Unite & Recover

Wide Bay Hospital and Health Service

ANNUAL REPORT 2021–2022

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). The Wide Bay Hospital and Health Service has no Open Data to report on overseas travel for the 2021-2022 year.

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 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

16 September 2022

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

Dear Minister

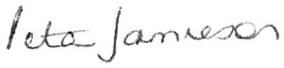
I am pleased to submit for presentation to the Parliament the *Annual Report 2021-2022* and financial statements for Wide Bay Hospital and Health Service.

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* (ARR).

A checklist outlining the annual reporting requirements is provided on page A-6 of this annual report.

Yours sincerely



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 strategic plan 2018-2022, *Care Comes First… Through Patients' Eyes*, considers and supports the Queensland Government's objectives for the community, *Unite & Recover – Queensland's Economic Recovery Plan*, with a particular contribution towards the objectives of safeguarding our health and backing our frontline services, supporting jobs, growing our regions, building Queensland and investing in skills. 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 31 about how our performance indicators from 2021-2022 have supported our strategic objectives.

From the Chair and Chief Executive

The 2021-2022 year has seen the Wide Bay Hospital and Health Service (WBHHS) secure the most significant infrastructure spend in our region's history, return some local specialty services, innovate with new models of care, transition to a new organisational structure and develop our plan for the future.

The New Bundaberg Hospital project has been in the planning phase for a number of years and in the last 12 months our WBHHS team worked with diligence and dedication to develop and then present the detailed business case to the Queensland Government.

That hard work paid off, with the New Bundaberg Hospital project receiving approval and $1.2 billion in the June 2022 State Budget.

This funding will not only provide a facility that will house all of our existing overnight beds and an additional 121 beds, but will also future proof our region's public health care system by enhancing its capability and capacity for future service expansion.

On top of the New Bundaberg Hospital, there has been significant progress on a number of key projects that align with our Strategic Plan commitment to "Plan today for future infrastructure" including:

- Opening the new ward 1 at Maryborough Hospital, expanding inpatient bed numbers and upgrading of roof infrastructure to secure the long-term future of the site.
- Construction progressing on the $39.6 million Hervey Bay mental health inpatient Unit, with completion expected in 2023
- $40 million funding secured for the expansion of Hervey Bay Hospital which will provide 35 additional beds including 10 intensive care beds.

In November 2021, WBHHS returned rheumatology outpatient clinics at Hervey Bay Hospital in partnership with visiting clinicians from Metro North HHS. This is the first time in many years this specialty has been available locally to public patients and is an example of how WBHHS met its objective to "Deliver more care locally".

Our commitment to "Excellence through innovation" has been displayed through the roll out of new models of care in the 2021-2022 year. These models include Residential aged care facility Support Service (RaSS), Rapid Interdisciplinary Senior Engagement (RISE), Specialist Palliative Care in Aged Care (SPACE), mental health crisis centre and our COVID-19 virtual ward.

WBHHS is committed to working with our patients, carers and consumers to "Enhance holistic health care". Our team has placed our stakeholders at the centre of our strategic planning through our successful Let's talk health community consultation campaign, involving in person and digital forums.

On top of this, WBHHS Community Reference Groups (CRG) and our Aboriginal and Torres Strait Islander Health Advisory Council continue to make crucial contributions to our decision making, shaping our future care. Throughout the last year, our First Nations project team has been consulting with community and stakeholders to develop our first *WBHHS Health Equity Strategy*. We're looking forward to implementing this strategy which will guide the delivery of care to our First Nations peoples.

We're proud of our WBHHS teams and their continued professionalism, dedication and adaptability throughout the COVID-19 pandemic. It's been an incredibly challenging period as our staff handle fatigue and constant change. We've been ensuring we support them through the creation of the WBHHS Staff Wellness Group.

Staff have also been actively involved in shaping our organisational restructure which was implemented in March 2022, the development of our strategic and health service plans, and in the development of the business case for a New Bundaberg Hospital.

It's also exciting that a major milestone occurred in early 2022 when the first students started on the Regional Medical Pathway. Thanks to this partnership program with Central Queensland HHS, CQ University and the University of Queensland, we now have medical students beginning their studies in Bundaberg. Our hope is that students form strong bonds to the area and as they complete their studies that they will commence their clinical careers as part of our team.

