Unite & Recover

Central Queensland Hospital and Health Service

ANNUAL REPORT 2021–2022

Queensland Government

Accessibility

Open data

Information about consultancies, overseas travel, and the Queensland language services policy is available at the Queensland Government Open Data website (https://data.qld.gov.au).

Public availability statement

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 Central Queensland Hospital and Health Service Board Secretary on (07) 4920 5759. Alternatively, you can request a copy by emailing CQHHS_Board@health.qld.gov.au.

Interpreter Service statement

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.

Licence

Attribution

Content from this annual report should be attributed as: State of Queensland (Central Queensland Hospital and Health Service) Annual Report 2021-2022.

ISSN 2202-5332 (print) ISSN 2652-2640 (online)

Acknowledgement

Acknowledgement of Traditional Custodians

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.

1 September 2022

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 2021–2022 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 is provided at page 79 of this Annual Report.

Yours sincerely

Mr Paul Bell AM
Chair
Central Queensland Hospital and Health Board

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Statement on Queensland Government objectives for the community

CQ Health's strategic vision *Destination 2030: Great Care for Central Queenslanders* (Destination 2030), and *CQ Health Strategic Plan 2018-2023 (updated 2021)* support the Queensland Government objectives which are built around *Unite and Recover – Queensland's Economic Recovery Plan*.

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:

- **Safeguarding our health**
  Safeguard the health of Queenslanders by keeping our health system pandemic-ready and supporting priority vaccinations to our vulnerable populations.
- **Building Queensland**
  Drive investment in health infrastructure and hospitals that supports our recovery and the wellbeing of our diverse communities.
- **Growing our regions**
  Help Queensland's regions grow by attracting clinical expertise and building capacity within our rural and remote health network.
- **Investing in skills**
  Ensuring we have a skilled and capable workforce delivering high-quality contemporary care.
- **Backing our frontline services and supporting jobs**
  Supporting investment in world class frontline health services.

From the Chair and Chief Executive

Central Queensland Hospital and Health Service has emerged from the COVID-19 pandemic and is returning to business as usual, with many developments to look forward to.

A new Chief Executive started in April 2022 and is focused on building and refreshing the CQ Health Executive Team, including appointing an Executive Director of Aboriginal and Torres Strait Islander Health.

We would like to acknowledge the tremendous amount of work CQ Health staff has done throughout the COVID-19 pandemic. Our hospitals continued to provide great care to our communities throughout a very difficult year, working around travel restrictions and staff sickness. Our teams continued to show flexibility and step up as required to ensure our patients remained well cared for.

A lot of work has been done around keeping people away from hospital wherever possible. Different initiatives have been very successful in this space, including Geriatric Evaluation and Rapid Intervention team to support elderly patients, and the Mental Health Co-responder program in partnership with the Queensland Ambulance Service, where experienced mental health clinicians support people in crisis in their homes.

Our teams delivered **138,222** vaccinations in the financial year. We closed the doors to community-based vaccination locations in April 2022 and handed the task over to primary care providers.

COVID-19 testing clinics did **83,787** tests across Central Queensland. These clinics closed in June 2022 following declining demand and the easy access to rapid antigen tests.

Research continues to be a priority for CQ Health, and two staff have been awarded National Health and Medical Research Council (NHMRC) research grants. Professor Gulam Khandaker is studying early detection and intervention of cerebral palsy in children in low- and middle-income countries; and Linda Medlin’s research focuses on communication training for mental health professionals: developing cultural sensitivity and capability to improve Aboriginal and Torres Strait Islander mental health outcomes. These grants demonstrate that quality research can be done in regional areas, making a difference for our community and further afield.

Here are just some examples of Central Queenslanders supported by CQ Health teams in an average day from 2021-2022:

- Ambulances arriving at hospitals: 108
- ED presentations: 404
- Surgeries performed: 36
- Hospital inpatients: 357
- Babies born: 6
- Number of patients seen in outpatient clinics: 1103
- Dental clinic visits: 568
- Number of women undergoing Breast screen procedures: 32
- Number of Telehealth appointments: 50
- Neonatal patients: 7
- Hospital in the Home appointments: 2
- Number of Radiology examinations performed: 356

About us

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.

Vision, purpose, values

Vision: Great Care for Central Queenslanders

Purpose: Great people, delivering quality care and improving health

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 all of the time

Priorities

CQ Health's priorities are clearly expressed in the *CQ Health Strategic Plan 2018-2023 (updated 2021)*:

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

Aboriginal and Torres Strait Islander Health

Health Equity for some of our most vulnerable in the community will be further strengthened by continuing work to ensure the voices of our community are key to the design, priorities and direction of the health service in the implementation of our Health Equity Strategy.

The health service has appointed the inaugural Executive Director Aboriginal and Torres Strait Islander Health. This key role will work with the Chief Executive and the Executive Management Team to provide leadership and high-level strategic advice across the health service and ensure Health Equity is considered in all our planning and service delivery. The Directorate continues to build with the recruitment of the Project Manager Health Equity and the Nurse Unit Manager Aboriginal and Torres Strait Islander Health.

The Aboriginal and Torres Strait Islander Health and Wellbeing Directorate continued to work closely with the Public Health Unit on the continuing COVID-19 response. Four Aboriginal and Torres Strait Islander Health Worker positions were funded to enhance the work in keeping our Aboriginal and Torres Strait Islander communities safe during COVID-19. Staff provided information, supported contact tracing and liaised with

the community for promotion and education, and assisted with vaccination clinics. These roles were based in locations across the health service and in particular Woorabinda to ensure connection with communities.

The Gladstone artwork project continued into 2021-2022. The art project, facilitated by two local Aboriginal and Torres Strait Islander artists, involved working 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 artworks were designed with young people and based on sharing the stories of community members of a special story of a 'Health Journey' with a cultural knowledge, wisdom, and perspective. The artworks were showcased at a community launch in November 2021. They are on permanent display, providing a beautiful connection for the community.

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 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

Car Park concessions

In 2021-2022, 7,081 concession passes and discounted parking tickets were issued for Rockhampton Hospital car park at an estimated cost of $115,182.

Targets and challenges

Key challenges for CQ Health include:

- the impact of ongoing growth in demand for health services
- the impacts of COVID-19 particularly on workforce
- availability of workforce resources to meet service delivery and business needs, including challenges with recruitment and retention in a rural and regional setting.

The *CQ Health Strategic Plan 2018-2023 (updated 2021)* identifies opportunities for the health service, including to:

- vaccinate the Central Queensland community against COVID-19 in collaboration with our healthcare partners.
- develop innovative and progressive rural healthcare delivery supported by the digital revolution and virtual care models.
- use ingenuity and research to develop community-driven care that is delivered close to home by a values-driven healthcare team.
- partner with universities and health service partners to produce locally trained medical graduates delivering improved recruitment and retention.
- develop a sustainable financial response supporting future sustainability in a post-pandemic setting.
- establish an Aboriginal and Torres Strait Island Health and Wellbeing Directorate to deliver equity across the workforce and community.
- deliver increased capacity in cancer, cardiac, renal, mental health services to reduce the need for patient travel.

The *CQ Health Strategic Plan 2018-2023 (updated 2021)* identifies six 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:

- The vaccine program fails to control the pandemic adversely impacting our ability to be financially sustainable, meet key performance targets and maintain services to meet community health needs – over the course of the reporting period this risk has been constantly monitored and reviewed with the risk reducing as vaccination rates across the State increased. As at 27 April 2022 this risk was removed as a strategic risk for the health service.
- Resources are not sufficient to meet future increases in demand for health services driven by population demographics and lifestyle – the health service is undertaking comprehensive linked planning activities including the Local Area Needs Assessment (LANA), Clinical Services Plan development and subsequent updating of the L2 Master Plan to be able to better ensure appropriate resourcing for projected service demand. These documents will promote the adoption of more contemporary models of care such as virtual care, hospital in the home, telehealth undertaken by multidisciplinary teams to complement existing inpatient and ambulatory care models.
- Aged and outdated infrastructure restrict the delivery of safe and contemporary care, increasing costs and reducing efficiency – Significant work has been under way with projects during the reporting period

including capital improvements such as Gladstone Emergency Department, Emerald Hospital, Rockhampton cardiac laboratory, Woorabinda MPHS, Blackwater MPHS and Moura MPHS.

- The ineffectual roll out of electronic medical records and other ICT infrastructure reduces the ability to deliver innovative and progressive health care and limits the use of virtual care models – A digital first strategy to transform our services providing digital access to patients, consumers, staff and partners has been completed. During the reporting period Integrated and Virtual Care and Remote Patient Monitoring were established, with Telehealth services also expanded with digital health capability and capacity assessed. The telehealth platform software was updated to encompass all services and staff and utilisation increased. A Decision Support Service dashboard has been developed to report on telehealth for admitted and non-admitted patients.
- Inability to recruit and maintain the right staff in the right place compromises the ability to deliver Great Care and Great Patient Experience – During the reporting period the Workforce Division has realigned the Workforce Strategy and service delivery models that embrace interdisciplinary teams with the right skill mix.
- Consumer and community input is not effectively integrated into health service planning and delivery impacting our ability to provide effective health outcomes – The health service has progressed in its initial development of the Aboriginal and Torres Strait Islander Health Equity Statement, improved engagement and collaboration across facilities, including consumer input with launch of new CQHHS Clinical Networks to ensure depth in numbers and diversity including rural representation.

Governance

Our people

Board membership

Cr 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.

Dr Lisa Caffery
Date of original appointment: 18 May 2016
Current term of office: 10 June 2021 – 31 March 2024

Dr Lisa Caffery is a respected business and community engagement leader with more than 20 years' professional experience in regional Queensland. Dr Caffery is the founder and principal of an advisory firm which utilises her strong background in stakeholder relations, performance management and social research. She is currently Board Chair of Sunwater Ltd, Deputy Chair of the Central Queensland Hospital

Foundation and holds several other non-executive board roles in the private and not-for-profit sectors. She resides in Emerald with her young family and is a dedicated advocate for improving health services and outcomes in rural and regional areas. Dr Caffery completed her PhD at Central Queensland University with a research focus on rural health equity and social impact. She holds undergraduate and postgraduate qualifications from the University of Queensland and the University of Southern Queensland. She is also a graduate of the Australian Institute of Company Directors course.

Dr Poya John Sobhanian
Date of original appointment: 18 May 2016
Current term of office: 18 May 2021 – 31 March 2024

Dr Sobhanian's passion is a healthier Central Queensland. Poya is a University of Queensland (UQ) trained Dentist, who completed his placement at the local hospitals of Rockhampton, Yeppoon and Emerald. He later served at Gladstone Oral Health Services and established Sunvalley Dental in Gladstone,

Poya has previously served in local government as a Gladstone Region Councillor, as a Director on the Gladstone Area Water Board and as a Director on the Gladstone Ports Corporation. Poya has a special interest in Audit and Risk having served in multiple Audit committees across different fields. He is Chair of the CQHHS Audit and Risk Committee.

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: 1 April 2022 – 31 March 2026

Ms Tina Zawila has over 35 years' experience in the finance industry. She is a Chartered Accountant, Financial Planner and Business Advisor and is a 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. She was also appointed as a non-Executive Director of the Gladstone Area Water Board in December 2021 and is a member of the Audit and Risk Committee.

Ms Zawila also serves on local not-for-profit boards including Gladstone Area Group Apprentices Limited and Clava Pty Ltd trading as Yaralla Sports Club. 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.

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: 1 April 2022 – 31 March 2026

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 Premier's 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 women of influence.

