Wide Bay Hospital and Health Service

2019–2020 ANNUAL REPORT

Queensland Government

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

An electronic copy of this report is available at www.health.qld.gov.au/widebay/publication-schemes Hard copies of the annual report can also be obtained by phoning the office of Wide Bay Hospital and Health Service Chief Executive on (07) 4150 2020. Alternatively, you can request a copy by emailing WBHHS-HSCE@health.qld.gov.au.

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) 4150 2124 or (07) 4122 8607 and we will arrange an interpreter to effectively communicate the report to you.

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If you have an enquiry regarding this annual report please contact Wide Bay Hospital and Health Service on (07) 4150 2020

Acknowledgment of Traditional Owners

Wide Bay Hospital and Health Service respectfully acknowledges the traditional owners and custodians, both past and present, of the area we service. We also declare our commitment to reducing inequalities in health outcomes for Aboriginal and Torres Strait Islander people in line with the Australian Government's Closing the Gap initiative.

Recognition of Australian South Sea Islanders

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

Letter of compliance

2 September 2020

The Honourable Steven Miles MP
Deputy Premier, Minister for Health and Minister for Ambulance Services
GPO Box 48
Brisbane QLD 4001

Dear Deputy Premier

I am pleased to submit for presentation to the Parliament the Annual Report 2019–2020 and financial statements for Wide Bay Hospital and Health Service.

I certify that this annual report complies with:

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

A checklist outlining the annual reporting requirements can be found on page A-6 of this annual report.

Yours sincerely

Peta Jamieson

Peta Jamieson
Chair
Wide Bay Hospital and Health Board

Contents

Statement on Queensland Government objectives for the community

Wide Bay Hospital and Health Service's (WBHHS) strategic plan, *Care Comes First… Through Patients' Eyes*, considers and supports the Queensland Government's objectives for the community, *Our Future State: Advancing Queensland's Priorities*, with a particular contribution towards the objectives to Keep Queenslanders healthy and Give all our children a great start. It also supports the directions outlined in *My health, Queensland's future: Advancing health 2026* for its healthcare priorities to provide patient-centred care. More information about our strategic directions can be found on page 4, and there is detailed information on page 25 about how our performance indicators from 2019–2020 have supported our strategic objectives.

From the Chair and Chief Executive

The 2019–2020 year has been another landmark period for Wide Bay Hospital and Health Service (WBHHS), during which we have continued to innovate, sustainably meet wait time targets, built capacity and planned for future infrastructure. This has been made all the more remarkable by the impacts of the COVID-19 pandemic, which has required an extraordinary planning, response and recovery effort. The pandemic led to a refocusing and rebalancing of services in the second half of the year, and will continue to play a critical part in service provision and planning in the year to come.

We continue to deliver goals in line with our 2018–2022 strategic plan, *Care Comes First… Through Patients' Eyes*. The plan is our vision for providing the best possible care for our community into the future, through enhancing health care and access, building capacity and infrastructure, developing and supporting our staff, and fostering innovation.

The maintenance of our waiting lists is one of our enduring success stories, with the vast majority of Wide Bay patients being seen within clinically recommended timeframes for an Elective Surgery procedure, or an Endoscopy, Specialist Outpatient or General Dental appointment — meaning earlier diagnostic results, treatment and better outcomes overall. Along with other health services in Queensland and Australia, there was a need to rebalance our services from late March 2020, in line with Commonwealth Government directives to postpone and later resume non-urgent work to reflect our changing COVID-19 response needs. Despite this, we're proud to say our teams maintained an impressive record of delivering no long waits for most of our patients.

One of the significant positives to emerge from the COVID-19 pandemic has been the agility and innovation it has triggered in our service delivery. Examples include the expansion of Telehealth and the development of virtual clinics across a variety of our clinical areas, to allow patients to attend appointments from the comfort of their own homes; home visits by our Midwifery Group Practice teams; and getting vital and timely consumer feedback through online platforms.

Innovation has not stopped there. In June we launched our Mental Health Hospital in the Home (HiTH) program, a statewide first providing multidisciplinary intensive mental health support for patients in their own environment, leading to better outcomes for consumers and reducing inpatient admissions. Earlier in the year we launched our Geriatric Emergency Department Intervention (GEDI) and Eat, Walk, Engage programs — part of the Queensland Government's Healthy Ageing strategy, aiming to enhance and fast-track care for frail and elderly patients. And we commenced our Integrated Care model, delivering flexible and multidisciplinary care to patients — many with chronic illnesses — while helping to reduce hospitalisations and lengths of stay, and provide more care at home.

It has been a big year for current and future infrastructure projects. We have seen the completion and reopening of our Emergency and Specialist Outpatient departments at Maryborough Hospital, and the near completion of refurbishment works at Eidsvold Multipurpose Health Service. We opened a new Cardiac Investigations Unit at Hervey Bay Hospital, in partnership with GenesisCare, enabling better access to early intervention for heart conditions and better health outcomes for Fraser Coast patients.

There is also a great deal to look forward to. We have completed the detailed design phase of the $39.61 million Hervey Bay Acute Mental Health Inpatient Unit project, with construction on track to start in the final quarter of 2020. And we continue to make significant progress on the detailed business case for a new hospital in Bundaberg, after the Queensland Government supported the next stage of planning last year.

We are advancing our work on a regional medical program, with the aim of growing our own future medical workforce, following the signing of a Memorandum of Understanding in 2018–2019 with Central Queensland Hospital and Health Service, CQUniversity Australia and The University of Queensland. The plan is for the first intake of the pre-medical students for the CQUniversity Australia, Bachelor of Medical Science Degree to be in 2022.

If ever there has been a year when we have truly realised the value of our workforce at all levels, this has been it. While COVID-19 has brought immense challenges to our organisation, as it has done for many like us, we have been incredibly proud to see close up the precise planning, quick thinking and extraordinary commitment of our staff as our community has needed us more than ever. To all of you we say thank you — for working together to make us one of the best performing health services in Queensland, for being both outstanding members of staff and members of your own community, and for constantly finding something in reserve in times of challenge. You are our everyday health heroes.

Peta Jamieson
Chair
Wide Bay Hospital and Health Board

Debbie Carroll
Chief Executive
Wide Bay Hospital and Health Service

About us

Established on 1 July 2012, Wide Bay Hospital and Health Service (WBHHS) is an independent statutory body governed by the Wide Bay Hospital and Health Board (the Board), which reports to the Deputy Premier, Minister for Health and Minister for Ambulance Services.

WBHHS's responsibilities are set out in legislation through the *Hospital and Health Boards Act 2011*, *Hospital and Health Boards Regulations 2012*, *Financial Accountability Act 2009* and subordinate legislation.

WBHHS delivers quality, patient- and family-focused health services that reflect the needs of the Wide Bay community, which includes the geographical areas of the Bundaberg, Fraser Coast and North Burnett local government areas, and part of the Gladstone local government area.

WBHHS delivers public hospital and health services under a service agreement with the Department of Health. This agreement identifies the minimum services to be provided, performance indicators and key targets.

Strategic direction

WBHHS contributes to the Government's objectives for the community, *Our Future State: Advancing Queensland's Priorities*, with a particular focus on Keep Queenslanders healthy and Give all our children a great start.

We do this by delivering quality health care for the Wide Bay region in a way that responds to community needs, provides the right service, at the right time, in the right place, and supports people in the region to live the healthiest lives possible.

WBHHS's vision, *Care Comes First … Through Patients' Eyes*, supports the directions outlined in *My health, Queensland's future: Advancing health 2026* for its healthcare priorities to provide patient-centred care.

Vision, Purpose, Values

Our vision is *Care Comes First… Through Patients' Eyes*.

Our purpose is to support people to improve their lives by delivering patient-centred, high-quality health care for Wide Bay.

Up until now, our behaviours have been guided by the Queensland public service values. These values are:

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

Examples of these values in action include:

Customers first

In response to community feedback, WBHHS was able to recognise the Agnes Water Discovery Coast Community Health Service as that community's closest health centre for Patient Travel Subsidy Scheme (PTSS) purposes, after expanding public clinics there. As a result, patients from Agnes Water, Lowmead, Baffle Creek, Wartburg, Rules Beach, Deepwater, Captain Creek, and the Town of 1770 are now eligible for PTSS when they travel to Bundaberg for appointments.

Ideas into action

WBHHS is planning for the future with its $39.61 million Fraser Coast Mental Health Project, which includes a new 22-bed acute inpatient unit at Hervey Bay Hospital and refurbishing the existing mental health inpatient unit at Maryborough Hospital into a new 10-bed sub-acute older people's mental health unit. The new facilities aim to support best practice and

safety for consumers and staff, improve management of consumers transitioning between inpatient and community mental health settings, and strengthen the recruitment and retention of a locally skilled mental health workforce.

Unleash potential

The efforts of the WBHHS Oral Health team to see more patients on time was recognised with a Highly Commended award at the Premier's Awards for Excellence in 2019, in the Keep Queenslanders Healthy category. The honour was bestowed on the team after it increased its activity by 50 per cent, reduced the maximum waiting time from more than three years to under the recommended two years, and cut its waiting list from 15,646 people to 8,939 in a 10-month period.

Be courageous

WBHHS nurses answered a neighbouring health service's call for help following a positive COVID-19 test by a staff member at the North Rockhampton Nursing Centre. Many WBHHS staff volunteered to go into an uncertain environment, with 11 selected to be part of the team who ensured the nursing home was staffed and meeting COVID-19 safety requirements, while its normal team remained in isolation.

Empower people

A stronger voice has been given to Elders and traditional custodians of local clans through the formation of the WBHHS Aboriginal and Torres Strait Islander Health Advisory Council. The Council gives Elders and community members direct input into health service planning, helps ensure WBBHS provides culturally appropriate services and that local facilities are welcoming and safe environments for First Nations people.

Throughout 2019–2020, with the help of its newly established Organisational Development team, WBHHS developed its own specific set of organisational values and behaviours through a process that included significant consultations with staff and community representatives. These values are set to be launched in July 2020. For more information about the values process, go to page 18.

Priorities

The Wide Bay Hospital and Health Board sets our strategic priorities through the WBHHS Strategic Plan, which outlines how we will meet the needs of our communities over the duration of the plan.

In this context, five strategic directions have been developed and committed:

Enhance holistic health care
We will put patients, carers and consumers at the centre of all we do

Deliver more care locally
We will provide high-quality, innovative services and develop our health technology

Plan today for future infrastructure
We will develop our health infrastructure to meet our region's needs

Develop and support our staff
We will invest in and nurture our staff

Excellence through innovation
We will improve our services through strategic partnerships and active innovation.

As well as delivering core health services and key initiatives to improve patient outcomes, during 2020–2021 WBHHS will:

- Continue to progress the detailed business case for a new hospital in Bundaberg
- Commence construction of the new Mental Health Inpatient Unit at Hervey Bay Hospital
- Complete works to refurbish Eidsvold Multipurpose Health Service
- Continue to progress the development of a local four-year postgraduate medical program under the Memorandum of Understanding between WBHHS, Central Queensland HHS, The University of Queensland and CQUniversity Australia
- Launch WBHHS's own organisational values and behaviours, to provide consistency across the HHS and set clear expectations for new and existing staff
- Continue to improve health service delivery through virtual and innovate models of care, as part of WBHHS's Transform and Optimise initiative.

Aboriginal and Torres Strait Islander Health

WBHHS's Aboriginal and Torres Strait Islander Health team aims to promote the provision of patient-centred, high-quality, culturally appropriate health care, by all of our healthcare practitioners, across the lifespan.

Our Aboriginal and Torres Strait Islander Health staff provide patient support in specialty health areas such as maternity and infant health, mental health, drugs and alcohol, chronic disease, and sexual health.

Our Aboriginal and Torres Strait Islander Health workers provide an important advocacy and liaison service, enabling them to act as a cultural link between health professionals, Aboriginal and Torres Strait Islander patients, and patients' carers and families. They also play a crucial role in following up patients in the community and helping to reduce potentially preventable hospitalisations and re-admissions.

In 2019–2020, WBHHS restructured and realigned its Aboriginal and Torres Strait Islander Health workforce reporting lines in accordance with the statewide Aboriginal and Torres Strait Islander Workforce Framework, to enable it to more effectively deliver Closing the Gap goals.

Closing the Gap

WBHHS's commitment to Closing the Gap has been identified as a key action under our Strategic Plan 2018–2022, *Care Comes First… Through Patients' Eyes*.

Specific Closing the Gap initiatives aim to reduce gaps in life expectancy between Aboriginal and Torres Strait Islander people and non-Indigenous Australians, by improving access to culturally secure health services and programs.

WBHHS is in the process of implementing its *Aboriginal and Torres Strait Islander Closing the Gap Health Plan*, which is guided by three strategic directions under Queensland Health's Statement of Action:

- Improve and promote opportunities to embed Aboriginal and Torres Strait Islander representation in WBHHS's leadership, governance and workforce
- Improve local engagement and partnerships between WBHHS and Aboriginal and Torres Strait Islander people, communities and organisations
- Improve transparency, reporting and accountability in our efforts to Close the Gap in health outcomes for Aboriginal and Torres Strait Islander Queenslanders.

In September 2019, WBHHS established an Aboriginal and Torres Strait Islander Health Advisory Council for Wide Bay, to enable local Elders and community members to help guide the implementation of its Closing the Gap Health Plan. The Council also has input into WBHHS health planning and service delivery, provides local information and context, and helps to identify local needs and priorities.

Throughout the COVID-19 pandemic, WBHHS and Council members met fortnightly to ensure appropriate measures and responses for the Aboriginal and Torres Strait Islander community, which is considered to be a vulnerable group. This included desktop scenario-planning exercises to ensure response preparedness.

Due to social distancing and gathering restrictions as a result of the pandemic, WBHHS embraced technology and held an online celebration for National Reconciliation Week (May 27–June 3) in 2020, using the Microsoft Teams platform.

This enabled WBHHS employees to still come together to mark the special ceremony, which featured a customary Welcome to Country, speeches and a short video celebrating our Aboriginal and Torres Strait Islander achievements and milestones from the previous 12 to 18 months.

In early 2020, WBHHS commissioned work by a local Butchulla artist for the windows of the upgraded Maryborough Hospital emergency department. Due to be installed in July 2020, it is intended that the artwork will both be a fitting tribute to local Aboriginal heritage and an important way to make the emergency waiting area a more welcoming environment for patients.

Our community-based and hospital-based services

WBHHS is responsible for the delivery of public hospital and health services including medical, surgical, emergency, acute inpatient, outpatient, mental health, oral health and a range of specialist, community and outreach services.

We serve a population of more than 219,000 people across a geographical area of approximately 37,000 square kilometres (see map below).

WBHHS is responsible for the direct management of the facilities and community health services based within our geographical boundaries, including:

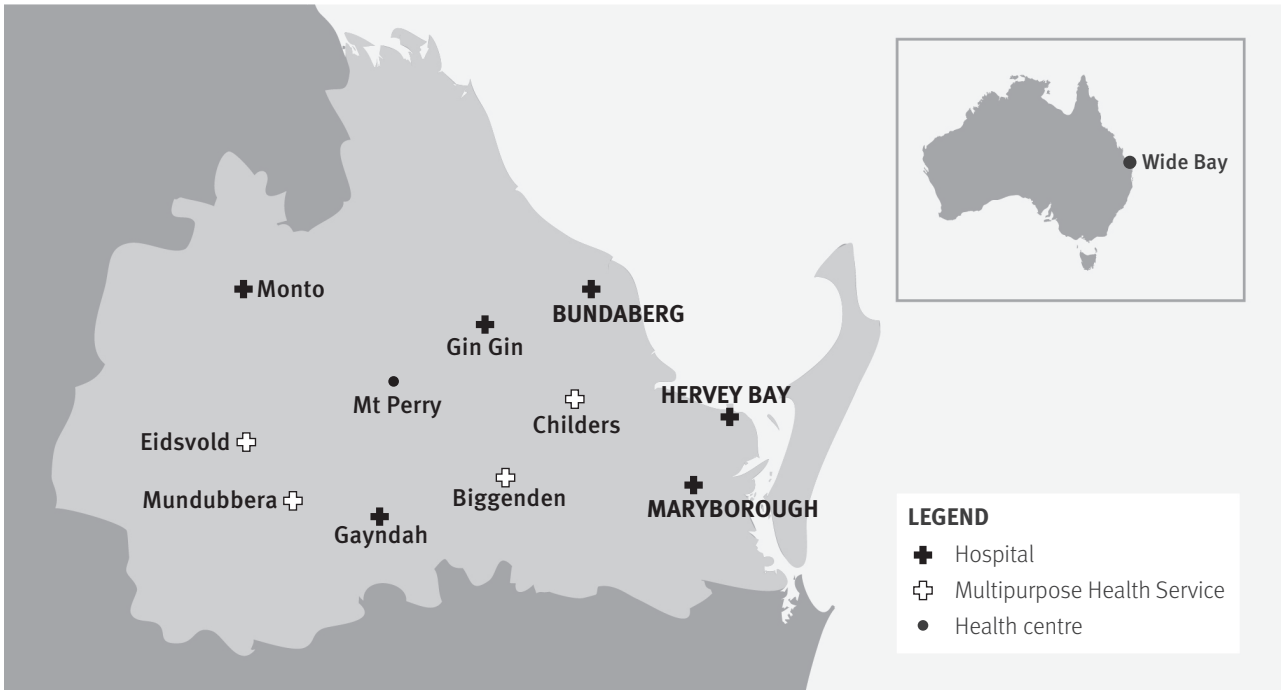
- Bundaberg Hospital
- Hervey Bay Hospital
- Maryborough Hospital
- Biggenden Multipurpose Health Service (MPHS)
- Childers MPHS
- Eidsvold MPHS
- Gayndah Hospital
- Gin Gin Hospital
- Monto Hospital
- Mundubbera MPHS
- Mt Perry Health Centre.

In addition, WBHHS provides a range of outreach health services to the Discovery Coast community from the Agnes Water Discovery Coast Community Health Service.

We also partner with various external organisations to supplement and support specialist services to the Wide Bay community. This helps our patients to be seen cost-effectively and within clinically recommended timeframes, which improves their health outcomes.

WBHHS, in conjunction with the local councils in its service region, provides free on-site and on-street parking at all its facilities.

Wide Bay Hospital and Health Service Area



Specialty services

Acute pain management	General surgery	Orthopaedics
Alcohol and other drug services	Gerontology	Palliative care
Allied health	Gynaecology	Paediatrics
Anaesthetics	Hospital in the Home	Pathology
Breast screen	Indigenous health services	Pharmacy
Cancer care	Integrated Care	Public health
Cardiology	Intensive and high-dependency care	Radiation therapy
Child Development	Internal medicine	Rehabilitation
Child Health	Medical imaging including computer tomography (CT)	Renal services, including dialysis
Colorectal surgery	Medical oncology	School health
Community Health	Mental health services	Sexual health
Coronary care	Obstetrics	Specialist Outpatients
Early Parenting Intervention	Offender health	Transition Care Program
Emergency medicine	Ophthalmology	Urology
ENT surgery (paediatric)	Oral health and oral surgery, including school-based program	Women's health
Gastroenterology		
General medicine		

Targets and challenges

WBHHS is continuing to deliver performance improvements while providing sustainable patient-centred, high-quality and safe healthcare services. We operate in a complex and challenging environment and, similar to other health services in Australia and internationally, balancing efficient service delivery with high-quality health outcomes to ensure that healthcare expenditure achieves value for our communities is a constant challenge.

Ongoing challenges in the delivery of healthcare services to our communities include:

- Service demand and capacity — the Wide Bay region has an ageing and low socio-economic population with high levels of acute and chronic disease, which place increasing demand on public healthcare services
- Workforce — recruiting and retaining highly qualified staff in rural and regional areas is an ongoing challenge that the service continues to manage
- Financial pressures — while the health service performed efficiently this year, there are ever-increasing service demand pressures that impact on the delivery of a balanced budget
- Operating environment — the delivery of health services in an environment in which there are competing priorities between public policy, planning, regulatory frameworks and our community's expectations. Adaptability to change has been critical, along with managing community expectations of the services that we can provide
- Outdated infrastructure — the service has a number of buildings and facilities that limit capacity to introduce new and advanced service models and technologies. There are, however, upgrade and construction projects currently under way or in the planning stages to address the most critical of these.

Overlaying all of this in 2019–2020 has been the challenge of the COVID-19 pandemic, particularly from service delivery, workforce and financial perspectives.

In addition, a unique challenge for WBHHS is the complexity of providing services from three major hospitals. Demand for a full range of services to be provided at each major hospital impacts on our ability to provide efficient services.

Our key demographics and health risk factors

The Wide Bay region carries some significant health risk factors, with high rates of smoking, obesity, mental illness and risky drinking. These combined demographic and behavioural risk factors place significant demands on the public health sector.

Table 1: Key demographic and health risk statistics for the Wide Bay region

	Wide Bay	Qld
Average rate of annual population increase	0.7%	1.5%
Aged 65+	25.2%	15.4%
Unemployment (as at December quarter 2019)	8.1%	6.1%
Median total family income	$58,929	$86,372
Aboriginal or Torres Strait Islander background	4.7%	4%
"In need of assistance" with a core activity as a result of a profound or severe disability	8.8%	5.2%
List their highest level of schooling as Year 11 or 12	41.4%	58.9%
Residents who are daily smokers	16%	11%
Residents who are obese	31%	25%
Residents who are risky drinkers	23%	21%
Residents with mental health or behavioural problems	16.7%	14.4%

References:

Queensland Treasury and Trade — Queensland Regional Profiles, Wide Bay (as at 30 June 2020)

The Health of Queenslanders 2018 — Chief Health Officer, Queensland

Central Queensland, Wide Bay, Sunshine Coast PHN Baseline Needs Assessment 2015–16

Addressing our challenges

During 2019–2020, WBHHS implemented a range of new, upgraded or expanded services to meet rising demand. This included the rollout of agile and innovative service models to the adapt to the fast-changing COVID-19 environment, while continuing to meet the everyday service needs of the community.

We have also continued to plan for the future healthcare needs of our community. Looking ahead, WBHHS is completing a refresh of its Health Services Plan 2019–2032, with regard to projected activity, proposed infrastructure solutions detailed in the Bundaberg Hospital redevelopment project, and the WBHHS Master Plan. The Health Services Plan will include Fraser Coast and rural facilities, as well as initiatives being developed under our Transform and Optimise program to improve sustainable and patient-centred models of service delivery.

A selection of service enhancements and achievements in 2019-2020, as they align with our strategic directions, is listed as follows.

For performance indicators specific to strategic plan key measurables, please refer to page 25.

WBHHS Strategic Direction: Enhance holistic health care

WBHHS has continued to prioritise patient- and family-centred care across the lifespan, while also focusing on health promotion and consumer engagement to enhance the patient experience. Achievements include:

- Launch of Mental Health Hospital in the Home (HiTH) program, a statewide first providing multidisciplinary intensive mental health support for patients in their own environment, leading to better outcomes for consumers and reducing inpatient admissions
- Launch of CT perfusion medical imaging technique at Bundaberg and Hervey Bay hospitals, improving diagnosis and recovery outcomes for stroke patients
- Launch of the Geriatric Emergency Department Intervention (GEDI) program at Bundaberg, Hervey Bay and Maryborough hospitals, aiming to enhance and fast-track care for frail and elderly patients
- Launch of the Eat, Walk, Engage program in Bundaberg and Fraser Coast hospitals, a multidisciplinary approach to improving care for older people in hospital by preventing delirium and promoting recovery.

