matters - Electronic Presentation of the Audited Financial Report

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

D J Olive CPA
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane

Appendix 1: Open Data

Consultancies

Not now required in annual reports, the information is published on the Queensland Government Open Data website at: https://data.qld.gov.au/

Overseas Travel

Not now required in annual reports, the information is published on the Queensland Government Open Data website at: https://data.qld.gov.au/

Appendix 2: Compliance Checklist

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant minister	ARRs – section 8	3
Accessibility	Table of contents	ARRs – section 10.1	4
	Glossary	ARRs – section 10.1	NIL
	Public availability	ARRs – section 10.2	2
	Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 10.3	2
	Copyright notice	*Copyright Act 1968* ARRs – section 10.4	2
	Information licensing	*Queensland Government Enterprise Architecture – Information licensing* ARRs – section 10.5	2
General information	Introductory information	ARRs – section 11.1	10
	Agency role and main functions	ARRs – section 11.2	13
	Operating environment	ARRs – section 11.3	8–9
	Machinery of government changes	ARRs – section 11.4	NIL
Non-financial performance	Government objectives for the community	ARRs – section 12.1	12
	Other whole-of-government plans / specific initiatives	ARRs – section 12.2	12
	Agency objectives and performance indicators	ARRs – section 12.3	13
	Agency service areas, service standards and other measures	ARRs – section 12.4	14
Financial performance	Summary of financial performance	ARRs – section 13.1	18
Governance –management and structure	Organisational structure	ARRs – section 14.1	21
	Executive management	ARRs – section 14.2	28
	Related entities	ARRs – section 14.3	NIL
	Government bodies	ARRs – section 14.4	NIL

Appendix 2: Compliance Checklist (continued)

Summary of requirement		Basis for requirement	Annual report reference
	Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* (section 23 and Schedule) ARRs – section 14.5	30
Governance – risk management and accountability	Risk management	ARRs – section 15.1	31
	External Scrutiny	ARRs – section 15.2	31
	Audit committee	ARRs – section 15.3	31
	Internal Audit	ARRs – section 15.4	31
	Public Sector Renewal	ARRs – section 15.5	32
	Information systems and record keeping	ARRs – section 15.6	32
Governance – human resources	Workforce planning, attraction and retention and performance	ARRs – section 16.1	35
	Early retirement, redundancy and retrenchment	Directive No. 11/12 *Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	39
Open Data	Open Data	ARRs – section 17	83
Financial Statements	Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	80
	Independent Auditors Report	FAA – section 62 FPMA – section 50 ARRs – section 18.2	81
	Remuneration disclosures	*Financial Reporting Requirements for Queensland Government Agencies* ARRs – section 18.3	72

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