Mr Matthew Cooke
Date of original appointment: 18 May 2019
Current term of office: 1 April 2022 – 31 March 2026

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

Ms Michelle Webster
Date of original appointment: 1 April 2022
Current term of office: 1 April 2022 – 31 March 2026

Ms Webster has over 30 years' experience as a local government professional serving various communities. Over the past 10 years she has held a senior executive position with Central Highlands Regional Council and has lived and worked within Central Queensland, which has provided a broad understanding of the benefits and challenges of living in rural and remote communities. From a professional perspective Ms Webster has been successful in the executive management of commercial portfolios including Emerald Airport, Saleyards, Quarries, Property acquisitions and disposals and an extensive housing portfolio, including delivery of extensive capital works programs. She has also served as the Executive Officer of the Central Highlands (Qld) Housing Company Limited. Ms Webster understands the importance of service provision to the community having been responsible for the delivery and improvement in customer service outcomes. Ms Webster brings to the Board qualifications in Accounting, Leadership, Management, Project Management and Planning and is the holder of a Bachelor of Commerce degree. She is a graduate and member of the Australian Institute of Company Directors.

Immediate past members

Dr Anna Vanderstaay 18 May 2016 – 1 February 2022

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: as listed below					
Position	Name	Meetings/ sessions attendance	Approved annual fee	Approved annual sub-committee fee per committee	Actual fees received
Chair	Mr Paul Bell AM	10	$75,000	$4,000 (member)	$93,000
Deputy Chair	Dr Lisa Caffery	11	$40,000	$4,000 (chair) $3,000 (member)	$47,000
Member	Dr Poya Sobhanian	9	$40,000	$4,000 (chair) $3,000 (member)	$50,000
Member	Dr Anna Vanderstaay (retired 2 February 2022)	7	$40,000	$4,000 (chair) $3,000 (member)	$28,000
Member	Mr Matthew Cooke	4	$40,000	$4,000 (chair) $3,000 (member)	$35,000
Member	Ms Leann Wilson	7	$40,000	$3,000 (member)	$43,000
Member	Ms Tina Zawila	11	$40,000	$4,000 (chair) $3,000 (member)	$50,000
Member	Professor Fiona Coulson	10	$40,000	$4,000 (chair) $3,000 (member)	$46,000
Member	Mr John Abbott AM	10	$40,000	$4,000 (chair) $3,000 (member)	$47,000
Member	Ms Michelle Webster (appointed April 2022)	2	$40,000	$3,000 (member)	$11,000

No. scheduled meetings/ sessions	11 Board meetings 3 Special Meetings held
Total out of pocket expenses	$309.17

Our committees

During the reporting period the Board had six committees – Executive Committee, Finance and Performance Committee, Quality and Safety Committee, Audit and Risk Committee, Aboriginal and Torres Strait Islander Health and Wellbeing Committee and Investment, Research and Planning Committee.

The composition of the Board's Committees was reconstituted at its meeting of 29 April 2022 following changes to the Board membership during 2022.

Executive Committee

The Executive Committee was chaired by Mr Paul Bell AM for the period 1 July 2021 to 29 April 2022 and from 29 April 2022 by Dr 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 the Health Service 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 the health service.

Finance and Performance Committee

The Finance and Performance Committee was chaired by Ms Tina Zawila. The Finance and Performance Committee is responsible for monitoring and assessing the financial management and reporting obligations of the health service. 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 Performance Committee works in close cooperation with the Health Service Chief Executive and Chief Finance Officer.

Safety and Quality Committee

The Safety and Quality Committee was chaired by Dr Anna Vanderstaay from 1 July 2021 to 2 February 2022 and from 29 April 2022 by Professor Fiona Coulson.

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 Executive Director, Aboriginal and Torres Strait Islander Health and Wellbeing.

Investment, Research and Planning Committee

The Investment, Research and Planning Committee was chaired by Dr Lisa Caffery from 1 July 2021 to 29 April 2022 and from 29 April 2022 by Mr John Abbott.

The objectives of the Investment, Research and Planning Committee includes the oversight and reporting to the Board on matters of strategic importance relating to investment, research and capital planning across the Central Queensland Hospital and Health Service. The committee works in close cooperation with the Health Service Chief Executive and includes in its membership the Chair of CQShines, the Central Queensland Hospital Foundation.

Audit and Risk Committee

Members of the Audit and Risk Committee as at 30 June 2022 comprised:

- Chair: Dr Poya Sobhanian
- Members: Mr John Abbott AM and Ms Michelle Webster
  (Ms Tina Zawila was a member from 1 July 2021 to 29 April 2022)
- Mr Paul Bell AM (ex-officio 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/Queensland Audit Office.

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 met 5 times over the reporting period.

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

Executive management

Dr Emma McCahon
Health Service Chief Executive

Dr McCahon started her career in health as a paediatrician, has 15 years' experience in senior leadership and management roles in New South Wales Health and has held senior executive roles in large health services since 2011. Dr McCahon has strong clinical background and experience in leading turnaround for organisations to achieve financial, clinical, and cultural targets and outcomes. Dr McCahon has an Executive MBA and is a qualified Executive coach, she also has a certificate in Advanced Quality Improvement.

Before joining CQ Health in April 2022, Dr McCahon was Executive Director Medical Services at Western Sydney Local Health District where there are 11,000 staff and 190,000 ED presentations a year. At Western Sydney, Dr McCahon was professional lead for senior and junior medical staff, responsible for research ($70m clinical trial revenue) and Clinical Education as well as the Pandemic Operations Centre Controller. During her time at Western Sydney Dr McCahon also acted in the role of Executive Director Operations (Chief Operating Officer) and Chief Executive for the service, particularly notably during heightened periods of COVID-19 outbreaks in New South Wales.

Dr McCahon was Director of Clinical Operations of the Sydney Children's Hospitals Network for four years from 2015, where she had had oversight of the clinical operations of Children's Hospital at Westmead, Sydney Children's Hospital, and several State-wide services such as: New Born and Paediatric Emergency Transport Services; Perinatal Services Network; Children's Court Clinic; Poisons Information Service and Bear Cottage (Hospice) and responsibility for managing a budget of $740m and a 5000 staff, including nursing, allied health, junior and senior medical staff and clinical support staff.

Mr Colin Weeks
Chief Finance Officer, Assets and Corporate Services

Mr Weeks 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 18 years, Mr Weeks has held senior executive finance positions in the New Zealand and Australia public health sector and sees himself as part of the team in enabling excellent health outcomes to the community.

He is a full member of CPA and a graduate member of the Australian Institute of Company Directors.

Professor Pooshan Navathe
Executive Director Medical Services

Professor Navathe is the professional lead for all medical staff in the Hospital and Health Service. He describes his role as that of an Executive tasked with safety, quality, and system integrity within the Central Queensland Hospital and Health service. Professor Navathe's special interests are safety and governance, the education and mentoring of health professionals, implementing change, and enabling colleagues to attain professional excellence in their practice.

Professor Navathe has been a practising clinician specialising in occupational and aviation medicine for many years and has led those teams in New Zealand and Australia. In addition, he maintains a research interest in many areas and has many publications to his credit. He has been a teacher for the past three decades and maintains academic positions in universities as well as professional medical colleges.

Adjunct Professor Sue Foyle
Executive Director Nursing, Midwifery, Quality and Safety

Adjunct Professor Foyle 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. Adjunct Professor Foyle 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.

Adjunct Professor Foyle is a strong advocate for the profession of nursing and midwifery as well as patient safety and quality. Within CQ Health, Adjunct Professor Foyle has been a finalist and has also won the award for Clinical Excellence in recent years. Adjunct Professor Foyle'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. Adjunct Professor Foyle is well respected as both a national and international speaker on matters of safety and quality in health care.

Mr Andrew Jarvis
A/Executive Director Rockhampton Business Unit

Mr Jarvis has recently been relieving in the Executive Director role for the Rockhampton Business Unit, responsible for service delivery through the Rockhampton Hospital, Capricorn Coast Hospital and Mount Morgan Hospital. Rockhampton Hospital is the largest hospital in Central Queensland and the main referral hub for the region, providing a broad range of specialist medical, allied health and nursing services.

Mr Jarvis commenced his employment with CQ Health in 1994 as a surgical nurse and holds post graduate qualifications in management with a broad experience in surgical and peri-operative services leadership.

Mr Jarvis has a passion for integrated hub-and-spoke models of care that will increasingly work in partnership with other Central Queensland hospitals, specialist hospital services in Brisbane and community and primary care services to increase capacity, expertise and capability across CQ Health to improve local access as we deliver more care closer to home.

Ms Monica Seth
A/Executive Director Gladstone and Rural

Ms Seth's substantive position is Nursing and Midwifery Director – Gladstone and Rural Business Unit. Ms Seth is an experienced registered nurse/midwife with over 35 years of experience. Ms Seth has worked mostly in the public sector in Queensland in rural nursing and midwifery. Ms Seth has held senior nursing and health care management positions over the past 20 years. Supporting and growing our own health care professionals and leaders for the future is a passion for Ms Seth and she strives to ensure this occurs.

Ms Donna Cruickshank
Director Aboriginal and Torres Strait Islander Health and Wellbeing

Ms Cruickshank is the inaugural Executive Director Aboriginal and Torres Strait Islander Health and Wellbeing and commenced with CQ Health in June. Ms Cruickshank will lead the health service in ensuring the future directions of Aboriginal and Torres Strait Islander Health are at the forefront of our service provision by actively seeking to work with our families, communities, and Aboriginal and Torres Strait Islander health partners. Ms Cruickshank has previously held leadership and Executive positions in NSW Health and comes with a broad knowledge of Aboriginal health and workforce; human resources management; cultural education; health service planning; and strategic development. She holds a double Masters Health Service Management and Planning and has won NSW Public Sector Awards for her work in Aboriginal employment and cultural education.

Ms Shareen McMillan
Executive Director Workforce

Ms McMillan is the Workforce Division Executive Director within CQ Health, leading a team of 48 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.

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

Ms Sharon Woods
Executive Director Allied Health

As Executive Director Allied Health, Ms Woods provides leadership and management in the delivery of safe and quality allied health services, supporting coordination of care across the continuum. Ms Woods has held a number of senior clinical and leadership roles and has worked in regional and tertiary metropolitan Queensland health services for over 12 years. She has a very broad understanding of where allied health staff work, and the opportunities they can bring for service improvements and optimising patient care.

Ms Woods has a bachelor degree in health science, a master of nutrition and dietetics majoring in public health nutrition, and further post graduate qualifications in health service management and in health research. She strives to ensure allied health staff continue to lead innovation and transform care, meet the health service objectives and strategic plans, and work to better the health service and our consumers

Organisational structure and workforce profile

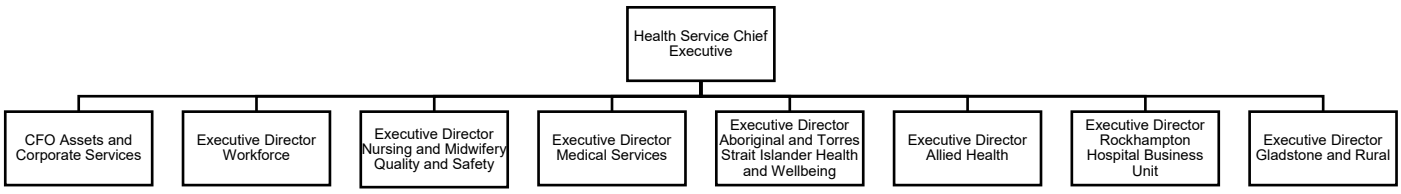

*Table 1: More doctors and nurses**

	2017-18	2018-19	2019-20	2020-21	2021-22
Medical staff [a]	313	328	343	376	357
Nursing staff [a]	1,338	1,385	1,498	1,604	1,641
Allied Health staff [a]	317	318	324	431	424

*Table 2: Greater diversity in our workforce**

	2017-18	2018-19	2019-20	2020-21	2021-22
Persons identifying as being First Nations [b]	92	98	108	115	118

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 26 June 2022.