Our achievements have all occurred while WBHHS rolled out one of the most successful COVID-19 responses in Australia – which safeguarded the community from initial potential outbreaks, weathered the peak of the pandemic locally and led to a rapid and high vaccination uptake. Once again, we could not do this without an outstanding team, and we continue to be grateful for their ongoing dedication, professionalism and adaptability.

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, WBHHS is an independent statutory body governed by the Wide Bay Hospital and Health Board (the Board), which reports to the Minister for Health and 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's strategic plan 2018-2022, *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.

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.

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.

Throughout 2019-2020, extensive consultation was undertaken and WBHHS developed its own specific set of organisational values and behaviours. We later launched and embedded these values in July 202, and they continue to guide our service throughout this reporting period. These values form the acronym *C.A.R.E. through patients' eyes*, and include:

- Collaboration
- Accountability
- Respect
- Excellence
- Through patients' eyes.

Example of these values being put in place include:

Collaboration

Development of the *WBHHS 2021-2026 Strategic Plan* involved initial consultation with staff and stakeholders to develop a draft plan. This was then presented to the public through an extensive Let's talk health community consultation campaign that embraced both in person and virtual consultation, with marketing and promotion across our entire region.

Accountability

WBHHS introduced a date-checker system and safety pause within the under 18's vaccination program to ensure correct dosage and frequency. This has improved accountability for this important program and has now been implemented across Queensland.

Respect

An invitation was extended to local schools to have youth representation on WBHHS Consumer Reference Groups (CRGs). The Bundaberg CRG now has four student members and the Fraser Coast CRG has two student members. This has enabled a youth perspective to be listened to respectfully and contribute to how we deliver care.

Excellence

WBHHS was among the first in Queensland to launch COVID-19 vaccination clinics, deploying innovative pop-up clinics across the region. We delivered the first Bunnings pop up vaccine clinic in the state and other initiatives that became standard practice across Queensland. This led to Wide Bay constantly being among the best vaccination rates.

Through patients' eyes

In 2021 WBHHS established RaSS, which gives residents of aged care facilities the option to receive safe clinical support in their own environment rather than visiting a hospital setting. It also ensures older patients are not unnecessarily coming into an unfamiliar and often stressful environment.

Priorities

The Board sets our strategic priorities through the WBHHS strategic plan 2018-2022 *Care Comes First… Through Patients' Eyes*, 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 by implementing the following values, initiatives and goals through:

- Providing care through patients' eyes
- Clear communication
- Health promotion
- Early intervention
- Delivering care across the lifespan
- Delivering on our commitment to Closing the Gap
- Delivering for our rural communities
- Delivering for people experiencing mental health difficulties.

Deliver more care locally
We will provide high-quality, innovative services and develop our health technology, by implementing the following values, initiatives and goals through:

- Connecting services
- Improving access to our services
- Exploring community-based digital technologies
- Expanding Telehealth.

Plan today for future infrastructure
We will develop our health infrastructure to meet our region's needs by implementing the following values, initiatives and goals through:

- Infrastructure planning
- New facilities
- Upgrading and developing existing facilities.

Develop and support our staff
We will invest in and nurture our staff by implementing the following values, initiatives and goals through:

- Recognising our strength is in our team
- Recruiting quality staff
- Delivering the best health care
- Going the extra mile
- Doing no harm
- Staff being role models.

Excellence through innovation
We will improve our services through strategic partnerships and active innovation by implementing the following values, initiatives and goals through:

- Building partnerships
- Developing a research and training campus
- Digital innovation
- Digital infrastructure
- Supporting a culture of research and innovation.

Aboriginal and Torres Strait Islander Health

WBHHS's Aboriginal and Torres Strait Islander Health teams are committed to working collaboratively with all health teams to promote the provision of patient-centred, high-quality, and culturally safe health care, across the patient lifespan.

Our WBHHS Aboriginal and Torres Strait Islander Health staff work in partnership with all staff to build respectful relationships, network, advocate, liaise and ensure the cultural safety of consumers, patients, and communities.

WBHHS 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 other key areas of the service.

Closing the Gap

During the past 12 months, the Queensland Government passed legislation that prioritises First Nations health equity and mandated the participation of Aboriginal and Torres Strait Islander peoples in the co-design, delivery, monitoring and review of healthcare services and systems.