- Expansion of WBHHS's Choosing Wisely Australia® program, with a focus on reducing unnecessary healthcare practices in the areas of medical imaging, pathology and pharmacy, to ensure patients receive the right care, at the right time, using the right resources.
- Expansion of Nurse Navigator program to include specialist portfolios such as Integrated Care, Aboriginal and Torres Strait Islander Health, and Chronic Disease, to ensure more patients receive personalised and tailored care that suits their individual needs.
- School immunisation and Deadly Ears screenings completed across all schools in the North Burnett region, ensuring we give all our children a healthy start.
- Maintenance of an immunisation coverage rate of more than 95 per cent of five-year-olds in Wide Bay, through partnerships with local providers and accompanying work by the Wide Bay Public Health Unit including follow-up of overdue children, advocacy and education.
- Senior WBHHS rural dietitian has joined a statewide project group focusing on childhood obesity in Queensland, providing a rural focus to this important body of work.
- Rolling improvements to upgraded WBHHS website – including substantial resources focused on COVID-19 information– providing quality and accessible content to patients, consumers and health professionals.
- Release of fifth annual Quality of Care Report, highlighting a range of quality indicators that continue to meet and exceed state and national benchmarks.
- Development of palliative care support information, education opportunities and resources on WBHHS intranet, providing quick access for staff and enabling enhanced support for patients at the end of life.

WBHHS Strategic Direction: Deliver more care locally

WBHHS has maintained productivity and sustained excellent waiting times, while continuing to expand and enhance access to local, high-quality care. Achievements include:

- Opening of Cardiac Investigations Unit at Hervey Bay Hospital, in partnership with GenesisCare, enabling better access to early intervention for heart conditions and better health outcomes for Fraser Coast patients.
- Launch of Integrated Care model, delivering flexible and multidisciplinary care to patients, while helping to reduce hospitalisations and lengths of stay, and provide more care at home.
- Continuation of, and significant growth in, tele-chemotherapy model of care at all WBHHS rural facilities, enabling rural patients to receive chemotherapy closer to home where clinically appropriate.
- Successful implementation of virtual clinics for outpatient appointments including Bundaberg Renal Services, Bundaberg Family Unit, WBHHS Sexual Health, Cancer Care and Gayndah Allied Health.
- Telehealth Clinical Nurse Consultant role developed to support the ongoing expansion of telehealth services with a focus on rural Telehealth development.
- Five allied health professionals supported through the Rural Generalist Pathway, enhancing patient health outcomes through providing them access to highly skilled multidisciplinary clinicians with a rural focus.
- Enhanced access to range of rural health services for vulnerable patients through telehealth support to remain at home, including for dietetics, exercise physiology, cardiac and pulmonary rehab, occupational therapy, physiotherapists, psychology, social work and speech pathology appointments.

WBHHS Strategic Direction: Excellence through innovation

WBHHS teams have collaborated with each other and external stakeholders to constantly innovate, leading to better patient care, efficiency and safety outcomes. Achievements include:

- Launch of WBHHS Cancer Care Clinical Trials Unit, giving Wide Bay patients access to trials usually available only in metropolitan hospitals and enabling them to be part of life-changing research, both through locally governed trials and teletrials in partnership with tertiary hospitals.
- Migration of all adult and child Oral Health patient records to full electronic records, enabling enhanced record management, easier access and improved information sharing.

- Implementation of digital dental x-rays systems in both adult and school dental services, anchored to electronic patient clinical records.
- Access to a specialist palliative care physician enabled for Wide Bay patients via Telehealth, through a partnership with the Sunshine Coast Specialist Palliative Care Rural Telehealth Service.
- Development of partnership between BreastScreen Wide Bay and Integrated Wellness Centre (IWC), Bundaberg, to enable free outreach mammograms to be provided for Aboriginal and Torres Strait Islander women and others in the target age range, utilising the mobile BreastScreen van.

WBHHS Strategic Direction: Plan today for future infrastructure

WBHHS continues to invest in important infrastructure builds and upgrades to ensure our facilities are fit for purpose and meet the needs of our growing population. Achievements include:

- Completion of Infrastructure Master Plan for Fraser Coast and rural facilities, to ensure we can continue to sustainably meet the health needs of our communities.
- Continual upgrade and renewal of clinical equipment, as part of the rolling Health Technology Equipment Replacement program, to ensure all appliances are compliant, up to date and can support clinicians to provide the best possible care to patients.
- Development of targeted user groups, including clinicians and consumers, to consult on a range of infrastructure projects, designs and models of care, including the Bundaberg Hospital Redevelopment and the Hervey Bay Mental Health Inpatient Unit.

WBHHS Strategic Direction: Develop and support our staff

WBHHS is constantly working to improve the employee experience, from graduate training and recruitment through to innovative training delivery, research support and enhancing career pathways. Achievements include:

- Development, rollout and coordination of WBHHS-specific employee engagement survey, with a view to enhancing culture and job satisfaction, and improving patient outcomes. This has included substantial and targeted follow-up work to ensure departments of all sizes and at all levels are implementing actions specific to their teams.
- Significant consultation and development on WBHHS's own set of organisational values and behaviours, with launch set to occur in July 2020. These aim to provide clear, consistent and meaningful guidance on WBHHS's expectations as we deliver the best possible patient-centred care.
- Development of promotional recruitment videos targeting specific professional streams and vacancies, to complement the existing promotional videos that accompany all job advertisements on the SmartJobs website and other social media platforms such as LinkedIn and Facebook.
- Rollout of targeted education and statewide collaboration projects, contributing to improved digital health literacy among clinicians.
- Involvement in high school engagement programs and job expos with a view to growing and retaining a local workforce.
- High compliance rate in completing mandatory training in new Maybo occupational violence education program for staff, which includes a focus on preventing violence through improved communication and situational awareness.

Governance

Our people

Board membership

The Board

The Wide Bay Hospital and Health Board consists of nine non-executive members who are appointed by the Governor in Council, on the recommendation of the Deputy Premier, Minister for Health and Minister for Ambulance Services. The Board is responsible for the governance activities of the organisation, deriving its authority from the *Hospital and Health Boards Act 2011* and the *Hospital and Health Boards Regulation 2012*.

The Board sets the strategic direction for the health service and is accountable for its performance against key objectives and goals to ensure they meet the needs of the community. It also:

- Ensures safety and quality systems are in place that are focused on the patient experience, quality outcomes, evidence-based practices, education and research
- Monitors performance against plans, strategies and indicators to ensure the accountable use of public resources
- Ensures risk and compliance management systems are in place and operating effectively
- Establishes and maintains effective systems to ensure that health services meet the needs of the community.

The Chair and members provide a significant contribution to the community through their participation on the Board and committees. Remuneration acknowledges this contribution and is detailed on page FS-28.

The Governor in Council approves the remuneration for Board Chairs, Deputy Chairs and Members. The annual fees paid by WBHHS are consistent with the *Remuneration Procedures for Part-Time Chairs and Members of Queensland Government Bodies*. These are as follows:

- Board Chair – $75,000
- Board Member – $40,000
- Committee Chair – $4,000
- Committee Member – $3,000.

In addition, total out-of-pocket expenses paid to the Board during the reporting period was $6,111.56.

The Board has legislatively prescribed committees that assist it to discharge its responsibilities. The Board and each committee of the Board operate in accordance with a Charter that clearly articulates the specific purpose, role, functions, responsibilities and membership.

Executive

As set out in section 32B of the *Hospital and Health Boards Act 2011*, the Board Executive Committee supports the Board in progressing the delivery of strategic objectives for Wide Bay Hospital and Health Service and by strengthening the relationship between the Board and the Chief Executive to ensure accountability in the delivery of services.

Safety and Quality

The Safety and Quality Committee is established in line with the requirements of the *Hospital and Health Boards Regulation 2012*. The role of the Board Safety and Quality Committee is to ensure a comprehensive approach to governance matters relevant to safety and quality of health services is developed and monitored.

The committee is also responsible for advising the Board on matters relating to safety and quality of health care provided by the health service including but not limited to strategies to minimise preventable harm, improving the experience of patients and carers receiving health services and promoting improvements in workplace health and safety.

Audit and Risk

The Board Audit and Risk Committee is established in line with the requirements of the *Hospital and Health Boards Regulation 2012* (the Regulation). In accordance with the Regulation, the committee provides independent assurance and assistance to the Board on:

- The service's risk, control and compliance frameworks

- The service's external accountability responsibilities as prescribed in the *Financial Accountability Act 2009*, the *Financial Accountability Regulation 2009*, and the *Financial and Performance Management Standard 2019*.

The committee meets quarterly and operates with due regard to the Treasury's Audit Committee Guidelines. The committee's work is supported by a number of standing invitees to the meeting, including the Executive Director of Finance and Performance, Executive Director Governance, Internal Audit and External Audit representatives.

Finance

The Board Finance Committee is established in line with the requirements of the *Hospital and Health Boards Regulation 2012*. The Executive Director of Finance and Performance is a standing invitee to this committee, which advises the Board on matters relating to overseeing financial performance and monitoring financial systems, financial strategy and policies, capital expenditure, cash flow, revenue and budgeting to ensure alignment with key strategic priorities and performance objectives.

Table 2: Board Committee memberships and attendance

Name	Date originally appointed	Term	Board	Board Executive	Safety & Quality	Finance	Audit & Risk
Meetings held			**12**	**4**	**9**	**5**	**7**
Peta Jamieson Board Chair / Executive Chair	26/06/2015	18/05/2017 – 17/05/2021	11/12	4/4	9/9	5/5	7/7
Prof Bryan Burmeister Deputy Board Chair	18/05/2014	18/05/2018 – 17/05/2021	10/12	4/4	9/9	1/2	—
Trevor Dixon Finance Chair	18/05/2017	18/05/2018 – 17/05/2021	11/12	—	—	5/5	7/7
Karen Prentis Audit and Risk Chair	18/05/2017	18/05/2020 – 31/03/2024	12/12	—	—	5/5	7/7
Prof Phillip Clift Safety and Quality Chair	18/05/2017	18/05/2018 – 17/05/2021	11/12	—	8/9	2/2	7/7
Anita Brown	18/05/2017	18/05/2018 – 17/05/2021	12/12	4/4	—	4/4	3/3
Simone Xouris	18/05/2017	18/05/2018 – 17/05/2021	12/12	3/4	9/9	1/2	—
Leon Nehow	18/05/2020	18/05/2020 – 31/03/2024	1/1	—	—	—	—
Dr Sandra Rattenbury	18/05/2020	18/05/2020 – 31/03/2024	1/1	—	—	—	—
Joy Jensen	18/05/2013	18/05/2017 – 03/10/2019	3/4	1/1	3/3	—	—
George Plint	18/05/2014	18/05/2018 – 04/10/2019	4/4	—	2/3	1/1	—

Note: Some Board and Board committee memberships changed throughout 2019–2020. The above table reflects the number of meetings attended, against the number of meetings individual members were eligible to attend.

Peta Jamieson
Chair

Peta has extensive experience in Queensland State Government, Brisbane City Council and the Local Government Association of Queensland, and is the director of her own management consultancy.

She has extensive executive and operational experience and a clear understanding of how government and its policies and processes work.

Peta is a strong advocate for the Bundaberg and Wide Bay Burnett region. She is actively involved with community, commercial and government bodies such as the Wide Bay Burnett Regional Organisation of Councils on local and regional projects and initiatives.

Peta is a Graduate of the Australian Institute of Company Directors and holds a Graduate Certificate in Business Administration, Master of Science in Environmental Management and Bachelor of Arts (Honours). She is also a Director on the Gladstone Ports Corporation Board.

Professor Bryan Burmeister
Deputy Chair

Bryan is an oncologist based at GenesisCare Fraser Coast and also practices at Hervey Bay Hospital.

Since 1997 he has been on the staff of the Faculty of Health Sciences, University of Queensland, where he is involved in teaching and examining medical students as well as supervising clinical research.

Bryan's recent research achievements include being a principal or co-investigator on more than 30 clinical trials and projects, a number of which have been awarded funding by the Australian National Health and Medical Research Council. He has more than 25 proffered papers at learned society meetings and has published more than 135 papers in peer-reviewed journals.

Bryan is a former President of the Trans-Tasman Radiation Oncology Group, Deputy Chair of the Medical and Scientific Advisory Committee of Cancer Council Queensland, and Chair of the Australian and New Zealand Melanoma Trials Group.

Karen Prentis
Board Member

As a highly experienced non-executive director and Chair, Karen has extensive experience in providing leadership in the development of strong corporate governance, risk management, compliance and strategic thinking for significant organisations in both public and private sectors.

She also has more than 30 years' experience in the financial services industry as a non-executive director and independent compliance committee Chair in funds management.

Karen's current roles include her appointment as Chair of Audit and Risk committees for several State Government departments, a director of the Children's Hospital Foundation and a director on financial services boards. She is a Graduate of the Australian Institute of Company Directors, and holds a Bachelor of Economics and a Master of Administration.

Emeritus Professor Phillip Clift
Board Member

Phillip has spent almost three decades living and working in rural and regional Australia, where he has held the most senior position on the university campus.

He has had significant experience in regional development, community engagement and the health sector, including being a foundation member of the South West Health Board in Western Australia, where he negotiated the establishment of a combined public and private hospital development on the university campus.

More recently, he was a Board Director of Wide Bay Medicare Local and was part of the Bid Committee for the proposed Primary Health Network (PHN).

Phillip holds degrees from The University of Queensland and The University of Edinburgh. He is a Fellow of the Royal Statistical Society, a Fellow of the Institute of Managers and Leaders Australia/New Zealand, and is currently Chair of The University of Queensland Rural Clinical School Advisory Committee.

Anita Brown
Board Member

Anita is an experienced director, executive manager, governance and legal professional, having worked across a broad range of environments and industries in Australia and internationally.

She has been a solicitor since 1998 and holds bachelor degrees in accountancy and law, a masters degree in law, and certificates in risk management and governance practice and administration.

Anita's previous executive roles include General Counsel and Company Secretary for Transfield Services Americas, and Executive General Manager (Legal and Risk) and Company Secretary for Easternwell Group.

She is also a former non-executive director of the Real Estate Institute of Queensland Ltd (REIQ), and TAFE Queensland.

Trevor Dixon
Board Member

Trevor has more than 30 years' board experience, coupled with a wealth of expertise in corporate finance, accounting, governance and risk.

From 2004–2017 he was an independent director of Prime Super, a $3 billion not-for-profit industry superannuation fund focusing on rural and regional Australia. Throughout his time with the fund, he was also the Deputy Chair of Directors, and chaired the Investment; Remuneration; and Audit, Compliance and Risk committees.

Trevor is a Fellow of CPA Australia and has held a number of Chief Finance Officer roles with a variety of large and smaller privately-owned businesses in Wide Bay and interstate, particularly in the building and agriculture sectors.

His finance background has led to him having a strong governance and risk management focus, and — combined with his strong operational experience — has enabled him to make significant contributions to all of the boards on which he has served.

Simone Xouris
Board Member

Simone has more than 25 years' experience in the health sector and continues to practice in a private capacity as an Accredited Practising Dietitian.

She is currently the General Manager of RHealth, a not-for-profit primary healthcare organisation serving rural and remote communities, and also sits on the Fraser Coast and Southern Downs advisory groups for youth mental health organisation Headspace.

Simone's previous roles have included practising as a dietitian in a variety of locations and positions including public hospitals, community health and private organisations, in rural and remote locations and overseas.

She is a graduate of the Australian Institute of Company Directors.

Leon Nehow
Board Member

Leon has extensive experience as a public servant in State Government, spanning more than 20 years.

Leon, who is of Torres Strait Islander, South Sea Islander, and Aboriginal heritage, has lived in the Fraser Coast region for the past 16 years and, in that time, has been a vocal and engaged participant in initiatives for the benefit of Aboriginal and Torres Strait Islander people and the wider community.

Leon is currently the Principal Officer for Indigenous Strategy and Policy at Fraser Coast Regional Council. His previous roles include Senior Project Officer at the Department of Aboriginal and Torres Strait Islander Partnerships (DATSIP), and a range of roles in Queensland Government departments including cultural development and Indigenous support work.

Leon is a member of the Wide Bay/Burnett/Fraser Coast Regional Community Forum, a Queensland Government initiative to bring local people and government representatives together to discuss local priorities and champion opportunities.

Dr Sandra Rattenbury
Board Member

Sandra has more than 40 years' experience in emergency medicine, general practice and education and training, including a range of senior clinical and health administration roles.

She is currently a Staff Specialist in Emergency Medicine at Bundaberg Hospital, as well as the WBHHS Director of Medical Services (Rural), and the Education and Training Coordinator for emergency medicine at the Wide Bay Regional Training Hub.

Prior to joining WBHHS in 2010, Sandra's previous roles include being a Consultant in Emergency Medicine at Hutt Hospital, New Zealand; a General Practitioner, with a scope including obstetrics, at the Onslow Medical Centre, NZ, which she established; and various medical officer and GP roles in acute and community settings in the UK, NZ and Canada.

She is an Associate Fellow of the Royal Australasian College of Medical Administrators, a Fellow of the Australasian College for Emergency Medicine, and a Fellow of the Royal NZ College of General Practitioners.

Executive management

The Health Service Chief Executive (Chief Executive) is accountable to the Board for all aspects of WBHHS performance, including the overall management of human, material and financial resources and the maintenance of health service and professional performance standards. The Executive Management Team supports the Chief Executive and comprises executive directors with specific responsibilities and accountabilities for the effective performance of the organisation.

To guide the operation of the organisation, an executive committee structure has been designed to facilitate effective strategic governance, operational and management review, improve the transparency of decision making and management of risk. Each executive-level committee has terms of reference clearly describing their respective purpose, functions and authority. These committees provide essential integration and uniformity of approach to health service planning, service development, resource management, and performance management and reporting.

Deborah Carroll
Chief Executive

Deborah has worked in the public health sector for almost 40 years and has held leadership roles across a number of health facilities throughout Queensland.

She has undertaken significant postgraduate studies, including a Master of Health Administration and Information Systems, and a Graduate Certificate in Health Service Planning.

Deborah completed her general nurse training in 1981 at Mackay Base Hospital, and later gained a Bachelor of Health Science (Nursing) with Distinction from Central Queensland University in 1995, a Graduate Diploma in Emergency Nursing and endorsement as a Rural and Isolated Practice registered nurse.

She held several senior positions in north and central Queensland health services, in which she oversaw the introduction of new models of care and clinical governance advances, and the successful completion of several large capital works projects.

Deborah joined WBHHS in 2006 as Executive Director of Nursing and Midwifery Services. She was appointed Chief Operating Officer in 2014, and appointed Chief Executive in May 2020.

Scott McConnel
Executive Director of Finance and Performance

Scott is a qualified accountant and senior executive with more than 25 years' experience across a diverse range of industries in the private and public sectors, both in Australia and internationally.

He has a strong track record of leading continuous improvement and driving change, and in strategic planning for sustainability.

Scott completed a Bachelor of Commerce degree with first-class honours in 1994 and was accepted into the prestigious BHP Billiton four-year graduate program, before spending seven years working in London's financial services industry at senior and director level.

He joined Queensland Health in 2011 as Chief Finance Officer at Darling Downs HHS, and has been WBHHS Executive Director for Finance and Performance since December 2015. He is also a Fellow of Certified Practicing Accountants Australia and a Graduate of the Australian Institute of Company Directors.

Peter Wood
Acting Executive Director of Acute Health and Community Services

Peter has almost 30 years' experience in health care in Australia and internationally, 20 of which have been spent in senior leadership roles.

His previous appointments have included Executive Director BMI Healthcare and General Manager roles with portfolios including Medicine, Surgery, Cardiology, Emergency Services and Critical Care.

Peter has completed a BSC (Hons) Health Management, a postgraduate diploma in healthcare management and a Master of Healthcare Leadership and Management at the universities of Lancaster and Auckland.

Prior to joining WBHHS in 2017 as the General Manager of Emergency and Critical Care, Peter worked in healthcare management roles in the UK and New Zealand. He is currently undertaking a Master of Business Administration.

Robyn Bradley
Executive Director of Mental Health and Specialised Services

Robyn has worked in health management roles for more than 20 years, and has held management and executive leadership positions both in Wide Bay and South West Queensland.

She completed her degree in Occupational Therapy at Curtin University, Western Australia, in 1990 and has subsequently engaged in further studies towards her Master of Health Management.

Robyn has presented papers both at mental health and allied health national and international conferences on rural models of care for mental health services, including

a national Primary Health Network (PHN) conference in 2017 on national mental health planning frameworks and tools.

She has been instrumental in developing new mental health infrastructure and models of care, including the construction and opening of a 20-bed Community Care Unit, a 10-bed Step Up Step Down facility run in partnership with non-government service providers, and current planning for the construction of a new 22-bed acute inpatient unit in Hervey Bay.

Katrina Mathies
Executive Director of Governance

Katrina has more than 30 years of healthcare experience, more than a decade of which has been spent in senior leadership and management roles.

She a began her mental health nursing career at the Baillie Henderson Hospital in 1985, later attaining her general nursing certificate from Toowoomba Hospital. She completed her Bachelor of Health Science (Nursing) at Monash University in 1995.

Prior to joining WBHHS in March 2017, Katrina held several clinical and corporate leadership roles with Darling Downs HHS, followed by six months as Acting Executive Director of Clinical Governance for Townsville HHS.

Katrina holds a Graduate Diploma in Information Technology, a Graduate Diploma in Health Services Management and is a Graduate of the Australian Institute of Company Directors.

Peter Heinz
Executive Director of Human Resource Services

Peter has worked within the public service — both at the federal and state level — for more than 30 years, holding a variety of senior posts in both sectors.

He was appointed WBHHS Executive Director of Human Resource Services in April 2016, after acting in the role since February 2014. Prior to this, he was Human Resources Manager for Bundaberg and North Burnett for four years.

Peter has previously held senior HR roles with the Department of Employment, Economic Development and Innovation; the Department of Tourism, Regional Development and Industry; and the Environmental Protection Agency.

His other roles in the public sector have been with the Department of Defence, including roles in the Australian Signals Directorate, Defence Intelligence Organisation and the Royal Australian Navy, where he was initially trained as a linguistics analyst.

Dr Jennifer King
Executive Director of Medical Services

Jennifer has more than 36 years' experience in health care, including 22 years working at a senior executive level in both the public and private healthcare sectors.

Some of her previous roles include Executive Director of the Mater Mothers', Adults' and Children's Hospital in Brisbane, Executive Director of Princess Alexandra and QEII Hospitals, Executive Director of Logan and Beaudesert Hospitals, and General Manager of Brisbane's Wesley Hospital.

Jennifer is a Fellow of the Royal Australasian College of Medical Administrators (RACMA) and a Fellow of the Australian Institute of Company Directors.

Fiona Sewell
Executive Director of Nursing and Midwifery Services

Fiona has more than 30 years' experience in nursing, more than 15 of which has been spent in senior leadership roles.