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

Strategic workforce planning and performance

The CQ Health Workforce Strategy 2020 – 2030 (the Workforce Strategy) aligns with Queensland Health Strategic Health Workforce Planning Framework and outlines our priorities:

- Attract and retain people with the right skills and capabilities, who demonstrate our values and support the needs of our community;
- 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;
- Plan for the future workforce and work collaboratively with each other; and
- Our people reach their best potential through learning and development.

This year's emphasis was on attracting and retaining people. This included the establishment of a Recruitment and Retention Workgroup to action strategies to attract and retain the right fit and enable hiring managers to successfully recruit to fit.

The Workforce Strategy also continues to support the integrated planning for service and infrastructure expansions with the CQ Health Infrastructure Delivery Unit and CQ Health Workforce Planning team collaborating to develop and deliver workforce plans to operationalise the Capital Infrastructure Projects.

Implementation of the Workforce Strategy continues, and progress is reported biannually to the CQ Health Board.

Organisational Cultural Strategy

The *Organisational Cultural Strategy* (OCS) 2020-2030 implementation plan continues to strive towards meeting the seven strategy objectives.

Continual cultural improvement feedback and ideas is supported via the Culture Pulse Staff Engagement Survey, along with a "Share your Ideas" online portal to encourage staff to share suggestions and feedback on how further improvements could be developed towards building a great workplace for all to enjoy.

The Working for Queensland Survey and internal Pulse surveys continue to be valuable tools to collect feedback and informs what initiatives to target to deliver best practice cultural outcomes.

Leadership Development

CQ Health Leadership and Management Development Program aligns with the Framework to inform 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 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.

CQ Health has continued to focus on increasing our leadership and management capability and investing in our leaders. A suite of programs continues to be delivered to a wide cross section of staff, including:

- Expansion of our management essentials program to include courses from the Centre for Leadership Excellence on people, teams and finance.
- Manage4Improvement Program
- Step Up Program
- Take the Lead Program
- Mentoring Program
- Executive and Board Teaming
- Senior Leadership Development Program (Gladstone)
- Conversations That Make a Difference
- Management Essentials Series
- Leadership Summits
- A range of in-house developed leadership programs

Leadership Summits

As part of our CQ Health strategic plan performance indicator to deliver 'Great People, Great place to Work', 166 permanent leaders have now received leadership development training and support. During the reporting period CQ Health hosted three Leadership Summits, with 279 attendees, 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; and helping to identify key priorities for improvement.

Workforce Diversity and Inclusion

At CQ Health, we recognise our diverse workforce and acknowledge the value of our cultural differences and the importance of inclusion as a core component to delivering a culturally competent service to our patients. 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. One of the seven Organisational Culture Strategy 2020-2030 objectives is that 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

CQ Health aims to build awareness, which is supported by a dedicated CQ Health Workforce Diversity & Inclusion Sub-Committee and CQ Health Diversity & Inclusion Annual Action Plan and includes various diversity priority groups.

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.

Continuous improvement of our health, safety and wellbeing management system (SMS) remains ongoing with progress made on actions arising from the external audit and the SMS transition. Successes include the update of local safety information/notice/alert templates, review and update of current procedures, strengthening our commitment to consultation, robust incident investigations and the development of awareness activities to ensure worker understanding.

To support the health and wellbeing of our workforce CQ Health introduced access to a new Employee Assistance Service (EAS) provider. This provider has dedicated phonelines for both First Nations and LGBTIQ+ cohorts along with the regular 24/7 counselling sessions and manager hotlines. Employees continued to be offered up to 10 sessions per year for themselves and their immediate family members. CQ Health actively uses EAS to provide on-the-ground support to our workers for critical incidents and non-urgent workload matters.

CQ Health's commitment to worker consultation continued with the continuation of our Health and Safety Representative (HSR) Network quarterly meetings, and an annual half day forum focusing on practical skills presented by Workforce Safety Wellbeing. The HSRs were given a direct line to the HSCE at the forum which offered a great reciprocal learning opportunity.

Workforce profile

	FTE
Total FTE for Central Queensland Hospital and Health Service	3,513

Early retirement, redundancy and retrenchment

No redundancy/early retirement/retrenchment packages were paid during the period.

CQ Health has Open Data to report on consultancies and the Queensland Language Services Policy. The data can be found on the Queensland Government Open Data website (https://data.qld.gov.au). CQ Health has no Open Data to report on overseas travel.

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 2021-2022 period, no directions were given by the Minister to CQ Health.

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, Certified Practising Accountant Australia (CPA) and the Information Systems Audit and Control Association (ISACA). The health services continue to support their ongoing professional development.

External scrutiny, information systems and recordkeeping

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 Eventide Home Rockhampton but has not been publicly released under the provisions of the Hospital and Health Boards Act 2011.

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 in accordance with the purpose of the *Public Records Act 2002*, 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 schedules 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.

CQ Health not being an ieMR (integrated electronic Medical Record) site has continued to be challenging due to COVID-19, with an increase in the number of paper-based clinical records over the past 2 years, leading to storage issues in all primary, secondary and tertiary record storage.

The efficient disposal of clinical records also continues to be a challenge, noting the new Health Sector (Clinical Records) Retention and Disposal Schedule was introduced in July 2021, replacing previous QDAN 683 v.1

During the reporting period CQ Health was not required to submit any Lost Records to the Queensland State Archives.

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.

Queensland Public Service ethics and values

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.

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. Eleven complaints referring to human rights were received in the July 2021 to June 2022 reporting period.

Of the eleven complaints eight have been investigated and closed with the remaining three currently in progress. Governance committees, including Statewide departments are provided with progress reports to support ongoing monitoring and governance oversight.

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

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.

Performance

Non-financial 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%:
  • Category 1 one day
  • Category 2 two days and
  • Category 3 patients 10 days
• 99% of patients seen within clinically recommended time frame at 30 June each year for:
  • Outpatient appointment
  • Elective surgery
  • Oral health appointment
  • Scope
• Annual reduction in percentage of Severity Assessment Code (SAC) 1 and 2 incidents
• 5% reduction in smoking rate
• 5% annual increase in Telehealth appointments reflecting reduced patient travel
• Increase in compliments received year on year
	The median wait time for elective surgery treatment in CQ Health was reduced by 1.8 per cent, from 55 days in 2020-2021 to 54 days in 2021-2022.
	In response to the COVID-19 pandemic the delivery of planned care services has been impacted. This has resulted from occasions of temporary suspension of routine planned care services to manage priority demand, increased cancellations resulting from patient illness and staff furloughing as a result of illness or Health Service Directives.
	There was a continued impact in the delivery of outpatient appointments, oral health appointments and endoscopy procedures.
	There was a 27.8 per cent increase in the number of Severity Assessment Code (SAC) 1 incidents from 18 to 23 and a 4.3 per cent decrease in the number of SAC 2 incidents from 116 to 111.
	Since the 10000LivesCQ program was launched in November 2017 over 12,983 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 2021. These are the latest available figures on smoking rates.
	Telehealth appointments continue to reduce the need for patient travel. There was 0.6 per cent increase in telehealth appointments, with18,274 telehealth outpatient service events in the reporting period, compared to 18,158 in the previous year.
	During the reporting period, 1005 compliments were received compared with 1204 compliments in 2020-2021.

Great People, Great Place to Work *Great staff working in great teams with a culture of supporting and investing in our people's future*	A measure of the service's ability to retain staff is the permanent separation rate. During 2021-2022 the permanent separation rate was 11.23 per cent, consistent with the increased rate experienced by Queensland Health. Across the 10 Working for Queensland factors the results for CQ Health were similar to the prior year results with all 10

• Workforce retention rates improve • Improvement against Working for Queensland key indicators • Aboriginal and Torres Strait islander employment targets met • Rate of locum and agency staff usage is reduced • 150 staff receive leadership training	factors being within 7% of last year's results, showing improvement in 3 and minor reduction in the remaining 7. Minimum employment targets were met for Aboriginal and/or Torres Strait Islander staff, averaging 3.14% throughout the reporting period against minimum target of 3%. Locum usage reduced by 16% and Agency increased by 11% for this reporting period. 166 permanent leaders received leadership development training and support.
Great Learning and Research *Great place to learn, research and shape the future of healthcare* • Increase Research Ready grant applications • Increase ethics applications • More education programs developed, delivered or reviewed • More clinical placements	Nine teams and 47 individuals submitted Research Ready grant applications, a slight decrease from 11 team and 57 individual applications in the previous year. The number of ethics applications increased from 22 in 2020-2021 to 29 in 2021-2022. In the past 12 months ten nurses have completed a training course to undertake the role of Sexual Assault Nurse Examiner across the health service. The Mental Health Nurse Academic Partnership program was delivered jointly by mental health professionals from CQ Health and CQUniversity lecturers with a blended approach of face-to-face workshops, competency skills assessments and academic assignments delivered on-line. This partnership program replaces the state-wide Transition Support Program (TSP), which has previously been used to support the transitioning graduate nurses and other staff. A total of 104 staff undertook Transition to Practice Programs. CQ Health was provided one of five pilot programs in clinical supervision for nursing and midwifery from the Office of the Chief Nursing and Midwifery Officer to support the rollout of the clinical supervision framework for Queensland Nurses and Midwives. In partnership with Mater Education Centre and the Clinical Excellence Division CQ Health offered its first Stillbirth Improve Workshop, with great feedback received from participants. CQ Health supported 365 separate student nursing and midwifery placements across Central Queensland, equating to 46,216 hours of support. Additionally, CQ Health supported 1060 hours of re-entry nursing placement and 418 hours to Queensland Ambulance Service.