To improve health outcomes, our service will ensure that key members of WBHHS, WBHH Board, First Nations stakeholders and communities will remain at the table to co-construct policies and programs which are culturally safe and sustainable.

Guiding principles in the *Hospital and Health Boards Act 2011* include a commitment to the delivery of responsive, capable and culturally safe health care.

The *WBHHS First Nations Health Equity Strategy (FNHES) 2022-2025* is aimed at addressing the socio-economic and cultural inequities faced by First Nations people residing in the WBHHS region. To enable the success of the strategy, First Nations people will continue to be actively engaged throughout the implementation and review stages of the WBHHS FNHES.

A 2022 snapshot of the WBHHS First Nations population profile indicates 55 per cent of the Wide Bay First Nations population are 24 years old or younger compared to 33 per cent for the total population of Wide Bay. The median age is 23 years for First Nations people compared to 47 years for the overall population, while only 6 per cent of First Nations people are aged 65 years or older compared to 25 per cent for all Wide Bay. This is reflective of the limited number of Elders within our First Nations communities.

WBHHS First Nations Health Priorities under the Closing the Gap Plan and the WBHHS FNHES identify key performance measures (KPM's) with an intent to improve the wellbeing and life expectancy disparity between Aboriginal and Torres Strait Islander people and non-First Nations Australians.

KPMs and actions include:

1. Improving First Nations health and wellbeing outcomes
2. Actively eliminate racial discrimination and institutionalised racism within the organisation
3. Increasing access to healthcare services
4. Influencing the social, cultural, and economic determinants of health
5. Delivering sustainable, culturally safe, and responsive health services
6. Working with First Nations peoples, communities, and organisations to design, deliver, monitor, and review health services.

The appointment of the WBHHS Aboriginal and Torres Strait islander Health Advisory Council is an integral part of new health planning reforms and their developments. Community consultation continues to be central to these pieces of work, not only during planning but through to establishment and monitoring.

Shared commitment of intent to reconciliation

Culturally significant events are celebrated across the WBHHS annually, NAIDOC and Reconciliation celebrations are key to building reframed relationships which acknowledge, embrace, and celebrates the humanity of Indigenous Australians in the spirit of the Sovereign Nations Reconciliation.

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 221,687 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:

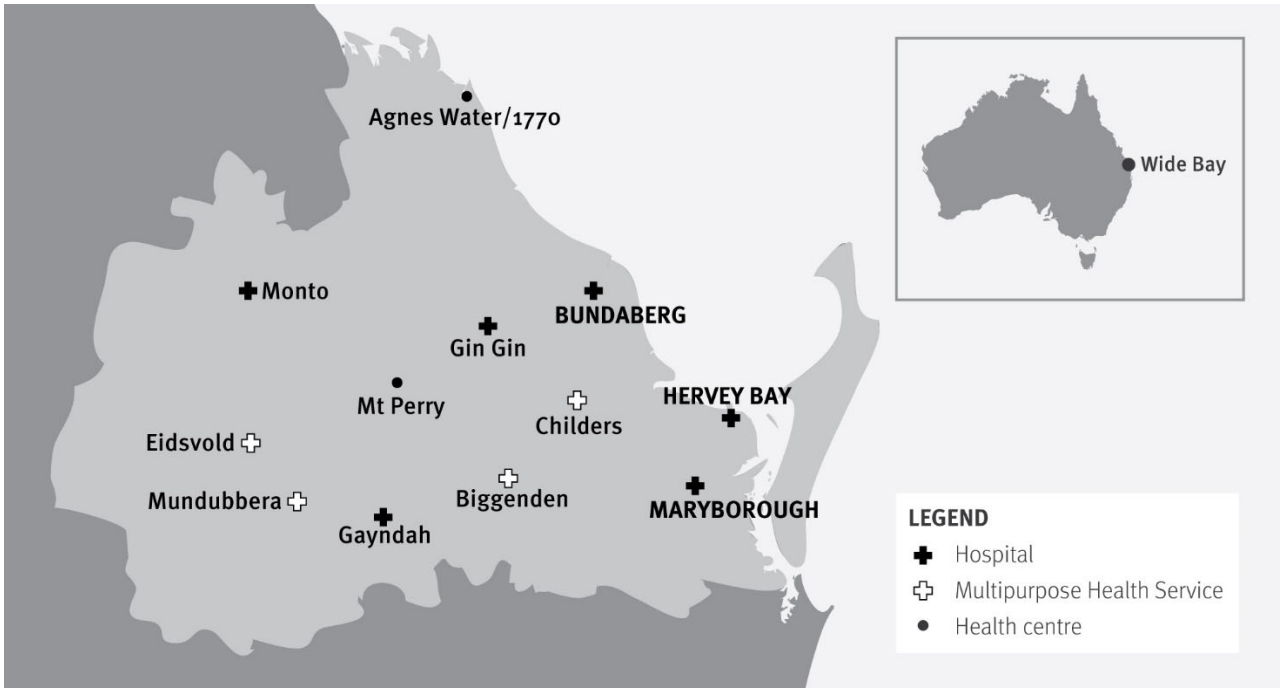
- Bundaberg Hospital
- Hervey Bay Hospital
- Maryborough Hospital
- Biggenden Multipurpose Health Service (MPHS)
- Childers MPHS
- Eidsvold MPHS
- Gayndah Hospital
- Gin Gin Hospital
- Monto Hospital
- Mundubbera MPHS
- Mt Perry Health Centre.

