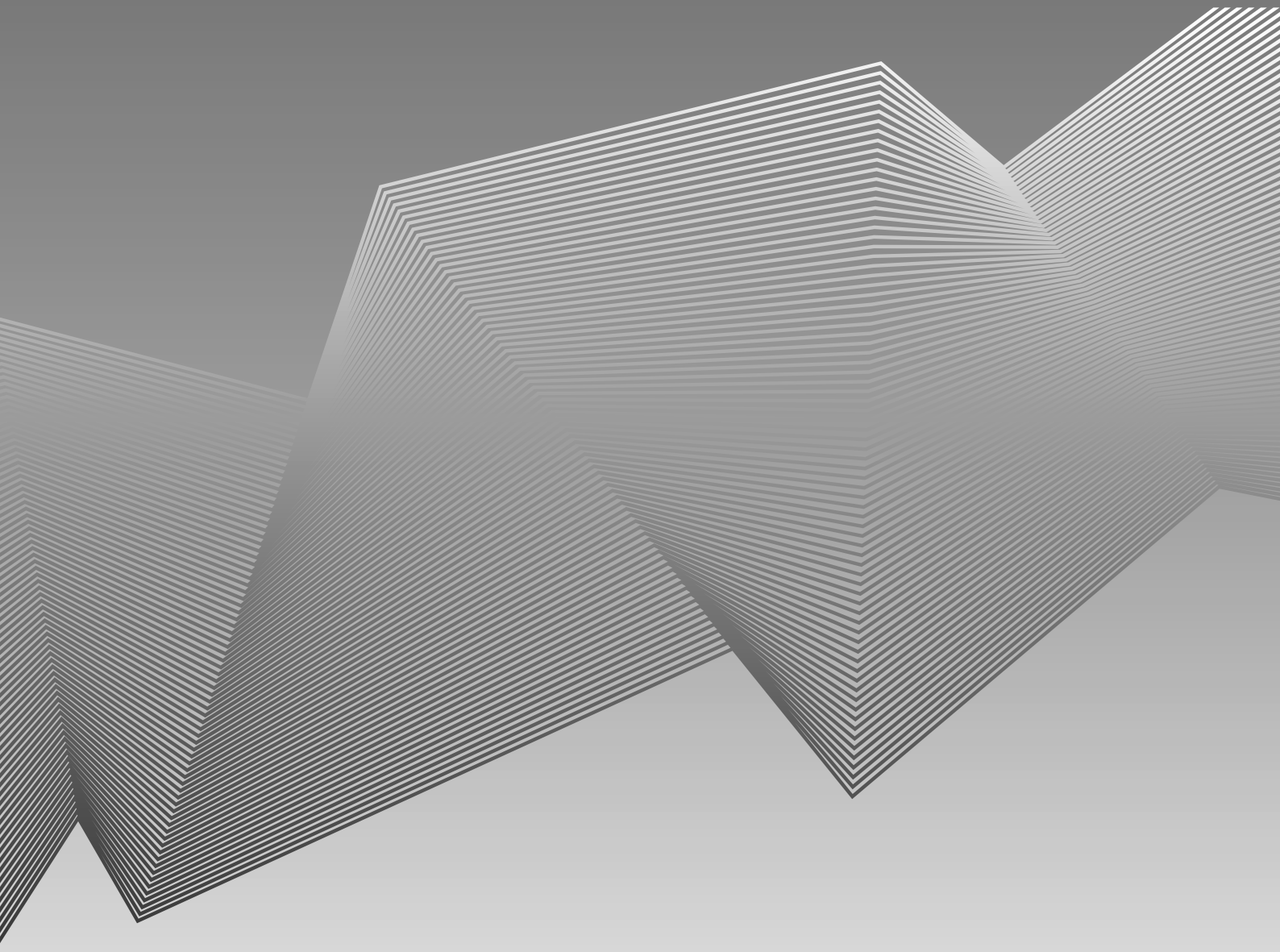
Central Queensland
Hospital and Health Service

ANNUAL REPORT 2020–2021



Queensland Government

Accessibility

An electronic copy of this report is available at www.health.qld.gov.au/cq. Hard copies of the annual report are available by phoning CQHH Board Secretary on (07) 4920 5759. Alternatively, you can request a copy by emailing CQHHS_Board@health.qld.gov.au

Information on consultancies and Queensland Language Policy will be published on the Queensland Health Open Data website (https://data.qld.gov.au). There was no overseas travel expenditure for the reporting period.

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on telephone (07) 4920 5759 or (07) 3115 6999 and we will arrange an interpreter to effectively communicate the report to you.

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Aboriginal and Torres Strait Islander people are advised that this publication may contain words, names, images and descriptions of people who have passed away.

Acknowledgement

Acknowledgement to Traditional Owners

We respectfully acknowledge the Traditional Owners of the land, as well as the significant spiritual and cultural connection to the animals, waters, plants and country throughout Central Queensland. We also respectfully acknowledge Elders, past present and future, and thank Elders, community and health services with whom we walk with great pride to address the health needs as partners to close the health gap between Aboriginal peoples and Torres Strait Islander peoples and the wider Central Queensland population.

Recognition of Australian South Sea Islanders

Central Queensland Hospital and Health Service (CQ Health) formally recognises the Australian South Sea Islanders as a distinct cultural group within our geographical boundaries. CQ Health is committed to fulfilling the *Queensland Government Recognition Statement for Australian South Sea Islander Community* to ensure that present and future generations of Australian South Sea Islanders have equality of opportunity to participate in and contribute to the economic, social, political and cultural life of the State.

Letter of compliance

Queensland Government

Central Queensland Hospital and Health Service

2 September 2021

The Honourable Yvette D'Ath MP
Minister for Health and Ambulance Services
GPO Box 48
Brisbane QLD 4001

Dear Minister

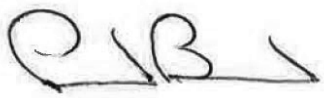
I am pleased to submit for presentation to the Parliament the Annual Report 2020–2021 and financial statements for Central Queensland Hospital and Health Service.

I certify that this Annual Report complies with:

- the prescribed requirements of the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2019*; and
- the detailed requirements set out in the *Annual Report Requirements for Queensland Government agencies*.

A checklist outlining the annual reporting requirements can be found on page 74 of this annual report.

Yours sincerely



Mr Paul Bell AM
Chair
Central Queensland Hospital and Health Board

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1. Statement on Queensland Government objectives for the community

CQ Health's strategic vision *Destination 2030: Great Care for Central Queenslanders* (Destination 2030), and *Strategic Plan 2018-2022 (updated 2020)*, support the Queensland Government objectives highlighted in *Our Future State: Advancing Queensland's Priorities.*

The CQ Health Strategic Plan sets a clear ambition – driven by the vision of Great Care for Central Queenslanders – for Central Queenslanders to be among the healthiest in Australia, and for our health service to be among the best in the country.

Achieving CQ Health's strategic vision will support the delivery of the Queensland Government's objectives for the community, particularly:

- Keep Queenslanders healthy by providing services closer to home with 10,000 fewer patient journeys; 10,000 fewer lives lost to smoking related diseases and a broader strategy to address obesity, diabetes, alcohol and mental wellbeing; closing the gap in Indigenous life expectancy.
- Give all our children a great start by General Practitioners and specialist hospital services in Brisbane to develop an expanded range of family, women's and children's services across a broad range of services including children's cardiac, cancer and surgical services.

2. Message from the Chair

This annual report outlines the progress CQ Health made in 2020-2021.

During the reporting period, CQ Health opened the new Emergency department and revitalised specialist outpatient department at Gladstone Hospital and acquired the former Gladstone Mater hospital, now known as the Gladstone Hospital west wing.

Funding has been confirmed and planning work continues to progress many more significant developments for our services. Central Queensland Hospital and Health Board (the Board) recognises the commitments to deliver service and infrastructure improvements including:

- $5.7 million of a $16.3 million project to deliver the 42-bed residential rehabilitation and treatment facility
- $3.5 million of a $7.2 million project to deliver 8 residential aged care beds at Moura
- $2 million out of a $12.5 million project to increase the number of aged care beds from 4 to 14, construct a new kitchen and upgrade laundry facilities at Woorabinda
- $2.4 million out of a $18.2 million project to deliver a cardiac theatre in Central Queensland
- $2.8 million out of a $5.8 million project to refurbish the mental health facility at Rockhampton.

CQ Health delivered a $2.7 million operational deficit which can be attributed to the significant increase in demand for healthcare and the additional services delivered as well as the ongoing impact of COVID-19.

A comprehensive savings and efficiency plan is in place to maximise investment into frontline service delivery and the delivery of safe and sustainable services.

The Board increased its focus on identifying short-term and long-term risks and the development of mitigations to reduce the potential impact. The five-year roadmap developed as the next phase of realising the strategic vision identified in *Destination 2030: Great Care for Central Queenslanders* (Destination 2030), is closely linked with risk mitigation.

The focus on cultural improvement - supporting Destination 2030 and its commitment to deliver great care and great people – continued with the Board Executive Committee implementation of a new Organisational Culture Strategy.

I thank former Board member Andrew Island for his contribution and welcome new member John Abbott to the Board. I recognise the commitment of all Board members, and their input into the Board committees including: Executive Committee; Aboriginal and Torres Strait Islander Health Committee; Quality and Safety Committee; and Finance and Resource Committee.

I also thank Chief Executive Steve Williamson, his executive team and the great staff for their care, integrity, respect, and commitment.

3. Message from the Chief Executive

CQ Health's 4336 staff continued to deliver great care for Central Queenslanders during a particularly challenging year.

While there was not an active COVID-19 patient in Central Queensland during the financial year, the pandemic had significant impact on health service delivery and financial performance.

The availability of appropriately skilled staff was impacted by COVID-19 travel restrictions and the staffing of testing clinics throughout the year and vaccination clinics during the fourth quarter.

Health service delivery was further impacted by unprecedented and sustained increased demand for care across Central Queensland. Staffing additional beds opened to reduce the impact of the increased demand was particularly challenging.

A Business Case for Change to change the structure of the Executive Management Team was launched in June 2021. The proposed Executive and organisational structure is designed to provide the best executive leadership framework and the most effective organisation structure possible to support our frontline services, help address the challenges of COVID-19, and to help realise the great opportunities for our region.

The proposal streamlines the structure into a Chief Operating Officer model and introduces an Executive Director Aboriginal and Torres Strait Islander Health to deliver the support required to enable health equity.

CQ Health has begun planning more than $100 million of infrastructure commitments that will deliver healthcare, access, and infrastructure improvements across the Central Queensland footprint. The commitments range from a cardiac theatre to save Central Queenslanders travelling to Brisbane for cardiac intervention, to aged care investment in Moura and Woorabinda and a new hospital in Blackwater.

I recognise the strategic support from Chair Paul Bell and the Central Queensland Hospital and Health Board.

I would like to thank the amazing staff of CQ Health. Their dedication and willingness to put their community first has contributed to improved health outcomes and protected Central Queensland from COVID-19.

4. About us

4.1. Strategic direction

CQ Health was established under the *Hospital and Health Boards Act 2011*.

CQ Health's long-term strategic vision *Destination 2030: Great Care for Central Queenslanders* was approved by the Board and adopted by CQ Health on 27 October 2017.

This strategic vision provides targets for 2020, 2025 and 2030. Annual actions and projects to deliver the vision are identified in a CQ Health roadmap. Similar roadmaps are developed for each of the strategic objectives (see below) and five geographic/project areas: Rockhampton, Gladstone, rural and remote, out-of-hospital services and Closing the Gap.

4.2. Vision, Purpose, Values

Vision: Great Care for Central Queenslanders

Purpose: Great people, delivering quality care and improving health outcomes

Values: CQ Health is committed to our guiding values:

- Care – We are attentive to individual needs and circumstances
- Integrity – We are consistently true, act diligently and lead by example
- Respect – We will behave with courtesy, dignity and fairness in all we do
- Commitment – We will always do the best we can

4.3. Priorities

CQ Health's priorities are clearly expressed in the *CQ Health Strategic Plan 2018-2022 (updated 2020)*:

- Great Care, Great Experience
- Great People, Great Place to Work
- Great Partnerships
- Great Learning and Research
- Sustainable Future

4.4. Aboriginal and Torres Strait Islander Health and Wellbeing

2020-2021 was a challenging year responding to Aboriginal and Torres Strait Islander health priorities and the ever-changing COVID-19 pandemic. The challenge was met by establishing the Aboriginal and Torres Strait Islander Health and Wellbeing Directorate. The directorate aims to strengthen foundations, build capacity, provide leadership, be accountable, be transparent, and ensure cultural governance across priority areas for Aboriginal and Torres Strait Islander health.

The Aboriginal and Torres Strait Islander Health and Wellbeing Directorate secured $35,000 funding to deliver the Transforming Emergency Departments Towards Cultural Safety, Gladstone Hospital, Emergency Department Project. Creating culturally welcoming emergency departments was identified as a priority action in the *Suicide Prevention Health Taskforce Action Plan.*

The project involves consultation with Gladstone Aboriginal and Torres Strait Islander Traditional Owner Groups, Elders, consumers, community and key staff to deliver a culturally safe and welcoming emergency department that helps Aboriginal and Torres Strait Islander consumers feel, safe, heard, valued and able to participate in their own health care journey.

The artwork project will be facilitated by two local Aboriginal and Torres Strait Islander artists. The artwork will share a special story of a 'Health Journey' from local Aboriginal and Torres Strait Islander cultural knowledge, wisdom, and perspective. It will strengthen CQ Health's connection to our Aboriginal and Torres Strait Islander communities, including the wider community.

The aim of the artwork is to:

- Provide an environment that is culturally safe and welcoming to Aboriginal and Torres Strait Islander consumers
- Engage and empower our Aboriginal and Torres Strait Islander consumers in their health care journey and feel valued
- Contribute to health equity outcomes for our Aboriginal and Torres Strait Islander consumers
- Recognise, acknowledge, and pay respect to the strong connection Aboriginal and Torres Strait Islander peoples have to health, language, family, land and sea
- Be co-designed by our local Aboriginal and Torres Strait Islander young people
- Strengthen consumer partnerships with health care providers
- Share cultural knowledge between non-Indigenous staff and consumers

4.5. Our community-based and hospital-based services

CQ Health is responsible for providing public hospital and health services including medical, surgical, emergency, obstetrics, paediatrics, specialist outpatient, mental health, critical care and clinical support services.

It also provides mental health services, oral health services, offender health services and aged care services, with facilities also providing community health services.

CQ Health is responsible for the direct management of facilities within its geographical boundaries including:

- Biloela Hospital
- Capricorn Coast Hospital
- Emerald Hospital
- Gladstone Hospital
- Moura Community Hospital
- Rockhampton Hospital

CQ Health also provides services from Multipurpose Health Services (MPHS) and outpatient clinics. MPHS are located at:

- Baralaba
- Blackwater
- Mount Morgan
- Springsure
- Theodore
- Woorabinda.

Outpatient clinics are located at:

- Capella
- Gemfields
- Tieri

Aged care facilities are located at:

- North Rockhampton Nursing Centre
- Eventide Nursing Home

4.5.1. Car Park concessions

In 2020-2021 7,327 concession passes and discounted parking tickets were issued for Rockhampton Hospital car park at an estimated cost of $116,572.

4.6. Targets and Challenges

Key challenges for CQ Health include:

- the impact of unprecedented and ongoing demand for health services
- the impacts of COVID-19
- availability of workforce resources to meet service delivery and business needs, including challenges with recruitment and retention

The *CQ Health Strategic Plan 2018-2022 (updated 2020)* identifies opportunities for the health service, including:

- To partner with university and health service partners to produce locally trained medical graduates delivering improved recruitment and retention.
- To deliver increased capability in cancer, cardiac and other services to reduce the need for patient travel and support neighbouring health services.
- To use research, technology and innovation to improve health outcomes and increase life expectancy in an area of Queensland impacted by its distance from a tertiary medical facility.

The *CQ Health Strategic Plan 2018-2022 (updated 2020)* identifies four strategic risks that CQ Health must manage in delivering our vision of Great Care for Central Queenslanders. The risks, and CQ Health's response to those risks include:

- Failure to meet accredited or industry benchmark quality and safety standards – continue to develop robust systems that measure, evaluate and implement improvements in quality and safety governance and performance.
- Asset and ICT infrastructure to meet Destination 2030 vision – continue to develop a strategy for service-wide implementation of electronic medical records. Develop and benchmark project infrastructure delivery.
- Insufficient workforce resources to meet service delivery and business needs – continue to design a Workforce Capability Development Framework and improve all aspects of the recruitment function.
- Failure to meet financial and business unit performance expectations – continue to develop a medium term (five year) financial model to complement Destination 2030.

5. Governance

5.1. Our people

5.1.1. Board membership

Mr Paul Bell AM (Board Chair)

Date of original appointment: 25 September 2015

Current term of office: 18 May 2020 – 31 March 2024

Mr Paul Bell AM was appointed as Chair of the Central Queensland Hospital and Health Board in May 2016. Mr Bell served in local government for 35 years as a Councillor and Mayor on the Central Highlands as well as holding the president's role at a national and state local government level.

Mr Bell has a long history of board leadership in the health, energy, rail, superannuation and community service sectors and has a strong belief in the public sector and its ability to deliver, given the right leadership and clear objectives.

Mr Bell is Chair of the Central Highlands Healthcare Ltd Board and Chair of the Queensland Local Government Grants Commission. He is also active on a number of non-government organisations in his local community.

In 2005, Mr Bell was awarded the Order of Australia, General Division. He has a Bachelor of Business Administration (BBus Admin. CQU) and is a Member of the Australian Institute of Company Directors.

Mrs Lisa Caffery

Date of original appointment: 18 May 2016

Current term of office: 11 June 2021 – 31 March 2024

Mrs Lisa Caffery is an experienced strategic professional in the specialist fields of social impact, community engagement and research. Mrs Caffery is a self-employed consultant with leadership and governance experience across the private and public sectors.

She also serves on regional not-for-profit boards as Deputy Chair for the Central Queensland Hospital Foundation and the Central Highlands Science Centre Inc.

Mrs Caffery has held numerous advisory and strategy development roles in mining, local government, not-for-profit and regional development sectors. She is nearing completion of a Doctor of Philosophy (PhD) at Central Queensland University with a research focus in health, rural and remote communities and social impact.

Mrs Caffery holds a Bachelor of Arts (Journalism), a Master of Public Relations and is a graduate of the Australian Institute of Company Directors. Mrs Caffery resides in the rural town of Emerald in the Central Highlands and is committed to improving health services and outcomes for people living in regional areas.

Dr Poya John Sobhanian

Date of original appointment: 18 May 2016

Current term of office: 18 May 2021 – 31 March 2024

Dr Poya John Sobhanian is affectionately known as Dr PJ by his patients. Dr Sobhanian is passionate about delivery of health services and strategic risk management. A graduate of the University of Queensland School of Dentistry, Dr Sobhanian undertook his placements at the local hospitals of Rockhampton, Yeppoon and Emerald. He later helped serve publicly at the Gladstone Hospital. Dr Sobhanian also established the Gladstone private dental practice of Sunvalley Dental.

In addition to his business background, Dr Sobhanian has extensive governance experience, including being past Chair of the Gladstone Regional Council's Commercial Services Committee and member of the internal audit Business Improvement Committee, as well as, non-Executive Director at the Gladstone Area Water Board, helping drive tangible Information Technology improvements via the Information Technology Optimisation Committee. Dr Sobhanian strongly believes in working together to best drive leading, innovative results for our communities.

Professor Fiona Coulson

Date of original appointment: 18 May 2020

Current term of office: 18 May 2020 - 31 March 2024

Professor Fiona Coulson as the Deputy Vice-President Educational Strategy and Innovation at CQUniversity, has a leading role in designing and implementing strategies that position CQUniversity as the most engaged, accessible, inclusive provider of tertiary education with a focus on the quality of the student learning journey. This includes oversight of CQUniversity's key strategic program of work and innovative, high-profile "institutional legacy" projects which support the CQUniversity Strategic Plan.

Prior to the role of Deputy Vice-President, Office of Education Strategy and Innovation, Prof Coulson held previous roles at CQUniversity including Deputy Vice-Chancellor (Strategic Development), and Dean of the University's largest School; the School of Health, Medical and Applied Sciences. Prof Coulson has a background in medical research, primarily in the relationship between diabetes and inflammation and their effects on gastrointestinal motility and respiratory function. Prof Coulson's medical research has spanned across multiple institutions, including The University of Queensland, Griffith University, and the Bloomberg School of Public Health at Johns Hopkins University in Baltimore, USA. Prof Coulson's upbringing in small towns across outback Queensland has made her a powerful advocate for the role played by regional Australia in our national prosperity, and the transformative effect that training, education and research yields in non-metropolitan communities. Prof Coulson and her family proudly call Rockhampton, Central Queensland, their home.

Ms Tina Zawila

Date of original appointment: 18 May 2019

Current term of office: 18 May 2019 - 31 March 2022

Ms Tina Zawila has more than 30 years' experience in the finance industry. She is a Chartered Accountant, financial planner and business advisor and director of a public accounting firm in Gladstone.

She is a non-Executive Director of Gladstone Airport Corporation, Chair of the Corporation's Finance and Audit Committee and a member of the Nominations, Remuneration and Human Resources Committee.