	CQ Health took 159 graduate nurses and midwives compared with 89 the previous year. Graduate nurses are provided the opportunity to enrol in a masters of clinical nursing program in partnership with CQUniversity. This program is jointly facilitated by CQUniversity and the health service's Education and Research Unit staff and has also been expanded to 5 other health services across Queensland. In 2021, 30 graduates were enrolled in the program and in 2022 this has increased to 40 (which is more than 50% of the cohort). CQ Health's Medical Education Unit provided intern training including the ALSi (Advanced Life Support for interns) program, ultrasound guide cannulation workshop, acute care skills workshop and Resident Medical Officer (RMO) education including RMO Masterclass lunchtime education sessions and role play practice sessions. The Medical Education Unit also provided monthly Grand Rounds which address a variety of quality and safety topics, open to all staff. In 2021-2022, allied health clinicians continued to provide contribution to the high school program Prevention of Alcohol Related Trauma in Youth (P.A.R.T.Y.), in collaboration with nursing teams. In 2021 allied health offered 5735 days of clinical placement across the health service. Of these offers, 3893 days were accepted and provided across Rockhampton, Gladstone, Biloela, and Emerald locations. In 2022, allied health offered over 5574 days of clinical placement. To date, 1824 days have been accepted and provided across the health service with more to be provided in the second semester. Allied health commenced hosting the practical component of the Certificate III in Allied Health Assistance for students from Central Queensland University. Various professions across allied health have facilitated and delivered local student education programs to students attending placement in the health service. Allied Health clinicians and assistants attended local Continuing Professional Development education for their profession, delivered by clinicians within the health service. In 2021 allied health established a targeted training fund for CQ Health to support allied health workforce development and workload management. There were 24 successful programs supported under this scheme bringing leading experts to

	Central Queensland to deliver training and development or supporting clinicians to visit exemplar sites to bring clinical programs and protocols back to Central Queensland.
Great Partnerships *Working collaboratively with our partners to deliver great care and improve the health of Central Queenslanders* • Service Level Agreements established with private service providers • Full medical program is delivered in partnership with key providers • Aboriginal and Torres Strait Islander community is involved in the co-design of culturally appropriate care • Closing the gap milestones for 2023 achieved	CQ Health continues to establish Service Level Agreements with private service providers as required (for example, to provide services such as radiology and ophthalmology). The Regional Medical Pathway partnership achieved significant milestones including the expansion of the Governance Framework to include key workgroups with representation from each partner organisation. The first cohort of CQUniversity's Bachelor of Medical Science (Pathway to Medicine) students commenced in March. CQ Health's Aboriginal and Torres Strait Islander Health and Wellbeing Unit continued engagement activities to deliver culturally appropriate services, particular in response to COVID-19 and in the planning of the Health Equity Strategy. Progress continued towards achieving closing the gap milestones set out in the health service's roadmap to delivering *Destination 2030: Great Care for Central Queenslanders.* Milestones for 2021-2022 focused on development of a Health Equity strategy and recruitment. Employment targets were met for Aboriginal and/or Torres Strait Islander staff. The health service appointed the inaugural Executive Director Aboriginal and Torres Strait Islander Health and the directorate expanded with recruitment of the Project Manager Health Equity and the Nurse Unit Manager Aboriginal and Torres Strait Islander Health.

Sustainable Future
Securing the future of great healthcare with efficient, effective, affordable and sustainable services
• Break even to 1% budget surplus for reinvestment
• Continue development of or open:
  ○ Mental Health Unit refurbishment and expansion
  ○ Emerald Hospital Emergency Department
  ○ 42-bed residential drug and alcohol centre at Rockhampton
	CQ Health achieved a surplus of 0.23 per cent of actual budget for 2021-2022.
	Development continues on the Emerald Hospital Emergency Department. Project works started mid 2022.
	The Rockhampton Residential Rehabilitation and Withdrawal Management Service for adults commenced on 6 December 2021 and is named Binbi Yadubay.
	Work is under way on the model of care and business case for the Cardiac Theatre in Rockhampton.
	Planning continues for renal dialysis at Yeppoon and Mental Health Unit refurbishment and expansion.

○ Cardiac Theatre at Rockhampton Hospital ○ Renal dialysis at Yeppoon • 5% annual reduction in medical labour spend on locums.	CQ Health achieved a 6% annual reduction in labour spend on locums.

Service standards

Central Queensland Hospital and Health Service	2021-2022 Target	2021-2022 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%	68%
• Category 3 (within 30 minutes)	75%	69%
• Category 4 (within 60 minutes)	70%	80%
• Category 5 (within 120 minutes)	70%	95%
Percentage of emergency department attendances who depart within 4 hours of their arrival in the department[1]	>80%	75%
Percentage of elective surgery patients treated within the clinically recommended times[2]		
• Category 1 (30 days)	>98%	89%
• Category 2 (90 days)[3]	..	77%
• Category 3 (365 days)[3]	..	79%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days[4]	<2	0.5
Rate of community mental health follow up within 1-7 days following discharge from an acute mental health inpatient unit[5]	>65%	60.5%
Proportion of re-admissions to acute psychiatric care within 28 days of discharge[6]	<12%	5.0%
Percentage of specialist outpatients waiting within clinically recommended times[7]		
• Category 1 (30 days)	98%	70%
• Category 2 (90 days)[8]	..	44%
• Category 3 (365 days)[8]	..	61%
Percentage of specialist outpatients seen within clinically recommended times[7]		
• Category 1 (30 days)	98%	85%
• Category 2 (90 days)[8]	..	59%
• Category 3 (365 days)[8]	..	59%
Median wait time for treatment in emergency departments (minutes)[1]	..	15
Median wait time for elective surgery treatment (days)[2]	..	54
Efficiency measure		
Average cost per weighted activity unit for Activity Based Funding facilities[9]	$5,070	$5,468
Other measures		
Number of elective surgery patients treated within clinically recommended times[2]		
• Category 1 (30 days)	1,876	1,487
• Category 2 (90 days)[3]	..	1,355
• Category 3 (365 days)[3]	..	743
Number of Telehealth outpatients service events[10]	17,133	18,274
Total weighted activity units (WAU)[11]		

• Acute Inpatients	51,030	48,868
• Outpatients	13,306	10,744
• Sub-acute	4,785	6,396
• Emergency Department	19,625	16,686
• Mental Health	5,419	4,747
• Prevention and Primary Care	2,774	2,628
Ambulatory mental health service contact duration (hours)[12]	>38,352	33,839
Staffing[13]	3,419	3,513

1	During the COVID-19 pandemic Emergency Departments across Queensland were presented with demand from both COVID-19 and regular patients. In response many public Emergency Departments established fever clinics to assess and treat suspected COVID-19 cases in a safe and effective manner. As fever clinic services represent an extension of regular operational services and as a result, the 2021-2022 Actual includes some fever clinic activity. Emergency Department performance (including POST) has been impacted by the increased patient treatment time and resources required to manage COVID-19 precautions.
2	In response to the COVID-19 pandemic the delivery of planned care services has been impacted. This has resulted from occasions of temporary suspension of routine planned care services to manage priority demand, increased cancellations resulting from patient illness and staff furloughing as a result of illness or Health Service Directives.
3	As the system focuses to manage the backlog of deferred care patients, treated in time performance will continue to be impacted. As a result, the continuation of treat in time performance targets for category 2 and 3 patients applicable for 2021-2022 will be carried forward into 2022-2023.
4	Staphylococcus aureus (including MRSA) bloodstream (SAB) infections 2021-2022 Estimated Actual rate is based on data reported between 1 July 2021 and 31 March 2022.
5	Mental Health rate of community follow up 2021-2022 Actuals are as of 16 August 2022.
6	Mental Health readmissions 2021-2022 Actuals are for the period 1 July 2021 to 31 May 2022, as of 16 August 2022.
7	In response to the COVID-19 pandemic the delivery of planned care services has been impacted. This has resulted from occasions of temporary suspension of routine planned care services to manage priority demand, increased cancellations resulting from patient illness and staff furloughing as a result of illness or Health Service Directives.
8	As the system focuses to manage the backlog of deferred care patients, treated in time performance will continue to be impacted. As a result, the continuation of treat in time performance targets for category 2 and 3 patients applicable for 2021-2022 will be carried forward into 2022-2023.
9	The 2021-2022 Target varies from the published 2021-2022 Service Delivery Statement due to a change in the WAU phase. All measures are reported in QWAU Phase Q24. The variation in difference of Cost per WAU to target is a result of the additional costs of the COVID-19 pandemic. 2021-2022 Actuals are as of 22 August 2022.
10	Telehealth 2021-2022 Actual is as of 18 August 2022.
11	The 2021-2022 Actual is below target due to a decrease in routine care services resulting from occasions of temporary suspension of routine planned care services to manage priority demand, increased cancellations resulting from patient illness and staff furloughing as a result of illness or Health Service Directives. The 2021-2022 Target varies from the published 2021-2022 Service Delivery Statement due to a change in the WAU phase. All measures are reported in QWAU Phase Q24. The 2021-2022 Actual figures are as of 22 August 2022. As the Hospital and Health Services have operational discretion to respond to service demands and deliver activity across services streams to meet the needs of the community, variation to the Target can occur.
12	Due to a range of factors, including the stretch nature of the target and the impact of the COVID-19 pandemic on service access and capacity, the 2021-2022 Target has not been met. Figures are as of 16 August 2022.
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. 2021-2022 Actual is for pay period ending 26 June 2022.

Financial summary

CQ Health reported an operational surplus of $1.766 million and a total comprehensive income surplus result of $28.789 million for the 2021-22 financial year.

The continued impact of COVID-19 resulted in direct labour and non-labour costs of $26.954 million for the 2021-22 financial year, relating to servicing fever clinics, vaccination programs and COVID-19 inpatient care.

The challenge to permanently recruit to clinical positions continued, causing a significant impact on 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 2022, CQ Health had reported anticipated maintenance of $12.5 million.

CQ Health has the following strategies in place to mitigate any risks associated with these items:

- seek assistance from Priority Capital Program
- annual maintenance plan
- maintain the operational maintenance budget

Key financial highlights are outlined in the table below:

Measures	2021-22 Actuals $'000s	2020-21 Actuals $'000s
Income	766,972	698,395
Expenses	765,206	701,096
Operating result	1,766	(2,701)
Cash and cash equivalents	12,873	3,170
Total assets	501,752	469,714
Total liabilities	49,322	39,750
Total equity	452,430	429,964

Financial Statements - 30 June 2022

STATEMENT OF COMPREHENSIVE INCOME

Year ended 30 June 2022

OPERATING RESULT	Notes	2022 $'000	2021 $'000
Income			
User charges and fees	B1-1	**59,007**	56,671
Funding for public health services	B1-2	**679,042**	612,056
Grants and other contributions	B1-3	**26,095**	25,217
Other revenue	B1-4	**2,828**	4,451
		766,972	698,395
Total income		**766,972**	698,395
Expenses			
Employee expenses	B2-1	**78,600**	75,925
Health service employee expenses	B2-2	**419,142**	389,564
Supplies and services	B2-3	**210,165**	191,864
Other expenses	B2-4	**16,885**	15,991
Depreciation	C5-1,C9	**40,414**	27,752
Total expenses		**765,206**	701,096
Operating result		**1,766**	(2,701)
Other comprehensive income			
Items that will not be reclassified to operating result			
Increase/(decrease) in asset revaluation surplus	C7-2	**27,023**	1,625
Total other comprehensive income		**27,023**	1,625
Total comprehensive income		**28,789**	(1,076)

The accompanying notes form part of these financial statements

STATEMENT OF FINANCIAL POSITION

As at 30 June 2022

	Notes	2022 $'000	2021 $'000
Current assets			
Cash and cash equivalents	C1	**12,873**	3,170
Receivables	C2-1	**13,401**	12,042
Contract assets	C8-1	**1,458**	1,380
Inventories	C3	**4,997**	5,803
Other assets	C4	**1,044**	1,479
Total current assets		**33,773**	23,874
Non-current assets			
Property, plant and equipment	C5-1	**467,166**	444,755
Right-of-use assets	C9	**813**	1,085
Total non-current assets		**467,979**	445,840
Total assets		**501,752**	469,714
Current liabilities			
Payables	C6	**46,468**	38,136
Lease liabilities	C9,CF-2	**634**	847
Contract liabilities	C8	**2,184**	646
Total current liabilities		**49,286**	39,629
Non-current liabilities			
Lease liabilities	C9,CF-2	**36**	121
Total non-current liabilities		**36**	121
Total liabilities		**49,322**	39,750
Net assets		**452,430**	429,964
Equity			
Contributed equity		**390,459**	396,782
Accumulated surplus/(deficit)		**(13,346)**	(15,112)
Asset revaluation surplus	C7-2	**75,317**	48,294
Total equity		**452,430**	429,964