She completed her nursing training at Maryborough Base Hospital in 1990 before gaining further experience in other Queensland public and private healthcare facilities.

Fiona moved back to the Wide Bay region in 1994 to take a nursing role at Bundaberg Hospital, following which she was appointed to a diverse range of senior nursing roles at both clinical and managerial levels.

She has successfully completed studies in the areas of orthopaedic nursing, emergency nursing, investigations management and report writing, as well as a postgraduate certificate in health leadership, management and quality, and a Master of Business Administration.

Stephen Bell
Executive Director of Allied Health

Stephen Bell is a registered psychologist with 25 years of healthcare experience, including a decade in senior and executive leadership positions.

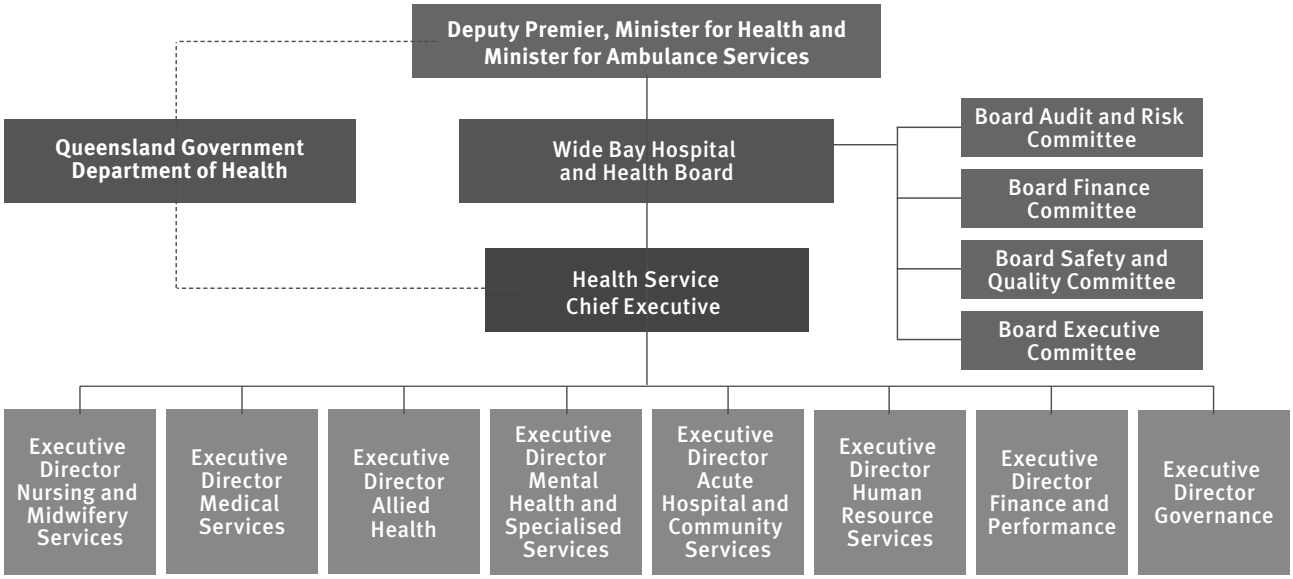
Initially gaining his Bachelor of Psychology degree from James Cook University in 1994, Stephen has worked in a diverse range of specialist and acute public mental health service roles across Queensland, in locations including the Sunshine Coast, Charters Towers and Wide Bay.

As the former Acting Chief Operating Officer for WBHHS's Fraser Coast region, he led several significant achievements and new services including approval for a new Clinical Decisions Unit at Hervey Bay Hospital, and substantial reductions in wait lists for specialist outpatients and endoscopy procedures.

Stephen has a Graduate Certificate of Health Management and is an Associate Fellow of the Australasian College of Health Service Management.

Organisational structure and workforce profile

Organisational structure



Wide Bay Hospital and Health Service (WBHHS) employed a total of 3,341 full-time equivalent staff in 2019–2020, an increase of 114 compared to 2018–2019.

Of that figure, more than 65 per cent of staff performed clinical roles.

WBHHS also values diversity in its workforce, recognising our staff bring a range of skills, experience and influences with them to our workplace. This includes employees from Aboriginal and Torres Strait Islander backgrounds, as well as employees who are Culturally and Linguistically Diverse (CALD) or who have a disability.

In line with WBHHS's strategic plan to develop and support our staff, we have continued to work to increase workforce diversity, including more Aboriginal and Torres Strait Islander people as per statewide targets. As at 30 June 2020, WBHHS employed 60 people who identified as Aboriginal or Torres Strait Islander (10 per cent increase year-on-year), 429 people who were Culturally and Linguistically Diverse (3 per cent decrease year-on-year) and 82 people with a disability (no change year-on-year).

For further details on breakdowns of clinical and First Nations staff members, please see Tables 3 and 4 on the next page.

In 2019–2020, 396.1 full-time equivalent staff separated employment from WBHHS. This equates to a permanent separation rate of 11.8 per cent, compared to 11.4 per cent in 2018–19 and 12.0 per cent in 2017–18. It remains a strategic priority to reduce vacancy rates for critical roles and reduce turnover rates below or in line with Queensland Health averages. WBHHS's turnover rate for 2019–2020 — which specifically measures the turnover of permanent roles — was 5.8 per cent.

Table 3: More doctors and nurses*

	2015–16	2016–17	2017–18	2018–19	2019–20
Medical staff[a]	366	381	360	387	425
Nursing staff[a]	1,237	1,249	1,290	1,377	1,433
Allied Health staff[a]	313	317	336	343	345

Table 4: Greater diversity in our workforce*

	2015–16	2016–17	2017–18	2018–19	2019–20
Persons identifying as being First Nations[b]	33	44	48	55	60

Note: * Workforce is measured in MOHRI – Full-Time Equivalent (FTE). Data presented reflects the most recent pay cycle at year's end. Data presented is to Jun-20.

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

Strategic workforce planning and performance

WBHHS recognises that building a sustainable, educated and valuable workforce to meet future needs, and nurturing an organisational culture that values, recognises and celebrates our workforce, is key in delivering our vision of *Care Comes First…Through Patients' Eyes*.

WBHHS aligns its workforce strategies to the strategies contained in Queensland Health's *Advancing health service delivery through workforce: A strategy for Queensland, 2017–2026*, the Queensland Health *Workforce Diversity and Inclusion Strategy 2017–2022*, the *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026* and the Public Service Commission's (PSC) 10-year human capital outlook.

During the 2019–2020 year, we have continued to build on our recruitment initiatives to promote our region and to attract and retain a diverse skilled workforce. Promotional videos targeting specific vacancies and professions have been developed to complement the existing promotional videos that accompany all job advertisements on the SmartJobs website and other social media platforms such as LinkedIn and Facebook.

As required by the *Public Sector Ethics Act 1994*, the Code of Conduct for the Queensland Public Service has been in place since 2011 and applies to all health service staff. Queensland Health policies and procedures provide for the performance management framework including mandatory requirements for orientation, induction and training, and performance improvement.

Workforce Capability initiatives continue to be developed and implemented, including workshops on workplace culture, building stronger teams and effective communication. Workplace harassment (bullying), sexual harassment and discrimination sessions are run regularly, and all workshops are able to be adapted as in-services to meet particular team needs when requested or identified.

In addition, a temporary Director of Organisational Development was recruited to focus on implementing a number of initiatives linked to the WBHHS Strategic Plan, including developing and rolling out a set of values for WBHHS, implementing a leadership framework with developmental opportunities for all levels and all streams, implementing a face-to-face orientation program and coordinating an employee engagement survey.

The employee engagement survey has not only led to a range of actions being implemented with the aim of constantly enhancing our workplace, but also provided a strong platform from which to develop WBHHS's organisational values. These values, which are supported by behaviours WBHHS expects its workforce to uphold, were developed as a result of workshops and input from staff across the region and are set to be launched in July 2020.

Other organisational development initiatives are still in development phase and are due to be launched during the 2020–2021 year.

Among these are the embedding of the new values in the performance appraisal and development (PAD) process. Not only will this reinforce the importance of the values, but it is also anticipated it will further support the organisation's strategic goal to have more than 90 per cent compliance with staff PAD completion. This is seen as an important way to continually develop and support our staff, both on an individual level and to ensure ongoing and growing workforce capability. As at 30 June 2020, WBHHS's PAD compliance was 79.2 per cent, a figure we intend to keep building on.

Throughout 2019–2020, WBHHS continued on its health, safety and wellbeing journey with a number of new initiatives and continued improvement in safety performance indicators and outputs.

Staff safety remained a key focus, particularly during the latter part of the financial year when the COVID-19 pandemic hit. From March to June 2020, the focus for WBHHS was predominantly around responding to the pandemic and positioning WBHHS to be able to deal with an outbreak in our region. All staff did an outstanding job and demonstrated the ability to be flexible and agile in this rapidly and constantly changing environment.

In June 2020, 11 dedicated nurses from WBHHS put their hands up to volunteer to travel to the North Rockhampton Nursing Centre following a highly publicised positive COVID-19 test of a staff member working at the facility. WBHHS was extremely proud of these nurses for stepping up and helping out during a very uncertain situation.

It was pleasing to see continued safety improvements in most divisions across the HHS in terms of reduced incidents, WorkCover average leave rates and proactive management of safety. The positive improvements in our safety record ensured that WBHHS secured a significant reduction in WorkCover premium for the 2019–2020 year.

We also continued to actively encourage reporting of occupational violence in the workplace, as part of the management of one of WBHHS's key Occupational Health and Safety (OHS) risks.

While our occupational violence numbers are trending down, the risk remains high — which is why WBHHS is currently training all staff in Maybo Australia's occupational violence training throughout the 2019–2020 and 2020–2021 years. Maybo's philosophies are based around preventing violence through improved communication and situational awareness, helping to change behaviours.

All WBHHS frontline staff are required to complete the online training, with staff in higher-risk areas also receiving more intensive training in assault avoidance and/or physical intervention. This is an important step for WBHHS in our continued journey to making our workplaces as safe as possible for our staff.

To date, there has been a high compliance rate regarding the mandatory training component, with the remaining staff to complete their training by September 2020.

Moving into 2020–2021, our focus will remain safety orientated, with control effectiveness audits and reviews forming a major part of our future plans, to ensure our safety controls are in place and sustainable. We will also continue to pro-actively respond to the COVID-19 pandemic as part of our new normal.

Our Employee Assistance Provider, Converge International, continues to offer a confidential, personal coaching and short-term counselling service to all staff for a variety of personal and/or work issues and provides access to qualified professionals including psychologists, social workers and management coaches throughout Queensland.

During the initial phase of the COVID-19 pandemic, WBHHS accessed Converge International to provide intense support to all staff through webinars, virtual counselling sessions, and COVID-19 specific information sheets covering a range of issues including financial wellbeing, psychological wellbeing and working from home tips.

In line with our strategic plan, WBHHS continues to develop and support our staff through a range of programs and initiatives, including:

- Nursing Graduate program across WBHHS facilities
- Medical Graduate program at Hervey Bay and Bundaberg hospitals
- Workplace-Based Assessment program, offered through Hervey Bay Hospital, which delivers continuous assessment of an International Medical Graduate's skills in a hospital setting over the course of a year, rather than in a one-off exam
- Medical Training program, in partnership with tertiary institutions and Learned Colleges
- Education, Training and Research support
- Cultural Capability Program.

Early retirement, redundancy and retrenchment

No early retirement, redundancy or retrenchment packages were paid during the 2019–2020 period.

Our risk management

WBHHS recognises that risk management is an essential element of good corporate governance and is committed to managing risk in order to ensure its strategic and operational objectives are achieved.

WBHHS has established and maintained a risk management system based on the Australian/New Zealand Standard ISO31000:2018 *Risk Management — Principles and guidelines*, and the National Safety and Quality Health Service Standard 1 — *Governance for Safety and Quality in Health Service Organisations*.

WBHHS has refined and enhanced its approach to managing risk to drive a consistent approach to managing risk across a multidisciplinary, complex organisation.

Risk management issues are regularly monitored and reported to the Board through the Audit and Risk Committee and the Safety and Quality Committee.

A significant ongoing focus has been on the delivery of risk management training and the operationalisation of risk management practice. This area will continue being developed to deliver high-quality risk management training that empowers WBHHS employees to undertake their work duties while remaining risk aware, ultimately informing service and strategic planning processes.

It is anticipated that this ongoing activity will build workforce core competencies in risk management activity over the longer term, supporting enhanced decision making, improved quality and performance in WBHHS.

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 2019–2020 period, no directions were given by the Deputy Premier, Minister for Health and Minister for Ambulance Services to WBHHS.

Internal audit

To ensure the effective, efficient and economic operation of the internal audit function, WBHHS internal audit operates under its own charter and reports directly to the Board Audit and Risk Committee. The charter aligns with the *International Standards for Professional Practice of Internal Auditing* developed by the Institute of Internal Auditors.

The primary role of internal audit is to conduct independent, objective and risk-based assurance activities.

During the 2019–2020 period, WBHHS used a model of contracted auditors for the purpose of internal audit arrangement. The scope of work set out in the approved Internal Audit Plan 2019–2020 was delivered through a contractual arrangement with KPMG.

In line with its Terms of Reference and having due regard to Queensland Treasury's Audit Committee Guidelines, the Board Audit and Risk Committee oversaw delivery of the internal audit program, including the review of report findings and management responses.

External scrutiny, information systems and recordkeeping

WBHHS operations are subject to regular scrutiny from external oversight bodies. These include but are not limited to the Queensland Audit Office (QAO), Crime and Corruption Commission, Office of the Health Ombudsman, Australian Council on Healthcare Standards, Queensland Ombudsman, and the Coroner.

WBHHS has mechanisms in place to monitor and report on corrective actions taken to implement recommendations made from external agencies.

The *Public Records Act 2002* and *Queensland State Archives (QSA) Records Governance Policy April 2019 v1.0.2* has provided the overarching guidance for administrative records governance within WBHHS. The Queensland State Archives also provides additional guidelines relevant to retention and disposal of both paper-based and digitised records, and the Queensland Health Corporate Services Division Corporate Information Management (CIM) provide additional resources and tools to support administrative records governance.

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

Corporate records governance leadership, authority and responsibilities are assigned to appropriately qualified and experienced staff.

Clinical records are maintained in accordance with a retention and disposal system compliant with the *Queensland State Archives Health Sector (Clinical Records) Retention and Disposal Schedule (QDAN683 V.1)* and any disposal freeze issued by the State Archivist. A WBHHS Clinical Records Management Guideline inclusive of a culling schedule ensures clinical records are appropriately stored, archived and destroyed.

WBHHS has also developed an Information Governance Framework and Operating Model which encompasses the strategic drivers, legislative environment and the policies and procedures which impact the governance of the WBHHS's information and data.

This Information Governance Framework (IGF) and Operating Model provides a consistent enterprise approach to information governance. The framework includes the following components:

- obligations, including legislation, policies and standards
- roles, responsibilities and governing bodies
- decision rights
- enterprise governance controls
- principles
- risks
- performance measures.

Queensland Public Service ethics

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

All staff employed by WBHHS are required to undertake training in the *Code of Conduct for the Queensland Public Service* during their orientation, and re-familiarise themselves with the Code at regular intervals.

All employees are expected to uphold the code by committing to and demonstrating the intent and spirit of the ethics principles and values. WBHHS supports and encourages the reporting of Public Interest Disclosures. All employees have a responsibility to disclose suspected wrongdoing in accordance with the WBHHS Public Interest Disclosure Policy.

Human Rights

Queensland's *Human Rights Act 2019* (the Act) came into force on 1 January 2020, with the aim of protecting and promoting human rights, building a culture in the Queensland public sector that respects and promotes human rights, and promoting dialogue about the nature, meaning and scope of human rights.

Under the Act, hospital and health services are required to disclose details of the actions taken to further its objectives; to detail any complaints received under the Act, and their outcomes; and to detail reviews of policies, programs, procedures, practices or services undertaken for their compatibility with human rights.

In 2019–2020, WBHHS took a wide range of actions to further the objectives of the Act, including an executive determination that human rights training be mandatory for all employees. The Human Rights training module is currently being developed for incorporation into WBHHS's mandatory training program, and is being supported by the development of a dedicated Human Rights intranet site with information and links for staff.

As key position holders providing advice to line managers and employees, legal and human resources staff have been provided with targeted training on the Act. The training has been delivered online using the general Queensland Human Rights Commission training package, as well as the package specifically designed for mental health workers and those in other specific clinical settings. Information has also been shared with line managers and employees to help them understand their obligations under the Act, in the form of FAQ documents, Heads of Department presentations, the distribution of posters published by the Commission, and providing staff access to the Commission's online training program.

There is also planning under way for Human Rights Month promotional activities in November 2020. This will be aided by an internal Expression of Interest process seeking Human Rights Champions, which yielded several interested participants across the HHS. A network has now been established for the channelling of promotional activities within the workplace and the spreading of awareness, with the goal of promoting a human rights culture in the workplace.

Also key to WBHHS's implementation has been a comprehensive review of our policies, programs, procedures, practices and services to ensure they are compatible with the objectives of the Act.

This includes:

- Ongoing review of contractual and partnership arrangements
- Ongoing assessment of strategic documents for incorporation of human rights considerations
- Human rights considerations built into development of all new or reviewed policies and procedures
- Development of a complaints template to aid staff when assessing the complaint against the domains of the Act
- Consideration of options for risk management (Riskman) recording and reporting to ensure compliance with the reporting aspects of complaints and the Act
- A plan for the review and upgrade of the Consumer Feedback procedure to include Human Rights requirements.

In 2019–2020, WBHHS did not receive any complaints under the *Human Rights Act 2019*.

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

Service standards

Table 5: Service Standards — Performance 2019–20

Service Standards	Target	Actual
Effectiveness measures		
Percentage of patients attending emergency departments seen within recommended timeframes: [a]		
Category 1 (within 2 minutes)	100%	99.5%
Category 2 (within 10 minutes)	80%	82.0%
Category 3 (within 30 minutes)	75%	77.8%
Category 4 (within 60 minutes)	70%	79.8%
Category 5 (within 120 minutes)	70%	95.2%
Percentage of emergency department attendances who depart within four hours of their arrival in the department [a]	>80%	80.2%
Percentage of elective surgery patients treated within clinically recommended times: [b]		
Category 1 (30 days)	>98%	99.8% [1]
Category 2 (90 days)	>95%	97.6%
Category 3 (365 days)	>95%	100.0%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days [c]	<2	0.8 [2]
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit [d]	>65%	66.9%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge [d]	<12%	9.1% [3]
Percentage of specialist outpatients waiting within clinically recommended times: [e]		
Category 1 (30 days)	98%	98.6% [1]
Category 2 (90 days)	95%	98.1%
Category 3 (365 days)	95%	89.2%
Percentage of specialist outpatients seen within clinically recommended times: [e]		
Category 1 (30 days)	98%	99.2% [1]
Category 2 (90 days)	95%	97.9%
Category 3 (365 days)	95%	97.5%
Median wait time for treatment in emergency departments (minutes) [a]	..	14
Median wait time for elective surgery (days) [b]	..	29

[1] Non urgent elective surgery and specialist outpatient services were temporarily suspended as part of COVID-19 preparation. Seen in time performance and service volumes were impacted as a result.

[2] The Epidemiology and Research Unit in the Communicable Diseases Branch are unable to provide full year SAB data as resources are redirected to the COVID-19 response. SAB data presented as Mar-20 FYTD and is preliminary.

[3] Readmission to acute Mental Health inpatient unit data presented as May-20 FYTD.

Service Standards	Target	Actual
Efficiency Measure		
Average cost per weighted activity unit for Activity Based Funding facilities [f,g]	$ 4,734	$5,014 [4]
Other Measures		
Number of elective surgery patients treated within clinically recommended times: [b]		
Category 1 (30 days)	2,145	1,973 [1]
Category 2 (90 days)	1,680	1,421
Category 3 (365 days)	1,576	1,352
Number of Telehealth outpatient occasions of service events [h]	7,220	6,911
Total weighted activity units (WAU's) [g]		
Acute Inpatient	54,794	53,792 [5]
Outpatients	16,062	15,602
Sub-acute	8,431	7,802
Emergency Department	16,932	16,101
Mental Health	4,431	4,343
Prevention and Primary Care	2,562	3,488
Ambulatory mental health service contact duration (hours) [d]	>34,523	39,874
Staffing [i]	3,266	3,341

[4] Cost per WAU data presented as Mar-20 FYTD.

[5] Delivery of activity and weighted activity units was impacted by two significant factors in 2019-20; the introduction of a revised Australian Coding Standard "0002 Additional diagnoses" from 1 July 2019, resulted in lower weighted activity units being calculated for admitted patients relative to the same casemix of 2018-19 year and COVID-19 preparation and the temporary suspension of non-urgent planned care services reduced the volume of patient activity. Activity data presented is preliminary. Data presented is full year as at 17 August 2020.

Source: [a] Emergency Data Collection, [b] Elective Surgery Data Collection, [c] Communicable Diseases Unit, [d] Mental Health Branch, [e] Specialist Outpatient Data Collection, [f] DSS Finance, [g] GenWAU, [h] Monthly Activity Collection, [i] DSS Employee Analysis. **Note:** Targets presented are full year targets as published in 2019-20 Service Delivery Statements.

Strategic objectives and performance indicators

WBHHS's guiding document has been the Strategic Plan 2018–2022, which sets out the vision for how we work to improve the health and wellbeing of our community.

WBHHS Strategic Direction: Enhance holistic health care

Performance indicators against strategic measurables include:

- Significant expansion of consumer representation on WBHHS committees and creation of new consumer groups, including Consumer Partnership Group, Cancer Care Consumer Advisory Group and Bundaberg Paediatric Consumer Advisory Group.
- All but one committee aligned to National Safety and Quality Health Service (NSQHS) Standards includes consumer representation, with recruitment continuing.
- In total, more than 260 consumers were registered as at 30 June 2020 to partner with WBHHS to plan, monitor, contribute to and provide feedback on services and programs.
- Establishment of virtual COVID-19 Consumer Advisory Group, to collaborate on processes and information sharing during COVID-19.
- During 2019-2020, WBHHS more than doubled its social media following, growing from 6,767 Facebook likes on 1 July 2020 to 14,271 by 30 June 2020. A major contributor to this was the public desire for COVID-19 information during the peak of the pandemic response, with some single posts achieving an audience reach of between 50,000 and 90,000.
- 99.5 per cent of complaints acknowledged within 5 calendar days (target is 100 per cent).
- 87.5 per cent of complaints resolved within 35 calendar days (target is at least 80 per cent). Average complaint resolution timeframe is 18 calendar days.
- 68.2 per cent of Severity Assessment Code 1 (SAC1) clinical incident investigations completed within 90 days (target is at least 70 per cent). Average investigation completion timeframe for SAC1 investigations is 99.3 days.
- Significant progress on meaningful consumer partnerships to meet our goal of fully complying with the criteria for the NSQHS's Partnering with Consumers standard. This includes the development of a suite of documents and resources now being used and promoted throughout the organisation, including a procedure for consumer and community engagement, information for consumer representatives, and quick reference guides for consumer roles.