Ms Zawila also serves on local not-for-profit boards and committees including Gladstone Area Group Apprentices Ltd and EQIP Gladstone – Business Industry and Tourism.

Ms Zawila holds a Bachelor of Business (Accounting) with Distinction and Diploma of Financial Planning. She has completed the Australian Institute of Company Directors course and is a Fellow of the Institute of Managers and Leaders.

Dr Anna Vanderstaay

Date of original appointment: 18 May 2016

Current term of office: 18 May 2021 – 31 March 2024

Dr Anna Vanderstaay is a local General Practitioner and has worked in a number of rural, regional and metropolitan areas across Queensland. Born and raised in Rockhampton, she has worked in a number of hospitals throughout the state, across a number of clinical specialties, and brings valuable health knowledge to the Board.

Dr Vanderstaay works in a private General Practice in Yeppoon, as well as being involved in the training of medical students and General Practice registrars. She is a Graduate of the Australian Institute of Company Directors and holds Fellowship of the Royal Australian College of General Practitioners.

Mr John Abbott AM

Date of original appointment: 18 May 2021

Current term of office: 18 May 2021 – 31 March 2024

Mr John Abbott is currently the Chancellor of Central Queensland University, and the Board Chairman of both Queensland Wool Processing Pty Ltd, and Inter-port Global Consolidated Holdings Pty Ltd.

His experience includes many years of being Chairman of boards. He is also the Deputy Chairman of Regional Development Australia (Central and Western Queensland). Mr Abbott was appointed as a Member of the Order of Australia in recognition for his contribution to education, regional development and to the resources Industry.

Mr Abbott is also an experienced executive with over 40 years in all aspects of company leadership and governance in a wide range of industries. He has degrees in both Engineering and Law, and is a Fellow of the Institution of Engineers.

Ms Leann Wilson

Date of original appointment: 18 May 2019

Current term of office: 18 May 2019 - 31 March 2022

Ms Leann Wilson is the Executive Director of Regional Economic Solutions (RES), which is a majority Indigenous owned business in partnership with the global engineering and project management company Ausenco. RES's focus is to identify opportunities to secure local businesses and employment into project supply chains and engage with stakeholders to support business government and Indigenous groups to create sustainable economic and social development outcomes.

Ms Wilson sits on a number of state and national boards and in recognition of her influence, in 2016 received the Premiers Reconciliation Award, in 2017 was selected as a non-government delegate to join the Australian government to the 61st Commission on the Status of Women held in New York and in 2019 was recognised by the Financial Review as one of the top 100 woman of influence.

Mr Matthew Cooke

Date of original appointment: 18 May 2019

Current term of office: 18 May 2019 - 31 March 2022

Mr Cooke is a proud Aboriginal and South Sea Islander man from the Bailai (Byellee) people in Gladstone, Central Queensland.

Mr Cooke joins the Central Queensland Hospital and Health Board having a background in serving the Aboriginal and Torres Strait Islander Community Controlled Health Sector as both a Director and CEO over the past 10 years.

Mr Cooke is currently the Chief Executive Officer for the Gladstone Region Aboriginal and Islander Community Controlled Health Service Limited t/a Nhulundu Health Service.

Mr Cooke's past leadership roles include Chairperson of the National Aboriginal Community Controlled Health Organisation, Chief Executive of the Queensland Aboriginal and Islander Health Council and Director of the Western Queensland Primary Health Network.

Mr Cooke is actively involved in all aspects of Aboriginal and Torres Strait Islander affairs at national, state, regional and local levels. In 2007 he was named Young Leader in Aboriginal and Torres Strait Islander Health, in 2008 received the Deadly Vibe Young Leader Award and in 2011 received the Australian Institute of Management 2011 Young Manager of the Year Award – Gladstone.

Mr Cooke is also a member of the Australian Institute of Company Directors.

Immediate past members

Mr Andrew Ireland 18 May 2019 – 17 May 2021

Government bodies (statutory bodies and other entities)

Central Queensland Hospital and Health Board						
Act or instrument	*Hospital and Health Boards Act 2011*					
Functions	The Central Queensland Hospital and Health Board controls CQ Health					
Financial reporting	Transactions of the entity are accounted for in the financial statements					
Remuneration						
Position	Name	Meetings/ sessions attendance	Approved annual fee	Approved annual sub-committee fee per committee	Number of Committees	Actual fees received
Chair	Mr Paul Bell AM	11	$75,000	$4,000 (as member)	5	$90,000
Deputy Chair	Ms Lisa Caffery	10	$40,000	$4,000 (as Chair) $3,000 (as member)	1 2	$44,000
Member	Dr Poya Sobhanian	11	$40,000	$4,000 (as Chair) $3,000 (as member)	1 2	$50,000
Member	Dr Anna Vanderstaay	11	$40,000	$4,000 (as Chair) $3,000 (as member)	1 1	$50,000
Member	Mr Matthew Cooke (Approved 3 month Leave of Absence from 31 May 2021)	8	$40,000	$4,000 (as Chair) $3,000 (as member)	1 2	$40,000
Member	Ms Leann Wilson	6	$40,000	$3,000 (as member)	1	$40,000
Member	Ms Tina Zawila	11	$40,000	$4,000 (as Chair) $3,000 (as member)	1 2	$43,000
Member	Mr Andrew Ireland	10	$40,000	$3,000 (as member)	2	$44,000
Member	Professor Fiona Coulson	10	$40,000	$3,000 (as member)	1	$40,000
Member	Mr John Abbott AM	2	$40,000			$5,000
No. scheduled meetings/ sessions	11 Board Meetings					
Total out of pocket expenses	$349.56					

Our committees

During the reporting period the Board had five committees – Executive Committee, Finance and Resource Committee, Quality and Safety Committee, Audit and Risk Committee and Aboriginal and Torres Strait Islander Health and Wellbeing Committee. On 25 June 2021 the Board established an additional committee that will focus on matters including investment, research and planning.

The composition of the Board's Committees was reconstituted at its meeting of 25 June 2021 following changes to the Board membership in May 2021.

Executive Committee

The Executive Committee was chaired by Ms Lisa Caffery.

The Executive Committee is responsible for supporting the Central Queensland Hospital and Health Board in its role of overseeing the strategic direction of CQ Health. The Committee's scope is to work with CQ Health Chief Executive to progress the strategic issues identified by the Board. The committee therefore works in close cooperation with the Health Service Chief Executive to strengthen the relationship between the Board and the Health Service Chief Executive and to ensure accountability in the delivery of services by CQ Health.

Finance and Resource Committee

The Finance and Resource Committee was chaired by Ms Tina Zawila.

The Finance and Resource Committee is responsible for monitoring and assessing the financial management and

reporting obligations of CQ Health. It oversees resource utilisation strategies including monitoring the service's cash flow and its financial and operating performance. The committee is also responsible for bringing the attention of the Board to any unusual financial practices. The Finance and Resource Committee works in close cooperation with the Health Service Chief Executive and Chief Finance Officer.

Safety and Quality

The Safety and Quality Committee was chaired by Dr Anna Vanderstaay.

The Safety and Quality Committee is responsible for advising the Board on matters relating to the safety and quality of health services provided by the service, including the service's strategies to address the maintenance of high quality, safe and contemporary health services to patients. The committee works in close cooperation with the Health Service Chief Executive, Executive Director Nursing and Midwifery, Quality and Safety, and the Director Shared Services.

Aboriginal and Torres Strait Islander Health and Wellbeing Committee

The Aboriginal and Torres Strait Islander Health and Wellbeing Committee was chaired by Mr Matthew Cooke.

The Aboriginal and Torres Strait Islander Health and Wellbeing Committee's purpose is to support the Central Queensland Hospital and Health Board in providing strategic oversight of health and wellbeing of its Aboriginal and Torres Strait Islander communities through the development and subsequent delivery of initiatives in the context of the CQ Health Strategic Plan. The committee works in close cooperation with the Health Service Chief Executive and the Director, Aboriginal and Torres Strait Islander Health and Wellbeing.

Audit and Risk Committee

Members of the Audit and Risk Committee as at 30 June 2021 comprised:

- Chair: Dr Poya Sobhanian
- Members: Ms Tina Zawila and Mr John Abbott AM
- Mr Paul Bell AM (ex-offico Board Chair)

The Committee has standing rights of attendance for the following positions:

- Health Service Chief Executive
- Chief Finance Officer, Assets and Commercial Services
- Executive Director Nursing and Midwifery, Quality and Safety
- Internal Audit
- External Audit

The Audit and Risk Committee has observed the terms of its charter and had due regard to the Audit Committee Guidelines. The Audit and Risk Committee considered recommendations made by the Queensland Audit Office including performance audit recommendations.

The Audit and Risk Committee followed an approved work plan reflecting the committee's charter. The role of the committee is to provide independent assurance and assistance to the Board in the areas of:

- Risk, control and compliance frameworks,
- external accountability responsibilities as prescribed in the *Financial Accountability Act 2009*, the *Hospital and Health Boards Act 2011*, the *Hospital and Health Boards Regulation 2012* and the *Statutory Bodies Financial Arrangements Act 1982*;

The functions and responsibilities of the Audit and Risk Committee as contained in its charter and linked to the committee's work plan cover the areas of:

- Financial statements
- Integrity oversight and misconduct prevention.
- Risk management
- Internal control
- Internal audit
- Compliance

5.1.2. Executive structure

Executive Management

Steve Williamson – Health Service Chief Executive

Steve has significant health leadership experience across hospital, community health, aged care, other health and care services, and in military hospitals. Steve moved from the United Kingdom in early 2017 to become Health Service Chief Executive for CQ Health which provides hospital and health services across a regional and rural area of over 110,000km to a population of over 220,000 Central Queenslanders.

During his first year, Steve led the development of *Destination 2030: Great Care for Central Queenslanders*, the hospital and health service's long-term strategic vision. This vision will deliver great care for Central Queenslanders, enabling improved health, closing the gap in Aboriginal and Torres Strait Islander health outcomes, supporting more care closer to home in Central Queensland, and shaping the future of health across the Central Queensland region.

Steve has also been a Chief Executive in a combined Hospital and Community Healthcare Foundation Trust in the National Health Service in England, and has held senior leadership roles in local government and in the UK's Courts Service. Steve moved to Central Queensland with his wife Jacqueline, their two children Josh and Daisy who are at school in Rockhampton, and their dog Toffee.

Steve is an Adjunct Professor at CQUniversity and plays A3 hockey for his local club.

Colin Weeks

Chief Finance Officer, Assets and Corporate Services

Colin is responsible for leading financial management and compliance, corporate services and asset management across CQ Health. His strong commercial and financial experience includes executive finance roles across public and private sector organisations working in highly complex environments involving national initiatives, service development and transformational change.

Over the past 17 years, Colin has held senior executive finance positions in the New Zealand and Australia public health sector. He holds a Bachelor of Accounting Science and is a member of the Australian Institute of Company Directors.

Professor Alan Sandford AM

A/Executive Director Medical Services

Alan is also the Director of Medical Academic Development, Central Queensland and Wide Bay Hospital and Health Services and President, Royal Australasian College of Medical Administrators.

He is an experienced Specialist Medical leader holding positions in Executive medical leadership over the past 34 years in Queensland, New South Wales, Tasmania, Victoria and the Middle East.

Focus areas include medical leadership, credentialing, clinical governance, medical workforce planning and medical prevocational training and accreditation.

Alan is a member of the Council of Presidents of Medical Colleges and a member of the Australian Medical Council - Specialist Medical Accreditation Committee.

He has worked and consulted in a wide variety of posts across all States in Australia with a particular focus on rural Australia.

He was appointed a Member of the Order of Australia in the 2017 Australia Day Honours for: *"Significant services to medical administration and health management in a number of executive roles."*.

Sue Foyle

Executive Director Nursing, Midwifery, Quality & Safety

Sue is an experienced nurse and midwife of over 30 years. Sue's background is predominantly in midwifery, but also has intensive care and emergency nursing expertise.

Sue has extensive management and leadership experience in maternity services and in clinical governance and is a graduate of the Australian Institute of Company Directors. She is passionate about ensuring there are systems in place to maintain and improve the reliability, safety and quality of health care delivered to Central Queenslanders.

Sue is a strong advocate for the profession of nursing and midwifery as well as patient safety and quality.

Within CQ Health, Sue has been a finalist and has also won the award for Clinical Excellence in recent years. Sue's leadership has also been recognised on a statewide level, being awarded the Outstanding Achievement in Nursing Award in 2019 by the Association of Queensland Nursing and Midwifery leaders.

Sue is well respected as both a national and international speaker on matters of safety and quality in health care.

Sue joined CQ Health in 2016 as the Director of Nursing and Midwifery for Rockhampton Hospital and Director of Maternity Services for Central Queensland. More recently Sue has been appointed to the Executive Director Nursing, Midwifery; Quality and Safety role.

Kerrie-Anne Frakes

Executive Director Rockhampton Business Unit

Kerrie-Anne is the Executive Director for the Rockhampton Business Unit. She has an extensive history in developing and implementing innovative Models of Care and delivering transformational service changes and improved health outcomes for Central Queenslanders. She has won state and national awards for innovative models of care and has an extensive publication history in Chronic Disease Management and Service delivery evaluation.

Kerrie-Anne first came to Central Queensland in 1999 as a Queensland Health Rural Scholarship Graduate for Podiatry as the first public Podiatrist in the Central Queensland region. She has been the Director of Podiatry, and State-wide Podiatry Chair; Team Leader for Chronic Disease; Director of Clinical Support Services; Executive Director of Allied Health; and holds substantively the Executive Director of Strategy, Transformation and Allied Health Role for CQ Health.

Most recently Kerrie-Anne acted in the COVID-19 Chief Operating Officer role for CQ Health and led the response for both the North Rockhampton Nursing Centre Outbreak as well as for the Blackwater community.

She is passionate about regional and rural community capacity with a focus on workforce sustainability and care for patients closer to home.

Sandy Munro

Executive Director Gladstone and Banana

Sandy has an extensive background at the executive level in Queensland Health, including roles as Executive Director Gladstone and Banana, Executive Director of Nursing and Midwifery; Executive Lead for Quality and Safety; Nursing Director for Family Women and Children and Director of Nursing Gladstone.

She has previously worked in clinical roles across high dependency, intensive care, maternity and emergency and spent time in education and infection control prior to coming into management and executive leadership roles.

Sandy holds post graduate qualifications in nursing, midwifery, critical care and health management and leadership, with more than 30 years' experience in the health setting.

Strengths and interests: leadership and management, human resource and people management, governance, quality and safety.

Linda Medlin

A/Director Aboriginal and Torres Strait Islander Health and Wellbeing

Linda is the Acting Director of Aboriginal and Torres Strait Islander Health and Wellbeing Directorate. Linda has recently relocated to Rockhampton to be a presence within the Executive Team but centralising the position within CQ Health.

Linda has been with CQ Health now for near on two years and was previously recruited as the position of Senior Project Officer, Community Engagement, supporting the delivery of strategic programs aimed at improving the life expectancy of Aboriginal and Torres Strait Islander people in Central Queensland.

Linda commenced as a Generalist Health Worker in Central West and has worked her way through the ranks, doing roles such as Chronic Disease Coordinator, Mental Health Worker, Senior Policy Officer, Indigenous Respiratory Outreach Care Statewide Project Manager/Project Officer, Program of Experience in the Palliative Approach Statewide Project Officer, Research Candidature, Project Manager Aboriginal and Torres Strait Islander Health and Principal Advisor. Linda is involved as Chief Investigator in many research projects but of significance to CQ Health is the Digital Health Model to Enhance Immunisation and Developmental Screening in Australian Indigenous Children: The MOSAIC Project – Public Health, Communication Training for Mental Health Professionals: Developing Cultural Sensitivity and Capability to Improve Aboriginal and Torres Strait Islander People Mental Health Outcomes - QIMR; Strong Babies, Strong Families Implementation of Early Nurturing and Support for Aboriginal and Torres Strait Islander Children with Adverse Neurodevelopmental Outcomes - Queensland Paediatric Rehabilitation Service, Queensland Children's Hospital and the Learning Through Everyday Activities for Parents LEAP - Queensland Paediatric Rehabilitation Service, Queensland Children's Hospital.

Linda is very passionate about her people and their health and wellbeing and enjoys the role; addressing a variety of issues and challenges throughout Central Queensland in advocating for and linking with various key stakeholders to ensure a healthy and equitable outcome for all our Aboriginal and Torres Strait Islander community members.

Shareen McMillan

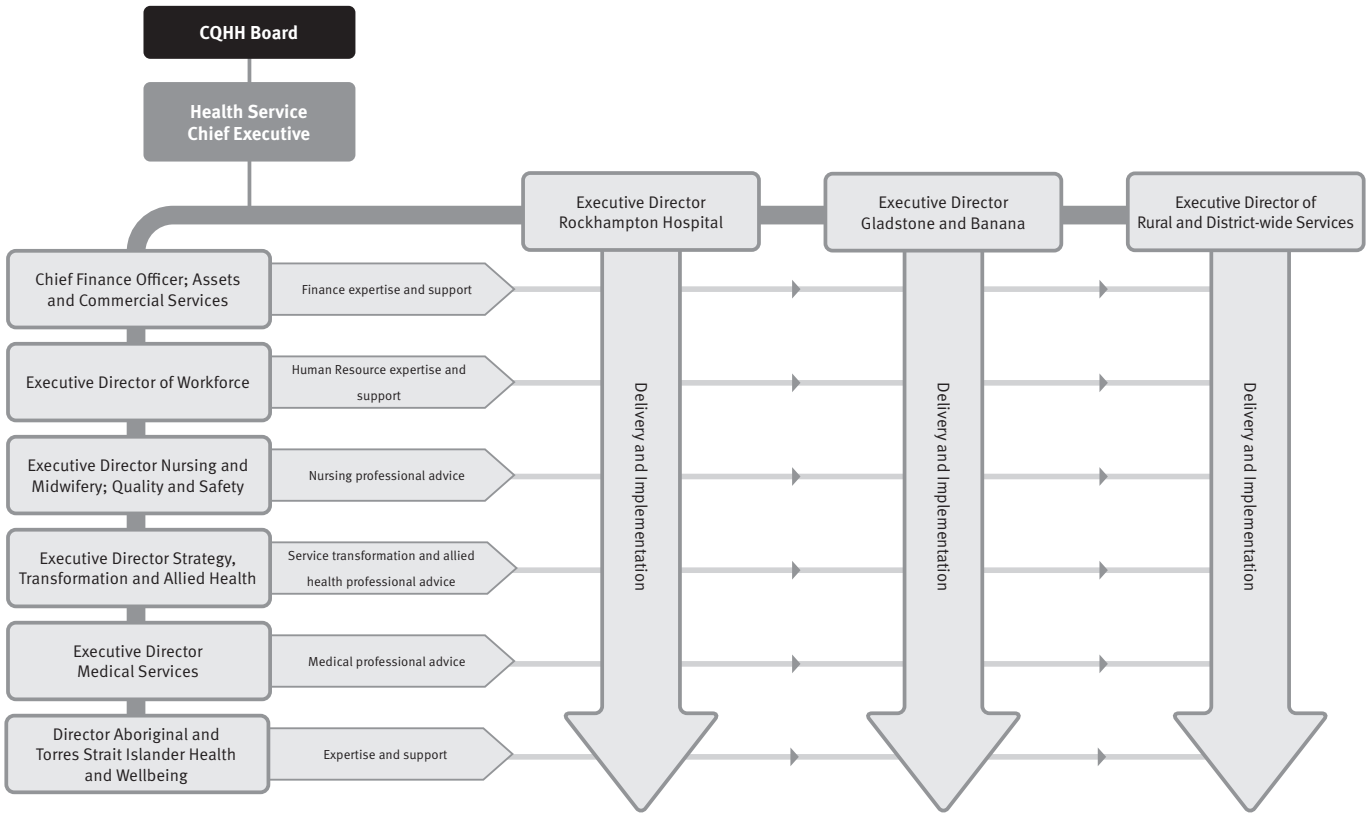
Executive Director Workforce

Shareen is the Workforce Division Executive Director within CQ Health, leading a team of 43 who undertake key projects and activities, including capability and leadership development programs; cultural change including embedding values and staff recognition programs; workplace planning; organisational change; human resource governance; human resource systems including learning management; safety and wellbeing; recruitment services; employee and industrial relations, as well as diversity and inclusion improvement strategies.

Shareen has worked in various government agencies and has a wide range of expertise in organisational and cultural change management; training and development; strategic and operational planning and reporting; employee and stakeholder engagement, performance and project management.

Shareen holds a degree in communications, Japanese language and tourism, receiving high distinction for her studies and a Japanese Language Award. Shareen has also completed a Graduate Diploma in Business Administration and Management with credit.

5.1.3. Organisational structure and workforce profile



5.1.4. Great People, Great place to work

CQ Health's strategic objective is to deliver great staff working in great teams with a culture of supporting and investing in our people's future.

CQ Health has more than 4000 great people filling more than 3000 positions, and all are committed to delivering to their community. Our staff save lives, improve health outcomes and deliver Central Queenslanders a healthier future.

CQ Health continued to focus on the recruitment of staff who live the organisation's values of Care, Integrity, Respect and Commitment. Delivering the right people with the right skills in the right place at the right time is an essential ingredient to meeting the community's health needs.