The accompanying notes form part of these financial statements

STATEMENT OF CHANGES IN EQUITY

Year ended 30 June 2022

	Accumulated surplus $'000	Asset revaluation surplus $'000	Contributed equity $'000	Total equity $'000
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**
Opening balance as at 1 July 2021	(15,112)	48,294	396,782	429,964
Operating result				
Operating result from continuing operations	1,766	-	-	1,766
Other comprehensive income				
Increase/(decrease) in asset revaluation surplus	-	27,023	-	27,023
Total comprehensive income for the year	1,766	27,023	-	28,789
Transactions with owners as owners:				
Net assets transferred (Note C7-1)	-	-	15,854	15,854
Equity injections - minor capital works	-	-	18,237	18,237
Equity withdrawals - depreciation funding	-	-	(40,414)	(40,414)
Net transactions with owners as owners	-	-	(6,323)	(6,323)
Balance at 30 June 2022	**(13,346)**	**75,317**	**390,459**	**452,430**

The accompanying notes form part of these financial statements

STATEMENT OF CASH FLOWS
Year ended 30 June 2022

	Notes	2022 $'000	2021 $'000
Cash flows from operating activities			
Inflows:			
User charges and fees		**63,994**	54,778
Funding public health services		**638,165**	585,168
Grants and other contributions		**18,275**	17,783
GST input tax credits from ATO		**13,457**	12,834
GST collected from customers		**699**	706
Other receipts		**2,579**	3,835
Outflows:			
Employee expenses		**(78,226)**	(77,768)
Health service employee expenses		**(416,163)**	(381,566)
Supplies and services		**(208,477)**	(198,312)
GST paid to suppliers		**(13,849)**	(12,759)
GST remitted to ATO		**(725)**	(666)
Interest payments on lease liabilities		**(5)**	(6)
Other		**(8,308)**	(8,121)
Net cash provided by / (used in) operating activities	CF-1	**11,416**	(4,094)
Cash flows from investing activities			
Inflows:			
Proceeds from the sale of property, plant and equipment		**41**	30
Outflows:			
Payments for property, plant and equipment		**(18,359)**	(11,285)
Net cash (used in) investing activities	CF-3	**(18,318)**	(11,255)
Cash flows from financing activities			
Inflows:			
Equity injections		**18,237**	12,475
Outflows:			
Principal payments of lease liabilities	CF-2	**(1,632)**	(1,382)
Net cash provided by financing activities	CF-3	**16,605**	11,093
Net increase/(decrease) in cash and cash equivalents		**9,703**	(4,256)
Cash and cash equivalents at the beginning of the financial year		**3,170**	7,426
Cash and cash equivalents at the end of the financial year	C1	**12,873**	3,170

The accompanying notes form part of these financial statements

NOTES TO THE STATEMENT OF CASH FLOWS

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

	2022 $'000	2021 $'000
Operating surplus/(deficit)	**1,766**	(2,701)
Non-cash items included in operating result:		
Depreciation	**40,414**	27,752
Funding for depreciation	**(40,414)**	(27,752)
Net gain on disposal of non-current assets	**(41)**	(30)
Loss on revaluation of land above asset reserve	**-**	231
Service below fair value - revenue	**8,226**	7,348
Service below fair value - expense	**(8,226)**	(7,348)
Changes in assets and liabilities:		
(Increase)/decrease in receivables	**647**	(2,045)
(Increase)/decrease in funding receivables	**(1,588)**	(2,507)
(Increase)/decrease in GST receivables	**(392)**	75
(Increase)/decrease in inventories	**806**	(858)
(Increase)/decrease in contract assets	**(78)**	4,901
(Increase)/decrease in prepayments	**435**	(1,244)
Increase/(decrease) in payables	**4,966**	925
Increase/(decrease) in lease liabilities	**(298)**	(16)
Increase/(decrease) in accounts payable	**328**	(5,777)
Increase/(decrease) in accrued contract labour	**2,979**	7,998
Increase/(decrease) in contract liabilities and unearned income	**1,538**	(1,241)
Increase/(decrease) in accrued employee benefits	**374**	(1,845)
Increase/(decrease) in GST payable	**(26)**	40
Net cash used in operating activities	**11,416**	**(4,094)**

CF-2 Changes in liabilities arising from financing activities

	2022				2021			
	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	**968**	**1,334**	**(1,632)**	**670**	984	1,366	(1,382)	968
Total	**968**	**1,334**	**(1,632)**	**670**	984	1,366	(1,382)	968

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 to Note B1-4) or expenses (refer to Note B2-4) as applicable.

The accompanying notes form part of these financial statements

SECTION A BASIS OF REPORT PREPARATION

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 responsible 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 2022, 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 2022-23 to 2024-25 financial years. 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 and 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 flow 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.

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.

SECTION B NOTES ABOUT OUR FINANCIAL PERFORMANCE

B1 REVENUE

Note B1-1: User charges and fees

	2022 $'000	2021 $'000
Revenue from contracts with customers		
Pharmaceutical Benefits Scheme	**26,850**	25,450
Sales of goods and services	**7,222**	6,672
Hospital fees	**23,180**	22,897
Other user charges and fees		
Revenue leases	**1,755**	1,652
Total revenue from contracts with customers	**59,007**	56,671

User charges and fees - accounting policies and disclosures

Revenue from contracts 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

	2022 $'000	2021 $'000
National Health Reform		
Revenue from contract with customers		
Activity based funding	**439,392**	404,166
Total revenue from contracts with customers	**439,392**	404,166
Other funding public health services		
Block funding	**90,517**	86,295
Teacher training funding	**15,757**	12,882
General purpose funding	**133,376**	108,713
Total revenue from other funding public health services	**239,650**	207,890
Total	**679,042**	612,056

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 2021-22 was $239m (2021: $198m).

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.

Due to the COVID-19 pandemic the Commonwealth Government has agreed to provide a guaranteed Activity Based Funding (ABF) envelope for the 2021-22 financial year under the National Health Reform Agreement (commonly known as a Minimum Funding Guarantee MFG). For the period July 2021 to December 2021, a partial MFG has been applied to funding sources outside of those exclusively funded by the state or funding listed as specific funding investment within the service agreement. This MFG for this period is 45% of the calculated penalty associated with under delivered activity for the period. For the months of January 2022 to June 2022, a full MFG has been applied to both the state and commonwealth portion of funding, resulting in no financial adjustments for the under delivery associated with this period against ABF 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. The net revenue from the operation of the car park will be retained by CQHHS to offset this reduction in funding. The GPM payment amount for the 2021-22 financial year is $465,000, (2020-21 $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.
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

	2022 $'000	2021 $'000
Revenue from contracts with customers		
Nursing home grants	**12,191**	10,894
Home support services	**618**	873
Transition care programs	**1,765**	2,139
Other revenue contracts	**1,820**	2,269
Total revenue from contract with customers	**16,394**	16,175
Grants and contributions		
Specific purpose grants	**582**	1,048
Other grants	**762**	549
Donations, bequests, other contributions	**131**	97
Services received below fair value		
Services received below fair value	**8,226**	7,348
Total grants and contributions	**9,701**	9,042
Total	**26,095**	25,217

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.

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 eligible 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.
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.

B1 REVENUE (continued)

Types of goods and services	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policies
Grants and 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.
Services 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.

B1-4: Other revenue

	2022 $'000	2021 $'000
Proceeds	**21**	14
Regulatory fees	**27**	24
Salary recoveries	**2,392**	2,604
Insurance recoveries	**-**	33
Other revenue	**388**	1,776
Total	**2,828**	4,451

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

	2022 $'000	2021 $'000
Employee benefits		
Wages and salaries	**67,097**	65,004
Annual leave levy	**4,357**	4,037
Employer superannuation contributions	**5,109**	4,815
Long service leave levy	**1,567**	1,517
Termination benefits	**1**	145
Employee related expenses		
Workers compensation premium	**219**	176
Other employee related expenses	**250**	231
Total	**78,600**	75,925

Note B2-2: Health service employee expenses

	2022 $'000	2021 $'000
Department of Health Queensland - health service employees	**419,142**	389,564
Total	**419,142**	389,564

	2022 No.	2021 No.
Full-Time Equivalent (FTE) Employees at 30 June	**153**	159
Full-Time Equivalent Health Service employees at 30 June	**3,360**	3,313
Total	**3,513**	3,472

*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 the 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 wage 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 $0.524m of COVID leave for the 2021-22 financial year, (2020-21: $1.344m).

An additional two days of leave was granted to all non-executive employees of the Department of Health and HHS's on 14 September 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.

In the 2020-21 financial year CQHHS paid the entire value of the leave of $2.175m to the Department of Health in advance. The leave is 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 Australian Retirement Trust. The Australian Retirement Trust 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 contributions 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 Notes 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 have been offset against the salary and wages cost in accordance with AASB 119 Employee Benefits.

Note B2-3: Supplies and services

	2022	2021
	$'000	$'000
Consultants and contractors	**30,286**	29,407
Electricity and other energy	**5,941**	5,609
Patient travel	**19,322**	19,612
Other travel	**1,330**	1,300
Building services^	**6,882**	6,065
Computer services	**3,443**	2,947
Motor vehicles	**1,749**	1,626
Communications	**8,132**	7,930
Repairs and maintenance	**11,425**	10,860
Minor works including plant and equipment	**1,118**	2,386
Short-term leases	**89**	195
Inventories consumed - held for distribution		
Drugs	**32,372**	29,775
Clinical supplies and services	**22,998**	19,437
Catering and domestic supplies	**8,092**	7,495
Outsourced service delivery		
Medical	**23,843**	19,596
Other services	**7,026**	4,053
Pathology, blood and parts	**21,013**	18,744
Other	**5,104**	4,827
Total	**210,165**	191,864

^ 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 C9 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

	2022 $'000	2021 $'000
External audit fees	**183**	183
Other audit fees	**-**	9
Insurance premiums	**6,426**	6,116
Losses from disposal of non-current assets	**1**	-
Special payments - ex gratia payments	**4**	6
Other legal costs	**63**	205
Advertising	**488**	362
Grants distributed	**552**	560
Interpreter fees	**41**	46
Impairment losses on trade receivables	**203**	139
Services received below fair value	**8,226**	7,348
Interest on lease payments	**5**	6
Other expenses	**693**	780
Revaluation decrement on land	**-**	231
Total	**16,885**	15,991

Accounting policy – other expenses

Audit fees

The external audit fee for 2022 is $183,000; (2021: $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 2021-22 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 2021-22 include the following payments over $5,000:

- Reimbursement of medical costs totalling $4,331 (2021: $6,180).

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.

SECTION C NOTES ABOUT OUR FINANCIAL POSITION

C1 CASH AND CASH EQUIVALENTS

	2022 $'000	2021 $'000
Imprest accounts	**12**	12
Cash at bank	**10,916**	1,221
QTC cash funds	**1,945**	1,937
Total	**12,873**	3,170

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 2022 as well as deposits at call with financial institutions.