Despite not having WBHHS infrastructure, outreach services are provided to Agnes Water and Miriam Vale via community centres.

We also partner with various external organisations to supplement and support specialist services to the Wide Bay community. This approach supports our patients to be seen and treated within clinically recommended timeframes, which improve 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
BreastScreen	Aboriginal and Torres Strait Islander 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	Rheumatology outpatients
Community Health	Mental health services	School health
Coronary care	Obstetrics	Sexual health
Early Parenting Intervention	Offender health	Specialist Outpatients
Emergency medicine	Ophthalmology	Transition Care Program
ENT surgery (paediatric)	Oral health and oral surgery, including school-based program	Urology
Gastroenterology		Women's health
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, balancing efficient service delivery with optimal health outcomes to ensure that healthcare expenditure achieves value for our communities.

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 National and State challenges that WBHHS continues to manage locally.
- 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.
- Ageing 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 underway or in the planning stages to address the most critical of these.
- Operating environment — the delivery of health services in an environment in which there are competing priorities between public policy, planning, and regulatory frameworks. Adaptability to change has been critical, along with managing community expectations of the services that we can provide.

Overlaying this in 2021-2022 has been the ongoing challenge of the COVID-19 pandemic, in terms of service delivery, workforce and financial perspectives. This was particularly the case as the Wide Bay experienced its case peak in the New Year period.

In addition, WBHHS has the unique complexity of providing services from three major hospitals. The community expectation to deliver a full range of services at each major hospital impacts on efficient service delivery.

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	0.8%	1.6%
Aged 65+	25.9%	15.7%
Unemployment (as at March quarter 2022)	6.7%	4.9%
Median total family income	$58,929	$86,372
Aboriginal or Torres Strait Islander background	4.2%	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	15%	10%
Residents who are obese	31%	25%
Residents who are risky drinkers	38%	38%
Residents with mental health or behavioural problems	28%	28%

References:

The Health of Queenslanders 2021 — Chief Health Officer, Queensland

Queensland Government Statistician's Office, Queensland Treasury, Queensland Regional Profiles: Resident Profile for WBHHS service region

Australian Bureau of Statistics, Labour force survey catalogue number 6202.0 and Department of Employment, Small Area Labour Markets (March 2022)

Addressing our challenges

During 2021-2022, WBHHS launched new services and innovative models of care to meet the needs of our community.

This included supporting our community during the ongoing COVID-19 pandemic with responsive and safe solutions. WBHHS continually led the way through our drive through fever clinics, being among the first areas in the state to offer vaccination hubs and pop-up clinics and supporting COVID-19 positive patients via our virtual ward.

New models of care were rolled out during the year to support people in residential aged care and palliative care, plus new specialist outpatient clinics were returned to the region's public patients.

WBHHS is actively planning how it will continue to provide patient-centred, innovative, enduring and sustainable care well into the future.