WBHHS Strategic Direction: Deliver more care locally

Performance indicators against strategic measurables include:

- All categories of emergency department patients seen within clinically recommended timeframes, with exception of Category 1 (98.7 per cent, compared to target of 100 per cent).
- Sustained achievement of more than 80 per cent of Wide Bay patients having an Emergency Length of Stay (ELOS) of four hours or less, prior to admission or discharge (80.3 per cent, with Queensland target at least 80 per cent).
- Meeting all targets for Elective Surgery for sixth consecutive year, with vast majority of patients treated in the clinically recommended timeframe.
- Meeting almost all targets for Specialist Outpatients, with vast majority of patients seen in the clinically recommended timeframe.
- Meeting almost all targets for Endoscopy, with vast majority of patients seen in the clinically recommended timeframe.
- Meeting all targets for general dental appointments, with no patient waiting longer than clinically recommended timeframe.
- 4.4 per cent increase in non-admitted Telehealth occasions of service compared to 2018–19 (WBHHS target is 20 per cent increase), and 112 per cent year-on-year increase in admitted Telehealth occasions of service.
- Increase in the number of specialties providing Telehealth from 24 in 2018–19 to 31 in 2019–20.
- Implementation of a Patient Experience Survey across multiple wards and facilities, with a focus on improving patient-centred care. Surveys were guided by the Australian Commission on Safety and Quality in Health Care's hospital patient experience question set, with outcomes including recommendations on changes to food options, set meal times and noise management.

WBHHS Strategic Direction: Excellence through innovation

Performance indicators against strategic measurables include:

- Funding secured to advance project work supporting the development of a regional medical program, in partnership with Central Queensland HHS, CQUniversity Australia and The University of Queensland.
- Annual WBHHS Excellence Awards held to recognise and reward innovation that leads to and drives better patient outcomes.
- End-of-year deficit of $7.6 million, equating to 1.1 per cent of $683 million operating revenue. For more information, see financial summary on page 28 and financial statements on page FS-1.
- Partnerships in place with the following local health service providers, to enhance access to specialist services close to home:
    - GenesisCare Cardiology — Cardiac investigations, coronary angiography and interventions (Hervey Bay, Bundaberg)
    - GenesisCare Oncology — Radiation oncology services (Hervey Bay, Bundaberg)
    - Mater Hospital Bundaberg — Paediatric ear, nose and throat services
    - iMed (CQ) — Onsite and offsite radiologist services, including interventional and consultancy services (Bundaberg, Hervey Bay and Maryborough) and radiology reporting (all Wide Bay facilities)
    - Bundaberg Private Day Hospital — Endoscopy services and cataract surgery
    - Hervey Bay Surgical Hospital — Endoscopy and ophthalmology services
    - Wide Bay Neuroscience — Neurological services
    - Bundaberg Health Promotions – Cardiac and pulmonary rehabilitation programs.

WBHHS Strategic Direction: Plan today for future infrastructure

Performance indicators against strategic measurables include:

- Significant progress on detailed business case for a new hospital in Bundaberg on a new site, which is due to be submitted to State Government in 2021.
- Completion and opening of upgraded emergency department, specialist outpatients department and main reception area at Maryborough Hospital.
- Funding secured and completion of detailed design phase for a new 22-bed acute mental health inpatient unit at Hervey Bay Hospital and 10-bed sub-acute older persons unit at Maryborough.
- Near completion of refurbishment works to Eidsvold Multipurpose Health Service, upgrading multiple patient and staff areas and improving water and fire safety infrastructure.
- Funding secured and major tenders awarded for substantial upgrade to Hervey Bay Hospital main power switchboard, to improve electrical infrastructure resilience, with works due to start in July 2020.
- Completion of upgrades to Maryborough Hospital air-conditioning system.
- Completion of upgrades to Maryborough Hospital electrical infrastructure.
- Implemented a formal system of asset lifecycle planning.
- Approval of capital investment proposals for asset renewal/replacement that are prioritised according to the Strategic Asset Management Plan.

WBHHS Strategic Direction: Develop and support our staff

Performance indicators against strategic measurables include:

- Continued investment in education, training and research support, with outcomes including:
    - More than 800 in-situ simulation education events carried out, involving more than 7,300 employee attendances, ensuring active ongoing proficiency in practices that supports the best possible patient outcomes. This included more than 100 Advanced Life Support scenarios facilitated in clinical work environments.
    - 128 COVID-19-specific simulation education sessions from March 2020 to May 2020 alone, with attendance of 1,424 clinicians, to enhance readiness and mitigate errors in times of pressure and rapid response.
    - More than 470 individual education courses delivered through WBHHS's TrainStation learning management system, including 200 online courses developed by our own staff to

meet the specific needs of our workforce and population.

  - WBHHS hosted a statewide Clinical Skills Development Service's Pocket Centre Simulation Collaborative in November 2019, in recognition of its leading statewide role in ward-based and in-situ simulation education.
  - 70.5 per cent staff completion rate of Cultural Practice training in 2019–2020, compared to 54 per cent in June 2019. Compliance in rural facilities exceeds 78 per cent.
  - Development of targeted Cultural Capability training sessions contextualised for key clinical areas, including Palliative Care, Oral Health and Midwifery.
  - Development and recruitment of three Associate Nurse Educator roles across WBHHS's rural division, to specifically support rural nurse education.
  - Supporting WBHHS staff to pursue health-related, outcome-focused research projects, with 84 research activities being conducted with Human Ethics Research Committee approval, and a further 70 in development.
- Recruitment of 88 graduate Registered Nurses — an increase of 28 per cent on the previous year's intake — including 39 at Bundaberg Hospital, 39 at Fraser Coast hospitals, and 10 in rural facilities.
- Recruitment of one or more graduate nurses to all seven rural hospitals or multipurpose health services, with many continuing in their roles beyond their graduate year.
- 55th Resident Medical Officer (RMO) has completed Hervey Bay Hospital's successful Workplace-Based Assessment program for international medical graduates, with another 12 RMOs currently completing the program and more on the waiting list. The current success rate of the program is 100 per cent.
- 10 per cent increase in Aboriginal and Torres Strait Islander workforce.
- 79.2 per cent of staff had taken part in a performance appraisal and development process up to 30 June 2020 (WBHHS target is at least 90 per cent).
- Turnover rate (measuring turnover of permanent roles only) of 5.8 per cent in 2019-2020.
- WorkCover average leave rate (measuring work time lost to injury) of 0.58 per cent, compared to 0.44 per cent in 2018–19 (Queensland Health target is 0.3 per cent). More work is planned in 2020–21 to ensure our safety controls are in place and sustainable, including control effectiveness audits and reviews.

Financial summary

2019–2020: in review

Wide Bay Hospital and Health Service ended the 2019–2020 financial year with a deficit of $7.6 million, which equates to 1.1 per cent of its operating revenue of $683 million.

The early half of this financial year saw ever increasing demand on the service in excess of funded levels with a cap on Commonwealth contributions continuing in 2019–2020.

The second half of the financial year saw the impact of COVID-19 and the necessity to provide appropriate but less efficient models of care in response to the emerging pandemic including fever clinics and dedicated isolation spaces. In addition, a number of revenue sources were reduced following slowdowns in elective work as directed by the Commonwealth. The Commonwealth and State agreed to guarantee funding under the National Health Reform Agreement, helping minimise the impact on the service.

Anticipated maintenance

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. Anticipated maintenance items are identified through the completion of triennial condition assessments, and the value and quantum of anticipated maintenance will fluctuate in accordance with the assessment programs and completed maintenance works.

As at 3 June 2020, WBHHS had a reported total anticipated maintenance of $52.3 million. WBHHS is currently completing a condition assessment program for its facilities, and the value of anticipated maintenance may vary as a result.

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

- Continue planned reduction of maintenance liability as identified in the current Asset Management and Maintenance Plan
- Address any unplanned item using annual maintenance budget if the risk profile changes and work needs to be carried out urgently
- Continue to seek assistance from the Priority Capital Program to address eligible items
- Maximise capital projects to reduce maintenance liability where possible.

2020–2021: an outlook

With uncertainty regarding any future COVID-19 progression, the service is supporting the State Government's recovery program focused on remaining ready to respond while being cognisant of the fiscal challenges.

WBHHS has launched the Health System Sustainability Program, focused on transformation and optimisation of services leveraging off technology and innovation in order to meet growing demand from an older, sicker, poorer population in a capped funding environment. This builds on the work the service has already implemented over recent years that continue to reap benefits in 2019–2020 and beyond, including improved value for money in clinical services sourced from the private sector, improved procurement outcomes in areas such as prosthetics, and better WorkCover performance.

Financial sustainability remains a key strategic risk to WBHHS, given tightening financial pressures and growing demand. The Board and Executive are committed to delivering productivity and efficiency improvements to meet increasing demand for services without compromising safety and quality.

Wide Bay Hospital and Health Service

Financial Statements - 30 June 2020

Wide Bay Hospital and Health Service

Wide Bay Hospital and Health Service

STATEMENT OF COMPREHENSIVE INCOME

for the year ended 30 June 2020

OPERATING RESULT	Notes	2020 $'000	2019 $'000
Income			
User charges and fees	A1-1	**54,979**	50,269
Funding for public health services	A1-2	**610,055**	580,306
Grants and other contributions	A1-3	**10,278**	9,981
Other revenue	A1-4	**7,859**	6,368
Total Revenue		**683,171**	646,924
Gain on disposals		**38**	18
Total Income		**683,209**	646,942
Expenses			
Employee expenses	A2-1	**69,662**	66,158
Health service employee expenses	A2-2	**388,025**	351,512
Supplies and services	A2-3	**203,101**	196,407
Interest on lease liabilities	B8-1	**259**	-
Depreciation and amortisation	B5-1	**22,402**	17,336
Impairment losses / (reversals)	B2-2	**243**	(178)
Other expenses	A2-4	**7,084**	6,540
Total Expenses		**690,776**	637,775
Operating Result for the year		**(7,567)**	9,167
Other Comprehensive Income			
Items that will not be reclassified subsequently to profit or loss			
Increase / (decrease) in asset revaluation surplus	B9-2	**5,188**	25,337
Total Other Comprehensive Income for the year		**5,188**	25,337
Total Comprehensive Income for the year		**(2,379)**	34,504

The accompanying notes form part of these statements.

Wide Bay Hospital and Health Service

STATEMENT OF FINANCIAL POSITION

as at 30 June 2020

	Notes	2020 $'000	2019 $'000
Current Assets			
Cash and cash equivalents	B1	**27,629**	27,700
Receivables	B2	**8,335**	13,921
Inventories	B3	**4,553**	4,721
Other assets	B4	**5,046**	773
Total Current Assets		**45,563**	47,115
Non-Current Assets			
Property, plant and equipment	B5-1	**307,283**	305,058
Right-of-use assets	B8-1	**10,159**	-
Other assets	B4	**-**	13
Total Non-Current Assets		**317,442**	305,071
Total Assets		**363,005**	352,186
Current Liabilities			
Payables	B6	**35,645**	31,954
Lease liabilities	B8-1	**1,647**	-
Accrued employee benefits		**2,973**	2,434
Other liabilities	B7	**66**	79
Total Current Liabilities		**40,331**	34,467
Non-Current Liabilities			
Lease liabilities	B8-1	**8,685**	-
Total Non-Current Liabilities		**8,685**	-
Total Liabilities		**49,016**	34,467
Net Assets		**313,989**	317,719
Equity			
Contributed equity	B9-1	**231,039**	229,266
Accumulated surplus / (deficit)		**4,019**	11,586
Asset revaluation surplus	B9-2	**78,931**	76,867
Total Equity		**313,989**	317,719

The accompanying notes form part of these statements.

Wide Bay Hospital and Health Service

STATEMENT OF CHANGES IN EQUITY

for the year ended 30 June 2020

	Notes	Contributed equity $'000	Asset revaluation surplus $'000	Accumulated surplus/ (deficit) $'000	Total equity $'000
Balance as at 1 July 2018		219,908	51,530	2,419	273,857
Operating Result					
Operating result from continuing operations		-	-	9,167	9,167
Other Comprehensive Income					
Increase in asset revaluation surplus		-	25,337	-	25,337
Total Comprehensive Income for the Year		-	25,337	9,167	34,504
Transactions with Owners as Owners:					
Non-appropriated equity asset transfers	B9-1	5,479	-	-	5,479
Non-appropriated equity injections - capital works	B9-1	21,215	-	-	21,215
Non-appropriated equity withdrawals - depreciation funding	B9-1	(17,336)	-	-	(17,336)
Net Transactions with Owners as Owners		9,358	-	-	9,358
Balance at 30 June 2019		**229,266**	**76,867**	**11,586**	**317,719**
Balance as at 1 July 2019		229,266	76,867	11,586	317,719
Operating Result					
Operating result from continuing operations		-	-	(7,567)	(7,567)
Prior year adjustments	B9-2	3,124	(3,124)		-
Other Comprehensive Income					
Increase in asset revaluation surplus		-	5,188	-	5,188
Total Comprehensive Income for the Year		3,124	2,064	(7,567)	(2,379)
Transactions with Owners as Owners:					
Equity asset transfers	B9-1	2,933			2,933
Non-appropriated equity injections - capital works	B9-1	18,118			18,118
Non-appropriated equity withdrawals - depreciation funding	B9-1	(22,402)			(22,402)
Net Transactions with Owners as Owners		(1,351)	-	-	(1,351)
Balance at 30 June 2020		**231,039**	**78,931**	**4,019**	**313,989**

The accompanying notes form part of these statements.

Wide Bay Hospital and Health Service

STATEMENT OF CASH FLOWS

for the year ended 30 June 2020

	Notes	2020 $'000	2019 $'000
Cash flows from operating activities			
Inflows			
User charges and fees		**642,580**	610,029
Grants and other contributions		**4,637**	4,634
GST input tax credits from ATO		**13,342**	14,671
GST collected from customers		**616**	540
Other receipts		**10,140**	5,293
Outflows			
Employee expenses		**(69,058)**	(65,970)
Health service employee expenses		**(384,402)**	(350,025)
Supplies and services		**(196,708)**	(192,807)
GST paid to suppliers		**(13,708)**	(13,731)
GST remitted to ATO		**(519)**	(459)
Other payments		**(6,819)**	(6,386)
Net cash provided by operating activities	CF-1	**101**	5,789
Cash flows from investing activities			
Inflows			
Sales of property, plant and equipment		**82**	18
Outflows			
Payments for property, plant and equipment		**(15,075)**	(27,547)
Net cash used in investing activities		**(14,993)**	(27,529)
Cash flows from financing activities			
Inflows			
Equity injections		**16,539**	35,701
Outflows			
Lease payments	CF-2	**(1,718)**	-
Net cash provided by financing activities		**14,821**	35,701
Net increase in cash and cash equivalents		**(72)**	13,961
Cash and cash equivalents at the beginning of the financial year		**27,700**	13,739
Cash and cash equivalents at the end of the financial year	B1	**27,629**	27,700

The accompanying notes form part of these statements.

Wide Bay Hospital and Health Service

NOTES TO THE STATEMENT OF CASH FLOWS

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

	2020 $'000	2019 $'000
Operating result	**(7,567)**	9,167
Non-cash items:		
Depreciation grant funding	**(22,402)**	(17,336)
Depreciation and amortisation	**22,402**	17,336
Donations below fair value	**(5,608)**	(5,206)
Services below fair value	**5,608**	5,206
Net (Gain) / Loss on disposal of assets	**169**	202
Donated non-cash assets	**(34)**	(34)
Interest on Lease Liabilities	**259**	-
Changes in assets and liabilities:		
(Increase) / Decrease in receivables	**7,165**	(385)
(Increase) / Decrease in inventories	**171**	(124)
(Increase) / Decrease in contract assets	**(4,246)**	-
(Increase) / Decrease in prepayments	**(28)**	(476)
Increase / (Decrease) in trade payables	**3,619**	(2,006)
Increase / (Decrease) in contract liabilities and unearned revenue	**(14)**	(741)
Increase / (Decrease) in accrued employee benefits	**607**	186
Net cash provided by operating activities	**101**	5,789

CF-2 Change in liabilities arising from financing activities

	2020 $'000	2019 $'000
Lease Liabilities		
Balance at 1 July 2019	**4,476**	-
Non-cash movements:		
New leases acquired during the year	**7,345**	-
Lease interest	**259**	-
Other non-cash adjustments	**(30)**	-
Cashflows:		
Lease repayments	**(1,718)**	-
	10,332	-

BASIS OF FINANCIAL STATEMENT PREPARATION

GENERAL INFORMATION

The Wide Bay Hospital and Health Service (WBHHS) was established on 1st July 2012 as a not-for-profit statutory body under the *Hospital and Health Boards Act 2011 and* is domiciled in Australia. The HHS is responsible for providing primary health, community and health services and hospital services in the area assigned under the *Hospital and Health Boards Regulation 2012*.

Funding is obtained predominately through the purchase of health services by the Department of Health (DoH) on behalf of both the State and Australian Governments. In addition, health services are provided on a fee for service basis mainly for private patient care.

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

The head office and principal place of business of WBHHS is:

c/- Bundaberg Hospital
271 Bourbong Street,
Bundaberg QLD 4670

COMPLIANCE WITH PRESCRIBED REQUIREMENTS

The financial statements:

- are general purpose financial statements and have been prepared in compliance with section 62(1) of the *Financial Accountability Act 2009* and section 43 of the *Financial and Performance Management Standard 2019;*
- have been prepared in accordance with all applicable new and amended Australian Accounting Standards and Interpretations as well as the *Queensland Treasury's Minimum Reporting Requirements for the year ended 30 June 2020*, and other authoritative pronouncements;
- have been prepared on an accrual basis (except for the statement of cash flows which is prepared on a cash basis).

PRESENTATION

The financial statements:

- are presented in Australian dollars;
- have been rounded to the nearest $1,000 or, where the amount is $500 or less, to zero unless the disclosure of the full amount is specifically required;
- present reclassified comparative information where required for consistency with the current year's presentation;
- 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' as WBHHS does not have an unconditional right to defer settlement beyond 12 months after the reporting date. All other assets and liabilities are classified as non-current.

MEASUREMENT

The financial statements:

- are prepared on a historical cost basis, except where stated otherwise.
    - **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** 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.
    - **Net realisable value** represents the amount of cash or cash equivalents that could currently be obtained by selling an asset in an orderly disposal.

AUTHORISATION OF FINANCIAL STATEMENTS FOR ISSUE

The general-purpose financial statements are authorised for issue by the Chair of the Board, the Chief Executive and the Chief Financial Officer at the date of signing the Management Certificate.

FURTHER INFORMATION

For information in relation to WBHHS's financial statements:
Visit the WBHHS website at: www.health.qld.gov.au/widebay

NOTES ABOUT FINANCIAL PERFORMANCE

A1 REVENUE

Note A1-1: User charges and fees

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Pharmaceutical Benefit Scheme	**28,924**	24,479
Sales of goods and services	**4,162**	7,228
Hospital fees	**20,851**	17,672
Other user charges and fees		
Sales of goods and services	**1,042**	890
Total	**54,979**	50,269

User charges and fees controlled by the HHS primarily comprises hospital fees (private patients), reimbursement of pharmaceutical benefits, sale of goods and services and inter-entity recoveries.

Disclosures – Revenue from contracts with customers

Revenue from contracts with customers is recognised when the HHS transfers control over a good or services to the customer. The following table provides information about the nature and timing of the satisfaction of performance obligations, significant payment terms, and revenue recognition for user charges and fees revenue associated with contracts with customers.

Type of goods or services	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policy
Hospital fees	WBHHS receives revenue for the provision of public health services to both admitted and non-admitted patients. Payments for these services are received from several sources such as private patients, compensable patients and ineligible patients at the time of discharge from hospital.	Revenue is recognised on delivery of the services to the customers under AASB 15.
Sales of goods and services	WBHHS receives inter-entity and other Government entity recoveries for services provided as well as small amounts of revenue from individuals for goods and services provided. Their services are generally provided to customers simultaneously receiving and consuming the benefits provided.	Revenue is recognised on delivery of goods and services to the customers under AASB 15.
Pharmaceutical benefit scheme (PBS) reimbursements	Public hospital patients can access medicines listed on the PBS if they are being discharged or attending outpatient day clinics and admitted receiving chemotherapy treatment. Medicare Australia reimburse the cost of the pharmaceutical items at the agreed wholesale price. Reimbursements are claimed electronically via PBS online payments and submitted to Medicare and directly paid to WBHHS.	Revenue is recognised as drugs are distributed to patients on behalf of the customer under AASB 15.

Note A1-2: Funding for public health services

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Activity based funding	**465,947**	443,504
Other funding for public health services		
Block funding	**70,053**	60,347
Department of Health funding *	**74,055**	76,455
Total	**610,055**	580,306

** Includes $2.2m (2019 $4.4m) in accrued funding from the Department at 30 June 2020, $1.4m of the accrued revenue relates to COVID-19. Refer to note C4 for more information on the impact of COVID-19 on the financial statements.*

WBHHS's funding is provided predominantly from the Department for specific public health services purchased in accordance with an enforceable contract under a Service Level Agreement. Payments received under this agreement represents funding from both the Commonwealth and State Governments. The Commonwealth pays their contribution of the National Health Funding directly to the Department, for distribution to the Hospital and Health Services.

A1 REVENUE *(Continued)*

The Service Level Agreement is reviewed periodically and updated for changes in activities and prices of services delivered by the HHS. Cash funding from the Department is received fortnightly for State payments and monthly for Commonwealth payments. At the end of the financial year, an agreed technical adjustment between the Department and WBHHS may be required for the level of services performed above or below agreed levels. The Service Level Agreement between the Department and WBHHS includes depreciation funding provided by non-cash revenue to be offset against an equity withdrawal which is presented in the Statement of Changes in Equity.

Disclosures – Funding for public health services

The following table provides information about the nature and timing of the satisfaction of performance obligations, significant payment terms, and revenue recognition for funding for the provision of public health services.

Type of goods or services	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policy
Activity based funding	WBHHS provides public health services to all patients under the Service Level Agreement with the Department. The Department's purchasing model determines the volume and type of services to be purchased from WBHHS, the prices that 'activity based' services are purchased and any efficiency adjustments applied. The SLA is reviewed periodically and updated for changes in activities and the prices of services delivered as service demands and state priorities change. The Commonwealth Government has agreed to provide a guaranteed Activity Based Funding envelope for the 2019-20 financial year as a result of the COVID-19 pandemic. As such, the DoH will not make any financial adjustments for under-delivery or over-delivery against ABF targets for the 2019-20 financial year.	Revenue is recognised as activity is delivered over time and using the Queensland Efficiency Price (QEP) or other prices in accordance with the SLA in accordance with AASB 15.
Block funding	Block Funding is received for other public health services that are not based on public health care activity, predominately for rural health facilities and teacher training and research. Block funding, although under enforceable agreement, do not contain sufficient specific performance obligations and is recognised as revenue when received.	Revenue is recognised on receipt of funding in accordance with AASB 1058.
Department of Health funding	WBHHS receives other funding from the Department including funding not covered by the National Health Reform Agreement (NHRA) and depreciation funding. Depreciation funding is provided to offset the depreciation/amortisation expense incurred by WBHHS. This is non-cash revenue and is offset with an equity withdrawal. Other funding not covered by the NHRA can be with or without specific performance obligations.	Depreciation funding is recognised under AASB 1058. Other funding revenue is recognised under AASB 15 where there are sufficiently specific performance obligations and AASB 1058 where there are not.