To deliver these and other performance indicators, CQ Health continued its cultural improvement program to retain the right staff longer. That program includes:

- Staff engagement
- Living our values – Everyone Every Day
- Staff recognition and rewards
- Leadership training and development
- Clarity of role, purpose and vision
- Transparency

More doctors and nurses*

	2016-17	2017-18	2018-19	2019-20	2020-21
Medical staff [a]	287	313	328	343	376
Nursing staff [a]	1,268	1,338	1,385	1,498	1,604
Allied Health staff [a]	294	317	318	324	431

Greater diversity in our workforce*

	2016-17	2017-18	2018-19	2019-20	2020-21
Persons identifying as being First Nations [b]	78	92	98	108	115

Note: * Workforce is measured in MOHRI – Full-Time Equivalent (FTE). Data presented reflects the most recent pay cycle at year's end. Data presented is to Jun-21.

Source: [a] DSS Employee Analysis, [b] Queensland Health MOHRI, DSS Employee Analysis

5.1.5. Strategic workforce planning and performance

The CQ Health Workforce Strategy 2020 – 2030 was endorsed by the CQ Health Finance and Resource Committee in March 2021.

The Workforce Strategy was developed in collaboration with the Department of Health's Strategic Workforce Planning Branch to align with CQ Health Destination 2030 objectives and the new direction established through the Queensland Health Strategic Health Workforce Planning Framework.

Our CQ Health Workforce Strategy 2020-2030 outlines our priorities:

- We attract and retain people with the right skills and capabilities, who demonstrate our values and support the needs of our community,
- We will create healthy and safe workplaces where mental, physical, social, financial and workplace wellbeing is supported,
- Our workforce reflects our diverse community, feels engaged with their work and valued for their contribution,
- We plan for the future workforce and work collaboratively with each other, and
- Our people reach their best potential through learning and development.

The Workforce Strategy is required to support integrated planning for service and infrastructure planning. The CQ Health Infrastructure Delivery Unit and CQ Health Workforce Planning team develop and deliver workforce plans in line with the Capital Infrastructure Projects. A number of workforce plans are currently under development to support important government health priorities in Central Queensland:

- The *Cardiac Services Workforce Plan* has been developed and is supported with a recruitment strategy and timeline aligned with commissioning of the Cardiac Catheterisation Laboratory and the scaling up of services from a 5-day service to 24/7 service.
- The *Emerald Hospital Emergency Department Workforce Plan* was developed to support the upgrade of the department to improve functionality, patient safety and patient flow.
- The *Rockhampton Hospital Emergency Department Workforce Plan* is in the initial strategic planning stage.

Implementation of the Workforce Strategy is underway. The progress of the strategies will be measured and reported through progress reports on a quarterly basis and an annual report to CQ Health Board.

Organisational Cultural Strategy

The *Organisational Cultural Strategy (OCS) 2020-2030* was launched in November 2020 and an implementation plan was created to assist in meeting its seven strategy objectives. Since that time, a Culture Pulse Staff Engagement Survey has been released and constantly remains open to all staff in recognition of our 24/7 service. Similarly, a "Share your Ideas" online portal has been created to encourage staff to share suggestions and feedback on how further improvements could be developed towards building a great workplace for all to enjoy.

Regular internal media items further engage staff, encouraging them to embrace and uphold the OCS objectives of:

- Conducting values-based recruitment and induction
- Developing leaders who embody our values and workplace culture
- Embedding values through our people development and in all that we do
- Rewarding and recognising values-driven performance and celebrating achievements
- Supporting and encouraging staff wellbeing
- Building pathways to promote a diverse, inclusive and culturally-capable workforce
- Promoting enjoyment, teamwork and a sense of belonging in the workplace for all.

Cultural improvement is monitored through the annual external Working for Queensland Survey, and internal Pulse surveys (trending monitored quarterly), with initiatives targeted to deliver best practice cultural outcomes.

Organisational Change

Organisational change training for our leaders is delivered as part of the Leadership Development suite of training programs to embed the Queensland Health organisational change management process and encourage strong communication and engagement with staff regarding proposed changes. Our organisational change management focus ultimately helps cultivate a positive organisational culture.

Leadership Development

Along with providing stable and consistent leadership, CQ Health has continued to focus on increasing our leadership and management capability and investing in our leaders. A suite of programs was delivered to a wide cross section of staff, activities including:

- CQ Health Management Essentials Program
- Manage4Improvement Program
- Step Up Program
- Take the Lead Program
- High Impact Leadership Program
- Mentoring Program
- Executive and Board Teaming
- Senior Leadership Development Program
- Conversations That Make a Difference
- Leadership Summits
- A range of in house developed leadership programs

The CQ Health Leadership and Management Development Program has been developed and endorsed for implementation. It aligns with the CQ Health Leadership and Management Development Framework and informs aspiring, new and current leaders of recommended development activities to be undertaken to prepare, develop and enhance their values-driven leadership skills and experience. The CQ Health Leadership Development Program has been designed to provide a guide for staff at each of the five leadership levels identified in the CQ Health Leadership and Management Development Framework – Leads Self, Leads Others, Leads Teams, Leads Leaders, and Leads Organisations. The Program and Framework work together to provide supervisors with a clear set of behavioural and experiential expectations and offerings to assist in building skills and experience where needed.

Leadership Summits

As part of our CQ Health strategic plan performance indicator to deliver 'Great People, Great place to Work', 150 staff receive leadership development training and support each year. During the reporting period CQ Health hosted three leadership summits designed to increase the leadership and management capability by investing in existing and emerging leaders. The summits provide valuable networking opportunities for senior staff who work across the geographic expanse of Central Queensland, with participants discussing strategies; hot issues; pulse survey results; and help identify key priorities for improvement. The delivery of the Leadership Summits needed to be adapted due to the COVID-19 health pandemic, however CQ Health was able to successfully deliver three summits over the year with more than 100 staff attending each.

2020 Working for Queensland Survey

Another performance indicator to deliver 'Great People, Great place to work' is continual improvement from Working for Queensland surveys. The Working for Queensland survey is an annual survey which measures Queensland public sector employee perceptions of their work, manager, team, and organisation. It is a CQ Health performance indicator to deliver continual improvement from the Working for Queensland Surveys. The information and feedback our staff provided during the 2020 Working for Queensland survey has been very valuable in shaping our future leadership and organisational cultural development. The survey highlighted areas with positive responses that we can learn from and areas we have targeted for improvement through staff engagement, the *CQ Health Organisational Culture Strategy 2020-2030* and CQ Health's strategic vision.

Workforce Diversity and Inclusion

CQ Health is committed to embedding cultural competence by having the ability to understand, communicate with and effectively interact with people across all cultures ensuring a safe, secure and supportive workplace that enables all employees to participate, contribute and innovate in a cohesive working environment. We recognise our diverse workforce and acknowledge the value of our cultural differences and the importance of inclusion is a core component to delivering a culturally competent service to our patients. As one of the seven Organisational Culture Strategy 2020-2030 objectives, we seek to develop pathways to promote a diverse, inclusive and culturally-capable workforce. Our focus areas and principles include:

- Attract, select and retain talent
- Create a diverse, inclusive and engaged workforce culture
- Develop individuals to achieve their full potential

Safety and Wellbeing

Delivering a safe working environment is vital in the delivery of a great place to work. Our response to ensure the health, safety and wellbeing of our staff during the COVID-19 pandemic continued. This included strengthening our respiratory protection program and completing and reviewing risk assessments for our fever and vaccination clinics.

To address occupational violence, Workforce Safety and Wellbeing continues to work closely with Security Services, Queensland Occupational Violence Strategy Unit and Mental Health Alcohol and Other Drugs Services to review controls and explore new opportunities including personal duress device (Twigg) and MAYBO safety pod trials.

After having MAYBO occupational violence prevention training implemented for over 12 months, a review of the program was undertaken with several recommendations accepted and actioned including implementing a consistent approach to theory training and assessment and introducing a lone worker module for our home visit and lone workers.

An external desktop audit against ISO 45001:2018 Occupational Health and Safety Management Systems was completed. The audit offered 11 opportunities for improvement with no criteria assessed as not met. Work associated with the previous audit against AS/NZS 4801 Safety Management System was also finalised.

A new Work Health and Safety Self-Assessment and Assurance Program was launched in October 2020. Changes were made to align more closely to the ISO 45001:2018 standard, and to address feedback from staff. The new program provides a more structured approach to hazard identification, risk management and control. The program was updated to include a mix of mandatory and requisite audit sections, a standard quarterly audit tool and a new assurance component including planned and structured site visits by Workforce Safety and Wellbeing Advisors.

CQ Health's commitment to worker consultation continued with commencement of Health and Safety Representative (HSR) Network quarterly meetings, and an annual half day forum focusing on practical skills presented by Workforce Safety Wellbeing for Health and Safety Representatives.

Separation rate

One of CQ Health's strategic visions is to deliver great people and a great place to work. A measure of the service's ability to retain staff is the permanent separation rate. During 2020-2021 that rate was 6.76 per cent.

5.1.6. Early retirement, redundancy and retrenchment

No early retirement or retrenchment packages were paid during this period.

5.2. Our risk management

The *Hospital and Health Boards Act 2011* requires annual reports to state each direction given by the Minister to the HHS during the financial year and the action taken by the HHS as a result of the direction. During the 2020-2021 period, no directions were given by the Minister to CQ Health.

5.2.1. Internal audit

CQ Health has partnered with Sunshine Coast Hospital and Health Service to establish an effective, efficient and economical internal audit function. The function provides independent and objective assurance and advisory services to the Board and executive management. It enhances CQ Health's governance environment through a systematic approach to evaluating internal controls and risk management.

The function has executed the strategic and annual audit plan prepared as a result of the review of significant operational and financial risks, materiality, contractual and statutory obligations and consideration of other assurance providers. Following consultation with the Audit and Risk Committee and executive management, the plans were approved by the Board.

The audit team are members of professional bodies including the Institute of Internal Auditors, CPA Australia and ISACA. The health services continue to support their ongoing professional development.

5.2.2. External scrutiny

CQ Health was the subject of one finalised investigation initiated by the Director-General under the provisions of the *Hospital and Health Boards Act 2011*. The investigation report related to North Rockhampton Nursing Centre, "Management, administration and delivery of public sector health services". The scope of the investigation related to the events that occurred during the period 3 May 2020 surrounding an employee attending the workplace at North Rockhampton Nursing Centre with symptoms of a respiratory infection and while awaiting test results for COVID-19, and action taken during the period 14 May 2020 to 18 May 2020 to respond to the situation. The investigation report is available at https://www.health.qld.gov.au/__data/assets/pdf_file/0020/1009091/Queensland-Health-North-Rockhampton-Nursing-Centre-Investigation-Report.pdf

5.2.3. Information systems and recordkeeping

There have been no changes to our functions, responsibilities or regulatory requirements to require changes to our recording-keeping systems, procedures and practices. The health service has a formal policy in place detailing the roles and responsibilities of staff for records management function and activities. Training for staff in the making and keeping of public records in all formats, including emails, is available online.

CQ Health is committed to transitioning from paper to digital records. Paper records required to be kept in accordance with the applicable destruction and retention scheduled are being captured and managed through the records management system. Public records are being retained as long as they are required, in accordance with general or core retention and disposal schedules. Over the course of the financial year, CQ Health followed the General Retention and Disposal Schedule for its record disposal program.

During the reporting period CQ Health was required to submit one Notification of Lost Records to the Queensland State Archives. The notification, submitted on 16 April 2021 related to the medical chart of a patient resident at a residential aged care facility within the Central Queensland Hospital and Health Service being unable to be located. The notification was acknowledged by the A/State Archivist on 21 May 2021.

5.2.4. Information Security attestation

During the mandatory annual Information Security reporting process, the Chief Executive Officer attested to the appropriateness of the information security risk management within CQ Health to the Queensland Government Chief Information Security Officer, noting that appropriate assurance activities have been undertaken to inform this opinion and CQ Health's information security risk position.

5.2.5. Queensland Public Service Ethics

CQ Health is committed to upholding the values and standards of conduct outlined in the Code of Conduct for the Queensland Public Service. The Code of Conduct applies to all employees, contractors and volunteers of CQ Health and espouses four core principles:

- Integrity and impartiality
- Promoting the public good
- Commitment to the system of government
- Accountability and transparency

CQ Health follows the Code of Conduct for Queensland Public Service and the *Public Sector Ethics Act 1994* which are essential components of the mandatory training requirements for all staff.

Code of Conduct training incorporates the principles of the *Public Sector Ethics Act 1994* and was delivered on a regular basis for staff across CQ Health over the reporting period. It is a mandatory requirement for staff with compulsory refresher training to be completed annually.

The Code of Conduct for Queensland Public Service, CQ Health procedures, polices and links to the Department of Health information and resources are available via CQ Health intranet site.

Code of Conduct training and staff orientation covers the appropriate requirements with a focus on:

- Operation of the *Public Sector Ethics Act 1994*
- Application of ethics principles and obligations to the public officials
- Rights and obligations of the officials in relation to contraventions of the approved code of conduct
- Workplace Harassment

Regular reviews of all human resource policies are conducted in line with the schedule of renewal and documents are updated as required. Additional updates or rewrites are undertaken as necessary due to changing legislation. When required new documents are developed in line with legislation or industrial awards changes to ensure a full suite of governance documents are available to staff at all times. All documents are developed using the current CQ Health templates and style guides and are in line with content guidelines.

5.2.6. Human Rights

CQ Health has continued to strengthen a culture of human rights through ongoing implementation of a comprehensive program aimed at increasing awareness of the *Human Rights Act 2019* at all levels of the organisation. CQ Health has focussed on empowering and building awareness with the Central Queensland community and our health service staff and consumers.

CQ Health continues to monitor and report consumer feedback that involves any alleged breach of Human Rights. Eight complaints referring to human rights were received in the July 2020 to June 2021 reporting period. All of the complaints were investigated and closed.

Governance committees, including the Queensland Health Human Rights working group are provided with regular progress reports with monitoring and reporting built into CQ Health clinical and corporate governance.

CQ Health continues to assess all policies, procedures and documentation for compatibility with the Act.

5.2.7. Confidential information

The *Hospital and Health Boards Act 2011* requires annual reports to state the nature and purpose of any confidential information disclosed in the public interest during the financial year. The chief executive did not authorise the disclosure of confidential information during the reporting period.

6. Performance

Strategic objective and performance indicators	Our performance
Great Care,Great Experience *Safe, compassionate care, delivered to the highest standards, close to home, with consumers at the heart of all we do.* • Reduce the median wait times for elective surgery by 10 per cent: - Category 1 one day - Category 2 two days and - Category 3 patients 10 days • 99 per cent of patients seen within clinically recommended time frame at 30 June each year for: - Outpatient appointment - Elective surgery - Oral health appointment - Scopes (i.e. endoscopies,bronchoscopies,colonoscopies) • Annual reduction in percentage of Severity Assessment Code (SAC) 1 and 2 incidents • 5 per cent reduction in smoking rate (10,000 Lives CQ project) • Reduce patient journeys as we deliver care closer to home • To meet our Making Tracks milestones • Use consumer feedback to improve patient experience	The median wait time for elective surgery treatment in CQ Health was 55 days, four days better than 59 days recorded in 2018-19, though 6 days more than the 49 days recorded in 2019-20. In preparation for COVID-19 and consistent with the National Cabinet decision, Queensland Health temporarily suspended non-urgent elective surgery in 2019-20. This has impacted the treat in time performance and has continued to impact performance during 2020-2021 as the system worked to reduce the volume of patients waiting longer than clinically recommended. There was a continued impact in the delivery of outpatient appointments, oral health appointments and scopes. There was an increase in the number of SAC 1 and 2 incidents across CQ Health. Since the 10000LivesCQ program was launched in November 2017 over 10,371 Central Queensland smokers have registered with Quitline, and our adult daily smoking rate has decreased from 17 per cent in 2016, to 15 per cent in 2020. These are the latest available figures on smoking rates. The rate of Telehealth usage continues to grow rapidly with almost 16,500 service events compared with more than 15,000 recorded in 2019-20. No measure available for the reduction of Aboriginal and Torres Strait Islander life expectancy gap. The Community and Consumer Advisory Committee continues to provide vital feedback to improve patient experience.

Strategic objective and performance indicators	Our performance
Great People, Great Place to Work *Great staff working in great teams with a culture of supporting and investing in our people's future.* • Continual improvement in staff satisfaction from Pulse and Working for Queensland surveys • 150 staff receive leadership development training and support each year • Maintain or improve the workforce separation rate • Increase Aboriginal and Torres Strait Islander workforce across all streams to reflect the community	Across the 10 Working for Queensland factors, the results for CQ Health were quite similar to our 2019 results, with all 10 factors being within 3 per cent of last year's results, showing improvement in one factor, minor reduction in five factors and four factors being equal to the 2019 results. 320 staff received training in Leadership Development courses during the 2020-2021 financial year, through in-house leadership development programs and partnerships formed through Clinical Excellence Queensland, including Leadership Summits and the new CQ Health Management Essentials Program – more than double the previous year, through very challenging circumstances brought about by COVID-19. Targeted Leadership and Development Training Programs were also developed for areas requiring significant organisational culture improvement. Improved workforce separation rate from 7.8 per cent in 2019-2020 to 6.76 per cent for the 2020-2021 financial year. An annualised Diversity and Inclusion Action Plan was developed for 2021 to support Queensland Health Diversity and Inclusion targets and focus areas were chosen to support a greater level of workplace participation for people with a disability and culturally and linguistically diverse people.

Strategic objective and performance indicators	Our performance
Great Learning and Research *Great place to learn, research and shape the future of healthcare.* • Increased research ready grant applications • Increased ethics applications and site specific assessment applications • Annual increase in the number of education programs developed, delivered or reviewed in partnership with consumers/community across all streams • Increased clinical placements in the health service • Increased simulation opportunities utilised by staff • Introduce innovative practices in learning and research, linking into the Minister's Rapid Results program	COVID-19 continued to impact the number of Research Ready Grant Program applications with 16 Expressions of Interest involving 96 individuals. After an increase in 2019-20, the number of Ethics and Site Specific Assessment applications remained stable in 2020-2021. CQ Health supported 743 separate student nursing and midwifery placements across Central Queensland equating to 99,784 hours of support. Additionally, CQ Health supported 4640 hours on re-entry nursing placement and 120 hours to Queensland Ambulance Service. CQ Health took 89 graduate nurses and midwives compared with 72 the previous year. The education team has assisted across a broad range of services during the pandemic response. Fit testing, developing orientation and competency resources, ventilation education and upskilling resources for fever clinics, vaccination clinics and support of residential aged care services. Consequently, many programs had to be prioritised and some cancellations occurred. CQ Health successfully obtaining a $50,000 Health Innovation, Investment and Research Office (HIIRO) Grant for research development and to develop an internal web page and two $15,000 seeding grants were awarded to clinicians.

Strategic objective and performance indicators	Our performance
Great Partnerships *Working collaboratively with our partners to deliver great care and improve the health of Central Queenslander*s. • Service Level Agreements established with private health service providers to deliver care closer to home • Primary Health Network partnerships to reduce non-acute hospital admission • Deliver a full medical program in partnership with Wide Bay Hospital and Health Service, CQUniversity (intake 2022) and The University of Queensland (intake 2023) • Listen to Aboriginal and Torres Strait Islander communities to co-design culturally appropriate clinical and non-clinical health services	The pandemic response impacted the development of Service Level Agreements. CQ Health significantly increased its Hospital in the Home capacity to delivery care closer to home. The Rural Medial Program partnership achieved significant milestones including finalisation of the CQUniversity's Bachelor of Medical Science (Pathway to Medicine) course. Applications opened in August. Graduate Nurse program – continue to partner with CQUniversity to offer the program to provide graduate nurses with the opportunity to articulate the program into a graduate certificate. CQ Health has made Aboriginal and Torres Strait Islander health a priority outcome and is committed to 'Closing the Gap' of life expectancy for Aboriginal and Torres Strait Islander people in Central Queensland. The CQ Health Aboriginal and Torres Strait Islander workforce sits at 3.16 per cent (136 employees). The Aboriginal and Torres Strait Islander workforce was boosted after the securing of First Nations COVID-19 funding. The funding supported the establishment of 2.5 Indigenous Health Liaison Officer positions that focused on COVID-19 health preventions, encouraging Aboriginal and Torres Strait Islander people to stay engaged in healthcare and continuity of care whilst working closely with partners, key stakeholders, and communities across the Central Queensland region.

Strategic objective and performance indicators	Our performance
Sustainable Future *Securing the future of great healthcare with efficient, effective, affordable and sustainable services.* • Deliver a budget in the range of break-even to 1% with any surplus to be reinvested • Open the Gladstone Hospital Emergency Department and deliver the Gladstone Hospital Specialist Outpatients, Emerald Hospital Emergency Department and Perioperative upgrade and the 42 bed Residential Drug and Alcohol Rehabilitation Centre on time and on budget. • 5% annual reduction in percentage of medical labour spend on locums	The budget delivered a deficit of 0.4 per cent. The ongoing travel restrictions associated with the pandemic impacted CQ Health's ability to recruit and retain staff, particularly international candidates. This impacted the required medical labour spend on locums. The Gladstone Hospital Emergency Department was opened on time and on budget and the Gladstone Hospital Specialist Outpatients Department is now fully operational. Planning work continues on the Emerald Hospital Emergency Department and Perioperative upgrade. The 42-bed Residential Drug and Alcohol Rehabilitation Centre is under construction and scheduled to be completed in 2021-2022. During the reporting period, the former Gladstone Mater facility was acquired and has been integrated into the Gladstone Hospital campus. Work is also underway to deliver projects that have received funding commitments including; cardiac theatre at Rockhampton Hospital; renal services at Capricorn Coast; upgrade of the mental health unit at Rockhampton; new Blackwater Hospital; 8 residential aged care beds at Moura; and 10 additional aged care beds and new kitchen at Woorabinda.