C2 RECEIVABLES

Note C2-1: Receivables

	2022 $'000	2021 $'000
Trade debtors	**5,280**	5,938
Less: Loss allowance	**(98)**	(109)
	5,182	5,829
GST receivable	**1,680**	1,288
GST payable	**(50)**	(76)
	1,630	1,212
Other fees and charges receivable	**6,589**	5,001
Total	**13,401**	12,042

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 the 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 2022 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

	2022				2021			
	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	**-**	**13.97%**	**-**	**-**	-	13.38%	-	-
Private health funds	**3,436**	**-**	**-**	**3,436**	3,947	-	-	3,947
Medicare ineligible	**927**	**9.66%**	**(90)**	**837**	799	12.60%	(101)	698
Other Government agencies	**1,100**	**0.74%**	**(8)**	**1,092**	1,149	0.74%	(8)	1,141
Other debtor & payroll	**6,327**	**-**	**-**	**6,327**	4,473	-	-	4,473
Lease receivables	**6**	**-**	**-**	**6**	417	-	-	417
Australian Taxation Office	**73**	**-**	**-**	**73**	154	-	-	154
Total Receivables	**1,630**	**-**	**-**	**1,630**	1,212	-	-	1,212
	13,499	**0.73%**	**(98)**	**13,401**	12,151	0.90%	(109)	12,042

Disclosure – movement in expected credit losses for trade and other debtors

	2022	2021
	$'000	$'000
Balance at 1 July	**109**	196
Amounts written off during the year	**(60)**	(134)
Amounts recovered during the year	**1**	3
Increase/(decrease) in allowance recognised in operating result	**48**	44
Balance at 30 June	**98**	109

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 D1-3 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 uncollectible, 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 $0.06 million (2021: $0.134 million).

C3 INVENTORIES

Note C3-1: Inventories

	2022 $'000	2021 $'000
Inventories held for distribution - at cost		
Clinical supplies	**3,470**	4,388
Catering and domestic	**33**	126
Pharmacy drugs	**1,493**	1,288
Other	**1**	1
Total	**4,997**	5,803

Accounting policy – inventories

Inventories are held for distribution 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.

An annual stocktake is undertaken of imprest clinical supply holdings.

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

C4 OTHER ASSETS

Note C4-1: Other assets

	2022 $'000	2021 $'000
Prepayment- COVID Response Leave	**307**	831
Other prepayments	**737**	648
Total	**1,044**	1,479

Accounting policy – COVID response leave

On 14 September 2020 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 is 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 2022	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Gross	**15,577**	**997,722**	**71,281**	**6,585**	**1,091,165**
Less: Accumulated depreciation	**-**	**(582,942)**	**(41,057)**	**-**	**(623,999)**
Carrying amount at 30 June 2022	**15,577**	**414,780**	**30,224**	**6,585**	**467,166**
Represented by movements in carrying amount:					
Carrying amount at 1 July 2021	**14,644**	**394,097**	**33,270**	**2,744**	**444,755**
Transfers in from other Queensland Government entities	**670**	**15,040**	**144**	**-**	**15,854**
Acquisitions	**-**	**-**	**6,686**	**11,674**	**18,360**
Transfers between classes	**-**	**7,833**	**-**	**(7,833)**	**-**
Net revaluation increments/(decrements)	**263**	**26,759**	**-**	**-**	**27,022**
Depreciation expense	**-**	**(28,949)**	**(9,876)**	**-**	**(38,825)**
Carrying amount at 30 June 2022	**15,577**	**414,780**	**30,224**	**6,585**	**467,166**

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
Disposals	-	-	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

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 an option period where the 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 2021-22, CQHHS's land was valued by SVS using market indices. The effective date of valuation was 30 June 2022. 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 market data 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 2022 resulted in $0.264 million increment in the fair value currently recorded (2021: $0.231 million decrement).

Buildings

In 2021-22 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 2022.

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.

The impact of the valuation exercise conducted in April 2022, with an effective date as at 30 June 2022, resulted in a building current replacement cost net increment of $26.759m (2021: Nil). The valuation result was largely due to an 8% increase in indexation valuation as recommended by AECOM in 2021-22 due to the rising construction costs.

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	
	2022	**2021**	**2022**	**2021**	**2022**	**2021**
	$'000	**$'000**	**$'000**	**$'000**	**$'000**	**$'000**
Land	**15,577**	14,644	**-**	-	**15,577**	14,644
Buildings	**-**	-	**414,780**	394,097	**414,780**	394,097
Total	**15,577**	14,644	**414,780**	394,097	**430,357**	408,741

C6 PAYABLES

	2022	2021
	$'000	$'000
Trade creditors	**12,499**	12,171
Accrued health service labour - Department of Health Queensland	**27,112**	24,133
Accrued employee benefits	**1,258**	884
Other	**5,599**	948
Total	**46,468**	38,136

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 vendor's 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 $15.854 million funding from the State as equity injections in 2022 (2021: $45.882 million). These outlays are paid by the Department of Health Queensland on behalf of the State.
- CQHHS received $40.414 million funding in 2022 (2021: $27.752 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

	2022	2021
	$'000	$'000
Transfer in - practical completion of projects from the Department of Health	**15,710**	45,159
Net transfer equipment between Hospital and Health Services	**-**	8
Net transfer equipment from the Department of Health	**144**	715
	15,854	45,882

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 have been transferred under this arrangement.

Note C7-2: Asset revaluation surplus by class

	Land	Buildings	2022 Total	2021 Total
	$'000	$'000	$'000	$'000
Balance 1 July	**-**	**48,294**	**48,294**	46,669
Revaluation increments/(decrements)	**264**	**26,759**	**27,023**	1,625
Balance 30 June	**264**	**75,053**	**75,317**	48,294

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.

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 2022, 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 on 1 July 2021, $0.646m was recognised as revenue in 2021-22.

The contract liabilities at 30 June 2022 includes $0.432m for various programs including The Australasian College for Emergency Medicine (ACEM), The Australasian College of Physicians (RACP) and Together in Minds programs where funds have been received in advance. This amount will be recognised as revenue in the 2022-23 financial year. A total $1.752m relates to various programs including: Care4QLD ($0.608m), Gladstone West-Wing Perioperative ($0.503m) and COVID Mental Health Package ($0.641m), where the milestones have not been achieved. These funds will be clawback by the Department in the 2022-23 financial year.

Note C8-1: Contract balances

	2022 $'000	2021 $'000
Contract assets - revenue receivable	**-**	-
Contract assets - revenue accruals	**1,458**	1,380
Total contract assets	**1,458**	1,380
Contract liabilities – revenue received in advance	**432**	26
Contract liabilities - refunds payable	**1,752**	620
Total contract liabilities	**2,184**	646

C9 RIGHT OF USE ASSETS AND LEASE LIABILITIES

Note C9-1: Leases as a Lessee **30 June 2022**	**Right-of-use assets** **Buildings** **$'000**	**Total** **$'000**
Carrying amount at 1 July 2021	**1,085**	**1,085**
Additions	**1,334**	**1,334**
Disposals	**(17)**	**(17)**
Amortisation expense for the year	**(1,589)**	**(1,589)**
Carrying amount at 30 June 2022	**813**	**813**

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**

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 is 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 the 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 interest is added back to the lease liabilities 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 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

	2022 $'000	2021 $'000
Amounts recognised in surplus or (deficit)		
Interest expense on lease liabilities	**5**	6
Short-term leases included in Note B2-3	**89**	195
Total cash outflow for leases	**94**	201

Note C9-3: 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. 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.

	2022 $'000	2021 $'000
Buildings		
No later than 1 year	**1,455**	1,960
Later than 1 year but no later than 5 years	**2,387**	4,502
Later than 5 years	**76**	133
Total	**3,918**	6,595

CQHHS has 10 operating leases for the 2021-22 (14: 2020-21) financial year with various parties on different terms and conditions for property and accommodation. The amount of $1.755 million has been received from leases held as a lessor in the 2021-22 financial year; (2021: $1.652 million).

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	2022 $'000	2021 $'000
Financial assets			
Cash and cash equivalents	C1	**12,873**	3,170
Financial assets at amortised cost:			
Receivables	C2-1	**13,401**	12,042
Total		**26,274**	15,212
Financial liabilities			
Payables	C6	**46,468**	38,136
Lease Liabilities	CF-2	**670**	968
Total		**47,138**	39,104

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 2022.

	2022				2021			
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	**46,468**	**46,468**	**-**	**-**	38,136	38,136	-	-
Lease Liabilities	**670**	**634**	**36**	**-**	968	847	121	-
Total	**47,138**	**47,102**	**36**	**-**	39,104	38,983	121	-

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 into 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 through 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 2022 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 2022.

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 rates have a minimal effect on the operating result of CQHHS.

D2 CONTINGENCIES

(a) Litigation in progress

As at 30 June 2022, the following cases were filed in the courts naming the State of Queensland acting through CQHHS as the defendant:

	2022 Number of cases	2021 Number of cases
Supreme Court	**4**	3
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 2022, CQHHS has 33 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 $660,000.

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 2022, 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:

	2022 $'000	2021 $'000
Property, Plant and Equipment		
No later than 1 year	**136**	11,510
Later than 1 year but no later than 5 years	**7,717**	-
Later than 5 years	**-**	-
Total	**7,853**	11,510

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 2022 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.

SECTION E NOTES ON OUR PERFORMANCE COMPARED TO BUDGET

E1 BUDGETARY REPORTING DISCLOSURES

This section discloses CQHHS's original published budgeted figures for 2021-22 compared to actual results, with explanations of major variances, in respect of CQHHS's Statement of Comprehensive Income, Statement of Financial Position and Statement of Cash Flows.

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

	Variance Notes	Original SDS Budget 2022 $'000	Actual 2022 $'000	Original SDS Budget V Actual Variance $'000	Variance % of original budget
OPERATING RESULT					
Income					
User charges and fees	**1**	48,873	**59,007**	10,134	21%
Funding public health services	**2**	618,739	**679,042**	60,303	10%
Grants and other contributions	**3**	20,221	**26,095**	5,874	29%
Other revenue	**4**	3,571	**2,828**	(743)	(21%)
Total revenue		691,404	**766,972**	75,568	
Total income		691,404	**766,972**	75,568	
Expenses					
Employee expenses		76,683	**78,600**	1,917	2%
Health service employee expenses	**5**	397,149	**419,142**	21,993	6%
Supplies and services	**6**	176,491	**210,165**	33,674	19%
Depreciation	**7**	28,090	**40,414**	12,324	44%
Other expenses	**8**	12,991	**16,885**	3,894	30%
Total expenses		691,404	**765,206**	73,802	
Operating results		-	**1,766**	1,766	
Other comprehensive income *Items that will not be reclassified subsequently to profit or loss*					
Increase/(decrease) in asset revaluation surplus	**9**	-	**27,023**	27,023	100%
Other comprehensive income for the year		-	**27,023**	27,023	
Total comprehensive income for the year		-	**28,789**	28,791	

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 of $10.134m is a result of the PBS reimbursement being greater than what anticipated in the budget by $2.61m. This has been partly offset by the unfavourable drugs expenditure budget variance of $1.879m. The inter-entity sales revenue for non-capital recoveries is also above budget by $2.086m. This is offset by the non-capitalised related expenditure and minor equipment expenditure. The sale of goods is above budget by $0.923m, worker compensation admitted patient fees is above budget by $0.514m and private single room fees is above budget by $0.764m

2 Funding public health service: The budget variance is due to further funding being received in the budget window adjustments for additional programs, as well as a further $42.845m for COVID-19 NPA and vaccination funding. This included $15.891m relating to the reconciliation of the 2020-21 financial year for COVID19. Depreciation funding (non-cash) has also increased by $12.324m to offset the increase in depreciation.

3. Grants and other contributions: The budget variance is mainly a result of service below fair value being higher than anticipated in the budget by $3.477m and nursing home benefit funding being higher than budgeted by $1.715m.

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

5 Health services employee expense: The budget variance relates to additional frontline staff to service growth in demand and program deliverables. 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 $15.846m. Further staff were also employed where backfill was required for staff on stood down leave due to vaccination status. The amount spent on overtime was $16.070m (including COVID) above budget. This was partly offset by vacant position mainly in the Health Practitioners, Managerial and Clerical and Professional labour streams.