Note A1-3: Grants and other contributions

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Australian Government - specific purpose payments	**4,397**	4,424
Other grants and contributions		
Other grants	**24**	207
Donations - other	**249**	144
Donations below fair value*	**5,608**	5,206
Total	**10,278**	9,981

**WBHHS receives corporate services support from the Department for no direct cost. Corporate services received would have been purchased if they were not provided by the Department of Health and include payroll services, accounts payable and banking services. An equal amount of expense is recognised as services below fair value, refer Note A2-3.*

Grants, contributions and donations are non-reciprocal transactions where the HHS does not directly give approximately equal value to the grantor.

Where the grant agreement is enforceable and contains sufficiently specific performance obligations for the HHS to transfer goods or 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, except for special purpose capital grants received to construct non-financial assets to be controlled by the HHS.

Contributed assets when applicable are recognised at their fair value.

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

A1 REVENUE *(Continued)*

Disclosures – Grants and contributions

The following table provides information about the nature and timing of the satisfaction of performance obligations, significant payment terms, and revenue recognition for Grants, Contributions and Donations assessed under AASB15 and AASB 1058.

Type of good or service	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policies
Transition care program (TCP) grant	The Australian Government, in partnership with the state and territory governments, are committed to providing an enhanced quality of life for older Australians and supporting positive and healthy ageing through the provision of high quality and cost-effective services for frail older people and their carers. An enforceable contract is in place and has sufficiently specific performance obligations.	Revenue is recognised as performance obligations are met in accordance with AASB 15.
General donations (cash)	In some instances, WBHHS receives cash donations to purchase specific equipment which is recognised on receipt.	Revenue is recognised on receipt in accordance with AASB 1058.
General donations (non-cash)	In some instances, WBHHS receives donated minor equipment under the asset recognition threshold however these are generally provided unconditionally.	Revenue is recognised on receipt in accordance with AASB 1058.
Donations below fair value	WBHHS receives corporate services support from the Department for no direct cost. Corporate services received would have been purchased if they were not provided by the Department and include payroll services, accounts payable and banking services. An equal amount of revenue is recognised as donations services below fair value.	Revenue is recognised on receipt in accordance with AASB 1058.

Note A1-4: Other revenue

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Contract staff recoveries	**6,142**	4,696
General recoveries	**977**	927
Other revenue		
General recoveries	**461**	479
Interest	**30**	45
Other revenue	**249**	221
Total	**7,859**	6,368

Other revenue primarily reflects recoveries of payments for contracted staff from third parties such as universities and other government agencies as well as recoveries of insurance claims from the Queensland Government Insurance Fund (QGIF). Revenue recognition for contract staff recoveries is accounted for under AASB 15 Revenue from Contracts with Customers, where revenue is initially deferred (as a contract liability) and recognised as or when the performance obligations are satisfied due. Revenue recognition for the balance of other revenue is based on either invoicing for related goods, services and/or the recognition of accrued revenue based on estimated volumes of goods or services delivered.

A1 REVENUE *(Continued)*

Disclosures – Other revenue

The following table provides information about the nature and timing of the satisfaction of performance obligations, significant payment terms, and revenue recognition for other revenue assessed under AASB15 and AASB 1058.

Type of good or service	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policies
Student placements (internal)	Contracts relating to internal staff placements through colleges such as Mercy Health, Australasian College for Emergency Medicine, Australian and New Zealand College of Anaesthetics. Performance obligations relate to the number of placements and locations of interns. The transaction price is based on the estimated cost of the placement at a certain level/classification. Revenue associated with these contracts is recognised over time as performance obligations are met.	Revenue is recognised as performance obligations are met in accordance with AASB 15.
Student placements (external)	Contracts with tertiary institutions for student clinical placements. Performance obligations are measures against an agreed price per student and revenue is recognised as performance obligations are met.	Revenue is recognised as performance obligations are met in accordance with AASB 15.
Salary recoveries	Contracts providing for health care staff e.g. Breast Care Nurses funded by the McGrath Foundation). Specific performance obligations exist based on permanent/temporary placement of FTE's for specific purposes and outcomes. The transaction price is based on the estimated cost of the placement at a certain level/classification. Revenue associated with these contracts is recognised over time as performance obligations are met.	Revenue is recognised as performance obligations are met in accordance with AASB 15.
Property leases	WBHHS has a number of telecommunication tower leases with specific performance obligations (use of buildings to hold communication towers).	Revenue is recognised under AASB 16.
Insurance recoveries	WBHHS is insured under the Department's insurance policy with the Queensland Government Insurance Fund (QGIF). Recoveries are made under the policy for general losses above a $10,000 threshold and health litigation payments above a $20,000 threshold.	Revenue is recognised on receipt in accordance with AASB 1058.
Research agreements	WBHHS has a number of research and clinical trial agreements. Most of these agreements are contingent on achieving certain objectives or meeting KPI's and some are enforceable agreements with refund conditions. However, performance obligations are not sufficiently specific as it allows funds to be used for broad objectives and/or the HHS to keep the results of the research specifically excluding it from being recognised under AASB 15.	Revenue is recognised on receipt in accordance with AASB 1058.

A2 EXPENSES

Note A2-1: Employee expenses

	2020 $'000	2019 $'000
Employee benefits		
Wages and salaries*	**59,163**	56,116
Annual leave levy	**3,944**	3,804
Employer superannuation contributions	**4,382**	4,260
Long service leave levy	**1,377**	1,178
Employee related expenses		
Workers' compensation premium	**796**	800
Total	**69,662**	66,158

**Wages and salaries includes $2.2m in one-off payments made to staff on a pro-rata basis (announced in September 2019), the full amount being $1,250 per FTE. This equates to payments being made to 1,784 full-time equivalent employees.*

Under section 20 of the *Hospital and Health Boards Act 2011* a Hospital and Health Service (HHS) can employ health executives and contracted senior health service employees, including Senior Medical Officers (SMO) and Visiting Medical Officers (VMO). All other employees are considered employees of the Department (health service employees, refer note A2-2).

A2 EXPENSES *(Continued)*

Employee expenses represent the cost of engaging board members and the employment of health executives, Senior Medical and Visiting Medical Officers who are employed directly by WBHHS.

Wages, salaries and sick leave

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

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

Annual and long service leave

Under the Queensland Government's Annual Leave Central Scheme and Long Service Leave Central Scheme, levies are payable to cover the cost of employees' annual leave (including leave loading and on-costs) and long service leave. No provision for annual leave and long service leave is recognised in WBHHS's financial statements as a liability is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 Whole of Government and General Government Sector Financial Reporting. These levies are expensed in the period in which they are paid or payable. Amounts paid to employees for annual leave and long service leave are claimed from the schemes quarterly in arrears.

Superannuation

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

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

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

Workers' compensation premium

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

Workers' compensation insurance is a consequence of employing employees but is not counted in an employee's total remuneration package. It is not an employee benefit and is recognised separately as employee related expenses.

	2020	2019
Number of WBHHS Employees (FTE) *	**157**	152

* FTE *reflects the number of employees including both full-time employees and part-time employees, as at 30 June, measured on a full-time equivalent basis (reflecting Minimum Obligatory Human Resource Information (MOHRI)).*

A2-2 Health Service Employees (FTE)

WBHHS is not a prescribed employer. Therefore, in accordance with the *Hospital and Health Boards Act 2011*, all staff, with the exception of executive staff and SMOs and VMOs (refer note A2-1), are employees of the Department and are referred to as Health Service employees. Under this arrangement:

- The Department provides employees to perform work for WBHHS and acknowledges and accepts its obligations as the employer of these employees;
- WBHHS is responsible for the day to day management of these Departmental employees;
- WBHHS reimburses the Department for the salaries and on-costs of these employees.

WBHHS discloses the reimbursement of these costs as Health Service Employee expenses.

	2020	2019
Number of Health Service Employees (FTE) *	**3,184**	3,075
Health Service employee expenses	**388,025**	351,512

* FTE *reflects the number of employees including both full-time employees and part-time employees, as at 30 June, measured on a full-time equivalent basis (reflecting Minimum Obligatory Human Resource Information (MOHRI))*

A2 EXPENSES *(Continued)*

Note A2-3: Supplies and services

	2020 $'000	2019 $'000
Clinical supplies and services	**27,467**	26,596
Outsourced clinical services	**24,644**	23,301
Clinical contractors and consultants *	**28,235**	24,556
Other contractors and consultants	**581**	634
Drugs	**35,804**	30,469
Pathology	**12,787**	11,644
Repairs and maintenance including minor capital works	**12,346**	11,401
Catering and domestic supplies	**7,190**	7,384
Patient travel **	**13,016**	17,225
Other travel	**3,689**	3,428
Electricity and other energy	**4,397**	4,742
Rental expenses	**256**	10
Lease expenses***	**1,983**	3,803
Motor vehicles	**478**	418
Communications	**5,096**	7,231
Computer services	**6,583**	1,728
Services below fair value****	**5,608**	5,206
Other	**12,941**	16,631
Total	**203,101**	196,407

* **Clinical contractors and consultants**: includes $19.7 million (2019: $15.4 million) for locum medical staff.

** **Patient travel:** Includes payments for aeromedical services of $4.4 million (2019: $4.2 million). 2019 also includes expenses of $4.6 million relating to ambulance services now centrally managed by the Department from 1 July 2019.

*** **Lease expenses**: include internal to government arrangements, short-term leases, and variable lease payments. Refer to Note B8-1 for breakdown of lease expenses and other lease disclosures.

**** **Services below fair value:** WBHHS receives corporate services support from the Department at no cost. Corporate services received include payroll services, finance transactional services (including accounts payable), banking services, administrative services and taxation. Contributions of services are recognised only if the services would have been purchased if they had not been donated and their fair value can be measured reliably. Where this is the case, an equal amount is recognised as revenue and an expense (refer note A1-3).

Note A2-4: Other expenses

	2020 $'000	2019 $'000
Insurance premiums QGIF	**5,388**	5,037
Other insurance	**214**	182
Inventory written off	**146**	109
Losses from the disposal of non-current assets	**204**	220
Legal costs	**272**	362
Advertising	**289**	230
Other *	**571**	400
	7,084	6,540

***Other:** includes audit fees paid or payable and special payments.
Audit fees: of $194 thousand to the Queensland Audit Office (2019: $181 thousand). There are no non-audit services included in this amount. Special payments: of $39 thousand (2019: $40 thousand) includes ex gratia and other expenditure that WBHHS is not contractually or legally obligated to make to other parties. In compliance with the Financial and Performance Management Standard 2019, WBHHS maintains a register tting out details of all special payments greater than $5,000. As at 30 June there was one payment to an external party in relation to the termination of a maintenance contract.

Insurance: WBHHS is insured under the Department's insurance policy with the Queensland Government Insurance Fund (QGIF) and pays a fee to the Department as a fee for service arrangement. QGIF covers property and general losses above a $10,000 threshold and health litigation payments above a $20,000 threshold and associated legal fees. Premiums are calculated on a risk assessment basis.

NOTES ABOUT FINANCIAL POSITION

B1 CASH AND CASH EQUIVALENTS

	2020 $'000	2019 $'000
Cash at bank and on hand	**26,338**	26,428
General trust at call deposits*	**1,291**	1,272
Total	**27,629**	27,700

Cash includes all cash on hand and in banks, cheques receipted but not banked at 30 June as well as all deposits at call with financial institutions and cash debit facility.

WBHHS's bank accounts are grouped with the Whole of Government (WoG) set-off arrangement with the Commonwealth Bank of Australia. As a result, WBHHS does not earn interest on surplus funds nor is it charged interest or fees for accessing its approved cash debit facility. Interest earned on the aggregate set-off arrangement balance accrues to the Consolidated Fund.

General trust at call deposits do not form part of the WoG banking arrangement and incur fees as well as earn interest. Interest earned from general trust accounts is used in accordance with the terms of the trust. These funds are held with the Queensland Treasury Corporation.

* WBHHS receives cash contributions from external entities and other benefactors in the form of gifts, donations and bequests for specific purposes. Contributions are also received from excess earnings from private practice clinicians under Granted Private Practice arrangements to provide for education, study and research in clinical areas. At 30 June 2020, the amount of $1.29 million (2019: $1.27 million) was in General Trust. Included in this was $511 thousand (2019: $515 thousand) for excess earnings from private practice clinicians.

B2 RECEIVABLES

Note B2-1: Trade and other receivables

	2020 $'000	2019 $'000
Trade receivables	**5,619**	8,509
Less: Loss allowance	**(345)**	(159)
	5,274	8,350
GST receivable	**1,595**	1,228
GST payable	**(191)**	(94)
	1,404	1,134
Accrued health service funding	**79**	4,437
Other DoH receivables *	**1,578**	-
Total	**8,335**	13,921

** Other DoH receivables represents capital project reimbursements accrued for projects funded by DoH and taken up as cash equity injections. 2020: $1.6m (2019: $nil).*

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

The maximum exposure to credit risk at balance date for receivables is the gross carrying amount of those assets inclusive of any allowance for impairment.

WBHHS calculates impairment based on an assessment of individual debtors within specific debtor groupings, including geographic location and service stream (e.g. Medicare ineligible patients, long stay patients etc). A provision matrix is then applied to measure lifetime expected credit losses. The allowance for impairment reflects WBHHS's assessment of the credit risk associated with receivables balances and is determined based on historical rates of bad debts (by category), forward looking adjustments (where applicable based on information such as local unemployment, industrial factors etc) for any change to current conditions likely to materially change the credit risk associated with debtor groups, and management judgement. The level of allowance is assessed taking into account the ageing of receivables, historical collection rates, and specific knowledge of the individual debtor's financial position.

The individually impaired receivables mainly related to overseas / ineligible patients.

Disclosure – Receivables

The closing balance of contract assets arising from contracts with customers at 30 June 2020 is $4.2 million. This amount is reported under note B4 other assets. As AASB 15 only came into effect from 1 July 2019, there is no requirement to reclassify 2019 comparative information. As such, equivalent balances relating to contracts with customers as at 30 June 2019 are included in the closing balance of receivables ($8.7 million).

B2 RECEIVABLES *(Continued)*

Note B2-2: Impairment of Receivables

(i) Ageing of trade receivables

	2020			2019		
	Gross receivables	Loss rate	Expected credit loss	Gross receivables	Loss rate	Expected credit loss
	$'000	%	$'000	$'000	%	$'000
Trade receivables						
Current	**3,628**	**3%**	**107**	6,092	1%	59
1 to 30 days overdue	**768**	**15%**	**116**	1,630	3%	54
31 to 60 days overdue	**310**	**9%**	**29**	369	6%	21
61 to 90 days overdue	**304**	**6%**	**18**	98	6%	6
Greater than 90 days	**609**	**12%**	**75**	320	6%	19
Total	**5,619**		**345**	8,509		159

(ii) Disclosure - Movement in loss allowance for trade receivables

	2020	2019
	$'000	$'000
Balance at 1 July	**159**	603
Amounts written off during the year	**(57)**	(266)
Increase/(decrease) in allowance recognised in operating result	**243**	(178)
Balance at 30 June	**345**	159

B3 INVENTORIES

	2020	2019
	$'000	$'000
Inventories held for distribution - at cost		
Pharmaceuticals	**1,689**	2,007
Clinical supplies	**2,790**	2,639
Catering and domestic	**63**	32
Other	**11**	43
Total	**4,553**	4,721

Inventories consist mainly of clinical supplies and pharmaceuticals held for distribution in hospital and health service facilities and are provided to public admitted patients free of charge except for pharmaceuticals which are provided at a subsidised rate.

Inventories held for distribution are measured at cost adjusted where applicable, for any loss of service potential. Cost is assigned on a weighted average cost

B4 OTHER ASSETS

	2020	2019
	$'000	$'000
Current		
Prepayments	**800**	773
Contract assets*	**4,246**	-
	5,046	773
Non-current		
Intangible Assets	**-**	13
	-	13
	5,046	786

**Contract assets includes $2.76 million associated with the Department of Health and $1.49m associated with contracts with other customers.*

Disclosure – Contract assets

Contract assets arise from contracts with customers and are transferred to receivables when the HHS's right to payment becomes unconditional. This usually occurs when the invoice is issued to the customer.

B5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION

Note B5-1: Property, Plant and Equipment - Balances and Reconciliations of Carrying Amount

Property, Plant and Equipment Reconciliation	Land Level 2 (at fair value) $'000	Buildings Level 3 (at fair value) $'000	Plant and equipment (at cost) $'000	Heritage and cultural (at fair value) $'000	Capital works in progress (at cost) $'000	Total $'000
Year ended 30 June 2019						
Opening net book value	**14,971**	**192,121**	**26,411**	**-**	**35,090**	**268,593**
Acquisitions	-	17	4,971	-	18,318	23,306
Disposals	-	-	(336)	-	-	(336)
Transfers from/(to) DoH / Other HHS	(50)	5,458	72	-	-	5,480
Transfers between classes	-	40,094	381	-	(40,475)	-
Revaluation increments/(decrements)	-	25,337	-	-	-	25,337
Depreciation charge for the year	-	(12,343)	(4,979)	-	-	(17,322)
Carrying amount at 30 June 2019	**14,921**	**250,684**	**26,520**	**-**	**12,933**	**305,058**
At 30 June 2019						
At cost/fair value	14,921	571,619	56,102	-	12,933	655,575
Accumulated depreciation	-	(320,935)	(29,582)	-	-	(350,517)
Carrying amount at 30 June 2019	**14,921**	**250,684**	**26,520**	**-**	**12,933**	**305,058**
Year ended 30 June 2020						
Opening net book value	**14,921**	**250,684**	**26,520**	**-**	**12,933**	**305,058**
Acquisitions	-	-	5,834	-	9,266	15,100
Disposals	-	-	(270)	-	-	(270)
Transfers from/(to) DoH / Other HHS	-	2.923	10	-	-	2,933
Transfers between classes	-	19,631	(19)	19	(19,631)	-
Revaluation increments/(decrements)	-	5,188		-	-	5,188
Depreciation charge for the year	-	(15,662)	(5,064)	-	-	(20,726)
Carrying amount at 30 June 2020	**14,921**	**262,764**	**27,011**	**19**	**2,568**	**307,283**
At 30 June 2020						
At cost/fair value	14,921	582,876	59,110	20	2,568	659,495
Accumulated depreciation	-	(320,112)	(32,099)	(1)	-	(352,212)
Carrying amount at 30 June 2020	**14,921**	**262,764**	**27,011**	**19**	**2,568**	**307,283**

Note B5-2: Accounting Policies

Recognition thresholds for property, plant and equipment

Items of a capital nature 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.

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

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

Acquisition of Assets

Actual cost is used for the initial recording of all non-current physical asset acquisitions. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use. Any training costs are expensed as incurred.

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

B5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (C*ontinued*)

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

Subsequent measurement of property, plant and equipment

Land and buildings are subsequently measured at fair value as required by Queensland Treasury's *Non-Current Asset Policies for the Queensland Public Sector*. These assets are reported at their revalued amounts, being the fair value at the date of valuation, less any subsequent accumulated depreciation and accumulated impairment losses where applicable. The cost of items acquired during the financial year has been assessed by management to materially represent their fair value at the end of the reporting period.

Plant and equipment is measured at historical cost net of accumulated depreciation and accumulated impairment losses in accordance with Queensland Treasury's *Non-Current Asset Policies for the Queensland Public Sector*.

Depreciation

Property, plant and equipment is depreciated on a straight-line basis progressively over its estimated useful life to the HHS.

Land is not depreciated.

Assets under construction (work-in-progress) are not depreciated until they are ready for use.

Key Judgement: 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.

Key Estimate: Management estimates the useful lives of property, plant and equipment based on the expected period of time over which economic benefits from use of the asset will be derived. Management reviews useful life assumptions on an annual basis having given consideration to variables including historical and forecast usage rates, technological advancements and changes in legal and economic conditions. WBHHS has assigned nil residual values to all depreciable assets.

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

Asset class	Depreciation rates
Buildings (including land improvements)	0.76% - 4.76%
Plant and Equipment	3.33% - 20.00%

Componentisation of complex assets

WBHHS's complex assets are its buildings. Complex assets comprise separately identifiable components (or groups of components) of significant value, that require replacement at regular intervals and at different times to other components comprising the complex asset. Components purchased specifically for particular assets are capitalised and depreciated on the same basis as the asset to which they relate. While components are not separately accounted for, there is no material effect on depreciation expense reported.

Impairment of non-current assets

Key Judgement and Estimate: All non-current physical assets are assessed for indicators of impairment on an annual basis. If an indicator of possible impairment exists, management determines the asset's recoverable amount. Any amount by which the asset's carrying amount exceeds the recoverable amount is recorded as an impairment loss.

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

As a not-for-profit entity, certain property, plant and equipment is held for the continuing use of its service capacity and not for the generation of cash flows. Such assets are typically specialised in nature. In accordance with AASB 136, where such assets are measured at fair value under AASB 13, that fair value (with no adjustment for disposal costs) is effectively deemed to be the recoverable amount. As a consequence, AASB 136 does not apply to such assets unless they are measured at cost.

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

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

Revaluations of non-current physical assets

The fair value of land and buildings are assessed on an annual basis by an independent professional expert or by the use of appropriate and relevant indices. For financial reporting purposes, the revaluation process for WBHHS is managed by the Financial Accounting Service with input from the Chief Financial Officer (CFO). The Building, Engineering, Maintenance Service (BEMS) Unit provides assistance to the quantity surveyors. The appointment of the independent expert was undertaken through a standing offer arrangement for Queensland State Government agencies and endorsed by the Board Audit and Risk Committee.

B5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (*Continued*)

Use of Specific Appraisals

Revaluations using independent professional experts are undertaken at least once every five years. However, if a particular asset class experiences significant and volatile changes in fair value, that class is subject to specific appraisal in the reporting period, where practicable, regardless of the timing of the last specific appraisal.

The fair values reported by WBHHS are based on appropriate valuation techniques that maximises the use of available and relevant observable inputs and minimise the use of unobservable inputs.

Use of Indices

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. WBHHS uses indices to provide a valid estimation of the assets' fair values at the reporting date.

The expert supplies the indices used for the various types of assets. Such indices are either publicly available or are derived from market information available to the expert. The expert provides assurance of their robustness, validity and appropriateness for application to the relevant assets. Indices used are also tested for reasonableness by applying the indices to a sample of assets, comparing the results to similar assets that have been valued by the expert, and analysing the trend of changes in values over time. Through this process, which is undertaken annually, management assesses and confirms the relevance and suitability of indices provided by the expert based on the entity's own circumstances.

Accounting for Change in Fair Value

Revaluation increments are credited to the asset revaluation surplus account 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.

WBHHS has adopted the gross method of reporting revalued assets which is where for assets revalued using a cost approach, accumulated depreciation is adjusted to equal the difference between the gross amount and the carrying amount.

Note B5-3: Valuation of Property, Plant and Equipment including Key Estimates and Judgements

Land

During the 2019-20 year, WBHHS engaged the services of the State Valuation Service (SVS) to provide an assessment of any movement in land prices via indices. The last comprehensive valuation of land was undertaken by SVS in the 2015-16 year.