6.1. Service standards - Performance 2020-2021

Central Queensland Hospital and Health Service	2020-21 Target	2020-21 Actual
Effectiveness measures		
Percentage of emergency department patients seen within recommended timeframes[1]		
Category 1 (within 2 minutes)	100%	100%
Category 2 (within 10 minutes)	80%	73%
Category 3 (within 30 minutes)	75%	72%
Category 4 (within 60 minutes)	70%	82%
Category 5 (within 120 minutes)	70%	96%
Percentage of emergency department attendances who depart within 4 hours of their arrival in the department[1]	>80%	77%
Percentage of elective surgery patients treated within the clinically recommended times[2]		
Category 1 (30 days)	>98%	92%
Category 2 (90 days)[3]	..	88%
Category 3 (365 days)[3]	..	81%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days[4]	<2	0.9
Rate of community mental health follow up within 1-7 days following discharge from an acute mental health inpatient unit[5]	>65%	60%
Proportion of re-admissions to acute psychiatric care within 28 days of discharge[6]	<12%	8.1%
Percentage of specialist outpatients waiting within clinically recommended times[7]		
Category 1 (30 days)	98%	90%
Category 2 (90 days)[8]	..	50%
Category 3 (365 days)[8]	..	74%
Percentage of specialist outpatients seen within clinically recommended times[9]		
Category 1 (30 days)	98%	88%
Category 2 (90 days)[8]	..	64%
Category 3 (365 days)[8]	..	61%
Median wait time for treatment in emergency departments (minutes)[1]	..	13
Median wait time for elective surgery treatment (days)[2]	..	55
Efficiency measure		
Average cost per weighted activity unit for Activity Based Funding facilities[10]	$4,822	$4,990
Other measures		
Number of elective surgery patients treated within clinically recommended times[2]		
Category 1 (30 days)	1,876	1,670
Category 2 (90 days)[3]	..	1,610
Category 3 (365 days)[3]	..	1,157
Number of Telehealth outpatients service events[11]	17,133	18,158
Total weighted activity units (WAU)[12]		
Acute Inpatients	50,028	48,941
Outpatients	13,019	15,689
Sub-acute	4,712	5,607
Emergency Department	17,296	17,916
Mental Health	4,942	4,846
Prevention and Primary Care	2,828	2,724
Ambulatory mental health service contact duration (hours)[5]	>38,352	40,361
Staffing[13]	3,308	3,472

1 During the rapid response to the COVID-19 pandemic, facilities utilised existing systems to manage presentations at fever clinics. In some cases, the management of these clinics was closely related to the management of the emergency department meaning that some fever clinic activity was managed via the emergency department systems. As a result, the 2020-21 Actual includes some fever clinic activity.

2 In preparation for COVID-19 and consistent with the National Cabinet decision, Queensland Health temporarily suspended non-urgent elective surgery in 2019-2020. This has impacted the treat in time performance and has continued to impact performance during 2020-2021 as the system worked to reduce the volume of patients waiting longer than clinically recommended.

3 Given the System's focus on reducing the volume of patients waiting longer than clinically recommended for elective surgery, and the continual impacts to services as a result of responding to COVID-19, treated in time performance targets for category 2 and 3 patients are not applicable for 2020-2021.

4 Staphylococcus aureus (including MRSA) bloodstream (SAB) infections Actual rate is based on data reported between 1 January 2020 and 31 December 2020.

5 Mental Health measures reported as at 22 August 2021.

6 Mental Health readmissions 2020-21 Actual is for the period 1 July 2020 to 31 May 2021.

7 Waiting within clinically recommended time is a point in time performance report and was impacted by preparing for COVID-19 in 2019-20.

8 Given the System's focus on reducing the volume of patients waiting longer than clinically recommended for specialist outpatients, and the continual service impacts as a result of responding to COVID-19, seen in time performance targets for category 2 and 3 patients are not applicable for 2020-2021.

9 As a result of preparing for COVID-19, the seen in time performance was impacted in 2019-20. This impact has continued throughout 2020-2021 as the system has worked to address provision of care to those patients waiting longer than clinically recommended.

10 The 2020-21 Target varies from the published 2020-21 Service Delivery Statement due to a change in the WAU phase. All measures are reported in QWAU Phase Q23. The variation in difference of Cost per WAU to target is a result of the additional costs of the COVID-19 pandemic. Data reported as at 23 August 2021.

11 Telehealth data reported as at 23 August 2021.

12 The 2020-21 Target varies from the published 2020-2021 Service Delivery Statement due to a change in the WAU phase. All measures are reported in QWAU Phase Q23. As HHSs have operational discretion to respond to service demands and deliver activity across services streams to meet the needs of the community, variation to target can occur. Data reported as at 23 August 2021.

13 Corporate FTEs are allocated across the service to which they relate. The department participates in a partnership arrangement in the delivery of its services, whereby corporate FTEs are hosted by the department to work across multiple departments.

6.2. Financial summary

CQ Health reported an operating deficit of $2.701 million for the 2020-21 financial year.

Our revenue from both COVID-19 and non-COVID-19 clinical activity increased, delivering corresponding increases in labour and non-labour costs.

The continued growth in demand for service, in both activity and program deliverables, contributed to the increase in labour costs, which was further impacted by COVID-19. Direct labour costs for COVID-19 were $6.613m, relating to servicing fever clinics as well as establishing the vaccination program.

The challenge to permanently recruit clinical positions continues, which results in a significant impact to the premium costs associated with engaging medical locum and agency nursing staff.

Anticipated maintenance is a common building maintenance strategy utilised by public and private sector industries. All Queensland Health entities comply with the Queensland Government Maintenance Management Framework which requires the reporting of anticipated maintenance.

Anticipated maintenance is defined as maintenance that is necessary to prevent the deterioration of an asset or its function, but which has not been carried out. Some anticipated maintenance activities can be postponed without immediately having a noticeable effect on the functionality of the building. All anticipated maintenance items are risk assessed to identify any potential impact on users and services and are closely managed to ensure all facilities are safe.

As of 30 June 2021, CQ Health has anticipated maintenance of $9.6 million.

CQ Health has strategies in place to mitigate any risks associated with these items such as seeking assistance from the Priority Capital Program and increasing operational maintenance budgets.

Key financial highlights are outlined in the table below.

Measures	2020-21 Actuals $'000s	2019-20 Actuals $'000s
Income	698,395	650,522
Expenses	701,096	665,345
Operating surplus (deficit)	(2,701)	(14,823)
Cash and cash equivalents	3,170	7,426
Total assets	429,964	400,435
Total liabilities	39,629	39,722
Total equity	429,964	400,435

7. Financial statements

7.1. Statement of comprehensive income for the year ended 30 June 2021

OPERATING RESULT	Notes	2021 $'000	2020 $'000
Income			
User charges and fees	B1-1	**56,671**	49,680
Funding for public health services	B1-2	**612,056**	574,867
Grants and other contributions	B1-3	**25,217**	22,461
Other revenue	B1-4	**4,451**	3,514
		698,395	650,522
Total income		**698,395**	650,522
Expenses			
Employee expenses	B2-1	**75,925**	71,814
Health service employee expenses	B2-2	**389,564**	359,114
Supplies and services	B2-3	**191,864**	193,490
Other expenses	B2-4	**15,991**	16,476
Depreciation	C5-1,C9	**27,752**	24,451
Total expenses		**701,096**	665,345
Operating result		**(2,701)**	(14,823)
Other comprehensive income			
Items that will not be reclassified to operating result			
Increase/(decrease) in asset revaluation surplus	C7-2	**1,625**	(1,674)
Total other comprehensive income		**1,625**	(1,674)
Total comprehensive income		**(1,076)**	(16,497)

The accompanying notes form part of these financial statements

7.2. Statement of financial position as at 30 June 2021

	Notes	2021 $'000	2020 $'000
Current assets			
Cash and cash equivalents	C1	**3,170**	7,426
Receivables	C2-1	**12,042**	7,605
Contract assets	C8	**1,380**	6,281
Inventories	C3	**5,803**	4,945
Other assets	C4	**1,479**	235
Total current assets		**23,874**	26,492
Non-current assets			
Property, plant and equipment	C5-1	**444,755**	412,491
Right-of-use assets	C9	**1,085**	1,174
Total non-current assets		**445,840**	413,665
Total assets		**469,714**	440,157
Current liabilities			
Payables	C6	**38,136**	36,851
Lease liabilities	C9,CF-2	**847**	984
Contract liabilities	C8	**646**	1,887
Total current liabilities		**39,629**	39,722
Non-current liabilities			
Lease liabilities	C9,CF-2	**121**	-
Total non-current liabilities		**121**	-
Total liabilities		**39,750**	39,722
Net assets		**429,964**	400,435
Equity			
Contributed equity		**396,782**	366,177
Accumulated surplus/(deficit)		**(15,112)**	(12,411)
Asset revaluation surplus	C7-2	**48,294**	46,669
Total equity		**429,964**	400,435

The accompanying notes form part of these financial statements
Central Queensland Hospital and Health Service was not required to include a budgeted statement of financial position in the original published Service Delivery Statement tabled in Parliament for the 2020-21 financial year

7.3. Statement of changes in equity for the year ended 30 June 2021

	Accumulated surplus $'000	Asset revaluation surplus $'000	Contributed equity $'000	Total equity $'000
Balance as at 1 July 2019	**2,412**	**48,343**	**373,549**	**424,304**
Operating result				
Operating result from continuing operations	(14,823)	-	-	(14,823)
Other comprehensive income				
Increase/(decrease) in asset revaluation surplus	-	(1,674)	-	(1,674)
Total comprehensive income for the year	(14,823)	(1,674)	-	(16,497)
Transactions with owners as owners:				
Net assets transferred (Note C7-1)	-	-	7,723	7,723
Equity injections - minor capital works	-	-	9,356	9,356
Equity withdrawals - depreciation funding	-	-	(24,451)	(24,451)
Net transactions with owners as owners	-	-	(7,372)	(7,372)
Balance at 30 June 2020	**(12,411)**	**46,669**	**366,177**	**400,435**
Opening balance as at 1 July 2020	(12,411)	46,669	366,177	400,435
Operating result				
Operating result from continuing operations	(2,701)	-	-	(2,701)
Other comprehensive income				
Increase/(decrease) in asset revaluation surplus	-	1,625	-	1,625
Total comprehensive income for the year	(2,701)	1,625	-	(1,076)
Transactions with owners as owners:				
Net assets transferred (Note C7-1)	-	-	45,882	45,882
Equity injections - minor capital works	-	-	12,475	12,475
Equity withdrawals - depreciation funding	-	-	(27,752)	(27,752)
Net transactions with owners as owners	-	-	30,605	30,605
Balance at 30 June 2021	**(15,112)**	**48,294**	**396,782**	**429,964**

The accompanying notes form part of these financial statements

7.4. Statement of cash flows for the year ended 30 June 2021

	Notes	2021 $'000	2020 $'000
Cash flows from operating activities			
Inflows:			
User charges and fees		**54,778**	52,137
Funding public health services		**585,168**	549,028
Grants and other contributions		**17,783**	16,548
GST input tax credits from ATO		**12,834**	13,144
GST collected from customers		**706**	566
Other receipts		**3,835**	3,213
Outflows:			
Employee expenses		**(77,768)**	(71,142)
Health service employee expenses		**(381,566)**	(355,335)
Supplies and services		**(198,312)**	(193,918)
GST paid to suppliers		**(12,759)**	(13,427)
GST remitted to ATO		**(666)**	(592)
Interest payments on lease liabilities		**(6)**	(7)
Other		**(8,121)**	(6,996)
Net cash used in operating activities	CF-1	**(4,094)**	(6,781)
Cash flows from investing activities			
Inflows:			
Sales of property, plant and equipment		**30**	117
Outflows:			
Payments for property, plant and equipment		**(11,285)**	(12,876)
Net cash used in investing activities	CF-3	**(11,255)**	(12,759)
Cash flows from financing activities			
Inflows:			
Equity injections		**12,475**	9,356
Outflows:			
Principal payments of lease liabilities	CF-2	**(1,382)**	(1,060)
Equity withdrawals		**-**	-
Net cash provided by financing activities	CF-3	**11,093**	8,296
Net increase/(decrease) in cash and cash equivalents		**(4,256)**	(11,244)
Cash and cash equivalents at the beginning of the financial year		**7,426**	18,670
Cash and cash equivalents at the end of the financial year	C1	**3,170**	7,426

The accompanying notes form part of these financial statements
Central Queensland Hospital and Health Service was not required to include a budgeted statement of cash flows in the original published Service Delivery Statement tabled in Parliament for the 2020-21 financial year

7.5. Notes to the statement of cash flows

CF-1 Reconciliation of surplus to net cash from operating activities

	2021 $'000	2020 $'000
Operating surplus/(deficit)	(2,701)	(14,823)
Non-cash items included in operating result:		
Depreciation	27,752	24,451
Funding for depreciation	(27,752)	(24,451)
Net gain on disposal of non-current assets	(30)	(64)
Loss on disposal - (netted off account)	-	36
Loss on revaluation of land above asset reserve	231	2,626
Service below fair value - revenue	7,348	5,733
Service below fair value - expense	(7,348)	(5,733)
Changes in assets and liabilities:		
(Increase)/decrease in receivables	(2,045)	676
(Increase)/decrease in funding receivables	(2,507)	(2,493)
(Increase)/decrease in GST receivables	75	(283)
(Increase)/decrease in inventories	(858)	(1,115)
(Increase)/decrease in contract assets	4,901	1,414
(Increase)/decrease in prepayments	(1,244)	358
Increase/(decrease) in payables	925	660
Increase/(decrease) in lease liabilities	(16)	984
Increase/(decrease) in accounts payable	(5,777)	172
Increase/(decrease) in accrued contract labour	7,998	3,762
Increase/(decrease) in contract liabilities and unearned income	(1,241)	656
Increase/(decrease) in accrued employee benefits	(1,845)	673
Increase/(decrease) in GST payable	40	(26)
Net cash used in operating activities	**(4,094)**	**(6,781)**

CF-2 Changes in liabilities arising from financing activities

	2021				2020			
	Opening balance	New leases acquired	Cash repayments	Closing balance	Opening balance	New leases acquired	Cash repayments	Closing balance
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Lease liabilities	984	1,366	(1,382)	968	253	1,791	(1,060)	984
Total	984	1,366	(1,382)	968	253	1,791	(1,060)	984

CF-3 Non-cash investing and financing activities

Assets and liabilities received or donated/transferred by the Hospital and Health Service to agencies outside of the Wholly-Owned Public-Sector Entities are recognised as revenues (refer Note B1-4) or expenses (refer to Note B2-4) as applicable.

The accompanying notes form part of these financial statements

7.6. Notes to the financial statements for the year ended 30 June 2021

GENERAL INFORMATION

The Central Queensland Hospital and Health Service (CQHHS) was established on 1 July 2012 as a statutory body under the *Hospital and Health Boards Act 2011*. CQHHS is respons ble for providing primary health, community and public health services in the area assigned under the *Hospital and Health Boards Regulation 2012*.

The 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 CQHHS is:

Rockhampton Hospital Campus
Canning Street
Rockhampton QLD 4700

STATEMENT OF COMPLIANCE

CQHHS has prepared these financial statements in compliance with section 62 (1) of the *Financial Accountability Act 2009* and section 39 of the *Financial and Performance Management Standard 2019*.

CQHHS is a not-for-profit statutory body and these general-purpose financial statements are prepared on an accrual basis (except for the statement of cash flow which is prepared on a cash basis) in accordance with Australian Accounting Standards and Interpretations applicable to not-for-profit entities.

In addition, the financial statements comply with Queensland Treasury's Minimum Reporting Requirements for the year ending 30 June 2021, and other authoritative pronouncements.

New accounting standards applied for the first time in these financial statements are outlined in Note G5.

Central Queensland Hospital Health Service has prepared these financial statements on a going concern basis, which assumes that CQHHS will be able to meet the payment terms of its financial obligations as and when they fall due. CQHHS is economically dependent on funding received from its service agreement with the Department of Health.

A service agreement framework is in place to provide CQHHS with a level of guidance regarding funding commitments and purchase activity for the 2020-21 to 2021-22. The Board and management believe that the terms and conditions of its funding arrangements under the service agreement framework will provide CQHHS with sufficient cash resources to meet its financial obligations for at least the next year.

In addition to CQHHS's funding arrangements under the service agreement framework, CQHHS has no intention to liquidate or to cease operations; under section 18 of the *Hospital and Health Boards Act 2011*, CQHHS represents the State of Queensland and has all privileges and immunities of the State.

THE REPORTING ENTITY

The financial statements include the value of all revenues, expenses, assets, liabilities and equity of CQHHS.

MEASUREMENT

Historical cost is used as the measurement basis in this financial report except for the following:

- Land, buildings, which are measured at fair value;
- Inventories which are measured at replacement value.

Historical cost

Under historical cost, assets are recorded at the amount of cash or cash equivalents paid or the fair value of the consideration given to acquire assets at the time of their acquisition. Liabilities are recorded at the amount of proceeds received in exchange for the obligation or at the amounts of cash or cash equivalents expected to be paid to satisfy the liability in the normal course of business.

Fair value

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

- The market approach uses prices and other relevant information generated by market transactions involving identical or comparable (i.e. similar) assets, liabilities or a group of assets and liabilities, such as a business.
- The cost approach reflects the amount that would be required currently to replace the service capacity of an asset. This method includes the current replacement cost methodology.
- The income approach converts multiple future cash flows amounts to a single current (i.e. discounted) amount. When the income approach is used, the fair value measurement reflects current market expectations about those future amounts.

Where fair value is used, the fair value approach is disclosed.

Present value

Present value represents the present discounted value of the future net cash inflows that the item is expected to generate (in respect of assets) or the present discounted value of the future net cash outflows expected to settle (in respect of liabilities) in the normal course of business.

Net realisable value

Net realisable value represents the amount of cash or cash equivalents that could currently be obtained by selling an asset in an orderly disposal.

7.6.1. Section A: Basis of report preparation

PRESENTATION MATTERS

Currency and rounding

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

Comparatives

The financial statements provide comparative information in respect to the previous period.

Current/non-current classification

Assets and liabilities are classified as either 'current' or 'non-current' in the statement of financial position and associated notes.

Assets are classified as 'current' where their carrying amount is expected to be realised within 12 months after the reporting date. Liabilities are classified as 'current' when they are due to be settled within 12 months after the reporting date, or where CQHHS does not have an unconditional right to defer settlement to beyond 12 months after the reporting date.

All other assets and liabilities are classified as non-current.

AUTHORISATION OF FINANCIAL STATEMENTS FOR ISSUE

The financial statements are authorised for issue by the Chairperson of CQHHS, the Health Service Chief Executive and the Chief Finance Officer at the date of signing the Management Certificate.

7.6.2. Section B: Notes about our financial performance

B1 REVENUE

Note B1-1: User charges and fees

	2021 $'000	2020 $'000
Revenue from contracts with customers		
Pharmaceutical Benefits Scheme	**25,450**	20,527
Sales of goods and services	**6,672**	5,724
Hospital fees	**22,897**	22,023
Other user charges and fees		
Revenue leases	**1,652**	1,406
Total revenue from contracts with customers	**56,671**	49,680

User charges and fees - accounting policies and disclosures

Revenue from contract with customers is recognised at a point in time when CQHHS transfers control over a good or service to the customer. Otherwise the revenue that is not from a contract with a customer is recognised upon receipt as per *AASB 1058 Income of Not-for Profit Entities*. The following table provides information about the nature, timing and revenue recognition for CQHHS user charges revenue.