6 Supplies and services: A major part of the variance is a result of impact of COVID19 which is $11.108m above budget. The COVID adverse budget variance is mainly contributed from pathology charges $3.763m, clinical supplies $2.999m, repairs & maintenance $1.239m and outsourced service delivery $1.507m. The outsourced service expenditure (excluding COVID) is above by $4.586m, as a result of clinical services and a increase in various contracts including Vanguard and CQ Radiology. Drug's expenditure is also unfavourable to budget but is offset by the PBS reimbursement and clinical supplies above budget by $0.721m.

7 Depreciation: The increase in depreciation against budget relates to changes in the useful life on building assets recommended by AECOM and the change in useful life for medical equipment, as recommended by Department of Health. The increase in depreciation is offset by the increase in depreciation funding.

8 Other expenses: The budget variance relates to the services below fair value being higher than anticipated in the budget by $3.477m.

9 Other comprehensive income: The budget did not anticipate any increases in the asset revaluation reserve. The land has increased by $0.264m and the building has increased by $26.759m as a result of an 8% indexation.

E1.2 BUDGET TO ACTUAL COMPARISON – STATEMENT OF FINANCIAL POSITION

	Variance Notes	Original SDS Budget 2022 $'000	Actual 2022 $'000	Original SDS Budget V Actual Variance $'000	Variance % of original budget
Current Assets					
Cash and cash equivalents	**10**	3,739	**12,873**	9,134	244%
Receivables	**11**	6,519	**13,401**	6,882	106%
Contract assets		1,380	**1,458**	78	6%
Inventories		5,003	**4,997**	(6)	-
Other assets	**12**	343	**1,044**	701	204%
Total Current assets		16,984	**33,773**	16,789	
Non-Current Assets					
Property, plant and equipment		461,804	**467,166**	5,362	1%
Right-of-use assets	**13**	1,085	**813**	(272)	(25%)
Total Non-Current assets		462,889	**467,979**	5,090	
Total Assets		479,873	**501,752**	21,881	
Current Liabilities					
Payables	**14**	33,585	**46,468**	12,883	38%
Lease liabilities	**15**	968	**634**	(334)	(35%)
Contract liabilities	**16**	646	**2,184**	1,538	238%
Total Current liabilities		35,199	**49,286**	14,087	
Non-Current Liabilities					
Lease liabilities		-	**36**	36	100%
Total Non-Current liabilities		-	**36**	36	
Total liabilities		35,199	**49,322**	14,123	
Net assets		444,674	**452,430**	7,756	
Equity					
Contributed equity		411,492	**390,459**	(21,033)	(5%)
Accumulated surplus/(deficit)	**17**	(15,112)	**(13,346)**	1,766	(12%)
Asset revaluation surplus	**18**	48,294	**75,317**	27,023	56%
Total Equity		444,674	**452,430**	7,756	

Note:

The 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 (revised SDS Budget). Reclassification in relation to the Statement of Financial Position has occurred for:

- GST payable has been offset with GST receivable to align with the treatment required in the reporting of actual under Queensland Treasury's Financial Reporting Requirements.
- Accrued employee benefits and unearned revenue in original SDS have been aggregated into payables due to immateriality in size.
- Any account groups displayed on the SDS with a zero balance have not been included in the statement.
- Equity has been disaggregated into contributed equity, accumulated surplus/deficit and asset revaluation surplus for improved transparency.

Materiality for notes commentary is based on the calculation of the line item's actual value percentage of the group total. If the percentage is greater than 5%, the line-item variance from budget to actual is reviewed. A note is provided for where this percentage is 5% or greater for Property, plant and equipment and 10% or greater for others or the variance is materially different.

E1.2 BUDGET TO ACTUAL COMPARISON – STATEMENT OF FINANCIAL POSITION (continued)

Explanation of major variances - statement of financial position

10 Cash and cash equivalents: The budget variance relates to increased cash received for COVID19 on the reconciliation of the 2020-21 financial year. $15.891m in cash was received. Also, the payment back to the Department for the fortnight ending 26th June 2022 totalling $21.401m did not occur until 6th July 2022.

11 Receivables: The main contributors to the receivables balance are private health funds $3.436m and Government agencies $6.327m. The receivables include a loss allowance of $0.098m.

12 Other assets: The budget variance relates to an increased in the amount of prepaid expenditure than anticipated in the budget. An amount of $0.307m has been included for COVID prepaid response leave

13 Right-of- use asset: The budget was based on 2020-21 closing balance and did not consider new leases or the amortisation of the leases. In the 2021-22 financial year $1.334m in new leases occurred and $1.589m in amortisation.

14 Payables: The budget variance relates to the payment of salaries wages back to the Department for the fortnight ending 26th June 2022 that did not occur until 6th July 2022. The amount of the salary & wages payable is $21.401m.

15 Lease liabilities: The 2021-22 financial year has resulted in $1.334m in new leases with the lease payment being higher at $1.632m.

16 Contract liabilities: The budget did not anticipate the amount of contract liabilities. The contract liabilities for the 2021-22 financial year include mainly: Gladstone West Wing Perioperative $0.503m; Care4QLD $0.604m and the COVID Mental Health Package $0.641m, where the milestones were not achieved under the service level agreement.

17 Accumulated surplus/(deficit): The original budget was based on a break-even position for the 2021-22 financial year. CQHHS has a recorded on a surplus of $1.766m.

18 Asset revaluation surplus: The budget did not anticipate an increase in the asset revaluation reserve. The land has increased by $0.364m and the building has increased by $26.759m. The buildings is based on 8% indexation as recommended by AECOM Valuers.

E1.3 BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOW

	Variance Notes	Original SDS Budget 2022 $'000	Actual 2022 $'000	Original SDS Budget V Actual Variance $'000	Variance % of original budget
Cash flows from operating activities					
Inflows:					
User charges and fees	**19**	49,365	**63,994**	14,629	30%
Funding public health services	**20**	618,740	**638,165**	19,425	3%
Grants and other contributions	**21**	15,472	**18,275**	2,803	18%
GST input tax credits from ATO		13,600	**13,457**	(143)	(1%)
GST collected from customers		675	**699**	24	4%
Other receipts	**22**	2,896	**2,579**	(317)	(11%)
Outflows:					
Employee expenses		(76,652)	**(78,226)**	(1,574)	2%
Health service employee expenses	**23**	(397,149)	**(416,163)**	(19,014)	5%
Supplies and services	**24**	(177,708)	**(208,477)**	(30,769)	17%
GST paid to suppliers		(13,418)	**(13,849)**	(431)	3%
GST remitted to ATO		(686)	**(725)**	(39)	6%
Interest payments on lease liabilities		(1)	**(5)**	(4)	400%
Other payments		(8,481)	**(8,308)**	173	(2%)
Net cash from/(used by) operating activities		26,653	**11,416**	**(15,237)**	
Cash flows from investing activities					
Inflows:					
Sales of property, plant and equipment		71	**41**	(30)	(42%)
Outflows:					
Payments for property, plant and equipment	**25**	-	**(18,359)**	(18,359)	100%
Net cash from/(used by) investing activities		71	**(18,318)**	**(18,389)**	
Cash flows from financing activities					
Inflows:					
Equity injections	**26**	107	**18,237**	18,130	16944%
Outflows:					
Principal payments of lease liabilities	**27**	(113)	**(1,632)**	(1,519)	1344%
Equity withdrawals	**28**	(28,090)	**-**	28,090	(100%)
Net cash from/(used by) financing activities		(28,096)	**16,605**	**44,701**	
Net increase/(decrease) in cash and cash equivalents		(1,372)	**9,703**	**11,075**	
Cash and cash equivalents at the beginning of the financial year		5,111	**3,170**	**(1,941)**	**(38%)**
Cash and cash equivalents at the end of the financial year		3,739	**12,873**	**9,134**	

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 (revised SDS Budget). Reclassification in relation to the statement of cash flows has occurred for:

- User charges in original SDS have been dissected into user charges and funding public health services.
- Interest receipts have been rolled into other receipts as immaterial for actual reporting.

Materiality for notes commentary is based on the calculation of the line item's actual value percentage of the group total. If the percentage is greater than 5%, 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 property, plant and equipment and 10% or greater for others or the variance is materially different.

E1.3 BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOW (continued)

Explanation of Major Variances - Statement of Cash Flows

19 User charges and fees: The User Charges higher than budget due to increased cash being received than anticipated in the budget. This is mainly driven from PBS reimbursement, sale of goods and inter-entity charges with other Hospital & Health Services and the Department.

20 Funding public health services: The budget variance mainly relates to increased cash received for COVID19. A major part of this relates to the $15.891m received on the reconciliation of the 2020-21 financial year. There is also further funding received for the various window adjustments that were not included in the initial cashflow budget.

21 Grants and other contributions: The budget variance is mainly a result of funds received for the nursing home benefit scheme being $1.715m higher than anticipated in the budget. The remaining variance is a result of other specific grants being higher than anticipated as well as donations being $0.131m higher than budgeted.

22 Other receipts: The budget was based on previous financial years. The 2021-22 financial year has resulted in less cash being collected for contract staff recoveries.

23 Health service employee expenses: The budget variance relates to further staff employed to manage the COVID pandemic and vaccination clinics. COVID labour costs was $15.846m. The amount spent on overtime was $16.070m (including COVID) above budget. This was partly offset by vacant position mainly in the Health Practitioners, Managerial and clerical and professional labour streams.

24 Supplies and services: The budget variance mainly relates to the cashflow budget not allowing sufficient cash outflow for the following. Outsourced Service Delivery $6.092m; Pathology $2.134m, Repairs and Maintenance $2.082m; Clinical Supplies $3.154m, Drugs $1.879m and Professional Services $1.147m. Of the $16.665m unfavourable budget variance $11.722m relates to COVID19.

25 Payments for property, plant & equipment: The budget variance is due to the budget for capital acquisitions being held by the Department. The budget variance is also impacted from COVID-19, as CQHHS prepared to meet the possible demand from COVID-19, with various capital purchases and projects associated with the COVID 19 pandemic. This is mainly offset by the capital equity injections.

26 Equity injections: Equity injections are above budget because the capital budget is held by the Department who reimburse CQHHS for payments made in relation to capital works that are funded by the Department by the way of equity injections. The cashflow was difficult to estimate when preparing budget.

27 Principal payments of lease liabilities: Insufficient outlay of cash was allowed in the budget for lease liabilities.

28 Equity withdrawals: Budget included the depreciation equity withdrawal as a cash flow item. This is a non- cash flow item.

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. Central Queensland Hospital Health Service has received additional funding of $19.892m under the National Partnership Agreement (NPA) as a reimbursement of direct costs incurred as a response to COVID-19 and $7.062m was received to offset the costs for the vaccination program. A further $15.891m was received that relates to the 2020-21 financial year reconciliation of COVID-19 expenditure.

Expenditure

Central Queensland Hospital Health Service continues to provide services above Service Agreement in response to the COVID-19 pandemic, Central Queensland Hospital Health Service has incurred additional expenditure of which $19.892m relates to direct COVID-19 expenditure and has been reimbursed under the NPA and $7.062m for the vaccination program, totalling $26.954m. This comprises of $15.846m in labour expenditure and $11.108m in non-labour, which mainly includes - Clinical supplies ($2.999m); Outsourced service delivery ($1.507m); Pathology charges ($3.763m) and repairs and maintenance ($1.239m).