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

The valuations for 2019-20 resulted in a revaluation adjustment of $nil to the carrying value of land (2019: $nil) due to the index rate of 0.25% being immaterial (cumulative rate -0.90%). This is in line with Queensland Treasury's Non-Current Asset Policy, chapter 3, where cumulative indexation increases of less than 5% are not required to be applied in that year. A full comprehensive revaluation will occur in 2020-21.

Buildings

A new 4 year rolling building valuation program commenced in 2019-20 based on major geographical locations of building and land improvement assets (i.e. Maryborough, Bundaberg, Hervey Bay and Rurals). As a result of this program, all buildings and land improvement assets with a cost threshold of $500,000 (representing 98% of the NBV of asset class) will be comprehensively valued over a 4-year period. WBHHS has engaged independent quantity surveyors AECOM to undertake the building valuations.

In 2020 the Maryborough building and land improvement assets were valued, reflecting 8% of the NBV of the building portfolio at the time of valuation. Those buildings which were not subject to comprehensive valuation (accounting for 92% of the NBV of the building portfolio at the time of valuation) were subject to a review through the use of indices.

Reflecting the specialised nature of health service buildings and on hospital-site residential facilities, for which there is no active market, fair value is determined using the current replacement cost methodology. Current replacement cost is a valuation technique that reflects the amount that would be required today to replace the service capacity of an asset. Current replacement cost is calculated as replacement cost less adjustments for obsolescence.

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

The replacement cost of an asset is adjusted for obsolescence. There are three types of obsolescence factored into current replacement cost, functional, economic and physical. Functional and economic obsolescence are adjustments to the gross value of the asset. This

B5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (C*ontinued*)

adjustment reflects the value embodied in components of a modern equivalent building that are either not present in the existing asset or that are inefficient or inadequate relative to a modern equivalent building due to technological developments or other external factors.

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

The independent valuation for 2019-20 resulted in a net increment to the building portfolio of $5.19 million increment (2019: $25.34 million increment) and to the asset revaluation surplus account. This is an increase of 2.01% to the fair value of buildings as at 30 June 2020. No adjustment was made to the remainder of buildings not subject to independent valuation due to the index rate of 2% being immaterial (cumulative rate 2.0%). This is in line with Queensland Treasury's Non-Current Asset Policy, chapter 3, where cumulative indexation increases of less than 5% are not required to be applied in that year. Should a recommendation be made to apply an increase in 2020-21 of 3% or greater, then the cumulative increase will be required to be taken up in that year.

In June 2019 the Queensland State Government announced approval had been granted for a detailed business case to be undertaken to build a new hospital in Bundaberg on a greenfield site. Given this decision, a review was conducted as to the impact of the remaining useful lives of the existing hospital buildings in Bundaberg and subsequent fair value. It was determined that although approval was granted to undertake a detailed business case, this did not indicate a successful final outcome therefore it would be premature at this stage to reset the useful lives of the existing hospital buildings. The detailed business case is due for completion in the first half of 2020-21. The useful lives will be reviewed once a decision has been made on the outcome of the detailed business case.

Note B5-4: Accounting Policies and Basis for Fair Value Measurement

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

Observable inputs are publicly available data that are relevant to the characteristics of the assets/liabilities being valued, and include, but are not limited to, published sales data for land.

Unobservable inputs are data, assumptions and judgements that are not available publicly, but are relevant to the characteristics of the assets/liabilities being valued. Significant unobservable inputs used by WBHHS include, but are not limited to, subjective adjustments made to observable data to take account of the specialised nature of health service buildings and on hospital-site residential facilities, including historical and current construction contracts (and/or estimates of such costs), and assessments of physical condition and remaining useful life. Unobservable inputs are used to the extent that sufficient relevant and reliable observable inputs are not available for similar assets/liabilities.

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

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

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

None of WBHHS’s valuations of assets are eligible for categorisation into level 1 of the fair value hierarchy and there was no transfer of assets between fair value hierarchy levels during the period.

B6 PAYABLES

	2020 $'000	2019 $'000
Trade payables	**6,333**	3,995
Accrued expenses	**11,939**	12,639
Department of Health payables	**17,373**	15,320
Total	**35,645**	31,954

Payables are recognised for amounts to be paid in the future for goods and services already received. Trade creditors are measured at the agreed purchase/contract price, gross of applicable trade and other discounts. The amounts are unsecured and normally settled within 30 - 60 days. Trade payables and accruals are presented as current liabilities as payment is due within 12 months from the reporting date.

B7 OTHER LIABILITIES

	2020 $'000	2019 $'000
Current		
Contract liabilities	**53**	-
Unearned revenue	**13**	79
	66	79

**Contract liabilities is mostly related to contracts with customers other than the Department.*

When there is an outstanding obligation to deliver services in consideration for revenue received, it is recognised as a liability until the obligation has been delivered according to the terms of the Agreement.

Disclosure – Contract liabilities
Contract liabilities arise from contracts with customers while other unearned revenue arise from transactions that are not contracts with customers.

Of the amount included in the contract liability balance at 1 July 2019, $79k has been recognised as revenue in 2019-20.
Revenue recognised in 2019-20 from performance obligations satisfied or partially satisfied in previous periods is $nil.

B8 RIGHT OF USE ASSETS AND LEASE LIABILITIES

Note B8-1: Leases as a lessee

Right-of-use assets

	Buildings $'000	2020 $'000
Opening balance 1 July (refer note E6-4)	4,476	**4,476**
Additions	7,345	**7,345**
Amortisation charge for the year	(1,662)	**(1,662)**
Carrying amount at 30 June 2020	**10,159**	**10,159**

Lease liabilities

	2020 $'000	2019 $'000
Current Lease liabilities	**1,647**	-
Non-current Lease liabilities	**8,685**	-
	10,332	-

Accounting policies – Leases as lessee

WBHHS measures right-of-use assets from concessionary leases at cost on initial recognition, and measures all right-of-use assets at cost subsequent to initial recognition. WBHHS has elected not to recognise right-of-use assets and lease liabilities arising from short-term leases and leases of low value assets. These lease payments are recognised as expenses on a straight-line basis over the lease term. An asset is considered low value where it is expected to cost less than $10,000 when new.

Where a contract contains both a lease and non-lease components such as asset maintenance services WBHHS allocates the contractual payments to each component on the basis of their stand-alone prices. However, for leases of plant and equipment WBHHS has elected

B8 RIGHT OF USE ASSETS AND LEASE LIABILITIES *(Continued)*

not to separate lease and non-lease components and instead accounts for them as a single lease component. As at 30 June 2020 WBHHS does not have any leases of plant and equipment.

When measuring the lease liability, the HHS 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 of the HHS's leases. To determine the incremental borrowing rate, WBHHS uses loan rates provided by Queensland Treasury Corporation that correspond to the commencement date and term of the lease.

Disclosures – Leases as lessee

(i) Residential Accommodation Leases

WBHHS has 46 residential accommodation leases with external parties. All of these have been classified as ROU assets and Lease liabilities in line with AASB 16. WBHHS does not have any residential leases recognised as lease expenses under A2-3 due to being short term or low value.

(ii) Commercial Accommodation Leases

WBHHS has 5 commercial office accommodation leases with external parties which have been recognised as ROU assets and Lease liabilities in line with AASB 16. WBHHS has 3 expired commercial hire agreements relating to temporary office accommodation. These are treated as short term contracts under AASB 16.

(iii) Office accommodation, employee housing and motor vehicles

The Department of Housing and Public Works (DHPW) provides the HHS with access to office accommodation, employee housing and motor vehicles under government-wide frameworks. These arrangements are categorised as procurement of services rather than as leases because DHPW has substantive substitution rights over the assets. The related service expenses are included under note A2-3.

(iv) Amounts recognised in profit or loss

	2020 $'000
Interest expense on lease liabilities	**259**
Breakdown of 'Lease expenses' included in Note A2-3	
- Expenses relating to short-term leases	**233**
- Expenses relating to internal-to-government arrangements that are not captured under AASB 16	**1,750**
	1,983

(v) Total cash outflow for leases

	2020 $'000
Lease Payments	**(1,718)**

2018-19 disclosures under AASB 17

WBHHS has non-cancellable operating leases relating predominantly to office and residential accommodation. Lease payments are generally fixed, but with escalation clauses on which contingent rentals are determined. No lease arrangements contain restrictions on financing or other leasing activities. Commitment for minimum lease payments in relation to non-cancellable operating leases are payable as follows:

	2019 $'000
Operating Leases	
No later than 1 year	2,150
Later than 1 year but no later than 5 years	4,380
Later than 5 years	-
Total	6,530

Disclosures – Leases as lessor

Lessor accounting under AASB 16 remains largely unchanged from AASB 17. WBHHS has non-cancellable operating leases predominantly for the use of space for telecommunication towers. Lease receipts from these operating leases are recognised as income on a straight-line basis over the term of the lease.

B8 RIGHT OF USE ASSETS AND LEASE LIABILITIES *(Continued)*

Note B8-2: Leases as a lessor

	2020 $'000	2019 $'000
Less than 1 year	**130**	48
1 to 2 years	**114**	130
2 to 3 years	**73**	114
3 to 4 years	**32**	73
4 to 5 years	**28**	32
More than 5 years	**88**	116
	465	513

B9 EQUITY

Note B9-1: Contributed Equity

	2020 $'000	2019 $'000
Opening balance at beginning of year	**229,266**	219,908
Non-appropriated equity injections		
Capital funding	**18,118**	21,215
Non-appropriated equity withdrawals		
Non-cash depreciation funding returned to Department of Health as a contribution towards capital works program	**(22,402)**	(17,336)
Equity asset transfers		
Land	**10**	(50)
Buildings	**2,923**	5,457
Other	**-**	72
Prior year error*	**3,124**	-
Balance at the end of the financial year	**231,039**	229,266

**Prior year error relates to an omission during the 2012 revaluation process, where a building was inadvertently excluded. The error was identified during the 2019 revaluation process and recognised in the ARR as at 30 June 2019. As the building was transferred from the DoH in 2012, an estimate for the fair value of the building at the time of transfer has been reallocated to the contributed equity account. The amount is immaterial for retrospective restatement and additional disclosure.*

Non-reciprocal transfers of assets and liabilities between wholly owned Queensland State Public Sector entities as a result of machinery-of-government changes are adjusted to contributed equity in accordance with Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities*. Appropriations for equity adjustments are similarly designated.

WBHHS receives funding from the Department to cover depreciation costs. However, as depreciation is a non-cash expenditure item, the Minister of Health has approved a withdrawal of equity by the State for the same amount, resulting in non-cash revenue and non-cash equity withdrawal.

Note B9-2: Asset revaluation surplus

	2020 $'000	2019 $'000
Land		
Balance at the beginning of the financial year	**2,115**	2,115
Revaluation increments/(decrements)	**-**	-
Total Land	**2,115**	2,115
Buildings		
Balance at the beginning of the financial year	**74,752**	49,415
Revaluation increments/(decrements)	**5,188**	25,337
Transfer to equity (prior year error)	**(3,124)**	-
Total Buildings	**76,816**	74,752
Balance at the end of the financial year	**78,931**	76,867

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

NOTES ABOUT RISK AND OTHER ACCOUNTING UNCERTAINTIES

C1 FINANCIAL RISK MANAGEMENT

Note C1: Financial instrument categories

Category	Note	2020 $'000	2019 $'000
Financial assets at amortised cost			
Cash and cash equivalents	B1	**27,629**	27,700
Receivables	B2	**8,335**	13,921
Total		**35,964**	41,621
Financial liabilities at amortised cost			
Payables	B6	**35,645**	31,954
Lease liabilities	B8-1	**10,332**	-
Total		**45,977**	31,954

Financial assets and financial liabilities are recognised in the statement of financial position when WBHHS becomes a party to the contractual provisions of the financial instrument.

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

(a) Credit risk

Credit risk is the potential for financial loss arising from a counterparty defaulting on its obligations. The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any allowance for impairment.

The carrying amount of financial assets, which are disclosed in more detail in notes B1 and B2, represent the maximum exposure to credit risk at the reporting date.

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

There are no significant concentrations of credit risk.

Major receivables at 30 June 2020 comprise Department of Health ($241 thousand), Health Funds ($2.97 million), other external debtors ($2.06 million).

Overall credit risk for the HHS is considered minimal.

(b) Liquidity risk

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

WBHHS is exposed to liquidity risk through its trading in the normal course of business. WBHHS aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times.

Under the whole-of-government banking arrangements, WBHHS has an approved working debt facility of $8.5 million (2019: $5 million) to manage any short-term cash shortfalls. This facility has not been drawn down as at 30 June 2020 (2019: nil).

Due to the short-term nature (less than 12 months) of the current payables, their carrying amount is assumed to approximate the total contractual cash flow.

(c) Interest rate risk

WBHHS is exposed to interest rate risk on its cash deposited in interest bearing accounts with Queensland Treasury Corporation (2020: $1.3m, 2019: $1.3m)

WBHHS does not undertake any hedging in relation to interest rate risk.

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

(d) Market Risk

WBHHS does not trade in foreign currency and is not materially exposed to commodity price changes.

C2 CONTINGENCIES

Litigation in progress

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

	2020 Number of cases	2019 Number of cases
Supreme Court	**4**	5
District Court	**1**	-
Tribunals, commissions and boards	**3**	12
	8	17

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). WBHHS's liability in this area is limited to an excess per insurance event of twenty thousand dollars. As at 30 June 2020, WBHHS has 31 claims currently managed by QGIF, some of which may never be litigated or result in payments to claims (excluding initial notices under Personal Injuries Proceedings Act). It is not possible to make a reliable estimate for the final amount payable, if any, in respect of the litigation before the courts at this time.

From time to time the HHS is engaged in legal matters which may give rise to potential liabilities. The outcome of such matters and any financial impacts are not known and cannot be reliably estimated at the date of certification of the financial statements.

C3 COMMITMENTS

(a) Capital expenditure commitments

Commitments for capital expenditure contracted for at reporting date but not recognised in the financial statements are payable as follows:

	2020 $'000	2019 $'000
Plant and Equipment		
No later than 1 year	**146**	79
Later than 1 year but no later than 5 years	**-**	-
Later than 5 years	**-**	-
Total	**146**	79

C4 IMPACT OF COVID-19 ON THE FINANCIAL STATEMENTS

The impact of the global COVID-19 pandemic is unfolding across the globe with far reaching consequences. Response to the COVID-19 pandemic has not had a material impact on the HHS's financial performance as at 30 June. Funding for COVID-19 impacts of $3.8 million was provided through the COVID National Partnership Agreement.

Areas considered are credit losses on receivables including current and future losses of revenue and related cash flow, additional grants and financial support such as ex-gratia and special payments, new or additional employee entitlements granted (e.g. leave or other employee benefits). The valuation of non-current assets measured using replacement cost is not expected to significantly move in the short term and the focus is on marked based land valuation which is updated on advice from Queensland Treasury and State Valuation Services by 30 June 2020.

Due to the COVID-19 pandemic, the Commonwealth Government has agreed to provide a guaranteed Activity Based Funding envelope for the 2019-20 financial year under the National Health Reform Agreement. As such, the Department will not make any financial adjustments for under-delivery or over-delivery against ABF targets for the 2019-20 financial year.

C5 IMPLEMENTATION OF S4/HANA

On 1 August 2019, WBHHS implemented s4/HANA, a new state-wide enterprise resource planning (ERP) system, which replaced FAMMIS ERP. The system is used to prepare the general-purpose financial statements, and it interfaces with other software that manages revenue and certain expenditure streams. Its modules are used for inventory and accounts payable management.

IT and application level controls were required to be redesigned and new workflows implemented. Extensive reconciliations were completed on implementation to ensure the accuracy of the data migrated.

KEY MANAGEMENT PERSONNEL

D1 KEY MANAGEMENT PERSONNEL DISCLOSURES

Key management personnel

The Minister for Health is identified as part of WBHHS KMP, consistent with guidance included in *AASB 124 Related Party Disclosures*. The responsible Minister is Hon Dr Steven Miles, Deputy Premier and Minister for Health and Minister for Ambulance Services.

The following details for key executive management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of WBHHS during 2019-20. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Position	Name	Contract classification/ appointment authority	Initial appointment date
Wide Bay Hospital and Health Service Board			
Non-executive Board Chair - Provides strategic leadership, guidance and effective oversight of management, operations and financial performance.	Peta Jamieson	Hospital and Health Boards Act 2011 Section 25 (1) (a)	26/06/2015 Appointed as Chair: 15/12/2016
Deputy Board Chair - Provide strategic leadership, guidance and effective oversight of management, operations and financial performance.	Bryan Burmeister	Hospital and Health Boards Act 2011 Section 25 (1) (b)	18/05/2014 Appointed as Deputy Chair: 08/09/2017
Non-executive Board Member - Provide strategic leadership, guidance and effective oversight of management, operations and financial performance.	Joy Jensen	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2013 (Resignation 02/10/2019)
	George Plint	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2014 (Resignation 04/10/2019)
	Karen Prentis	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2017
	Anita Brown	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2017
	Trevor Dixon	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2017
	Simone Xouris	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2017
	Emeritus Professor Phillip Clift	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2017
	Sandra Rattenbury	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2020
	Leon Nehow	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2020

D1 KEY MANAGEMENT PERSONNEL DISCLOSURES (C*ontinued*)

Position	Name	Contract classification/ appointment authority	Initial appointment date
Wide Bay Hospital and Health Service Executives			
Chief Executive – Responsible for the overall leadership and management of the WBHHS to ensure that it meets its strategic and operational objectives. The Chief Executive is the single point of accountability for ensuring patient safety through the effective executive leadership and management of all hospital and health services. This position is accountable to the Hospital and Health Board for ensuring the HHS achieves a balance between efficient service delivery and high-quality health outcomes.	Adrian Pennington	s24 / s70 Appointed by Board under s33 *Hospital and Health Board Act 2011*	10/09/2012 (Contract end date 16/12/2019)
	Debbie Carroll	s24 & s70 Appointed by Board under *Hospital and Health Board Act 2011 (Section 7 (3))*	2/12/2014 (Appointed to Chief Executive 27/04/2020)
Executive Director Acute Hospital and Community Services - Reports to the Chief Executive and is responsible for the strategic and operational management of the acute and sub-acute services including rural services, community health, indigenous health, cancer care services, oral health services and corporate services.	Debbie Carroll	HES3 Appointed by Chief Executive (CE) under s74 *Hospital and Health Boards Act 2011*	2/12/2014
	James Thomas (Acting)	HES2 Appointed by Chief Executive (CE) under s74 *Hospital and Health Boards Act 2011*	11/02/2019 (Resignation 24/5/2020)
	Peter Wood (Acting)	HES2 Appointed by Chief Executive (CE) under s74 Hospital and Health Boards Act 2011	13/4/2020
Executive Director Finance & Performance - Reports to the Chief Executive and provides single-point accountability for the Finance and Performance Division. Co-ordinates WBHHS's financial management, consistent with the relevant legislation and policy directions to support high-quality healthcare within WBHHS.	Scott McConnel	HES2 Appointed by Chief Executive (CE) under s74 *Hospital and Health Boards Act 2011*	7/12/2015
Executive Director Human Resources - Reports to the Chief Executive and responsible for the strategic and professional leadership of all WBHHS's Human Resource services. Liaises with local and state-wide stakeholders to ensure compliance with all legislative requirements, awards and directions of the government as they apply to the HHS.	Peter Heinz	HES2 Appointed by Chief Executive (CE) under s74 *Hospital and Health Boards Act 2011*	30/03/2016
Executive Director Mental Health and Specialised Services - Reports to the Chief Executive and responsible for the strategic and professional leadership of WBHHS's Mental Health, Alcohol and Other Drugs Service and Offender Health Services. Ensures compliance with legislative requirements in providing high-quality inpatient, outpatient and community care. Works in partnership with external service providers and primary health organisations to provide targeted service delivery that reflects community need.	Robyn Bradley	HES2 Appointed by Chief Executive (CE) under s74 *Hospital and Health Boards Act 2011*	23/11/2015
Executive Director Medical Services - Reports to the Chief Executive and responsible for strategic, professional and quality leadership of the WBHHS medical workforce, including oversight of medical recruitment and credentialing. Liaises with state-wide stakeholders to ensure compliance with legislative requirements.	Jennifer King	MMOI2 Appointed under Medical Officers (Queensland Health) Award - State 2015	24/2/2020
Executive Director of Nursing and Midwifery Services - Reports to the Chief Executive and responsible for strategic, professional and quality leadership of the WBHHS nursing workforce, including rural, offsite, community nursing services and education and training. Liaises with state-wide stakeholders to ensure compliance with legislative requirements.	Fiona Sewell	NRG13-2 Appointed under Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012	06/07/2015
Executive Director Governance - Reports to the Chief Executive and responsible for integrated governance, including clinical governance functions such as patient safety, consumer feedback, quality and accreditation, and corporate governance functions such as risk management, policy, compliance, education, research, strategic and operational planning.	Katrina Mathies	HES2 Appointed by Chief Executive (CE) under s74 *Hospital and Health Boards Act 2011*	27/02/2017
	Robyn Scanlan (Acting)	HES2 Appointed by Chief Executive (CE) under s74 *Hospital and Health Boards Act 2011*	13/04/2020
Executive Director Allied Health – Reports to the Chief Executive and responsible the professional leadership for all allied health practitioners including processional governance, credentialing, education and research.	Stephen Bell	HP7 Health Practitioners and Dental Officers (Queensland Health) Award – State 2015	01/08/2019

D1 KEY MANAGEMENT PERSONNEL DISCLOSURES (C*ontinued*)

KMP remuneration policies

Minister remuneration

Ministerial remuneration entitlements are outlined in the Legislative Assembly of Queensland's Members' Remuneration Handbook. WBHHS does not bear any cost of remuneration of the Minister. 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.

Key management personnel remuneration – Board

WBHHS is independently and locally controlled by the Hospital and Health Board (The Board). The Board appoints the Health Service Chief Executive and exercises significant responsibilities at a local level, including controlling the financial management of WBHHS land and buildings (section 7 *Hospital and Health Board Act 2011*).

Remuneration arrangement for the WBHHS are approved by the Governor in Council and the chair, deputy chair and members are paid an annual fee consistent with the government procedures titled '*Remuneration procedures for part-time chairs and members of Queensland Government bodies*.

Remuneration paid or owing to board members was as follows:

Name	Short Term Employee Expenses		Post-employment benefits	Total remuneration
	Monetary benefits	Non-monetary benefits		
	$'000	$'000	$'000	$'000
2019-2020				
Peta Jamieson	92	-	8	**100**
Joy Jensen	15	-	1	**16**
George Plint	13	-	1	**14**
Bryan Burmeister	48	-	4	**52**
Karen Prentis	47	-	4	**51**
Anita Brown	48	-	4	**52**
Trevor Dixon	49	-	4	**53**
Simone Xouris	48	-	4	**52**
Emeritus Professor Phillip Clift	49	-	4	**53**
Sandra Rattenbury	5	-	-	**5**
Leon Nehow	5	-	1	**6**

Name	Short Term Employee Expenses		Post-employment benefits	Total remuneration
	Monetary benefits	Non-monetary benefits		
	$'000	$'000	$'000	$'000
2018-2019				
Peta Jamieson	91	-	8	**99**
Joy Jensen	50	-	4	**54**
George Plint	46	-	4	**50**
Bryan Burmeister	49	-	4	**53**
Karen Prentis	47	-	4	**51**
Anita Brown	47	-	4	**51**
Trevor Dixon	50	-	4	**54**
Simone Xouris	47	-	4	**51**
Emeritus Professor Phillip Clift	48	-	4	**52**

D1 KEY MANAGEMENT PERSONNEL DISCLOSURES (C*ontinued*)

Key management personnel remuneration – Executive Team

The remuneration policy for WBHHS executives is set by the Director-General, Department of Health, as provided under the *Hospital and Health Boards Act 2011.*

The remuneration and other key terms of employment for the executive management personnel are specified in the contract of employment.