Types of goods and services	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policies
Pharmaceutical Benefits Scheme (PBS) *Pharmaceutical Benefit Act 1947 and National Health (Pharmaceutical Benefits) Regulations 2017.*	Public hospital patients can access medicines listed on the PBS if they are being discharged, attending outpatient day clinics, or are admitted receiving chemotherapy treatment. Medicare Australia reimburses for pharmaceutical items for each claim submitted at agreed wholesale prices including alternative distributions under section 100 of the Act minus any patient co-contributions.	PBS claims are made monthly, with revenue being recognised at a point in time as drugs are distributed to patients with revenue earned but not yet invoiced being recorded as a contract asset in Note C8.
Sales of goods and services	*National Disability Insurance Scheme* CQHHS is coordinating and delivering customised service to eligible clients with permanent and significant disabilities, with payment occurring for each valid claim up to the individual amount. *Client contributions and other sales of goods and services* Customer invoices are raised when the performance obligation has been satisfied and the goods and services are transferred to customers. Payment terms for patient debtors is 14 days and 30 days for other debtors.	*National Disability Insurance Scheme* Claims are made monthly with revenue recognised as customised care is delivered, with any revenue earned but not yet invoiced being recorded as a contract asset in Note C8. Contract liabilities (unearned or refunds) are included in Note C8 for amounts that are received in advance. *Client contributions and other sales of goods and services* Revenue is recognised when goods and services are transferred to customers at the transaction price. A receivable is recorded where CQHHS controls the right to revenue in Note C2.
Hospital fees	Transfer of distinct hospital services and goods applying the transaction prices in the Queensland Health - fees and charges for health care services directive. Payment occurs when private health funds accept claims.	Revenue is recognised as hospital care to be claimed from private health funds is provided to patients. Revenue may be adjusted depending on private health funds accepting claims. Any revenue earned but not yet received is recorded as a receivable in Note C2.
Revenue leases	CQHHS as a lessor has leases in place where outsourced service providers lease facilities or land owned by CQHHS to conduct their business. CQHHS receives monthly payments as per the lease contract.	Rental revenue from outsourced service providers is recognised on a periodic straight-line basis over the lease term in accordance with AASB 16. Unearned leases at year end are recorded as a payable in Note C6.

B1 REVENUE (continued)

Note B1-2: Funding public health services

	2021 $'000	2020 $'000
National Health Reform		
Revenue from contract with customers		
Activity based funding	**404,166**	386,804
Total revenue from contracts with customers	**404,166**	386,804
Other funding public health services		
Block funding	**86,295**	82,358
Teacher training funding	**12,882**	12,794
General purpose funding	**108,713**	92,911
Total revenue from other funding public health services	**207,890**	188,063
Total	**612,056**	574,867

Funding public health services - accounting policies and disclosures

Funding is provided predominantly from the Department of Health for specific public health services purchased by the Department in accordance with a service agreement. The Australian Government pays its share of National Health funding directly to the Department of Health, for on forwarding to the Hospital and Health Service. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by CQHHS. Cash funding from the Department of Health is received fortnightly for State payments and monthly for Commonwealth payments and is recognised as revenue as the performance obligations under the service level agreement are discharged. Commonwealth funding to CQHHS in 2020-21 was $198m (2020: $196m).

At the end of the financial year, an agreed technical adjustment between the Department of Health and CQHHS may be required for the level of services performed above or below the agreed levels, which may result in a receivable or unearned revenue. This technical adjustment process is undertaken annually according to the provisions of the service level agreement and ensures that the revenue recognised in each financial year correctly reflects CQHHS's delivery of health services.

Ordinarily, activity-based funding is recognised as public health services are delivered, however, due to the impacts of COVID-19, activity-based funding was guaranteed by the Commonwealth government for 2019-20 and 2020-21 financial years under the National Health Reform Agreement. As such, the Department of Health will not make any adjustments for under delivery against activity-based funding targets, except for items specially referenced in Table 1 Specific Funding Commitments of the Service Agreement. No additional funding is provided for over delivery against targets.

Disclosure - Rockhampton Car Park Reprioritisation of Funding

The Rockhampton Hospital Car Park has been operational since 4th March 2019 and the asset was transferred to CQHHS in May 2019. A Memorandum of Understanding governs the operational principles of the arrangement between the Department and CQHHS. CQHHS is required to return to the Department the Government Portfolio Amount (GPM) of $7.5m over a 20-year term by the way of reduction in CQHHS's annual appropriations under the service agreement for each financial year based on the Department estimate of the net revenue for the financial year. The net revenue from the operation of the car park is to offset the reduction in general purpose funding. The GPM payment amount for the 2020-21 financial year is $465,000, (2019-20 $465,000).

B1 REVENUE (continued)

Types of goods and services	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policies
National Health Reform Act 2011 **Activity - based funding**	The Department has an enforceable service agreement with CQHHS procuring public health services to be delivered by CQHHS with the service targets for ABF funding being sufficiently specific. Transfer of distinct public health care service activity can be either; the number of screen services provided for Breast Screen QLD; a Weighted Activity Unit (WAU) for a number of public health care services; Weighted Occasions of Service Unit (WOO) for part of the funding received for providing oral health services. Subject to departmental consideration and available pooled funds across the State, additional funding may be paid by the Department for identified purchasing incentives where activity exceeds the target set out in the Service Agreement or window adjustments. The Department pays for the delivery of public health care in fortnightly instalments and window adjustments.	Revenue is recognised throughout the financial year when activity is delivered by multiplying the weighted activity units by the Queensland Efficiency Price (QEP) or other prices in the contract. Revenue is recognised as a contract asset (accrual) in Note C8 for activity targets met. Revenue is not recognised for activity expected to exceed targets. The information for reliably measuring the revenue amount will not be known until the first quarter in the following financial year and any future revenue depends on events that are outside the control of CQHHS. Revenue amounts are recognised as a contract liability (refund) in Note C8 where activity targets have not been met. However, due to the impacts of COVID-19, activity-based funding was guaranteed by the Commonwealth government for 2019-20 and 2020-21 financial years under the National Health Reform Agreement. As such, the Department of Health will not make any adjustments for under delivery against activity-based funding targets, except for items specially referenced in Table 1 Specific Funding Commitments of the Service Agreement.
National Health Reform Act 2011 **Other funding public health services**	Other funding includes block funding, teacher training funding and general-purpose funding which apply to smaller public hospitals where using an activity-based funding model is not feasible. The general-purpose funding also includes other Government grants and depreciation funding where the Department funds CQHHS's depreciation and amortisation charges via non-cash revenue. The performance obligations in the Service Agreement are not sufficiently specific for these funding types, funding initiatives and grants. The Department pays these funds in fortnightly payments except for depreciation funding (Note C7).	The fortnightly receipts are recognised up-front as revenue in accordance with AASB 1058. Revenue is recognised as a receivable in Note C2 for any technical adjustments to the Service Agreement made at year end. Revenue amounts are recognised as a payable (refund) in Note C6 for unspent funds. Non-cash depreciation funding revenue is recognised when received and matches depreciation and amortisation expenses.

Note B1-3: Grants and other contributions

	2021 $'000	2020 $'000
Revenue from contracts with customers		
Nursing home grants	**10,894**	11,222
Home support services	**873**	981
Transition care programs	**2,139**	1,898
Other revenue contracts	**2,269**	1,484
Total revenue from contract with customers	**16,175**	15,585
Grants and Contributions		
Specific purpose grants	**1,048**	459
Other grants	**549**	467
Donations, bequests, other contributions	**97**	217
Services received below fair value		
Services received below fair value	**7,348**	5,733
Total grants and contributions	**9,042**	6,876
Total	**25,217**	22,461

Grants and other contributions - accounting policies and disclosures

Where the grant agreement is enforceable and contains sufficiently specific performance obligations for CQHHS to transfer goods and services to a third-party on the grantor's behalf, the transaction is accounted for under *AASB 15 Revenue from Contracts with Customers*. In this case, revenue is initially deferred as a contract liability and recognised as or when the performance obligations are satisfied. Otherwise, the grant is accounted for under *AASB 1058 Income of Not-for Profit Entities*, whereby revenue is recognised upon receipt of the grant funding.

CQHHS has not received any capital grants in the 2020-21 financial year. Capital grants are enforceable grants but are accounted for under AASB 1058, as the asset is not transferred to a customer but will become an asset owned by CQHHS.

The following table provides information about the nature, timing and revenue recognition for CQHHS grants and contributions.

B1 REVENUE (continued)

Types of goods and services	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policies
The Aged Care Act 1997 **Nursing home grants**	CQHHS is the service provider for eligible clients in three aged care facilities in Rockhampton; North Rockhampton Nursing Centre, Eventide Home Rockhampton and the Birribi unit. The Department of Human Services pays monthly invoices raised by CQHHS for providing aged care services in the nursing homes. The payment amount is based on a very specific assessment of each client care needs and therefore contains sufficiently specific performance obligations, resulting in a funding amount for a level of care. Prescribed ongoing appraisals must be undertaken to ensure the subsidy paid is at the right care level classification. The transactions price is the daily amount for a particular care level for each resident.	Claims are made monthly with revenue recognised as services are provided to nursing home residents. Adjustments may be required when appraisals indicate a change in care level. Contract assets (receivable) are included in Note C8.
The Aged Care Act 1997 **Home support services**	CQHHS coordinates and delivers home care services to eligible older clients by means of a service agreement and individual care plans considering any client contributions. Home support services are provided under the Commonwealth Home Support Program and the Queensland Community Support Scheme to eligible older clients who wish to remain in their home longer. Support can include help with daily tasks, home modifications, transport, social support and nursing care. The Commonwealth Home Support Program includes the Home Care Packages Program where CQHHS as the provider receives home care packages which pays for services provided to elig ble older clients with more complex needs. Services can be in-home aged care services or services to help people stay connected with their community. CQHHS receives quarterly payments in the first week of each quarter of delivering purchased services. Once every quarter, the amounts received are acquitted against the actual services delivered up to capped targets and in accordance with care plans, which have sufficiently specific performance obligations at the service transaction price.	Revenue is recognised at the completion of services delivered to clients at the relevant transaction price. Client contributions are recognised in user charges.

B1 REVENUE (continued)

Types of goods and services	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policies
Transition care program	CQHHS coordinates and provides transition care services to eligible older patients to assist with recovering from a hospital stay for up to 12 weeks with a possible extension of 6 weeks. Services include low-intensity therapy such as allied health services (physiotherapy, podiatry, social work and occupational therapy) nursing support, and personal care, with the performance obligations being sufficiently specific. Up to a capped number of clients, CQHHS receives monthly payments in advance from the Department of Human Services. Monthly payment in the first week of the month are compared with actual claims on a monthly basis adjusting amounts already received for the same month. A fixed daily rate applies for all transition care services.	Revenue is recognised based on the number of service days for each client multiplied by the fixed daily rate. Adjustments are estimated for amounts received in advance and recognised in the statement of financial position as a contract liability. Contract liabilities (unearned) are included in Note C8 for amounts received in advance.
Other revenue contracts -	CQHHS receives enforceable grants from other government agencies where the government is procuring health care and aged care services. Professional not-for-profit organisations purchase medical training positions for their members or medical staff in training in order to become medical specialists. CQHHS coordinates care to support eligible children with medical complexity, their family, and health care teams across Queensland through the Connect Care Program. The performance obligations in these revenue contracts are sufficiently specific and customers will pay for performance obligations or target outputs levels that are satisfied. Depending on the contract, invoices are raised in arrears or revenue is received in advance.	Revenue is recognised when services are transferred at a point in time or over time at the agreed price. Contract assets are included in Note C8. Contract liabilities (unearned) are included in Note C8 for amounts received in advance.
Grants & Contributions	*Specific Purpose & Other Grants* CQHHS receives enforceable specific purpose grants or other grants from government agencies, and other organisations for providing health services to eligible customers. The target level outputs and performance obligations for these health initiatives and programs are not sufficiently specific. *Donations, bequests and other contributions* Donations, bequest and other contributions are non-reciprocal transactions with no enforceable agreement and sufficiently specific performance obligations and CQHHS does not give equal value to the grantor.	*Specific Purpose & Other Grants* Revenue is recognised up front under AASB 1058. A revenue accrual is recorded in Note C2 Receivables. No refunds are recorded for unspent amounts where required in the agreements. *Donations, bequests and other contributions* Revenue is recognised when received under AASB 1058.
Service below fair value	The Department provides services free of charge to CQHHS which include payroll, accounts payable, finance, taxation, procurement and information technology infrastructure services. Contributions of services are recognised as the services would have been purchased if they had not been donated and their fair value can be measured reliably.	An equal amount is recognised as revenue and an expense.

Note B1-4: Other revenue

	2021 $'000	2020 $'000
Proceeds	**14**	-
Regulatory fees	**24**	33
Salary recoveries	**2,604**	2,328
Insurance recoveries	**33**	8
Other revenue	**1,776**	1,145
Total	**4,451**	3,514

Accounting policy – other revenue

Recognised up front under AASB 1058, other revenue primarily reflects revenue from non-core business activities such as interest on QTC investments and the patient trust account, insurance recoveries and regulatory fees and salary recoveries from Workcover and for non-executive employees contracted to other organisation, as detailed in Note B2-1.

Gain on disposal and revaluation of assets are recognised as they occur in the financial year in accordance with *AASB 102 Inventories*, AASB 116 *Property, Plant & Equipment*, and *AASB 136, Impairment of assets*.

B2 EXPENSES

Note B2-1: Employee expenses

	2021 $'000	2020 $'000
Employee benefits		
Wages and salaries	**65,004**	61,824
Annual leave levy	**4,037**	3,858
Employer superannuation contr butions	**4,815**	4,338
Long service leave levy	**1,517**	1,418
Termination benefits	**145**	75
Employee related expenses		
Workers compensation premium	**176**	159
Other employee related expenses	**231**	142
Total	**75,925**	71,814

Note B2-2: Health service employee expenses

	2021 $'000	2020 $'000
Department of Health Queensland - health service employees	**389,564**	359,114
Total	**389,564**	359,114

	2021 No.	2020 No.
Full-Time Equivalent (FTE) Employees at 30 June	**159**	153
Full-Time Equivalent Health Service employees at 30 June	**3,313**	3,139
Total	**3,472**	3,292

*FTEs are reflective of the minimum obligatory human resource information (MOHRI). This does not include Board members, executives engaged as a contractor, or employed under an award. CQHHS has engaged Health Service employees who are employed by the Department through service arrangements.

Accounting policy - employee benefits

Salaries and wages, sick leave, annual leave and long service leave levies and employer superannuation contributions are regarded as employee benefits.

CQHHS pays premiums to WorkCover Queensland in respect of its obligations for employee compensation.

Workers' compensation insurance is a consequence of employing employees. It is not an employee benefit and is recognised separately as an employee related expense.

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

Recoveries of salary and wages costs for CQHHS Health employees working for other agencies are offset against employee expenses. Recoveries of salaries and wages costs for health services employees working for other agencies are recorded as revenue as detailed in Note B1-4.

Accounting policy - sick leave

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

Accounting policy - annual leave and long service leave

Under the Queensland Government's Annual Leave Central Scheme and Long Service Leave Scheme, a levy is charged to CQHHS to cover the cost of annual and long service leave for employees. The levies are expensed in the period in which they are payable. Amounts paid to employees for annual leave and long service leave are claimed from the scheme quarterly in arrears.

Disclosure – COVID Response Leave

Health service employee expenses include $1.344m of COVID leave for the 2020-21 financial year.

An additional two days of leave was granted to all non-executive employees of the Department of Health and HHS's in November 2020, based on set eligibility criteria, as recognition of the effects of the COVID-19 pandemic on staff wellbeing. This leave must be taken within two years or eligibility is lost.

CQHHS paid the entire value of the leave of $2.175m to the Department of Health in advance. The leave expensed in the period in which it was taken, and the remaining balance recognised as a prepayment to the Department of Health. Refer to Note C4.

Accounting policy - superannuation

Employer superannuation contributions are paid to QSuper, the superannuation scheme for Queensland Government employees, at rates determined by the Treasurer on the advice of the State Actuary.

Contributions are expensed in the period in which they are paid or payable following completion of the employee's service each pay period. CQHHS's obligations are limited to those contributions paid to QSuper. The QSuper scheme has defined benefit and defined contribution categories. The liability for defined benefits is held on a whole-of-government basis and reported in those financial statements pursuant to *AASB 1049 Whole of Government and General Government Sector Financial Reporting*.

Board members and visiting medical officers are offered a choice of superannuation funds and CQHHS pays superannuation contributions into a complying superannuation fund. Contributions are expensed in the period in which they are paid or payable. CQHHS'S obligations are limited to those contr butions paid to eligible superannuation fund.

B2 EXPENSES (continued)

Therefore, no liability is recognised for accruing superannuation benefits in the CQHHS financial statements.

Key management personnel remuneration benefits disclosures and related party transactions are detailed in Note G1 and G2 respectively.

As CQHHS is not a prescribed employer, only certain employees can be contracted directly by CQHHS. Employee expenses represent the cost of engaging board members and employment of health executives including those engaged as a contractor, and senior or visiting medical officers who are employed directly by CQHHS. Any salary recoveries received from other agencies for these staff members has been offset against the salary and wages cost in accordance with AASB 119 Employee Benefits.

Note B2-3: Supplies and services

	2021 $'000	2020 $'000
Consultants and contractors	**29,407**	38,727
Electricity and other energy	**5,609**	5,956
Patient travel	**19,612**	20,883
Other travel	**1,300**	1,375
Building services^	**6,065**	8,431
Computer services	**2,947**	6,897
Motor vehicles	**1,626**	1,642
Communications	**7,930**	3,550
Repairs and maintenance	**10,860**	8,560
Minor works including plant and equipment	**2,386**	1,713
Short-term leases	**195**	382
Inventories consumed - held for distribution		
Drugs	**29,775**	25,903
Clinical supplies and services	**19,437**	18,244
Catering and domestic supplies	**7,495**	7,963
Outsourced service delivery		
Medical	**19,596**	18,250
Other services	**4,053**	4,334
Pathology, blood and parts	**18,744**	15,767
Other	**4,827**	4,913
Total	**191,864**	193,490

^ Includes internal to Government commercial office accommodation with DPHW

Accounting policy – distinction between grants and procurement

For a transaction to be classified as supplies and services, the value of goods or services received by CQHHS must be of approximately equal value to the value of the consideration exchanged for those goods or services. Where this is not the substance of the arrangement, the transaction is classified as grants distributed in Note B2-4.

Disclosure – leases

Lease expenses include lease rentals for short-term residential leases. Refer to Note C8 for breakdown of lease expenses and other lease disclosures.

Internal-to-government leases with the Department of Housing and Public Works for renting commercial office accommodation are recognised as a procurement of services as substantive substitution rights exists over the non-specialised assets.

Disclosure – patient travel

The Patient Travel Subsidy Scheme (PTSS) provides financial assistance contributing to travel costs and accommodation to eligible Queensland patients and where applicable escorts who need to travel to access eligible specialist medical services not available at their local public hospital or health facility.

B2 EXPENSES (continued)

Note B2-4: Other expenses

	2021 $'000	2020 $'000
External audit fees	**183**	183
Other audit fees	**9**	5
Insurance premiums	**6,116**	5,712
Losses from disposal of non-current assets	**-**	36
Special payments - ex gratia payments	**6**	7
Other legal costs	**205**	193
Advertising	**362**	376
Grants distributed	**560**	552
Interpreter fees	**46**	29
Impairment losses on trade receivables	**139**	341
Services received free of charge	**7,348**	5,733
Interest on lease payments	**6**	7
Other expenses	**780**	676
Revaluation decrement on land	**231**	2,626
Total	**15,991**	16,476

Accounting policy – other expenses

Audit fees

The external audit fee for 2021 is $183,000; (2020: $183,000).

Insurance

The insurance arrangements for Public Health Entities enables Hospital and Health Services to be named 'insured parties' under the Department of Health's policy. For the 2020-21 policy year, the premium was allocated to CQHHS according to the underlying risk of an individual insured party.

Special payments

Special payments represent ex gratia expenditure and other expenditure that CQHHS is not contractually or legally obligated to make to other parties. Special payments during 2020-21 include the following payments over $5,000:

- Reimbursement of medical costs totalling $6,180 (2020: $6,782).

Grant distributed

CQHHS distributes three grants received from funding as per Service Level Agreements:

(a) The provision of aged care residential services, community care, and respite care at Theodore Multi-Purpose Health Service. The services are outsourced to the Theodore Council of the Ageing,

(b) The provision of CQHHS research skills development. The services are outsourced to the Central Queensland University, and

(c) Provision of the 10,000 Lives project to University of Queensland.

Accounting policy – revaluations

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

7.6.3. Section C: Notes about our financial position

C1 CASH AND CASH EQUIVALENTS

	2021 $'000	2020 $'000
Imprest accounts	**12**	12
Cash at bank	**1,221**	5,067
QTC cash funds	**1,937**	2,347
Total	**3,170**	7,426

Accounting policy – cash and cash equivalents

For the purposes of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques receipted but not banked at 30 June 2021 as well as deposits at call with financial institutions.

CQHHS cash contributions primarily originate from private practice clinicians and external entities to provide for education, study and research in clinical areas. As at 30 June 2021 amounts of $1.94 million ($2.35 million in 2019-20) in general trust including $0.652 million ($0.649 million in 2019-20) for earnings in excess of the agreed amount under the Granted Practice retention arrangement.

C2 RECEIVABLES

Note C2-1: Receivables

	2021 $'000	2020 $'000
Trade debtors	**5,938**	3,980
Less: Loss allowance	**(109)**	(196)
	5,829	3,784
GST receivable	**1,288**	1,363
GST payable	**(76)**	(36)
	1,212	1,327
Other fees and charges receivable	**5,001**	2,494
Total	**12,042**	7,605

Accounting policy – receivables

At reporting date, lease receivables and trade receivables are recognised at amortised cost which approximates their fair value.

Receivables are recognised at the agreed transaction price. Receivables are generally settled within 30 days, while other receivables may take longer than 12 months. A large proportion of trade receivables arises on the date of discharge of patients; however, fees are submitted to the health funds to be recovered once claim processing has been finalised. This could delay the receivable by up to 60 days. Receivables for funding arrangements are recorded in Note C8 contract assets.