Health care activity

Central Queensland Hospital Health Service ability to deliver health care activity was significantly impacted due to COVD-19 pandemic. This has resulted in CQHHS not achieving the required service level agreement targets. Central Queensland Hospital Health Service achieved 6,844 (8.7%) NWAU below the target of 78,785 and below the prior year activity of 72,921. The impact of COVD-19 has seen the patient volumes well under the required levels to generate the WAU outputs required, with admitted patients, outpatients and emergency department presentations impacted. At times elective surgery had to be cancelled due to availability of clinical staff.

Asset valuation

Both comprehensive valuation and indexation has been applied to our land and building assets in the 2021-22 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. Central Queensland Hospital Health Service's 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.

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 responsibility 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.

	2022 $'000	2021 $'000
Patient trust receipts and payments		
Receipts		
Patient trust receipts	**4,888**	4,996
Total receipts	**4,888**	4,996
Payments		
Patient trust payments	**4,833**	5,082
Total payments	**4,833**	5,082
Increase/(decrease) in net patient trust assets	**55**	(86)
Patient trust assets opening balance	**956**	1,042
Patient trust assets closing balance	**1,011**	956
Patient trust assets		
Current assets		
Cash at bank and on hand	**639**	584
Patient trust and refundable deposits	**372**	372
Total	**1,011**	956

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:

	2022 $'000	2021 $'000
Receipts		
Billings - (Senior Medical Officers and Visiting Medical Officers)	**3,551**	4,133
Total receipts	**3,551**	4,133
Payments		
Payments to Senior Medical Officers and Visiting Medical Officers	**3,686**	3,009
Hospital and Health Service recoverable administrative costs	**396**	459
Hospital and Health Service education/travel fund	**3**	5
Total payments	**4,085**	3,473
Closing balance of bank account under a trust fund arrangement not yet disbursed and not restricted cash	**189**	223

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 responsibility 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)	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	1 February 2022
	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	-
	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	-
	Ms Michelle Webster	Hospital and Health Boards Act 2011 Section 23 (1)	18 May 2022	
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	23 November 2021
	Mr John Burns (Acting)	s33 Appointed by Board under Hospital and Health Board Act 2011 (Section 7 (3).	15 November 2021	3 April 2022
	Dr Emma McCahon	s33 Appointed by Board under Hospital and Health Board Act 2011 (Section 7 (3).	4 April 2022	-

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.	Professor Pooshan Navathe	MMOI1 Appointed under Medical Officers (Queensland Health) Award – State 2015 and Medical Officer (Queensland Health) Certified Agreement (No. 4) 2015	14 June 2022	-
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	-
	Ms Monica Seth (Acting)	HES 2 Appointed by CE under HHB Act 2011	28 March 2022	-
Acting Executive Director of Nursing Midwifery Quality and Safety Responsible for the 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	-
	Ms Kylie Cookson (Acting)	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 September 6 January 2022 6 June 2022	31 October 2021 27 March 2022 -
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 Linda Medlin	DSO2-1 Appointed by CE under HHB Act 2011	28 May 2020	26 June 2022

Executive Director, Aboriginal and Torres Strait Islander Health and Wellbeing Directorate Responsible for leading development and implementation of health programs and service improvement for the Aboriginal & Torres Strait and Islander community across CQHHS	Ms Donna Cruickshank	HES 2 Appointed by CE under HHB Act 2011	13 June 2022	-

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 of termination, regardless of the reason for termination.
- No performance bonuses were paid in the 2021-22 financial year (2021: $nil).

Board remuneration

Remuneration paid or owing to Board members during 2021-22 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	93	-	9	**102**
Ms Lisa Caffery - Deputy Chair	47	-	5	**52**
Dr Poya Sobhanian	50	-	5	**55**
Dr Anna Vanderstaay	28	-	3	**31**
Ms Tina Zawila	50	-	5	**55**
Ms Leann Wilson	43	-	4	**47**
Mr Matthew Cooke	35	-	4	**39**
Professor Fiona Coulson	46	-	5	**51**
Ms Michelle Webster	11	-	1	**12**
Mr John Abbott AM	47	-	5	**52**

* 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 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 Queensland are paid Board fees when approved by government.

Other key management personnel remuneration

Remuneration paid or owing to employees who occupied key management roles, including while providing leave cover during 2021-22 was as follows:

2021-22

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	408	27	10	40	-	**485**
Chief Finance Officer, Assets and Commercial Services	214	-	5	22	-	**241**
Executive Director, Medical Service Central Queensland	568	2	13	45	-	**628**
Executive Director, Rockhampton Hospital	196	-	4	17	-	**217**
Executive Director, Gladstone and Rural	273	-	6	25	-	**304**
Executive Director, Nursing, Midwifery, Quality and Safety	504	-	9	39	-	**552**
Executive Director, Workforce	191	-	4	19	-	**214**
Executive Director Aboriginal & Torres Strait Islander Health & Wellbeing	11	-	-	1	-	**12**
Director, Aboriginal & Torres Strait Islander Health & Wellbeing	129	1	3	11	-	**144**

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

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 & Wellbeing	211	3	4	22	-	**240**

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 $xxx million for the 2021-22 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 3,360 (2021: 3,313) 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.

CQShines Foundation
The Governor in Council approved CQShines 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 and Climate Action Plan 2030.

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

No new accounting standards or interpretations apply to CQHHS for the first time in 2021-22 that have any material impact on the financial statements.

Following the issuance of IFRIC's agenda decision on the Configuration or Customisation Costs in a Cloud Computing Arrangement in April 2021, CQHHS has changed its accounting policy for certain cloud computing and software-as-a-service (SaaS) costs. The effect of this change is detailed in Note G5-1 below.

G5-1 CONFIGURATION OR CUSTOMISATION COSTS IN A CLOUD COMPUTING ARRANGEMENT

Summary of change in accounting policy

CQHHS changed its accounting policies in 2021-22 after completing a full analysis of its previously capitalised software in response to the IFRIC agenda decision released in March 2021.

CQHHS' new accounting policy now considers where the software code resides, whether it is identifiable and whether CQHHS has the power to both obtain economic benefits from the software and restrict the access of others to those benefits. Configuration or customisation costs that do not qualify for recognition as an intangible asset are further assessed as to the appropriate timing of expense recognition, using the following criteria:

a) Where the configuration or customisation is considered a distinct (i.e., separately identifiable) service from the subsequent access to the cloud software, the costs are expensed when the configuration or customisation services are received. This is typically the case when the vendor providing the services is different from the vendor providing access to the software.

b) Where the configuration or customisation is not a distinct service from the department's right to access the software, the costs are expensed over the period of access on a straight-line basis. A prepayment asset is recognised when the payment is made up front. This is usually the case when the same vendor is providing both the configuration or customisation services and the access to the cloud software.

Any software that qualifies as an intangible asset is recognised are accounted for in accordance with the CQHHS' existing accounting policies on software assets in Note C5, which have not changed.

Impact of changes

As a result of the change in accounting policy, there has been no material impact on the financial statements.

APPENDICES

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 prescribed accounting standards, of the transactions of the Central Queensland Hospital and Health Service for the financial year ended 30 June 2022 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: 26 August 2022

Dr Emma McCahon
Chief Executive
Date: 26 August 2022

Colin Weeks
Chief Finance Officer
Date: 26 August 2022

Queensland Audit Office
Better public services

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 2022, 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 2022, 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.

Queensland Audit Office
Better public services

Valuation of specialised buildings ($415million)

Refer to note C5 in the financial report

Key audit matter	How my audit addressed the key audit matter
Buildings were material to Central Queensland Hospital and Health Service at balance date and were measured at fair value using the current replacement cost method. Central Queensland Hospital and Health Service performed a comprehensive revaluation of 15% of its building assets this year as part of the rolling revaluation program. All other buildings were assessed using relevant indices. The current replacement cost method comprises: • gross replacement cost, less • accumulated depreciation. Central Queensland Hospital and Health Service derived the gross replacement cost of its buildings at balance date using unit prices that required significant judgements for: • identifying the components of buildings with separately identifiable replacement costs, and • developing a unit rate for each of these components, including: – estimating the current cost for a modern substitute (including locality factors and oncosts), expressed as a rate per unit (e.g. $/square metre) – identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference. The measurement of accumulated depreciation involved significant judgements for determining condition and forecasting the remaining useful lives of building components. The significant judgements required for gross replacement cost and useful lives are also significant judgements for calculating annual depreciation expense. Using indexation required: • significant judgement in determining changes in cost and design factors for each asset type since the previous revaluation, and • reviewing assumptions and judgements used in the last comprehensive valuation to ensure ongoing validity of assumptions and judgements used.	My procedures 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, on a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the: – modern substitute (including locality factors and oncosts), and – 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 • recalculating the application of the indices to asset balances • 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 – testing 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, and – reviewing assets with an inconsistent relationship between condition and remaining useful life. We also reviewed management's annual assessment of useful lives and enquired with management about their plans for assets that are nearing the end of their useful life and confirmed the accuracy of revaluation postings to the general ledger and fixed asset register.

Queensland Audit Office
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 2022:

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.

30 August 2022

D J Toma
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

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.
ALSi	Advanced Life Support for interns
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 Heath Service
EAS	Employee Assistance Service
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.
HSR	Health and Safety Representative
ICT	Information and Communication Technology
ieMR	integrated electronic Medical Record
ISACA	Information Systems Audit and Control Association
LANA	Local Area Needs Assessment
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.
MPHS	Multipurpose Health Service
MRSA	Methicillin-resistant Staphylococcus aureus

NHMRC	National Health and Medical Research Council
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.
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.
RMO	Resident Medical Officer
SAB	Staphylococcus aureus bloodstreama
SAC	Severity Assessment Code
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.
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.
UQ	University of Queensland
WAU	Weighted activity unit

Compliance Checklist

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	• **A letter of compliance from the accountable officer or statutory body to the relevant Minister/s**	ARRs – section 7	iii
Accessibility	• **Table of contents** • **Glossary**	ARRs – section 9.1	iv 76-78
	• **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
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	3, 20-24
	• **Agency service areas and service standards**	ARRs – section 11.3	24-25
Financial performance	• **Summary of financial performance**	ARRs – section 12.1	25
Governance – management and structure	• **Organisational structure**	ARRs – section 13.1	14
	• **Executive management**	ARRs – section 13.2	12-14
	• **Government bodies (statutory bodies and other entities)**	ARRs – section 13.3	9
	• **Public Sector Ethics**	*Public Sector Ethics Act 1994* ARRs – section 13.4	18-19
	• **Human Rights**	*Human Rights Act 2019* ARRs – section 13.5	19
	• **Queensland public service values**	ARRs – section 13.6	18-19
Governance – risk management and accountability	• **Risk management**	ARRs – section 14.1	17
	• **Audit committee**	ARRs – section 14.2	11
	• **Internal audit**	ARRs – section 14.3	17-18
	• **External scrutiny**	ARRs – section 14.4	18
	• **Information systems and recordkeeping**	ARRs – section 14.5	18
	• **Information Security attestation**	ARRs – section 14.6	N/A
Governance – human resources	• **Strategic workforce planning and performance**	ARRs – section 15.1	15-17
	• **Early retirement, redundancy and retrenchment**	Directive No.04/18 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	17
Open Data	• **Statement advising publication of information**	ARRs – section 16	17
	• **Consultancies**	ARRs – section 31.1	https://data.qld.gov.au
	• **Overseas travel**	ARRs – section 31.2	https://data.qld.gov.au
	• **Queensland Language Services Policy**	ARRs – section 31.3	https://data.qld.gov.au
Financial statements	• **Certification of financial statements**	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	71
	• **Independent Auditor's Report**	FAA – section 62 FPMS – section 46 ARRs – section 17.2	72

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

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