Section 74 of the *Hospital and Health Boards Act 2011* provides the contract of employment for health executive staff must state the term of employment, the person's functions and any performance criteria as well as the person's classification level and remuneration package.

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

- Short-term employee benefits which include:

  Base – 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 vehicle and expense payments together with fringe benefits tax applicable to the benefit.

- Long term employee benefits include long service leave accrued.
- Post-employment benefits include superannuation contributions.
- Redundancy payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu on termination, regardless of the reason for termination.
- Performance bonuses are not paid under the contracts in place.

Remuneration paid or owing to executives was as follows:

Name	Short Term Employee Expenses		Long term benefits	Post-employment benefits	Termination benefits	Total remuneration
	Monetary benefits	Non-monetary benefits				
	$'000	$'000	$'000	$'000	$'000	$'000
2019-2020						
Adrian Pennington	208	8	2	8	212	**438**
Debbie Carroll*	260	-	5	23	-	**288**
Scott McConnel	216	-	5	22	-	**243**
Peter Heinz	191	-	4	19	-	**214**
Robyn Bradley	208	-	4	21	-	**233**
Katrina Mathies	176	-	4	17	-	**197**
Fiona Sewell	236	-	5	24	-	**265**
James Thomas	172	-	4	16	-	**192**
Jennifer King	153	-	3	11	-	**167**
Stephen Bell	191	-	4	20	-	**215**
Peter Wood	51	-	1	5	-	**57**
Robyn Scanlan	54	-	1	3	-	**58**

** During the 2019-20 year the position of Chief Executive became vacant. A recruitment process was undertaken in April 2020 resulting in Debbie Carroll being appointed to position. Prior to this appointment, Debbie held the substantive position of Executive Director Acute Hospital and Community Services. Remuneration in the table above is for both positions.*

Name	Short Term Employee Expenses		Long term benefits	Post-employment benefits	Termination benefits	Total remuneration
	Monetary benefits	Non-monetary benefits				
	$'000	$'000	$'000	$'000	$'000	$'000
2018-2019						
Adrian Pennington	381	32	7	33	-	**453**
Debbie Carroll	240	-	5	24	-	**269**
James Thomas*	77	-	1	7	-	**85**
Scott McConnel	211	-	4	21	-	**236**
Peter Heinz	194	-	4	19	-	**217**
Robyn Bradley	197	-	4	20	-	**221**
Katrina Mathies	203	-	4	18	-	**225**
Fiona Sewell	241	-	4	24	-	**269**
Jillian Newland	138	38	3	9	-	**188**

** Remuneration effective from 11 February 2019.*

D2 RELATED PARTY TRANSACTIONS

Transactions with people/entitles related to Key Management Personnel

WBHHS did not have any material transactions with people or entities related to Key Management Personnel during 2019-20 (2018-19 $nil).

WBHHS employs 4 staff which are close family members of Key Management Personnel, and were employed through an arms length process. They are paid in accordance with the Award for the job they perform.

Transactions with Queensland Government controlled entities

WBHHS 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
WBHHS receives funding in accordance with a service agreement with the Department (refer note A1-2). The Department receives its revenue from the Queensland Government (majority of funding) and the Commonwealth.

The signed service agreements are published on the Queensland Government website and publicly available. The total funding recognised in 2019-20 is $610.1 million (2018-19: $580.3 million), (refer Note A1-2).

As outlined in Note A2-2, WBHHS is not a prescribed employer and WBHHS health service employees are employed by the Department of Health and contracted to work for WBHHS. The cost of contracted wages for 2019-20 is $388 million (2018-19: $351.5 million).

In addition to the provision of corporate services support (refer Note A2-3), the Department provides other services including procurement services, communication and information technology infrastructure and support, ambulance services, drug supplies, pathology services, linen supply and medical equipment repairs and maintenance. Any expenses paid by Department on behalf of WBHHS for these services are recouped by the Department.

The value of these transactions during the year, and amounts owed and owing with the Department during the financial year are disclosed below.

For the year ending 30 June 2020		As at 30 June 2020	
Revenue Received $'000	**Expenses incurred $'000**	**Assets* $'000**	**Liabilities $'000**
$610,586	$441,666	$6,060	$17,043

** Includes $1.6m in capital project reimbursements accrued for projects funded by DoH and taken up as cash equity injections (2019: $nil).*

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

Other
There are a number of other transactions which occur between WBHHS and other Queensland State Government related entities. These transactions include, but are not limited to, rent paid to the Department of Housing and Public Works for a number of properties and insurance premiums paid to the Queensland Government Insurance Fund. These transactions are made in the ordinary course of WBHHS business and are on standard commercial terms and conditions.

There are no other individually significant or collectively significant transactions with related parties.

OTHER INFORMATION

E1 GRANTED PRIVATE PRACTICE

Granted private practice (GPP) 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.

GPP provides the option for SMOs and VMOs to either assign all of their private practice revenue to the HHS (assignment arrangement) and in return receive an allowance, or to share in the revenue generated from billing patients and pay a service fee to the HHS (retention arrangement). The service fee is used to cover the use of facilities and administrative support provided to the medical practitioner.

All monies received for GPP are deposited into separate bank accounts which are administered by the HHS on behalf of the GPP SMOs and VMOs. All assignment option receipts, and retention option service fees are included as income in the accounts of WBHHS.

	2020 $'000	2019 $'000
Receipts		
Billings from SMOs and VMOs	**8,885**	6,012
Interest	**10**	12
Total receipts	**8,895**	6,024
Payments		
Payments to SMOs and VMOs	**(278)**	(346)
Payments to HHS under assignment model (including transfer of excess earnings to general trust – refer to note B-1)	**(7,013)**	(5,380)
Hospital and Health Service recoverable administrative costs	**(198)**	(241)
Total payments	**(7,489)**	(5,967)
Increase/decrease in net granted private practice assets	**1,406**	58
Granted private practice assets opening balance	**1,025**	967
Granted private practice closing balance	**2,431**	1,025
Granted private practice assets		
Current assets		
Granted private practice cash at bank	**2,431**	1,025
Total	**2,431**	1,025

E2 FIDUCIARY TRUST TRANSACTIONS AND BALANCES

WBHHS acts in a fiduciary trust capacity in relation to patient trust accounts. Consequently, these transactions and balances are not recognised in the financial statements but are disclosed below for information purposes. Although patient funds are not controlled by WBHHS, trust activities are included in the audit performed annually by the Auditor-General of Queensland.

	2020 $'000	2019 $'000
Patient Trust receipts and payments		
Receipts		
Receipts from patients	**124**	93
Total receipts	**124**	93
Payments		
Payments to patients	**(128)**	(80)
Total payments	**(128)**	(80)
Increase/decrease in net patient trust assets	**(4)**	13
Patient trust assets opening balance	**52**	39
Patient trust assets closing balance	**48**	52
Patient trust assets		
Current assets		
Patient Trust cash at bank	**48**	52
Total	**48**	52

E3 RESTRICTED ASSETS

WBHHS holds a number of General Trust accounts which meet the definitions of restricted assets. These accounts require that the associated income is only utilised for the purposes specified by the issuing body.

WBHHS receives cash contributions from benefactors in the form of gifts, donations and bequests for specific purposes. Contributions are also received from private practice clinicians and from external entities to provide for education, study and research in clinical areas.

	2020 $'000	2019 $'000
Restricted assets		
Opening balance	**1,297**	1,232
Income	**523**	201
Expenditure	**(303)**	(136)
Closing balance	**1,517**	1,297

E4 TAXATION

WBHHS 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).

Both WBHHS and the Department satisfy section 149-25(e) of the *A New Tax System (Goods and Services) Act 1999 (Cth)* (the GST Act) and were able, with other hospital and health services, to form a “group” for GST purposes under Division 149 of the GST Act. This means that any transactions between the members of the "group" do not attract GST.

E5 CLIMATE RISK DISCLOSURE

The HHS has not identified any material climate related risks relevant to the financial report at the reporting date, however, will consider the emergence of such risks under the Queensland Government’s Climate Transition Strategy.

E6 FIRST YEAR APPLICATION OF NEW STANDARDS OR CHANGE IN POLICY

Changes in accounting policy

WBHHS did not voluntarily change any of its accounting policies during 2019-20.

Accounting standards early adopted for 2019-20

No Australian Accounting Standards have been early adopted for the 2019-20 financial year.

Accounting Standards Applied for the First Time in 2019-20

Three new accounting standards with material impact were applied for the first time in 2019-20:

- AASB 15 Revenue from Contracts with Customers

- AASB 1058 Income of Not-for-Profit Entities

- AASB 16 Leases

The effect of adopting these new standards are detailed in notes E6-1 to E6-4. No other accounting standards or interpretations that apply to the HHS for the first time in 2019-20 have any material impact on the financial statements

E6-1 AASB 15 REVENUE FROM CONTRACTS WITH CUSTOMERS

The HHS applied AASB 15 Revenue from Contracts with Customers for the first time in 2019-20. The nature and effect of changes resulting from the adoption of AASB 15 are described below.

New revenue recognition model
AASB 15 establishes a new five-step model for determining how much and when revenue from contracts with customers is recognised. The five-step model and significant judgments at each step are detailed below.

	Measurement basis
Step 1 – Identify the contract with the customer	Grant funding that the HHS receives may contain a contract with a customer and thus fall within the scope of AASB 15. This is the case where the funding agreement requires the HHS to transfer goods or services to third parties on behalf of the grantor, it is enforceable, and it contains sufficiently specific performance obligations.

E6-1 AASB 15 REVENUE FROM CONTRACTS WITH CUSTOMERS *(Continued)*

Step 2 – Identify the performance obligations in the contract	This step involves firstly identifying all the activities the HHS is required to perform under the contract, and determining which activities transfer goods or services to the customer. Where there are multiple goods or services transferred, the HHS must assess whether each good or service is a distinct performance obligation or should be combined with other goods or services to form a single performance obligation. To be within the scope of AASB 15, the performance obligations must be 'sufficiently specific', such that the HHS is able to measure how far along it is in meeting the performance obligations.
Step 3 – Determine the transaction price	When the consideration in the contract includes a variable amount, the HHS needs to estimate the variable consideration to which it is entitled and only recognise revenue to the extent that it is highly probably a significant reversal of the revenue will not occur. This includes sales with a right of return, where the amount expected to be refunded is estimated and recognised as a refund liability instead of revenue.
Step 4 – Allocate the transaction price to the performance obligations	When there is more than one performance obligation in a contract, the transaction price must be allocated to each performance obligation, generally this needs to be done on a relative stand-alone selling price basis.
Step 5 – Recognise revenue when or as the HHS satisfies performance obligations	Revenue is recognised when the HHS transfers control of the goods or services to the customer. A key judgement is whether a performance obligation is satisfied over time or at a point in time. And where it is satisfied over time, the HHS must also develop a method for measuring progress towards satisfying the obligation.

Other changes arising from AASB 15
AASB 15 also specifies the accounting for incremental costs of obtaining a contract and costs directly related to fulfilling a contract.

The standard requires contract assets (accrued revenue) and contract liabilities (unearned revenue) to be shown separately and requires contract assets to be distinguished from receivables.

There are extensive new disclosures, which have been included in Notes A1, B2, B4 and B7.

Transitional impact
Transitional policies adopted are as follows:

- The HHS applied the modified retrospective transition method and has not restated comparative information for 2018-19, which continue to be reported under AASB 118 Revenue, AASB 111 *Construction Contracts,* and related interpretations.
- The HHS elected to apply the standard retrospectively to all contracts, including completed contracts, at 1 July 2019. Completed contracts include contracts where the HHS had recognised all of the revenue in prior periods under AASB 1004 *Contributions.*
- The HHS applied a practical expedient to reflect, on transition, the aggregate effect of all contract modification that occurred before 1 July 2019.

To align with new terminology in AASB 15, accrued revenue and unearned revenue arising from contracts with customers have been renamed as contract assets and contract liabilities respectively. They are separately disclosed in Note B4 and Note B7.

WBHHS did not have any transitional adjustments on 1 July 2019 relating to the adoption of AASB 15 as the accounting treatment for the recognition of revenue did not change as a result of the new standard.

E6-2 AASB 1058 INCOME OF NOT-FOR-PROFIT ENTITIES

The HHS applied *AASB 1058 Income of Not-for-Profit Entities* for the first time in 2019-20. The nature and effect of changes resulting from the adoption of AASB 1058 are described below.

Scope and revenue recognition under AASB 1058
AASB 1058 applies to transactions where the HHS acquires an asset for significantly less than fair value principally to enable the HHS to further its objective, and to the receipt of volunteer services.

The HHS's revenue line items recognised under this standard from 1 July 2019 include user charges and fees, funding for public health services, grants and other contributions, and other revenue.

E6-2 AASB 1058 INCOME OF NOT-FOR-PROFIT ENTITIES *(Continued)*

General revenue recognition framework

The revenue recognition framework for in scope transactions, other than specific-purpose capital grants, is as follows.

1 Recognise the asset – e.g. cash, receivables, PP&E, a right-of-use asset or an intangible asset
2 Recognise related amounts – e.g. contributed equity, a financial liability, a lease liability, a contract liability or a provision;(grants and donations in many cases can have nil related amounts)
3 Recognise the difference as income upfront

The initial recognition and measurement of receivables arising from statutory requirements (such as taxes and stamp duty) falls under AASB 9 Financial Instruments, therefore AASB 9 governs the timing and amount of revenue recognised under AASB 1058 for such statutory income.

Specific-purpose capital grants
In contrast with previous standards such as AASB 1004, AASB 1058 allows deferral of income from capital grants where:

- the grant requires the HHS to use the funds to acquire or construct a recognisable non-financial asset (such as a building) to identified specifications;
- the grant does not require the HHS to transfer the asset to other parties; and
- the grant agreement is enforceable.

For these capital grants, the funding received is initially deferred in an unearned revenue liability and subsequently recognised as revenue as or when the HHS satisfies the obligations under the agreement.

Volunteer services
Under AASB 1058, the HHS will continue to recognise volunteer services only when the services would have been purchased if they had not been donated, and the fair value of the services can be measured reliability. This treatment is the same as in prior years.

AASB 1058 optionally permits the recognition of a broader range of volunteer services, however the HHS has elected not to do so.

Transitional impact
Transitional policies adopted are as follows:

- The HHS applied the modified retrospective transition method and has not restated comparative information for 2018-19. They continue to be reported under relevant standards applicable in 2018-19, such as AASB 1004.
- The HHS elected to apply the standard retrospectively to all contracts, including completed contracts, at 1 July 2019. Completed contracts are contracts where the HHS had recognised all of the revenue in prior periods under AASB 1004.
- The HHS applied a practical expedient to not remeasure at fair value assets previously acquired for significantly less than fair value and originally recorded at cost.

Revenue recognition for the HHS's appropriations, taxes, royalties and most grants and contributions will not change under AASB 1058, as compared to AASB 1004. Revenue will continue to be recognised when the HHS gains control of the asset (e.g. cash or receivable) in most instances.

WBHHS did not have any transitional adjustments on 1 July 2019 relating to the adoption of AASB 1058 as the accounting treatment for the recognition of revenue did not change as a result of the new standard.

E6-3 IMPACT OF ADOPTION OF AASB 15 AND AASB 1058 IN THE CURRENT PERIOD

There was no impact of adopting AASB 15 and AASB 1058 on the HHS's 2019-20 financial statements. Amounts that would have been reported if the previous revenue standards (AASB 1004, AASB 118, AASB 111 and related interpretations) had been applied in the current financial year are the same as the amounts reported under AASB 15 and AASB 1058.

E6-4 AASB 16 LEASES

The HHS applied AASB 16 Leases for the first time in 2019-20. The HHS applied the modified retrospective transition method and has not restated comparative information for 2018-19, which continue to be reported under AASB 117 Leases and related interpretations.

The nature and effect of changes resulting from the adoption of AASB 16 are described below.

Definition of a lease
AASB 16 introduced new guidance on the definition of a lease.

E6-4 AASB 16 LEASES *(Continued)*

For leases and lease-like arrangements existing at 30 June 2019, the HHS elected to apply the practical expedient to grandfather the previous assessments made under AASB 117 and Interpretation 4 *Determining whether an arrangement contains a lease* about whether those contracts contained leases. However, arrangements were reassessed under AASB 16 where no formal assessment had been done in the past or where lease agreements were modified on 1 July 2019.

Amendments to former operating leases for office accommodation and employee housing
In 2018-19, the HHS held operating leases under AASB 117 from the Department of Housing and Public Works (DHPW) for residential accommodation through the Government Employee Housing (GEH) program.

Effective 1 July 2019, the framework agreements that govern QGAO and GEH were amended with the result that these arrangements would not meet the definition of a lease under AASB 16 and therefore are exempt from lease accounting.

From 2019-20 onward, the costs for these services are expensed as supplies and services expenses when incurred. The new accounting treatment is due to a change in the contractual arrangements rather than a change in accounting policy.

Changes to lessee accounting
Previously, the HHS classified its leases as operating or finance leases based on whether the lease transferred significantly all of the risks and rewards incidental to ownership of the asset to the lessee.

This distinction between operating and finance leases no longer exists for lessee accounting under AASB 16. From 1 July 2019, all leases, other than short-term leases and leases of low value assets, are now recognised on balance sheet as lease liabilities and right-of-use assets.

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 the HHS 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 the HHS under residual value guarantees
- the exercise price of a purchase option that the HHS is reasonably certain to exercise
- payments for termination penalties, if the lease term reflects the early termination

The discount rate used is the interest rate implicit in the lease, or the HHS's incremental borrowing rate if the implicit rate cannot be readily determined.

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

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 will subsequently give rise to a depreciation expense and be subject to impairment.

Right-of-use assets differ in substance from leased assets previously recognised under finance leases in that the asset represents the intangible right to use the underlying asset rather than the underlying asset itself.

Short-term leases and leases of low value assets
The HHS has elected to recognise lease payments for short-term leases and leases of low value assets as expenses on a straight-line basis over the lease term, rather than accounting for them on balance sheet. This accounting treatment is similar to that used for operating leases under AASB 117.

Changes to lessor accounting
Lessor accounting remains largely unchanged under AASB 16. Leases are still classified as either operating or finance leases. However, the classification of subleases now references the right-of-use asset arising from the head lease, instead of the underlying asset.

E6-4 AASB 16 LEASES *(Continued)*

Transitional impact
Former operating leases as lessee

- The majority of the HHS's former operating leases, other than the exempt QFLEET, QGAO and GEH arrangements, are now recognised on-balance sheet as right-of-use assets and lease liabilities.
- On transition, lease liabilities were measured at the present value of the remaining lease payments discounted at the HHS's incremental borrowing rate at 1 July 2019.
- The HHS's weighted average incremental borrowing rate on 1 July 2019 was 2%.
- The right-of-use assets were measured as an amount equal to the lease liability, adjusted by the amount of any prepaid or accrued lease payments – this approach was used for all other operating leases.
- New right-of-use assets were tested for impairment on transition and none were found to be impaired.
- On transition, the HHS used practical expedients to:
  - not recognise right-of-use assets and lease liabilities for leases that end within 12 months of the date of initial application and leases of low value assets;
  - exclude initial direct costs from the measurement of right-of-use assets; and
  - use hindsight when determining the lease term.

The following table summarises the on-transition adjustments to asset and liability balances at 1 July 2019 in relation to former operating leases.

	$'000
Right-of-use assets – Buildings	**4,476**
Lease liabilities	**(4,476)**
Accumulated surplus	**-**

Reconciliation of operating lease commitments at 30 June 2019 to the lease liabilities at 1 July 2019

	$'000
Total undiscounted operating lease commitments at 30 June 2019	**6,530**
- discounted using the incremental borrowing rate at 1 July 2019 (2%)	**(131)**
Present value of operating lease commitments	**6,399**
- less internal-to-government arrangements that are no longer leases	**(116)**
- less leases with remaining lease term of less than 12 months	**(97)**
- less adjustments relating to cancelled leases*	**(4,388)**
- add/less adjustments due to reassessments of lease terms	**(394)**
- add/less other adjustments**	**3,072**
Lease liabilities at 1 July 2019	**4,476**

** One material lease classified as short term as at 1 July 2019 now cancelled.*
*** Represents the difference between methodologies used to calculate 30 June 2019 operating lease commitments and lease liability under AASB 16 (calculation includes commitments associated with all options as if they were exercised).*

E7 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE

At the date of authorisation of the financial report, there are no Australian accounting standards and interpretations with future effective dates that have a material impact on the HHS.

E8 EVENTS AFTER THE BALANCE DATE

There are no matters or circumstances that have arisen since 30 June 2020 that have significantly affected, or may significantly affect WBHHS's operations, the results of those operations, or the HHS's state of affairs in future financial years.

BUDGETARY REPORTING DISCLOSURE

F1 BUDGETARY REPORTING DISCLOSURES

This section discloses WBHHS's original published budgeted figures for 2019-20 compared to actual results, with explanations of major variances, in respect of WBHHS's Statement of Comprehensive Income, Statement of Financial Position and Statement of Cash Flows.

F2 BUDGET TO ACTUAL COMPARISON – STATEMENT OF COMPREHENSIVE INCOME

	Variance Notes	Original Budget 2020 $'000	Actual Result 2020 $'000	Variance $'000
OPERATING RESULT				
Income				
User charges and fees	1	33,229	**54,979**	21,750
Funding for public health services	2	596,788	**610,055**	13,267
Grants and other contributions		10,003	**10,278**	275
Other revenue	3	4,673	**7,859**	3,186
Total Revenue		644,693	**683,171**	38,478
Gain on disposals		10	**38**	28
Total Income		644,703	**683,209**	38,506
Expenses				
Employee expenses		70,442	**69,662**	(780)
Health service employee expenses	4	358,732	**388,025**	29,293
Supplies and services	5	189,320	**203,101**	13,781
Interest on lease liabilities		-	**259**	259
Depreciation and amortisation	6	19,633	**22,402**	2,769
Impairment losses		414	**243**	(171)
Other expenses		6,162	**7,082**	920
Total Expenses		644,703	**690,776**	46,073
Operating Results for the year		-	**(7,567)**	(7,567)
Other Comprehensive Income				
Items that will not be reclassified subsequently to profit or loss				
Increase / (decrease) in asset revaluation surplus		-	**5,188**	5,188
Other comprehensive income for the year		-	**5,188**	5,188
Total comprehensive income for the year		-	**(2,379)**	(2,379)

1. The increase relates primarily to an increase in Pharmaceutical Benefits Scheme revenue of $15.2m over budget, offset by an increase drug expenditure in note 5. The remaining increase relates primarily to; $3.4m in capital recoveries from the Department of Health which are not budgeted; an increase in hospital fees collected of $3.2m.