Disclosure – credit risk exposure of receivables

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. In terms of collectability, receivables will fall into one of the following categories:

Lease receivables

The credit risk on initial recognition for lease receivables was assessed as 0%. The credit risk or objective impairment for these lease contracts has been re-assessed at 30 June 2021 and the 0% credit risk rate has been maintained.

Trade receivables

CQHHS has assessed the credit risk to measure the expected credit losses on trade and other debtors. Loss rates are calculated separately for groupings of customers with similar loss patterns. CQHHS has identified five groupings for measuring expected credit losses based on the sale of services and the sale of goods reflecting the different customer profiles for these revenue streams.

Note C2-2 details the accounting policies for impairment of receivables, including the loss events giving rise to impairment and the movements in the allowance for impairment.

C2 RECEIVABLES (continued)

Note C2-2: Impairment of receivables

	2021				2020			
	Gross receivables	Loss rate	Expected credit losses	Carrying amount	Gross receivables	Loss rate	Expected credit losses	Carrying amount
	$'000	%	$'000	$'000	$'000	%	$'000	$'000
Third party insurance	-	13.38%	-	-	6	17.84%	(1)	5
Private health funds	3,947	0.00%	-	3,947	2,802	0.00%	-	2,802
Medicare ineligible	799	12.60%	(101)	698	612	30.81%	(189)	424
Other	1,149	0.74%	(8)	1,141	784	0.78%	(6)	778
Government agencies	4,473	0.00%	-	4,473	2,142	0.00%	-	2,142
Other debtor & payroll	417	0.00%	-	417	-	-	-	-
Lease receivables	154	0.00%	-	154	127	0.00%	-	127
Australian Taxation Office	1,212	0.00%	-	1,212	1,327	0.00%	-	1,327
Total outstanding	12,151	0.90%	(109)	12,042	7,800	2.51%	(196)	7,605

Disclosure – movement in loss allowance for trade and other debtors

	2021	2020
	$'000	$'000
Balance at 1 July	196	266
Amounts written off during the year	(134)	(413)
Amounts recovered during the year	3	2
Increase/(decrease) in allowance recognised in operating result	44	341
Balance at 30 June	109	196

Accounting policy – impairment of trade receivables

The allowance for impairment reflects the occurrence of loss events or lifetime expected credit losses.

For lease receivables, a loss event occurs if the lessee is no longer able to meet the terms and conditions of the lease contract.

The loss allowance amount for lease receivables is based on

- a twelve-months expected credit loss if the credit risk has not increased significantly at the reporting date since initial recognition, or
- a lifetime expected credit loss if the risk has increased significantly since initial recognition.

For trade receivables, loss events occur when Debtors do not pay in accordance with expected payment terms which may differ for debtor categories.

Australian Government agencies loss events rarely occur. No loss allowance is recorded for these receivables on the basis of materiality.

Refer to Note D1-2 for CQHHS's credit risk management policies.

Economic changes impacting the CQHHS debtors, and relevant industry data, will continue to form part of the documented risk analysis even though the associated risk factor has been set at 0%. The demand for services and collection of debts has not been significantly impacted by economic changes or COVID-19 at reporting date.

If no loss events have arisen in respect of a debtor or group of debtors, no allowance for impairment is made in respect of that debtor or group of debtors. If CQHHS determines that an amount owing by such a debtor does become uncollectible (after appropriate debt recovery actions have been taken), that amount is recognised in the impairment loss allowance and written-off directly against receivables. In other cases where a debt becomes uncollect ble, but the uncollectible amount exceeds the amount already allowed for impairment of that debt, the excess is recognised directly as a bad debt expense and written-off directly against receivables.

The amount written off in the current year regarding receivables is $0.134 million (2020: $0.413 million).

C3 INVENTORIES

Note C3-1: Inventories

	2021 $'000	2020 $'000
Inventories held for distribution - at cost		
Clinical supplies	**4,388**	3,469
Catering and domestic	**126**	103
Pharmacy drugs	**1,288**	1,372
Other	**1**	1
Total	**5,803**	4,945

Accounting policy – inventories

Inventories are held for distr bution and are valued at replacement value in accordance with *AASB 102 inventories*.

Cost is assigned on a weighted-average basis and includes expenditure incurred in acquiring the inventories and bringing them to their existing condition.

A stocktake is undertaken of imprest clinical supply holdings where clinical areas can purchase from suppliers directly.

A rolling stocktake is performed for pharmacy drugs selected by the iPharmacy system.

C4 OTHER ASSETS

Note C4-1: Other assets

	2021 $'000	2020 $'000
Prepayment- COVID Response Leave	**831**	-
Other prepayments	**648**	235
	1,479	235

Accounting policy – COVID response leave

The Queensland Government announced an additional two days of leave was granted to all non-executive employees in acknowledgement of the efforts of health workers, and those supporting health workers in response to COVID-19. The leave must be taken within two years or eligibility is lost. The COVID response leave balance cannot be cashed out and when an employee resigns from Queensland Health or moves into a casual position there is no cash out of the leave. The entire value of leave for health service employees was paid by CQHHS to the Department of Health in advance. The leave is expensed in the period in which it is taken, and the remaining balance treated as a prepayment to the Department of Health.

C5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION

Note C5-1: Property, plant and equipment – balances and reconciliations of carrying amount

30 June 2021	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Gross	14,644	881,061	68,373	2,744	966,822
Less: Accumulated depreciation	-	(486,964)	(35,103)	-	(522,067)
Carrying amount at 30 June 2021	14,644	394,097	33,270	2,744	444,755
Represented by movements in carrying amount:					
Carrying amount at 1 July 2020	14,255	364,155	30,155	3,926	412,491
Transfers in from other Queensland Government entities	620	44,539	723	-	45,882
Acquisitions	-	105	8,336	2,838	11,279
Donations	-	-	6	-	6
Transfers between classes	-	4,020	-	(4,020)	-
Net revaluation increments/(decrements)	(231)	1,625	-	-	1,394
Depreciation expense	-	(20,347)	(5,950)	-	(26,297)
Carrying amount at 30 June 2021	14,644	394,097	33,270	2,744	444,755

30 June 2020	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Gross	14,255	827,783	61,202	3,926	907,166
Less: Accumulated depreciation	-	(463,628)	(31,047)	-	(494,675)
Carrying amount at 30 June 2020	14,255	364,155	30,155	3,926	412,491
Represented by movements in carrying amount:					
Carrying amount at 1 July 2019	16,881	375,228	26,790	963	419,862
Transfers in from other Queensland Government entities	-	7,723	-	-	7,723
Acquisitions	-	24	8,783	4,069	12,876
Disposals	-	-	(89)	-	(89)
Transfers between classes	-	1,106	-	(1,106)	-
Net revaluation increments/(decrements)	(2,626)	(1,674)	-	-	(4,300)
Depreciation expense	-	(18,252)	(5,329)	-	(23,581)
Carrying amount at 30 June 2020	14,255	364,155	30,155	3,926	412,491

C5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

Note C5-2: Accounting policies

Initial measurement

Recognition thresholds

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

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

Acquisition of assets

Plant and equipment is initially recorded at cost, determined as the value given as consideration plus costs incidental to the acquisition, including all other directly attributable costs incurred to bring the asset to the location or condition necessary to be ready for use. Items or components that form an integral part of an asset are recognised as a single (functional) asset.

Major health infrastructure projects are managed by the Department on behalf of CQHHS. These assets are assessed at fair value on practical completion by an independent valuer. They are then transferred from the Department to CQHHS via an equity adjustment at the valuation amount.

Where assets are received free of charge from another Queensland Government entity, the acquisition cost is recognised as the gross carrying amount in the books of the other agency immediately prior to the transfer together with any accumulated depreciation. Assets acquired at no cost or for nominal consideration, other than from another Queensland Government entity, are recognised at their fair value at the date of acquisition.

Componentisation of complex assets

Where assets comprise of separately identifiable components, subject to regular replacement, components are assigned useful lives distinct from the asset to which they relate and depreciated accordingly. CQHHS has determined all specialised health service buildings are complex in nature and warrant componentisation (separate useful lives assigned to component parts). These buildings comprise three components:

- Shell
- Fit out
- Services including plant integral to the asset

Subsequent expenditure

Expenditure relating to repairs and maintenance is only capitalised to an asset's carrying amount if it extends the service potential or useful life of the existing asset. Maintenance expenditure that merely restores the original service potential (lost through ordinary wear and tear) is expensed. Carrying amounts impacted by repairs and maintenance of a capital nature are considered when determining the value at cost or the fair value.

Depreciation

Key judgement: Buildings, plant and equipment are depreciated on a straight-line basis reflecting the even consumption of economic benefits over their useful life to CQHHS. Annual depreciation is based on fair values and CQHHS's assessments of the useful remaining 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.

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 leasehold land is allocated progressively over the shorter of the estimated useful lives of the improvements or the unexpired period of the lease. The unexpired period of leases includes any option period where exercise of the option is probable.

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

Class	Depreciation rates (%)
Land improvements	1% - 5%
Building - shell	2% - 3%
Building - fit out	2% - 5%
Building - services	3% - 5%
Other building	2% - 10%
Plant and equipment	5% - 20%

Impairment of non-current assets

Key judgement: All non-current assets are assessed for indicators of impairment on an annual basis. This occurs through the stocktake process for plant and equipment assets and through the revaluation process for property assets. Where impairment is identified for plant and equipment assets, management determines the asset's recoverable amount (higher of value in use and fair value less costs to sell). Any amount by which the asset's carrying amount exceeds the recoverable amount is considered an impairment loss and recognised immediately in the Statement of Comprehensive Income.

C5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

The valuation methodology for property includes an assessment as to whether the asset is impaired, i.e. the asset has experienced physical or technological obsolescence. Where obsolescence is identified, the comprehensive revaluation process incorporates the impact, ensuring that the asset is held at fair value, with any associated decrements realised in the Asset Revaluation Reserve or Statement of Comprehensive Income as required.

Subsequent measurement at fair value

Fair value is the price that would be received or paid for an asset at arm's length between willing market participants 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.

Key estimate and judgement:

Property assets are initially recognised at cost and subsequently valued by external valuers who use multiple inputs to derive fair value. The derivation of these inputs is subject to judgements and assumptions about the property's highest and best use.

Observable inputs are publicly available data that are relevant to the characteristics of the assets/ liabilities being valued, and include, but are not limited to, published sales data for land and residential dwellings. Unobservable inputs are used where observable inputs are not available and include data, assumptions and judgements that are not available publicly, but are relevant to the characteristics of the assets being valued. These include subjective adjustments made to observable data to take account of the specialised nature of health service buildings and on hospital site residential facilities, such as:

- historical and current construction contracts (and/or estimates of such costs), with consideration of locational factors in deriving appropriate unit rate costs;
- assessments of physical condition and any impairment; and
- remaining useful life, with consideration of the future service requirements of the facility.

All CQHHS assets measured at fair value 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:

Fair value level	Description	CQHHS valuations
1	Valuation is derived from unadjusted quoted market prices in an active market for identical assets	n/a*
2	Valuation is substantially derived from inputs that are observable, either directly or indirectly	Land
3	Valuations is substantially derived from unobservable inputs	Buildings

*None of CQHHS's property assets are eligible for categorisation into level 1 on the fair value hierarchy.

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

Revaluation of property at fair value

Land and building classes measured at fair value are assessed on an annual basis either by comprehensive valuations, desktop valuations or by the use of appropriate indices undertaken by independent professional valuers/quantity surveyors.

Comprehensive revaluations are undertaken at least once every five years. However, if a particular asset class experiences significant and volatile changes in fair value, then that class is subject to specific appraisal in the reporting period, where practical, regardless of the timing of the last specific appraisal. Where assets have not been specifically appraised in the reporting period, their previous valuations are materially kept up to date via the application of relevant indices. CQHHS uses indices to provide a valid estimation of fair values for the assets at reporting date. Materiality is considered in determining whether the differences between the carrying amount and the fair value of an asset is material (in which case revaluation is warranted).

Land

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

In 2020-21, CQHHS's land was valued by SVS using independent market valuation or market indices. The effective date of valuation was 30 June 2021. Management has assessed the valuation provided by SVS as appropriate for CQHHS and accepted the result of the independent valuation.

The fair value of land was based on physical inspection and publicly available data on sales of similar land in nearby localities. SVS indicated that they used observable inputs from market transactions data and therefore these inputs fall into level 2 within the fair value hierarchy. The revaluation of land for 2021 resulted in $0.231 million decrement in the fair value currently recorded (2020: $2.626 million decrement).

Buildings

In 2020-21 CQHHS engaged AECOM as the independent valuers to undertake building revaluation in accordance with the fair value methodology. AECOM performed comprehensive valuation for modified retirements of existing assets, capital improvements to existing assets and valuations

C5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

of new built assets. Indexation was applied to the remaining building portfolio previously valued in prior financial years. The effective date of the valuation was 30 June 2021.

CQHHS values its buildings using the current replacement cost valuation methodology. The valuation is provided for a replacement building of the same size, shape and functionality that meets current design standards, and is based on estimates of gross floor area, number of floors, building girth and height and existing lifts and staircases. The valuation methodology for the independent valuation uses historical and current construction contracts. The replacement cost of each building at the date of valuation is determined by considering location factors and comparing against current construction contracts.

The valuation methodology makes an adjustment to the replacement cost of the modern-day equivalent building for any utility embodied in the modern substitute that is not present in the existing asset (e.g. mobility support) to give a gross replacement cost that is of comparable utility (the modern equivalent asset). The methodology makes further adjustment to total estimated life taking into consideration physical obsolescence impacting on the remaining useful life to arrive to the current replacement cost via straight line depreciation.

Indices used are also tested for reasonableness by applying the indices to a sample of assets, comparing the results to similar assets that have been valued by an independent professional valuer or quantity surveyor, and analysing the trend of changes in values over time. Through this process, which is undertaken annually, management assesses and confirms the relevance and suitability of indices provided based on CQHHS's own circumstances.

An index of 1% (2.1%: 2020) was recommended by AECOM to be applied to buildings not comprehensively revalued.

Any revaluation increment arising on the revaluation of an asset is credited to the asset revaluation surplus of the appropriate class, except to the extent it reverses a revaluation decrement for the class previously recognised as an expense. In that case, it is recognised as income. A decrease in the carrying amount on revaluation is charged as an expense to the extent it exceeds the balance, if any, in the revaluation surplus relating to that asset class.

Note C5-3: Categorisation of assets and liabilities measured at fair value

	Level 2		Level 3		Total Carrying Amount	
	2021	2020	2021	2020	2021	2020
	$'000	$'000	$'000	$'000	$'000	$'000
Land	**14,644**	14,255	**-**	-	**14,644**	14,255
Buildings	**-**	-	**394,097**	364,155	**394,097**	364,155
Total	**14,644**	14,255	**394,097**	364,155	**408,741**	378,410

C6 PAYABLES

	2021	2020
	$'000	$'000
Department of Health Queensland	**-**	944
Trade creditors	**12,171**	17,004
Accrued health service labour - Department of Health Queensland	**24,133**	15,514
Accrued employee benefits	**884**	2,729
Other	**948**	660
Total	**38,136**	36,851

Accounting policy – payables

Payables are unsecured and recognised upon receipt of the goods or services and are measured at the agreed purchase/contract price, gross of applicable trade and other discounts.

The amounts are unsecured and are generally settled in accordance with the vendors terms and conditions, typically within 30 days.

C7 EQUITY

Interpretation 1038 Contributions by Owners Made to Wholly-Owned Public-Sector Entities specifies the principles for recognising contributed equity by CQHHS. The following items are recognised as contributed equity by CQHHS during the reporting and comparative years:

- Cash equity contributions fund purchases of equipment, furniture and fittings associated with capital work projects managed by CQHHS. CQHHS received $45.882 million funding from the State as equity injections in 2021 (2020: $7.723 million). These outlays are paid by the Department of Health Queensland on behalf of the State.
- CQHHS received $27.752 million funding in 2021 (2020: $24.451 million) from the Department to account for the cost of depreciation. Funding for depreciation charges is via non-cash revenue. The Department retains the cash to fund future major capital replacements. As depreciation is a non-cash expenditure item, the Health Minister has approved a withdrawal of equity by the State for the same amount, resulting in a non-cash revenue amount and a corresponding non-cash equity withdrawal.

Note C7-1: Contributed equity - asset transfers

	2021 $'000	2020 $'000
Transfer in - practical completion of projects from the Department	**45,159**	7,723
Net transfer equipment between Hospital and Health Services	**8**	-
Net transfer equipment from the Department of Health	**715**	-
	45,882	7,723

Non-reciprocal transfers of assets are recognised through equity when the Chief Finance Officers of both entities agree in writing to the transfer. Construction of major health infrastructure is managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department to CQHHS. During this year several assets including the Gladstone Mater Hospital have been transferred under this arrangement.

Note C7-2: Asset revaluation surplus by class

	Land $'000	Buildings $'000	2021 Total $'000	2020 Total $'000
Balance 1 July	**-**	**46,669**	**46,669**	48,343
Revaluation increments/(decrements)	**-**	**1,625**	**1,625**	(1,674)
Balance 30 June	**-**	**48,294**	**48,294**	46,669

C8 CONTRACT BALANCES

Disclosure – Contract assets

Contract assets are transferred to receivables when CQHHS's right to payment becomes unconditional. This usually occurs when the invoice is issued to the customer.

Accrued revenue and unearned revenue that do not arise from contracts with customers are included in Note C2 receivables.

The credit risk or objective impairment for the contract assets has been assessed as 0% at 30 June 2021, as most of the contract asset balance relates to the Department or other Government agencies, and medical colleges.

Disclosure – Contract liabilities

Contract liabilities arise from contracts with customers while other unearned revenue arise from transactions that are not contracts with customers and included in C6 Payables.

Of the amount included in the contract liability balance at 1 July 2020, $0.196m was recognised as revenue in 2020-21. This is mainly due to the reassessment of the estimate of progress towards satisfaction of performance obligations under the NDIS program.

The contract liabilities at 30 June 2021 includes $0.026m relating to instalments received for Australasian College of Physicians and Australasian College of Emergency Medicine for which the milestone deliverables have not been achieved. This amount will be recognised as revenue in the 2021-22 financial year. In addition, $0.620m relates to funding to be returned for the COVID Mental Health program.

Note C8-1: Contract balances

	2021 $'000	2020 $'000
Contract assets - revenue receivable	-	400
Contract assets - revenue accruals	1,380	5,881
Total contract assets	1,380	6,281
Contract liabilities – revenue received in advance	26	701
Contract liabilities - refunds payable	620	1,186
Total contract liabilities	646	1,887

C9 RIGHT OF USE ASSETS AND LEASE LIABILITIES

Note C9-1: Leases as a Lessee **30 June 2021**	**Right-of-use assets** **Buildings** **$'000**	**Total** **$'000**
Carrying amount at 1 July 2020	1,174	1,174
Additions	1,409	1,409
Disposals	(43)	(43)
Amortisation expense for the year	(1,455)	(1,455)
Carrying amount at 30 June 2021	1,085	1,085

30 June 2020	**Right-of-use assets** **Buildings** **$'000**	**Total** **$'000**
Carrying amount at 1 July 2019	253	253
Additions	1,791	1,791
Amortisation expense for the year	(870)	(870)
Carrying amount at 30 June 2020	1,174	1,174

C9 RIGHT OF USE ASSETS & LIABILITIES (continued)

Accounting policy – leases as a lessee

Right-of-use assets

Right-of-use assets are initially recognised at cost comprising the following:

- the amount of the initial measurement of the lease liability
- lease payments made at or before the commencement date, less any lease incentives received
- initial direct costs incurred, and
- the initial estimate of restoration costs

Right-of-use assets are subsequently depreciated over the lease term and be subject to impairment testing on an annual basis.

The carrying amount of right-of-use assets are adjusted for any remeasurement of the lease liability in the financial year following a change in discount rate, a reduction in lease payments payable, changes in variable lease payments that depend upon variable indexes/rates of a change in lease term.

CQHHS has elected not to recognise right-of-use assets and lease liabilities arising from short-term leases and leases of low value assets. The lease payments are recognised as expenses on a straight-line basis over the lease term. Low value is considered where it expected to cost less than $10,000.

For leases of plant and equipment, CQHHS has elected not to separate lease and non-lease components and instead accounts for them as a single lease component.

Lease liabilities

Lease liabilities are initially recognised at the present value of lease payments over the lease term that are not yet paid. The lease term includes any extension or renewal options that CQHHS is reasonably certain to exercise. The future lease payments included in the calculation of the lease liability comprise the following:

- fixed payments (including in-substance fixed payments), less any lease incentives receivable
- variable lease payments that depend on an index or rate, initially measured using the index or rate as at the commencement date
- amounts expected to be payable by CQHHS under residual value guarantees
- the exercise price of a purchase option that CQHHS is reasonably certain to exercise
- payments for termination penalties, if the lease term reflects the early termination

When measuring the lease liability, CQHHS uses its incremental borrowing rate as the discount rate where interest rate implicit in the lease cannot be readily determined, which is the case for all the CQHHS's leases. To determine the incremental borrowing rate, CQHHS uses loan rates provided by Queensland Treasury Corporation that correspond to the commencement date and term of the lease.

Lease rental payments are expensed on a straight-line basis over the term of the lease where the lease is 12 months or less after consideration of whether renewal options should be included, and leases do contain a purchase option.