2. The increase relates to amendments during the year to the service agreement with the Department of Health. Major amendments include $3.9m for enterprise bargaining increases, $3.8m for reimbursement of expenditure relating to COVID-19, $2.8m for Oral Health services and $2.8m for depreciation funding (non cash).

3. The increase relates primarily to additional revenue received during the year of $1.7m for salary recoveries from a number of contracts for student placements along with $1m in inter entity charging for recoveries with the Department and other Health Services originally budgeted for under user charges and fees.

F2 BUDGET TO ACTUAL COMPARISON – STATEMENT OF COMPREHENSIVE INCOME *(Continued)*

4. The increase relates primarily to an increase in delivery of activity across the HHS resulting in increased staffing levels which were not included in the original budget. Full time equivalent staffing levels increased by 114 between 2018-19 and 2019-20 predominantly in front line staffing positions. Additional labour costs due to Covid-19 of $2.1m and the one-off payment of $1,250 on a pro-rata basis to 1,784 full time equivalent employees of $2.2m also contributed to the increase.

5. Increase relates primarily to an increase in high cost drug expenditure ($14.3m offset by the increase in PBS revenue in note 1 above.

6. The increase relates primarily to depreciation on ROU assets of $1.6m which was not budgeted for. Leases which were recognised under AASB16 Leases for the first time in 2019-20 were capitalised as an ROU asset with a corresponding lease liability. The remainder of the increase relates primarily to an increase in building revaluations over original budget.

F3 BUDGET TO ACTUAL COMPARISON – STATEMENT OF FINANCIAL POSITION

	Variance Notes	Original Budget 2020 $'000	Actual Result 2020 $'000	Variance $'000
Current Assets				
Cash and cash equivalents	7	35,291	**27,629**	(7,662)
Receivables	8	7,318	**8,335**	(1,017)
Inventories		4,668	**4,553**	(115)
Other assets	9	362	**5,046**	4,684
Total Current Assets		47,639	**45,563**	(2,076)
Non-Current Assets				
Property, plant and equipment		330,231	**307,283**	(22,948)
Right-of-use assets	10	-	**10,159**	10,159
Intangibles		2	**-**	(2)
Other assets		-	**-**	-
Total Non-Current Assets		330,233	**317,442**	(12,791)
Total Assets		377,872	**363,005**	(14,867)
Current Liabilities				
Payables	11	31,869	**35,645**	3,776
Lease liabilities	10	-	**1,647**	1,647
Accrued employee benefits		2,497	**2,973**	476
Other liabilities		121	**66**	(55)
Total Current Liabilities		34,487	**40,331**	5,844
Non-Current Liabilities				
Lease liabilities	10	-	**8,685**	8,685
Other liabilities		-	**-**	-
Total Non-Current Liabilities		-	**8,685**	8,685
Total Liabilities		34,487	**49,016**	14,529
Net Assets		343,385	**313,989**	(29,396)
Equity				
Contributed equity		259,809	**231,039**	(28,770)
Accumulated surplus / (deficit)		11,023	**4,019**	(7,004)
Asset revaluation surplus		72,553	**78,931**	6,378
Total Equity		343,385	**313,989**	(29,396)

7. The decrease relates primarily to the deficit position of $7.5m which was not factored into the original budget.

8. Increase relates primarily to $1.6m in unbudgeted capital equity reimbursements from the Department.

9. Increase relates primarily to $2.2m in end of year funding receivables from the Department which are not budgeted for along with $2m in accrued revenue which was originally budgeted for under receivables and now classified as contract assets as a result of the introduction of AASB15 Revenue from Contracts with Customers which came into effect for the first time during 2019-20.

10. Leases falling under AASB16 were recognised as ROU assets and liabilities for the first time in 2019-20. Impacts on budgets to Income Statement and Balance Sheet accounts were not determined at the time of setting the original budget.

11. Increase relates primarily to timing differences between budget and actuals for accrued labour and non-labour expenses at year-end of $1.5m plus $1.3m for unbudgeted funding payables to the Department at year end.

F4 BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOWS

	Variance Notes	Original Budget 2020 $'000	Actual Result 2020 $'000	Variance $'000
Cash flows from operating activities				
Inflows				
User charges and fees	12	629,579	**642,580**	13,001
Grants and other contributions		4,574	**4,637**	63
GST input tax credits from ATO		13,991	**13,342**	(649)
GST collected from customers		-	**616**	616
Other receipts	13	4,673	**10,140**	5,467
				0
Outflows				0
Employee expenses		(70,442)	**(69,058)**	1,384
Health service employee expenses	14	(358,732)	**(384,402)**	(25,670)
Supplies and services		(188,243)	**(196,708)**	(8,465)
GST paid to suppliers		(14,000)	**(13,708)**	292
GST remitted to ATO		-	**(519)**	(519)
Other payments	15	(733)	**(6,819)**	(6,086)
Net cash from / (used by) operating activities		20,667	**101**	(20,566)
Cash flows from investing activities				
Inflows				
Sales of property, plant and equipment		10	**82**	72
Outflows				
Payments for property, plant and equipment	16	(3,694)	**(15,075)**	(11,381)
Net cash from / (used by) investing activities		(3,684)	**(14,993)**	(11,309)
Cash flows from financing activities				
Inflows				
Equity injections	17	3,694	**16,539**	12,845
Outflows				
Lease payments	18	-	**(1,718)**	(1,718)
Equity withdrawals	19	(19,633)	**-**	19,633
Net cash from / (used by) financing activities		(15,939)	14,821	30,760
Net increase / (decrease) in cash and cash equivalents		1,044	**(72)**	(1,116)
Cash and cash equivalents at the beginning of the financial year		34,247	**27,700**	(6,547)
Cash and cash equivalents at the end of the financial year		35,291	**27,629**	(7,662)

12. Consistent with movement in Statement of Comprehensive Income (notes 1 and 2) offset by depreciation funding (non-cash).

13. Consistent with movement in Statement of Comprehensive Income (note 3).

14. Consistent with movement in Statement of Comprehensive Income (note 4).

15. Increase primarily to insurance premiums (QGIF) $5.4m previously budgeted as supplies and services.

16. Increase relates primarily to capital projects managed by the Department not included in the original budget (included in the Department of Health's consolidated budget). Various improvements to Maryborough Hospital including the emergency department, outpatient clinics and air conditioning upgrades account for $8m spent during the year.

F4 BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOWS *(Continued)*

17. Increase relates primarily to capital project costs paid for by the HHS and reimbursed by the Department which were not included in the original budget (included in the Department of Health's consolidated budget). Various improvements to Maryborough Hospital including the emergency department, outpatient clinics and air conditioning upgrades account for $8.4m in reimbursements during the year. In addition, there was $1.5m transferred from operating to equity for the impact of recognising the lease payments on the balance sheet for leases which fall under AASB16 which came into effect for the first time in 2019-20.

18. Leases falling under AASB16 were recognised as right-of-use assets and liabilities for the first time in 2019-20. Impacts on budgets to Income Statement and Balance Sheet accounts were not determined at the time of setting the original budget.

19. Reflects change in treatment of depreciation from cash withdrawal to non-cash withdrawal offsetting depreciation funding (non-cash) under user fees and charges.

MANAGEMENT CERTIFICATE

These general-purpose financial statements have been prepared pursuant to Section 62(1) of the *Financial Accountability Act 2019* (the Act), Section 43 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;

(b) these financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Wide Bay Hospital and Health Service for the financial year ended 30 June 2020 and of the financial position of Wide Bay Hospital and Health Service at the end of that year; and

We acknowledge responsibility under Section 7 and Section 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.

Peta Jamieson
Board Chair
26 August 2020

Debbie Carroll
Chief Executive
26 August 2020

Scott McConnel
Chief Financial Officer
26 August 2020

Queensland Audit Office
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INDEPENDENT AUDITOR'S REPORT

To the Board of Wide Bay Hospital and Health Service

Report on the audit of the financial report

Opinion

I have audited the accompanying financial report of Wide Bay 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 2020, 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 2020, 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 (including Independence Standards)* (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.

Valuation of buildings $262.76 million

See note B5 of the financial report

Key audit matter	How my audit addressed the key audit matter
Buildings were material to Wide Bay Hospital and Health Service at balance date and were measured at fair value using the current replacement cost method. Wide Bay Hospital and Health Service performed a comprehensive revaluation over facilities at Maryborough 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. Wide Bay Hospital and Health Service derived the gross replacement cost of its buildings at the balance date using unit prices that required significant judgements for: • identifying the components of buildings with separately identifiable replacement costs • developing a unit rate for each of these components, including: – estimating the current cost for a modern substitute (including locality factors and oncosts, – identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference. • The measurement of accumulated depreciation involved significant judgements for forecasting the remaining useful lives of building components. The 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 comprehensive valuation • reviewing previous 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 associated with buildings that were comprehensively revaluated this year: – on a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the: – modern substitute (including locality factors and oncosts) – adjustment for excess quality or obsolescence. • evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices • evaluating useful life estimates for reasonableness by: – reviewing management's annual assessment of useful lives – at an aggregated level, reviewing asset management plans for consistency between renewal budgets and the gross replacement cost of assets – ensuring that no building asset still in use has reached or exceeded its useful life – enquiring of management about their plans for assets that are nearing the end of their useful life – reviewing assets with an inconsistent relationship between condition and remaining useful life. • Where changes in useful lives were identified, evaluating whether the effective dates of the changes applied for depreciation expense were supported by appropriate evidence.

Implementation of new finance system

Key audit matter	How my audit addressed the key audit matter
The Department of Health (the Department) is the shared service provider to Wide Bay HHS for the management of the financial management information system, and processing of accounts payable transactions in the system. The department replaced its primary financial management information system on 1 August 2019. The financial management system is the general ledger and it interfaces with other software that manages revenue, payroll and certain expenditure streams. Its modules are used for inventory and accounts payable management. The replacement of the financial management system increased the risk of error in the control environment of Wide Bay HHS. The implementation of the financial management system was a significant business and IT project for the Queensland Health entities. It included: • ensuring accuracy and completeness of closing balances transferred between the old and new systems • establishing system interfaces with other key software programs • developing and documenting IT general controls and application controls • establishing and implementing new workflow processes • cleansing and migrating of vendor and open purchase order master data training of employees.	I have reported issues relating to internal control weaknesses identified during the course of my audit to those charged with governance of the Department of Health. My procedures included, but were not limited to: • assessing the appropriateness of the IT general and application level controls including system configuration of the financial management system by: – reviewing the access profiles of users with system wide access – reviewing the delegations and segregation of duties – reviewing the design, implementation and effectiveness of the key general information technology controls. • validating account balances from the old system to the new system to verify the accuracy and completeness of data migrated • documenting and understanding the change in process and controls for how material transactions are processed, and balances are recorded • assessing and reviewing controls temporarily put in place due to changing system and procedural updates • Undertaking significant volume of sample testing to obtain sufficient appropriate audit evidence, including: – verifying the validity of journals processed pre and post go-live – verifying the accuracy and occurrence of changes to bank account details – comparing vendor and payroll bank account details – verifying the completeness and accuracy of vendor payments, including testing for potential duplicate payments • Assessing the reasonableness of: the inventory stocktakes for completeness and accuracy the mapping of the general ledger to the financial statement line items.

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.

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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 2020:

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

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

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.

C. G. Strickland

27 August 2020

C G Strickland
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

Glossary

Term	Meaning
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 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).
Admitted Patient	A patient who undergoes a hospital's formal admission process as an overnight-stay patient or a same-day patient. Also may be referred to as 'inpatient'.
Allied Health professionals (Health Practitioners)	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology, clinical measurement sciences, dietetics and nutrition, exercise physiology, medical imaging, nuclear medicine technology, occupational therapy, orthoptics, pharmacy, physiotherapy, podiatry, prosthetics and orthotics, psychology, radiation therapy, sonography, speech pathology and social work.
Breast screen	An x-ray of the breast that can detect small changes in breast tissue before they can be felt by a woman or her doctor. A breast screen is for women who do not have any signs or symptoms of breast cancer. It is usually done every two years.
Cardiology	Management, assessment and treatment of cardiac (heart related) conditions. Includes monitoring of long-term patients with cardiac conditions, maintenance of pacemakers and investigative treatments.
Cardiac Angiography (coronary angiogram)	A special x-ray test. A coronary angiogram is the most accurate diagnostic test for a range of heart problems, including coronary heart disease.
Chemotherapy	The use of drugs to destroy cancer cells. Chemotherapy medications are also known as cytotoxic or anti-cancer medications.
Choosing Wisely	A global initiative that aims to improve the quality of healthcare through considering the necessity for tests, treatments and procedures where evidence shows they provide no benefit or, in some cases, lead to harm. WBHHS is a Champion Health Service in supporting the initiative.

Chronic disease	Diseases which have one or more of the following characteristics: • is permanent, leaves residual disability • is caused by non-reversible pathological alteration • requires special training of the individual for rehabilitation, and/or may be expected to require a long period of supervision, observation or care.
Clinical Governance	A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical workforce	Staff who are or who support health professionals working in clinical practice, have healthcare specific knowledge/experience, and provide clinical services to health consumers, either directly and/or indirectly, through services that have a direct impact on clinical outcomes.
Community Health	Provides a range of services to people closer to their home. Some of these services include children's therapy services, pregnancy and postnatal care, rehabilitation and intervention services, and programs that focus on the long-term management of chronic disease.
Community Hospital Interface Program (CHIP)	Focuses on the transition between the hospital and the community enhancing a safe continuum of care for the client.
Community Reference Groups (CRGs)	Provide communities with a structured network for input and feedback around planning, design, delivery and evaluation of healthcare within the Wide Bay Hospital and Health Service (WBHHS).
Computerised Tomography (CT)	A diagnostic imaging technique which uses x-rays that are rotated around a patient to demonstrate the anatomy and structure of organs and tissues.
Cultural Capability	Refers to an organisation's skills, knowledge, behaviours and systems that are required to plan, support, improve and deliver services in a culturally respectful and appropriate manner.
Demand	The health service activity that a catchment population can generate. Where the current and projected incidence and prevalence of diseases and conditions are known (using evidence from epidemiological studies), this data can be used to estimate demand in the catchment population. However, in most institutional planning, demand is measured by analysing expressed need or the amount of healthcare that the catchment population actually utilises. Because utilisation is influenced by other factors (such as existing service availability, access, cost and so-called 'supplier-induced demand'), the resultant estimates of demand inherently incorporate elements of supply.
Department of Health	Responsible for the overall management of the public sector health system, and works in partnership with Hospital and Health Services to ensure the public health system delivers high quality hospital and other health services.
Elective Surgery (elective procedure)	Surgery that is scheduled in advance because it does not involve a medical emergency.
Emergency Department (ED) 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.
Emergency Length of Stay (ELOS)	Measured from a patient's arrival in an emergency department until their departure, either to be admitted to hospital, transferred to another hospital or discharged home. The Queensland benchmark is for at least 80% of patients to have an ELOS of no more than four hours.
Endoscopy	Internal examination of either the upper or lower gastro intestinal tract.
Full-time equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
Gastroenterology	The branch of medicine focused on the digestive system and its disorders.
Gerontology	Multidisciplinary care for the elderly and is concerned with physical, mental, and social aspects and implications of ageing.

Governance	Aimed at achieving organisational goals and objectives, and can be described as the set of responsibilities and practices, policies and procedures used to provide strategic direction, ensure objectives are achieved, manage risks, and use resources responsibly and with accountability.
Gynaecology	The branch of medical science that studies the diseases of women, especially of the reproductive organs.
Health outcome	Change in the health of an individual, group of people or population attributable to an intervention or series of interventions.
Health Worker	An Aboriginal and/or Torres Strait Islander person who works to improve health outcomes for Aboriginal and/or Torres Strait Islander people.
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	A board made up of a mix of members with expert skills and knowledge relevant to managing a complex health care organisation.
Hospital and Health Service (HHS)	A separate legal entity 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.
Inpatient	A patient who is admitted to a hospital or health service for treatment that requires at least one overnight stay.
Internal Audit	An independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.
Life expectancy	An indication of how long a person can expect to live. Technically it is the number of years of life remaining to a person at a particular age if death rates do not change.
Long wait	A 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for an urgent (Category 1) operation, more than 90 days for a semi-urgent (Category 2) operation and more than 365 days for a routine (Category 3) operation.
Medical practitioner	A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.
Memorandum of Understanding (MOU)	A documented agreement that sets out how a partnership arrangement will operate.
Midwifery Group Practice (MGP)	A continuity-of-care maternity care model in which prospective mothers are given care and support by a single midwife (or small team of known midwives) who is primarily responsible for all pregnancy, labour, birth and postnatal care.
Multipurpose Health Service (MPHS)	Provide a flexible and integrated approach to health and aged care service delivery for small rural communities. They are funded through pooling of funds from Hospital and Health Services (HHS) and the Australian Government Department of Health and Ageing.
National Safety and Quality Health Service Standards (NSQHSS)	The Standards were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in consultation and collaboration with jurisdictions, technical experts and a wide range of other organisations and individuals, including health professionals and patients. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of care provided by health service organisations.
Non-admitted patient	A patient who does not undergo a hospital's formal admission process.

Nurse Navigators	Specialised registered nurses providing a service for patients who have complex health conditions and require a high degree of comprehensive, clinical care. Nurse navigators' roles aim to improve patient outcomes through coordinating care between various clinical areas, facilitating system improvements and building care partnerships.
Obstetrics	The branch of medicine and surgery concerned with childbirth and midwifery
Occasion of service (OOS)	A service provided to a patient, including an examination, consultation, treatment or other service.
Offender Health	Delivery of health services to prisoners in a Correctional Services Facility
Oncology	The study and treatment of cancer and tumours
Ophthalmology	Consultation, assessment, review, treatment and management of conditions relating to eye disorders and vision, and services associated with surgery to the eye.
Orthopaedics	Consultation, diagnosis, treatment and follow-up of patients suffering diseases and disorders of the musculoskeletal system and connective tissue.
Outpatient	Non-admitted health service provided or accessed by an individual at a hospital or health service facility.
Outpatient Clinic	Provides examination, consultation, treatment or other service to non-admitted non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.
Palliative Care	An approach that improves quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychological and spiritual.
Patient Travel Subsidy Scheme (PTSS)	Provides assistance to patients, and in some cases their carers, to enable them to access specialist medical services that are not available locally.
Performance Indicator	A measure that provides an 'indication' of progress towards achieving the organisation's objectives. Usually has targets that define the level of performance expected against the performance indicator.
Primary Health Care	Services include health promotion and disease prevention, acute episodic care not requiring hospitalisation, continuing care of chronic diseases, education and advocacy.
Primary Health Network (PHN)	Replace Medicare Locals from July 1 2015. PHNs are established with the key objectives of: • increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes • improving coordination of care to ensure patients receive the right care in the right place at the right time. • PHNs work directly with general practitioners, other primary health care providers, secondary care providers and hospitals to ensure improved outcomes for patients.
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.
Prosthetics	An artificial substitute or replacement of a part of the body such as a tooth, eye, a facial bone, the palate, a hip, a knee or another joint, the leg, an arm, etc.
Public Health	Public health units focus on protecting health, preventing disease, illness and injury, promoting health and wellbeing at a population or whole of community level.
Public hospital	A hospital that offers free diagnostic services, treatment, care and accommodation to eligible patients.

Public patient	A patient who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.
Radiation Oncology	A medical speciality that involves the controlled use of radiation to treat cancer either for cure, or to reduce pain and other symptoms caused by cancer. Radiation therapy (also called radiotherapy) is the term used to describe the actual treatment delivered by the radiation oncology team.
Risk Management	A process of systematically identifying hazards, assessing and controlling risks, and monitoring and reviewing activities to make sure that risks are effectively managed.
Separation	An episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). A separation also includes the process by which an admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital or changing type of care.
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.
Step Up Step Down	A Step Up Step Down Unit is a service to offer short-term residential treatment in purpose-built facilities delivered by mental health specialists in partnership with non-government organisations.
Sub-acute	Care that focuses on continuation of care and optimisation of health and functionality.
Sustainable care	A health system that provides infrastructure, such as workforce, facilities and equipment, and is innovative and responsive to emerging needs, for example, research and monitoring within available resources.
Telehealth	Delivery of health-related services and information via telecommunication technologies, including: • live, audio and/or video inter-active links for clinical consultations and educational purposes • store-and-forward Telehealth, including digital images, video, audio and clinical (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists • Telehealth services and equipment to monitor people's health in their home.
Tertiary hospitals	Hospitals that provide care that requires highly specialised equipment and expertise.
TrainStation	The WBHHS online learning management system.
Transition Care Program	Supports older people who have been discharged from hospital or a subacute facility to undertake a time limited low intensive therapy program to help improve general function and overall independence and to make an informed choices.
Triage category	Urgency of a patient's need for medical and nursing care.
Urology	Consultation, diagnosis, treatment and follow-up of patients suffering from diseases patients suffering from diseases and disorders of the kidney and urinary tract.
Weighted Activity Unit (WAU)	A single standard unit used to measure all activity consistently.

Annual Report 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 A-1
	• 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 10.1	3
	• Machinery of Government changes	ARRs – section 10.2, 31 and 32	N/A
	• Agency role and main functions	ARRs – section 10.2	3
	• Operating environment	ARRs – section 10.3	7
Non-financial performance	• Government's objectives for the community	ARRs – section 11.1	1
	• Other whole-of-government plans / specific initiatives	ARRs – section 11.2	25
	• Agency objectives and performance indicators	ARRs – section 11.3	25
	• Agency service areas and service standards	ARRs – section 11.4	7, 23
Financial performance	• Summary of financial performance	ARRs – section 12.1	28
Governance – management and structure	• Organisational structure	ARRs – section 13.1	17
	• Executive management	ARRs – section 13.2	15
	• Government bodies (statutory bodies and other entities)	ARRs – section 13.3	3
	• Public Sector Ethics	*Public Sector Ethics Act 1994* ARRs – section 13.4	21
	• Human Rights	*Human Rights Act 2019* ARRs – section 13.5	21
	• Queensland public service values	ARRs – section 13.6	3

Summary of requirement		Basis for requirement	Annual report reference
Governance – risk management and accountability	• Risk management	ARRs – section 14.1	20
	• Audit committee	ARRs – section 14.2	11
	• Internal audit	ARRs – section 14.3	20
	• External scrutiny	ARRs – section 14.4	20
	• Information systems and recordkeeping	ARRs – section 14.5	20
Governance – human resources	• Strategic workforce planning and performance	ARRs – section 15.1	18
	• Early retirement, redundancy and retrenchment	Directive No.04/18 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	20
Open Data	• Statement advising publication of information	ARRs – section 16	i
	• Consultancies	ARRs – section 33.1	https://data.qld.gov.au
	• Overseas travel	ARRs – section 33.2	https://data.qld.gov.au
	• Queensland Language Services Policy	ARRs – section 33.3	https://data.qld.gov.au
Financial statements	• Certification of financial statements	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	FS-42
	• Independent Auditor's Report	FAA – section 62 FPMS – section 46 ARRs – section 17.2	FS-43

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2019*

ARRs *Annual report requirements for Queensland Government agencies*

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Wide Bay Hospital and Health Service
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