Subsequent to initial recognition, the lease liabilities are increased by the interest charge and reduced by the amount of lease payments. Lease liabilities are also remeasured in certain situations such as a change in variable lease payments that depend on an index or rate (e.g. a market rent review), or a change in the lease term.

Disclosures – Leases as a lessee

Details of leasing arrangements as lessee

Category/Class of lease arrangement	Description of arrangement
Buildings	Central Queensland Hospital and Health Service (CQHHS) enters into residential lease contracts with real estate agents or individual house owners to provide rural and remote housing assistance to attract employees in isolated areas.
Concessionary lease for land	CQHHS owns a building which is situated on land owned by the Woorabinda Council. A medical clinic is operating from this building. No lease agreement is in place between the Woorabinda Council and CQHHS and no lease liability is recorded.
Office accommodation	Effective 1 July 2019, the internal-to-government non-cancellable leases for office accommodation and storage facilities through the Department of Housing and Public Works (DHPW) are exempt from lease accounting under AASB 16. This is due to DHPW having substantive substitution rights over the non-specialised, commercial office accommodation assets used within these arrangements. CQHHS has adopted Queensland Treasury's guidelines to categorise these leases as purchases of accommodation services and expenses are recorded as building services in this note and are no longer reported as non-cancellable lease commitments. The related service expenses are included in Note B2-3.

C9 RIGHT OF USE ASSETS & LIABILITIES (continued)

Note C9-2: Leases as a lessee

	2021 $'000	2020 $'000
Amounts recognised in surplus or (deficit)		
Interest expense on lease liabilities	**6**	7
Short-term leases included in Note B2-3	**195**	382
Total cash outflow for leases	**201**	389

Note C9-2: Leases as a lessor

Accounting policy – leases as a lessor

The CQHHS recognises lease payments from operating leases as revenue on a straight-line basis over the lease term.
Lease revenue from operating leases is reported as 'Revenue Leases' in Note B1-1. No amounts were recognised in respect of variable lease payments other than CPI-based or market rent reviews.
The CQHHS does not have any finance leases.

Disclosure – Leases as a lessor

Details of leasing arrangements as lessor

Asset Class	Description of arrangement
Buildings	CQHHS receives property rental payments for facilities owned by CQHHS to outsourced service providers who operate from these facilities.

Maturity analysis

The following table sets out a maturity analysis of future undiscounted lease payments receivable under CQHHS's operating leases.

	2021 $'000	2020 $'000
Buildings		
No later than 1 year	**1,960**	1,250
Later than 1 year but no later than 5 years	**4,502**	4,297
Later than 5 years	**133**	967
Total	**6,595**	6,514

CQHHS has 14 operating leases for the 2020-21 (14: 2019-20) financial year with various parties on different terms and conditions for property and accommodation. The amount of $1.652 million has been received from leases held as a lessor in the 2020-21 financial year; (2020:$1.431million).

7.6.4. Section D: Notes about risks and other accounting uncertainties

D1 FINANCIAL RISK DISCLOSURES

Note D1-1: Financial instrument categories

CQHHS has the following categories of financial assets and financial liabilities:

Category	Notes	2021 $'000	2020 $'000
Financial assets			
Cash and cash equivalents	C1	**3,170**	7,426
Financial assets at amortised cost:			
Receivables	C2-1	**12,042**	7,605
Total		**15,212**	15,031
Financial liabilities			
Payables	C6	**38,136**	36,851
Total		**38,136**	36,851

Note D1-2: Liquidity Risk – Contractual Maturity of Financial Liabilities

The following table sets out the liquidity risk of financial liabilities held by CQHHS. They represent the contractual maturity of financial liabilities, calculated based on undiscounted cash flows relating to the liabilities at 30 June 2021.

	2021				2020			
Financial Liabilities	Total $'000	<1 year $'000	1-5 years $'000	>5 years $'000	Total $'000	<1 year $'000	1-5 years $'000	>5 years $'000
Payables	**38,136**	**38,136**	**-**	**-**	36,851	36,851	-	-
Lease Liabilities	**968**	**847**	**121**	**-**	984	-	984	-
Total	**39,104**	**38,983**	**121**	**-**	37,835	36,851	984	-

Note D1-3: Financial risk management

A financial instrument is defined as any contract that gives rise to both a financial asset of one entity and a financial liability or equity instrument of another entity. The identifiable financial instruments for CQHHS are cash, Queensland Treasury Corporation investments, receivables and payables excluding prepayments and funds held in trust.

Financial risk management is implemented pursuant to Government and CQHHS policies. These policies focus on the unpredictability of financial markets and seek to minimise potential adverse effects on the financial performance of CQHHS.

CQHHS exposure to a variety of financial risks including how these risks are measured, is set out below:

Credit risk

Credit risk in relation to a financial instrument is the risk that a customer, bank or other counterparty will not meet its obligations in accordance with agreed terms. CQHHS has a credit management strategy in place which includes analysing ageing accounts receivable amounts and identifying cash inflows at risk.

CQHHS is exposed to credit risk in respect of its account receivables (Note C2-1). The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the accounts receivable, inclusive of any allowance for impairment.

Trade Debtor categories at risk

The trade debtors have been classified in the following five categories with Medicare ineligible patients and third-party insurance claims being the two categories with the highest credit risk.

1. Medicare ineligible patients with or without private health insurance and where Australia does not have a reciprocal health care agreement with the patient's country of origin.
2. Third party insurance claims for hospital charges pending legal action. The actual settlement of these claims can take many years. CQHHS may not be fully compensated for patients who seek compensation though motor vehicle and third-party insurance claims. The difference between treatment cost and the compensation amounts is written off.
3. Private Health Insurance.
4. Other debtors.
5. Government agencies

D1 FINANCIAL RISK DISCLOSURES (continued)

At 30 June 2021 the overall credit risk is determined to be low.

CQHHS credit risk strategy is to reduce the exposure to credit default by ensuring that CQHHS invests in secure assets considering legislative requirements and monitors all funds owed on a timely basis in accordance with expectations for each customer profile.

Liquidity risk

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

CQHHS is exposed to liquidity risk through its trading in the normal course of business and aims to reduce the exposure to liquidity risk by managing cash flows ensuring that sufficient funds are available to meet employee and supplier obligations at all times. An approved debt facility of $8.5 million under Whole-of-Government banking arrangements to manage any short-term cash shortfalls has been established. No funds had been withdrawn against this debt facility as at 30 June 2021.

Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises foreign exchange risk, interest rate risk and other price risks.

CQHHS is not permitted to trade in foreign currency and is not materially exposed to commodity price changes or other market prices. Interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates.

CQHHS does not recognise any financial assets or liabilities at fair value. Trade receivables and payables are recorded at the value of the original transaction less any allowances for impairment, which is assumed to approximate the fair value of the balance.

CQHHS has interest rate exposure on the 24-hour call deposits; however, there is no risk on its cash deposits as all interest earned on bank accounts that form part of the Whole-of-Government-Arrangements flow back into the Consolidated Fund (Note C1).

Changes in interest rate have a minimal effect on the operating result of CQHHS.

D2 CONTINGENCIES

(a) Litigation in progress

As at 30 June 2021, the following cases were filed in the courts naming the State of Queensland acting through CQHHS as defendant:

	2021 Number of cases	2020 Number of cases
Supreme Court	3	4
District Court	1	-
Magistrates Court	-	-
Tribunals, commissions and boards	-	-
Total	**4**	4

Disclosure – Litigation in progress

Insurance cover for CQHHS's exposure to litigation is underwritten by the Queensland Government Insurance Fund (QGIF) and WorkCover Queensland. For matters managed by QGIF, CQHHS's liability is limited to an excess of $20,000 per insurance event. As at 30 June 2021, CQHHS has 30 claims currently managed by QGIF (some of which may never be litigated or result in payments to claimants). At year end, the maximum exposure associated with these claims is $600,000.

During the financial year, 4 of the medical indemnity claims managed by QGIF were lodged with either the Supreme Court, District Court, or Magistrates Court. CQHHS legal advisers and management believe it would be misleading to estimate the final amounts payable (if any) in respect of the litigation before the courts at this time. As of 30 June 2021, there were no open claims before tribunals, commissions or boards that have been referred to QGIF for management or being managed by CQHHS.

D3 CAPITAL COMMITMENTS

Commitments for capital expenditure at reporting date are exclusive of anticipated GST and are payable as follows:

	2021 $'000	2020 $'000
Property, Plant and Equipment		
No later than 1 year	**11,510**	2,135
Later than 1 year but no later than 5 years	**-**	-
Later than 5 years	**-**	-
Total	**11,510**	2,135

Disclosure – Capital expenditure commitments

Material classes of capital expenditure commitments contracted for at reporting date but not recognised in the accounts as payable.

D4 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 using historical experience and other factors that are considered to be relevant. Revisions to accounting estimates are recognised in the period in which the estimate is revised and future periods as relevant.

Estimates and assumptions that have a potential significant effect are outlined in the following financial statement notes:

- Activity based funding revenue – Note B1-2
- Property, plant and equipment – Note C5
- Service received below fair value, free of charge – Note B1-3 and Note B2-4

D5 SUBSEQUENT EVENTS

There are no matters or circumstances that have arisen since 30 June 2021 that have significantly, or may significantly affect CQHHS's operations, the result of those operations, or the HHS's state of affairs in future financial years.

D6 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE

Accounting standards issued but with future commencement dates

There are no Australian accounting standards and interpretations with new or future commencement dates that are applicable to CQHHS activities or have a material impact on CQHHS.

7.6.5. Section E: Notes on our performance compared to budget

E1 BUDGETARY REPORTING DISCLOSURES

This section discloses CQHHS's original published budgeted figures for 2020-21 compared to actual results, with explanations of major variances, in respect of CQHHS's Statement of Comprehensive Income. CQHHS was not required to include a budgeted Statement of Financial Position or Cashflows in the original published Service Delivery Statement tabled in Parliament for the 2020-21 financial year. Therefore, explanation of major variances for both the Statement of Financial Position and Cashflows are not presented.

E1.1 BUDGET TO ACTUAL COMPARISON – STATEMENT OF COMPREHENSIVE INCOME

	Variance Notes	Original SDS Budget 2021 $'000	Actual 2021 $'000	Original SDS Budget V Actual Variance $'000	Variance % of original budget
OPERATING RESULT					
Income					
User charges and fees	1	47,292	**56,671**	9,379	20%
Funding public health services	2	589,983	**612,056**	22,073	4%
Grants and other contributions	3	20,922	**25,217**	4,295	21%
Other revenue	4	3,136	**4,451**	1,315	42%
Total revenue		661,333	**698,395**	37,062	
Total income		661,333	**698,395**	37,062	
Expenses					
Employee expenses		77,640	**75,925**	(1,715)	(2%)
Health service employee expenses	5	364,791	**389,564**	24,773	7%
Supplies and services	6	178,821	**191,864**	13,043	7%
Depreciation	7	31,697	**27,752**	(3,945)	(12%)
Other expenses	8	8,384	**15,991**	7,607	91%
Total expenses		661,333	**701,096**	39,763	
Operating results		-	**(2,701)**	(2,701)	
Other comprehensive income *Items that will not be reclassified subsequently to profit or loss*					
Increase/(decrease) in asset revaluation surplus	9	-	**1,625**	1,625	100%
Other comprehensive income for the year		-	**1,625**	1,625	
Total comprehensive income for the year		-	**(1,076)**	(1,076)	

Note:

Original Published Budget from the Service Delivery Statement (SDS) has been revised to improve transparency and analysis with comparatives by remapping particular budgeted transactions on the same basis as reported in actual financial statements. Reclassification for the Statement of Comprehensive Income has occurred for:

- User charges and fees in the original SDS have been dissected into user charges and funding public health services.
- Interest revenue has been rolled into other revenue as immaterial by size for individual reporting.
- Health Service employees have moved from under supplies and services and is presented as a labour expense along with employee expenses.
- Grants and subsidies have been rolled into other expenses as immaterial by size for individual reporting.
- Losses on sale/revaluation of assets are rolled into other expenses as immaterial for actual reporting.
- Insurance expenses have been budgeted in the original SDS as supplies and services, however, have been included in other expenses for actual reporting in accordance with Queensland Treasury's financial reporting requirements.
- Any account groups displayed on the SDS with a zero balance have not been included in the statement.

E1.1 BUDGET TO ACTUAL COMPARISON – STATEMENT OF COMPREHENSIVE INCOME (continued)

Materiality for notes commentary is based on the calculation of the line item's actual value percentage of the group total, as well as the dollar value. If the percentage is greater than 5%, or the dollar variance is significant the line item variance from budget to actual is reviewed. A note is provided for where this percentage is 5% or greater for employee expenses, supplies and services, and depreciation and 10% or greater for others or the variance is materially different.

Explanation of Major Variances - Statement of Comprehensive Income

1. User charges and fees: The budget variance is a result of the PBS reimbursement being greater than what was anticipated in the budget, because of higher usage of cancer drugs. This has been partly offset by the drugs expenditure budget variance. The inter-entity sales revenue for non-capital recoveries is also above budget by $2.492m. This is offset by the non-capitialised related expenditure and minor equipment expenditure.

2. Funding public health services: The budget variance is due to further funding being received in the budget window adjustments for additional programs totalling $12.082m, as well as a further $9.991m COVID-19 NPA funding.

3. Grants and contributions: The budget variance is mainly a result of the service below fair value not being higher than anticipated in the budget by $1.6m and nursing home benefit funding being higher than budgeted by $0.623m.

4.Other revenue: The budget variance relates to increased contract staff recoveries than anticipated in the budget.

5. Health service employees: The budget variance relates to additional frontline staff to service growth in demand and program deliverables through the various window adjustments. Overtime being paid is also above budget by $11.323m. The impact of COVID-19, including delivery of the vaccination program, has also resulted in further employees being employed with the direct labour cost for COVID-19 being $6.613m.

6. Supplies and services: The variance is a result of an increase in expenditure for drugs which is partly offset by the increase in PBS reimbursement and the increase in pathology services as result of COVID-19. Repairs and maintenance is greater than anticipated in the budget as a result of increased expenditure occurring for corrective maintenance on various buildings and inter-entity charges from BTS.

7. Depreciation: The decrease in depreciation against budget relates to changes in the expected commissioning dates of some capital projects and a lower asset base due to assets being revalued down in the 2019-20 financial year. There were also changes to the useful life of several building assets.

8. Other expenses: The budget variance mainly relates to the services below fair of $7.348m not being included in the budget.

9. Asset revaluation surplus: The revaluation surplus is a result a $0.767m decrement on comprehensive revaluations of various buildings and a $2.392m increment on the revaluation of site improvements.
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E2 IMPACT OF COVID-19

On 27 February 2020, the prime Minister of Australia activated the Australian Health Sector Emergency Response Plan in response to the outbreak of the Novel Coronavirus or COVID-19. The State of Queensland responded to this with a Pandemic Plan led by the Queensland Disaster Management Committee. The impact of the COVID-19 pandemic on CQHHS has been assessed as follows:

Revenue

The COVID-19 National Partnership Agreement (NPA) remains in effect with COVID-19 remaining a declared Pandemic. Both Commonwealth and State Government have agreed to reimburse additional costs incurred because of the response to COVID-19 pandemic. CQHHS has received additional funding of $9.991m in 2020-21, (2019-20: $6.136m) under the National Partnership Agreement (NPA) as a reimbursement of direct costs incurred as a response to COVID-19. An additional $1m was received to offset the costs for the Vaccination program in 2020-21.

Expenditure

CQHHS continues to provide services above Service Agreement in response to the COVID-19 pandemic, CQHHS has incurred additional expenditure of $6.613m in labour expenditure for the 2020-21 (2019-20: $3.699m) and $3.378m in non-labour expenditure for the 2020-21 (2019-20: $2.437m), which relates to direct COVID-19 expenditure and has been reimbursed under the NPA. CQHHS has also incurred additional costs to rollout the Vaccination program in 2020-21.

Health care activity

CQHHS ability to deliver health care activity continues to be impacted due to the COVID-19 pandemic, however continued to meet the increased patient demand particularly to Emergency Department.

Asset valuation

Both comprehensive valuation and indexation has been applied to our land and building assets in the 2020-21 financial year. The valuers have confirmed based on the information at the time that COVID-19 has had no material impact to the valuation for both the land and buildings.

Collectability of receivables

The impairment of receivables has not been significantly impacted by COVID-19. CQHHS main income sources are the Queensland Government, Medicare and health insurance companies, which have been financially stable, and we have not seen any adverse impacts due to COVID-19 on collectability of revenue from these sources.

7.6.6. Section F: What we look after on behalf of third parties

F1 TRUST TRANSACTIONS AND BALANCES

CQHHS administers, but does not control, certain activities on behalf of the Government. In doing so, it has respons bility for administering those activities (and related transactions and balances) efficiently and effectively. But does not have the discretion to deploy those resources for the achievement of CQHHS own objectives.

Accounting policies applicable to administered items are consistent with the equivalent policies for controlled items, unless stated otherwise.

The CQHHS 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. The activities of trust accounts are audited by the Queensland Audit Office (QAO) on an annual basis.

	2021 $'000	2020 $'000
Patient trust receipts and payments		
Receipts		
Patient trust receipts	**4,996**	5,204
Total receipts	**4,996**	5,204
Payments		
Patient trust payments	**5,082**	5,086
Total payments	**5,082**	5,086
Increase/(decrease) in net patient trust assets	**(86)**	118
Patient trust assets opening balance	**1,042**	924
Patient trust assets closing balance	**956**	1,042
Patient trust assets		
Current assets		
Cash at bank and on hand	**584**	670
Patient trust and refundable deposits	**372**	372
Total	**956**	1,042

F2 GRANTED PRIVATE PRACTICE

Granted Private Practice permits Senior Medical Officers (SMOs) and Visiting Medical Officers (VMOs) employed in the public health system to treat individuals who elect to be treated as private patients. SMOs and VMOs receive a private practice allowance and assign practice revenue generated to the Hospital (assignment arrangement). Alternatively, SMOs and VMOs pay a facility charge and administration fee to the Hospital and retain an agreed proportion of the private practice revenue (retention arrangement) with the balance of revenue deposited into a trust account to fund research and education of clinical staff. In addition, all SMOs and VMOs engaged in private practice receive an incentive on top of their regular remuneration. Receipts and payments relating to both the granted private practice arrangements and right of private practice system during the financial year are as follows:

	2021 $'000	2020 $'000
Receipts		
Billings - (Senior Medical Officers and Visiting Medical Officers)	**4,133**	4,884
Total receipts	**4,133**	4,884
Payments		
Payments to Senior Medical Officers and Visiting Medical Officers	**3,009**	4,275
Hospital and Health Service recoverable administrative costs	**459**	446
Hospital and Health Service education/travel fund	**5**	10
Total payments	**3,473**	4,731
Closing balance of bank account under a trust fund arrangement not yet disbursed and not restricted cash	**223**	192

7.6.7. Section G: Other information

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES

The Minister for Health and Minister for Ambulance Services is identified as part of the CQHHS's key management personnel (KMP), consistent with additional guidance included in the revised version of *AASB 124 Related Party Disclosures*.

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

The following details for non-Ministerial key management personnel reflect those positions that have authority and respons bility for planning, directing and controlling the activities of CQHHS during the current financial year:

Position	Incumbent	Contract Classification and Appointment Authority	Date of Initial Appointment	Date of Resignation or Cessation
Non-executive Board Chair Provide strategic leadership, guidance and effective oversight of management, operations and financial performance.	Mr Paul Bell AM	Hospital and Health Boards Act 2011 Section 25 (1)(a)	25 September 2015	-
Non-executive Deputy Board Chair Provide strategic leadership, guidance and effective oversight of management, operations and financial performance.	Ms Lisa Caffery	Hospital and Health Boards Act 2011 Section 25 (1)(b)	4 October 2019	17 May 2021
Non-executive Deputy Board Chair Provide strategic leadership, guidance and effective oversight of management, operations and financial performance.	Ms Lisa Caffery	Hospital and Health Boards Act 2011 Section 25 (1)(b)	10 June 2021	-
Non-executive Board Members Provide strategic leadership, guidance and effective oversight of management, operations and financial performance.	Dr Poya Sobhanian	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2016	-
	Dr Anna Vanderstaay	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2016	-
	Ms Tina Zawila	Hospital and Health Boards Act 2011 Section 23 (1)	17 May 2019	-
	Ms Leann Wilson	Hospital and Health Boards Act 2011 Section 23 (1)	17 May 2019	-
	Mr Matthew Cooke	Hospital and Health Boards Act 2011 Section 23 (1)	17 May 2019	-
	Cr Andrew Ireland	Hospital and Health Boards Act 2011 Section 23 (1)	17 May 2019	17 May 2021
	Professor Fiona Coulson	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2020	-
	Mr John Abbott AM	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2021	-
Health Service Chief Executive Responsible for the overall leadership and management of the CQHHS to ensure that CQHHS meets its strategic and operational objectives.	Mr Steve Williamson	s33 Appointed by Board under Hospital and Health Board Act 2011 (Section 7 (3).	9 January 2017	-

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Position	Incumbent	Contract Classification and Appointment Authority	Date of Initial Appointment	Date of Resignation or Cessation
Chief Finance Officer, Assets, and Commercial Services Responsible for the management and oversight of the CQHHS finance framework including financial accounting, budget and performance management frameworks, assets and commercial services, information and technology, and corporate governance systems.	Mr Colin Weeks	HES 2 Appointed by CE under HHB Act 2011	14 April 2020	-
Executive Director, Rockhampton Hospital Responsible for the leadership, management and coordination of the Rockhampton Hospital Business Unit.	Ms Kerrie-Anne Frakes	HES 2 Appointed by CE under HHB Act 2011	10 February 2020	-
Executive Director Medical Services Central Queensland Responsible for the strategic and professional functions for CQHHS medical workforce, and clinical governance.	Dr Julieanne Graham	MMOI1 Appointed under Medical Officers (Queensland Health) Award – State 2015 and Medical Officer (Queensland Health) Certified Agreement (No. 4) 2015	16 July 2018	12 February 2021
Executive Director Medical Services Central Queensland Responsible for the strategic and professional functions for CQHHS medical workforce, and clinical governance.	Dr Jennifer King	Contractor	08 February 2021	13 May 2021
Executive Director, Gladstone and Rural Responsible for the leadership, management and coordination of Gladstone and Banana Business Unit.	Ms Sandralee Munro	NRG13 Appointed under Nurses and Midwives (Queensland Health) Award - State 2015 and Nurse and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018	13 November 2018	-
Acting Executive Director of Nursing Midwifery Quality and Safety Responsible for strategic and professional leadership of nursing workforce.	Ms Susan Foyle	NRG13 Appointed under Nurses and Midwives (Queensland Health) Award - State 2015 and Nurse and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018	13 November 2018	-
Executive Director, Workforce Responsible for provision of leadership and oversight of human resource, occupational health and safety functions, and Indigenous training and development for the Health Service.	Ms Shareen McMillan	HES 2 Appointed by CE under HHB Act 2011	03 December 2018	-
Director, Aboriginal & Torres Strait & Islander Health & Wellbeing Responsible for leading development and implementation of health programs and service improvement for the Aboriginal & Torres Strait and islander community across CQHHS.	Ms Sharni Tippett	DSO2-1 Appointed by CE under HHB Act 2011	11 December 2018	15 February 2021
Director, Aboriginal & Torres Strait & Islander Health & Wellbeing Responsible for leading development and implementation of health programs and service improvement for the Aboriginal & Torres Strait and islander community across CQHHS.	Ms Linda Medlin	DSO2-1 Appointed by CE under HHB Act 2011	28 May 2020	

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration policy

Section 74(1) of the *Hospital and Health Boards Act 2011* provides that each person appointed as a Health Executive must enter into a contract of employment. The Health Service Chief Executive must enter into the contract of employment with the Chair of the Board for the Hospital and Health Service and a Health Executive employed by a Hospital and Health Service must enter into a contract of employment with the Health Service Chief Executive. The contract of employment must state the term of employment (no longer than 5 years per contract), the person's functions and any performance criteria as well as the person's classification level and remuneration entitlements.

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

- Short-term employee benefits which include: **Monetary benefits** – consisting of base salary, allowances and leave entitlements paid and provided for the entire year or for that part of the year during which the employee occupied the specified position. Amounts disclosed equal the amount expensed in the statement of comprehensive income. **Non-monetary benefits** – consisting of provision of reportable as well as exempt benefits together with fringe benefits tax applicable to the benefit. Benefits provided to individual employees working for a public and non-profit hospital under a salary package arrangement where the grossed-up value is equal or lower than $17,667 are not reported in this Note.
- Long-term employee benefits include long service leave accrued.
- Post-employment benefits include superannuation contributions.
- Redundancy payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu on termination, regardless of the reason for termination.
- No performance bonuses were paid in the 2020-21 financial year (2020: $nil).

Board remuneration

Remuneration paid or owing to Board members during 2020-21 was as follows:

Board Member	Short-term employee expenses		Post employee expenses	Total Expenses
	Monetary expenses	Non-monetary expenses		
	$'000	$'000	$'000	$'000
Mr Paul Bell (AM) - Chair	90	-	8	**98**
Ms Lisa Caffery - Deputy Chair	44	-	4	**48**
Dr Poya Sobhanian	50	-	5	**55**
Dr Anna Vanderstaay	50	-	5	**55**
Ms Tina Zawila	43	-	4	**47**
Ms Leann Wilson	40	-	4	**44**
Mr Matthew Cooke	40	-	4	**44**
Cr Andrew Ireland	44	-	4	**48**
Professor Fiona Coulson	40	-	4	**44**
Mr John Abbott AM	5	-	1	**6**

* Board members who are employed by either CQHHS or the Department of Health are paid board fees when approved by government based on the meeting attended has been included.

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration paid or owing to Board members during 2019-20 was as follows:

Board Member	Short-term employee expenses		Post employee expenses	Total Expenses
	Monetary expenses	Non-monetary expenses		
	$'000	$'000	$'000	$'000
Mr Paul Bell (AM) - Chair	90	-	8	**98**
Ms Lisa Caffery - Deputy Chair	49	-	4	**53**
Professor Leone Hinton	39	-	4	**43**
Dr Poya Sobhanian	50	-	5	**55**
Dr Anna Vanderstaay	51	-	5	**56**
Ms Tina Zawila	43	-	4	**47**
Ms Leann Wilson	40	-	4	**44**
Mr Matthew Cooke	43	-	4	**47**
Cr Andrew Ireland	49	-	5	**54**
Professor Fiona Coulson	6	-	-	**6**

* Board members who are employed by either CQHHS or the Department of Health Queensland are paid Board fees when approved by government.

^ No payment to Professor Fiona Coulson has been made in the 2019-20 financial year, however an estimate of what has been earned based on the meeting attended has been included.

Other key management personnel remuneration

Remuneration paid or owing to employees who occupied key management roles, including while providing leave cover during 2020-21 was as follows:

2020-21

Position	Short-term employee expenses		Long term expenses	Post-employment expenses	Termination benefits	Total expenses
	Monetary expenses	Non-monetary expenses				
	$'000	$'000	$'000	$'000	$'000	$'000
Health Service Chief Executive	341	20	7	30	-	**398**
Chief Finance Officer, Assets and Commercial Services	203	-	4	20	-	**227**
Executive Director, Medical Service Central Queensland	452	3	7	24	-	**486**
Executive Director, Rockhampton Hospital	202	-	4	19	-	**225**
Executive Director, Gladstone and Rural	263	-	6	26	-	**295**
Executive Director, Nursing, Midwifery, Quality and Safety	265	-	6	26	-	**297**
Executive Director Workforce	196	-	4	20	-	**220**
Director Aboriginal & Torres Strait Islander Health & Wel being	211	3	4	22	-	**240**

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration paid or owing to employees who occupied key management roles, including while providing leave cover during 2019-20 was as follows:

2019-20

Position	Short-term employee expenses		Long term expenses	Post-employment expenses	Termination benefits	Total expenses
	Monetary expenses	Non-monetary expenses				
	$'000	$'000	$'000	$'000	$'000	$'000
Health Service Chief Executive	352	8	8	31	-	**399**
Chief Finance Officer, Assets and Commercial Services	481	30	1	4	-	**516**
Executive Director, Medical Service Central Queensland	525	-	12	39	-	**576**
Executive Director, Rockhampton Hospital	246	-	4	19	-	**269**
Executive Director, Gladstone and Banana	245	-	5	24	-	**274**
Executive Director, Nursing, Midwifery, Quality and Safety	254	-	5	23	-	**282**
Executive Director, Rural District Wide Services	178	-	4	16	-	**198**
Executive Director Workforce	189	-	4	19	-	**212**
Executive Director, Strategy, Transformation and Allied Health	158	-	3	16	-	**177**
Director Aboriginal & Torres Strait Islander Health & Wellbeing	119	-	4	14	-	**137**

G2 RELATED PARTY TRANSACTIONS

Transactions with people/entities related to key management personnel
There are no transactions with people/entities related to key management personnel.

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

Department of Health Queensland

Procurement of public hospital services

CQHHS receives funding in accordance with a service agreement with the Department. The Department receives its revenue from the Queensland Government (majority of funding) and the Commonwealth. CQHHS is funded for eligible services through block funding; activity-based funding or a combination of both. Activity based funding is based on an agreed number of activities per the Service Agreement and a state-wide price by which relevant activities are funded. Block funding is not based on levels of public care activity.

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

The signed service agreements are published on the Queensland Government website and publicly available.

In addition, the Department provides services free of charge to CQHSS which include payroll, accounts payable, finance, taxation, procurement and information technology infrastructure services. The fair value of these services is estimated at $7.348 million for the 2020-21 financial year and is recognised in the Statement of Comprehensive Income. The associated business expenses paid by the Department on behalf of CQHHS for providing these services are recouped by the Department.

Health service employees

CQHHS is not a prescribed employer and 3,313 (2020: 3,139) health service employees (MOHRI FTE) are employed by the Department and contracted to work for CQHHS.

Queensland Treasury Corporation

CQHHS has accounts with the Queensland Treasury Corporation for general and fiduciary trust monies.

Department of Housing and Public Works

CQHHS pays rent to the Department of Housing and Public Works for several properties used for employee accommodation, offices etc. In addition, the Department of Housing and Public Works provides vehicle fleet management services (QFleet) to CQHHS.

Transactions between Hospital and Health Services

Payments to and receipts from other Hospital and Health Services occur to facilitate the transfer of patients, drugs, staff and other incidentals.

Central Queensland Hospital Foundation

The Governor in Council approved Central Queensland Hospital Foundation to be established on 2 October 2020. CQHHS has provided secretarial advice and support in both the establishment and operations of the Foundation. The fair value of these services cannot be measured reliably and therefore is not included in the financial statements.

Other

Grants are also received from other Government departments and related parties, but there are no individually significant transactions.

G3 FEDERAL TAXATION CHARGES

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

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

G4 CLIMATE RISK DISCLOSURE

CQHHS has not identified any material climate-related risks relevant to the financial report at the reporting date, however, constantly monitors the emergence of such risks under the Queensland Government's Climate Transition Strategy.

G5 FIRST YEAR APPLICATION OF NEW ACCOUNTING STANDARDS OR CHANGE IN ACCOUNTING POLICY

New accounting policies AASB 1059 Service Concession Arrangements: Grantors

CQHHS has applied *AASB 1059 Service Concession Arrangements: Grantors* for the first time in 2020-21.

This standard defines service concession arrangements and applies a new control concept to the recognition of service concession assets and related liabilities. CQHHS does not currently have any arrangements that would fall within the scope of AASB 1059.

No other accounting standards or interpretations that apply to CQHHS for the first time in 2020-21 have any material impact on the financial statements.

7.7. Appendices

7.7.1. Appendix 1 - Management certificate

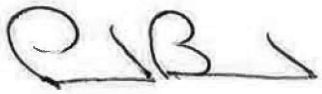
Certificate of Central Queensland Hospital and Health Service

These general-purpose financial statements have been prepared pursuant to section 62(1) of the *Financial Accountability Act 2009* (the Act), relevant sections of the *Financial and Performance Management Standard 2019* and other prescribed requirements. In accordance with section 62(1) (b) of the Act we certify that in our opinion:

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

b) the statements have been drawn up to present a true and fair view, in accordance with prescr bed accounting standards, of the transactions of the Central Queensland Hospital and Health Service for the financial year ended 30 June 2021 and of the financial position of the Central Queensland Hospital and Health Service at the end of that year.

We acknowledge our responsibility under sections 7 and 11 of the *Financial and Performance Management Standard 2019* for the establishment and maintenance, in all material respects, of an appropriate and effective system of internal controls and risk management processes with respect to financial reporting throughout the reporting period.



Cr Paul Bell, AM
Chairperson Health Service
Date: 27 August 2021

Steve Williamson
Chief Executive
Date: 27 August 2021

Colin Weeks
Chief Finance Officer
Date: 27 August 2021

7.7.2. Appendix 2 - Independent auditors report

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INDEPENDENT AUDITOR'S REPORT

To the Board of Central Queensland Hospital and Health Service

Report on the audit of the financial report

Opinion

I have audited the accompanying financial report of Central Queensland Hospital and Health Service.

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2021, and its financial performance and cash flows for the year then ended

b) complies with the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2019 and Australian Accounting Standards.

The financial report comprises the statement of financial position as at 30 June 2021, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

Basis for opinion

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

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

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

Key audit matters

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

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Better public services

Valuation of specialised buildings $394.1 million

Refer to Note C5.

Key Audit Matter Description	How my audit procedures addressed this key audit matter

Buildings were material to CQHHS at balance date and were measured at fair value using the current replacement cost method. CQHHS performed a comprehensive revaluation of 6% of its buildings' written down value this year with the remaining assets being revalued using indexation.
 	
The current replacement cost method comprises:
• gross replacement cost, less
• accumulated depreciation.
 	
CQHHS derived the gross replacement cost of its buildings at the balance date using unit prices that required significant judgements for:
• identifying the components of buildings with separately identifiable replacement costs; and
• developing a unit rate for each of these components, including:
  • estimating the current cost for a modern substitute (including locality factors and oncosts); and
  • identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference.
 	
Using indexation required:
• Significant judgment in determining the indexation factors that reflected the estimated change, since the previous balance date, in the cost inputs used in developing the gross replacement; and
• Reviewing previous assumptions and judgements used in the determination of fair value in intervening years between the comprehensive valuation to ensure ongoing validity of assumptions and judgements used.
 	
The measurement of accumulated depreciation involved significant judgements for forecasting the remaining useful lives of building components.
	Procedures performed included, but were not limited to:
	• assessing the adequacy of management's review of the valuation process and results;
	• reviewing the scope and instructions provided to the valuer;
	• assessing the appropriateness of the valuation methodology and the underlying assumptions with reference to common industry practices;
	• assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices;
	• assessing the competence, capabilities and objectivity of the experts used to develop the models;
	• for unit rates associated with buildings that were comprehensively revalued this year:
	  – on a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive unit costs including:
	  o modern substitute (including locality factors and oncosts)
	  o adjustment for excess quality or obsolescence
	• evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices;
	• evaluating useful life estimates for reasonableness by:
	  – reviewing management's annual assessment of useful lives;
	  – at an aggregated level, reviewing asset management plans for consistency between renewal budgets and the gross replacement cost of assets;
	  – ensuring that no building asset still in use has reached or exceeded its useful life;
	  – enquiring of management about their plans for assets that are nearing the end of their useful life;
	  – reviewing assets with an inconsistent relationship between condition and remaining useful life.
	
	Where changes in useful lives were identified, evaluating whether the effective dates of the changes applied for depreciation expense were supported by appropriate evidence.

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Better public services

Responsibilities of the entity for the financial report

The Board is responsible for the preparation of the financial report that gives a true and fair view in accordance with the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2019 and Australian Accounting Standards, and for such internal control as the Board determines is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

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

Auditor's responsibilities for the audit of the financial report

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

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

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances. This is not done for the purpose of expressing an opinion on the effectiveness of the entity's internal controls, but allows me to express an opinion on compliance with prescribed requirements.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the entity.
- Conclude on the appropriateness of the entity's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. I base my conclusions on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

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

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

Report on other legal and regulatory requirements

Statement

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2021:

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

b) I consider that, the prescribed requirements in relation to the establishment and keeping of accounts were complied with in all material respects.

Prescribed requirements scope

The prescribed requirements for the establishment and keeping of accounts are contained in the Financial Accountability Act 2009, any other Act and the Financial and Performance Management Standard 2019. The applicable requirements include those for keeping financial records that correctly record and explain the entity's transactions and account balances to enable the preparation of a true and fair financial report.

31 August 2021

David Toma
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

8. Glossary

Word	Definition
Accessible	Accessible healthcare is characterised by the ability of people to obtain appropriate healthcare at the right place and right time, irrespective of income, cultural background or geography.
Activity Based Funding (ABF)	A management tool with the potential to enhance public accountability and drive technical efficiency in the delivery of health services by: • capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery • creating an explicit relationship between funds allocated and services provided • strengthening management's focus on outputs, outcomes and quality • encouraging clinicians and managers to identify variations in costs and practices so they can be managed at a local level in the context of improving efficiency and effectiveness • providing mechanisms to reward good practice and support quality initiatives.
Acute	Having a short and relatively severe course.
Acute care	Care in which the clinical intent or treatment goal is to: • manage labour (obstetric) • cure illness or provide definitive treatment of injury • perform surgery • relieve symptoms of illness or injury (excluding palliative care) • reduce severity of an illness or injury • protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function • perform diagnostic or therapeutic procedures.
Admission	The process whereby a hospital accepts responsibility for a patient's care and/or treatment. It follows a clinical decision, based on specified criteria, that a patient requires same-day or overnight care or treatment, which can occur in hospital and/or in the patient's home (for hospital-in-the-home patients).
Allied Health staff	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; leisure therapy; medical imaging; music therapy; nuclear medicine technology; occupational therapy; orthoptics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work.
Best practice	Cooperative way in which organisations and their employees undertake business activities in all key processes, and use benchmarking that can be expected to lead to sustainable world class positive outcomes.
Clinical governance	A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical practice	Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/or manage illness, together with associated professional activities for patient care.
CQ Health	Central Queensland Hospital and Health Service
e-Learning	QH Online Training Environments.
Emergency department waiting time	Time elapsed for each patient from presentation to the emergency department to start of services by the treating clinician. It is calculated by deducting the date and time the patient presents from the date and time of the service event.
Full time equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
Health outcome	Change in the health of an individual, group of people or population attributable to an intervention or series of interventions.
Hospital	Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.
Hospital and Health Board	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to managing a complex health care organisation.
Hospital and Health Service	Hospital and Health Service are separate legal entities established by Queensland Government to deliver public hospital services.
Hospital in the home (HITH)	Provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.

Word	Definition
Long wait	A 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for a category 1 patient, more than 90 days for a category 2 patient and more than 365 days for a category 3 patient.
Outpatient	Non-admitted health service provided or accessed by an individual at a hospital or health service facility.
Outpatient service	Examination, consultation, treatment or other service provided to non-admitted non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.
Patient flow	Optimal patient flow means the patient's journey through the hospital system, be it planned or unplanned, happens in the safest, most streamlined and timely way to deliver good patient care.
Performance indicator	A measure that provides an 'indication' of progress towards achieving the organisation's objectives. Usually has targets that define the level of performance expected against the performance indicator.
Private hospital	A private hospital or free-standing day hospital, and either a hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients or insurers. Patients admitted to private hospitals are treated by a doctor of their choice.
Public hospital	Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.
Statutory bodies / authorities	A non-departmental government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.
Sustainable	A health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs, for example, research and monitoring within available resources.
Telehealth	Delivery of health-related services and information via telecommunication technologies, including: • live, audio and/or video inter-active links for clinical consultations and educational purposes • store-and-forward Telehealth, including digital images, video, audio and clinical (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists • teleradiology for remote reporting and clinical advice for diagnostic images • Telehealth services and equipment to monitor people's health in their home.
Triage category	Urgency of a patient's need for medical and nursing care.

9. Checklist

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister/s	ARRs – section 7	iii
Accessibility	Table of contents Glossary	ARRs – section 9.1	iv 72-73
	Public availability	ARRs – section 9.2	i
	Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 9.3	i
	Copyright notice	*Copyright Act 1968* ARRs – section 9.4	i
	Information Licensing	*QGEA – Information Licensing* ARRs – section 9.5	i
General information	Introductory Information	ARRs – section 10	2-3
Non-financial performance	Government's objectives for the community and whole-of-government plans/specific initiatives	ARRs – section 11.1	1
	Agency objectives and performance indicators	ARRs – section 11.2	21-25
	Agency service areas and service standards	ARRs – section 11.3	26
Financial performance	Summary of financial performance	ARRs – section 12.1	27
Governance – management and structure	Organisational structure	ARRs – section 13.1	15
	Executive management	ARRs – section 13.2	12-14
	Government bodies (statutory bodies and other entities)	ARRs – section 13.3	10
	Public Sector Ethics	*Public Sector Ethics Act 1994* ARRs – section 13.4	20
	Human Rights	*Human Rights Act 2019* ARRs – section 13.5	20
	Queensland public service values	ARRs – section 13.6	20
Governance – risk management and accountability	Risk management	ARRs – section 14.1	19-20
	Audit committee	ARRs – section 14.2	11
	Internal audit	ARRs – section 14.3	19
	External scrutiny	ARRs – section 14.4	19
	Information systems and recordkeeping	ARRs – section 14.5	19
	Information Security attestation	ARRs – section 14.6	19
Governance – human resources	Strategic workforce planning and performance	ARRs – section 15.1	16-18
	Early retirement, redundancy and retrenchment	Directive No.04/18 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	18
Open Data	Statement advising publication of information	ARRs – section 16	i
	Consultancies	ARRs – section 33.1	https://data.qld.gov.au
	Overseas travel	ARRs – section 33.2	Nil
	Queensland Language Services Policy	ARRs – section 33.3	https://data.qld.gov.au
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	67
	Independent Auditor's Report	FAA – section 62 FPMS – section 46 ARRs – section 17.2	68-71

FAA *Financial Accountability Act 2009*
FPMS Financial and Performance Management Standard 2019
ARRs Annual report requirements for Queensland Government agencies

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Central Queensland Hospital and Health Service

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