In 2021-2022, WBHHS has progressed its *Strategic Plan 2022-2026*, *Health Services Plan 2022-2037* (HSP), *Local Area Needs Assessment* (LANA) and the first WBHHS FNHES, so they may be finalised and implemented in the second half of 2022.

The WBHHS Strategic Plan 2022-2026 underwent extensive staff, stakeholder and community consultation during the reporting period. Once finalised this document will provide our direction for the next four years.

During the year, WBHHS also developed and finalised its HSP which considered the needs of all 11 WBHHS facilities, transform and optimise initiatives, projected activity, proposed infrastructure such as the new Bundaberg Hospital and master planning for the Fraser Coast and rural facilities. It also considered current service arrangements and aligning them with changing local resident health needs, while making effective use of available and future health resources (funding, staff and infrastructure). The HSP will be released in the second half of 2022.

The Draft FNHES was also developed during the reporting period, with it due to be presented to stakeholders for consultation in July 2022 and completed by September 2022.

A selection of service enhancements and achievements in 2021-2022, as they align with our strategic directions, is listed as follows.

For performance indicators specific to strategic plan key measurables, please refer to page 28.

- WBHHS COVID-19 response under the leadership of our Health Emergency Operations Centre (HEOC) and Incident Management Teams (IMT) across the region saw our health service maintain flexibility and essential acute care throughout the pandemic despite immense strain on our services.
- Launched new models of care to support patients to receive care in the community when appropriate through SPACE, RISE, RaSS and our COVID-19 virtual ward.
- Completed our organisational restructure which took in the knowledge and opinions of our staff across the region and resulted in a model of facility-based management
- Rollout of our red bench domestic and family violence awareness initiative in partnership with the Red Rose Foundation has resulted in 14 benches being installed at our sites across the region.
- Establishment of specialist COVID-19 vaccine referral clinic at Hervey Bay and Bundaberg hospitals as well as WBHHS inpatient vaccination service.
- Development and production of research papers evaluating COVID-19 vaccination adverse event profile and barriers to rural vaccination.
- WBHHS provided access to “Magseed markers”to replace traditional hookwires for women at Hervey Bay Hospital – improving their access to more accurate and less invasive removal of impalpable breast lesions.
- Continued our commitment to engagement through our Consumer Partnership and CRGs as well as our Let’s talk health community consultation campaign
- Invested in the development of our staff through Step Up and Lead, Lead for Performance and other initiatives
- A continued agile and flexible approach to modifying infrastructure and assets to reduce risks associated with the COVID-19 pandemic, such as segregating clinical areas, improving ventilation along with establishing onsite and offsite fever and vaccination clinics.
- Hosting the local pilot of the Prevent Alcohol and Risk Related Trauma in Youth’ (P.A.R.T.Y.) Program at Hervey Bay Hospital giving high-school students real-life experiences in the emergency and trauma units
- Invested in our infrastructure to enhance service delivery through refurbishment and replacement including our capital build program.

Governance

Our people

Board membership

The Board

The Board consists of nine non-executive members who are appointed by the Governor in Council, on the recommendation of the Minister for Health and 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 Regulation).

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-31.

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 $4,626.42.

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 WBHHS and by strengthening the relationship between the Board and the Chief Executive to ensure accountability in the delivery of services.

Safety and Quality

The Board Safety and Quality Committee is established in line with the requirements of the Regulation. The role of the 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 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 of Governance, Internal Audit and External Audit representatives.

Finance

The Board Finance Committee is established in line with the requirements of the Regulation. The Executive Director of Finance and Performance is a standing invitee to this committee, which advises the Board on matters relating to the oversight of financial performance and the monitoring of 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 member terms

Name	Date originally appointed	Term
Meetings held		
Peta Jamieson Board Chair / Executive Chair	26/06/2015	18/05/2021-31/03/2024
Karen Prentis Deputy Board Chair / Audit & Risk Chair	18/05/2017	18/05/2020-31/03/2024 Appointed as Deputy Chair 21/10/2021 – 31/03/2024
Trevor Dixon Finance Chair	18/05/2017	18/05/2021-31/03/2024
Simone Xouris Safety & Quality Chair	18/05/2017	18/05/2021-31/03/2024
Leon Nehow	18/05/2020	18/05/2020-31/03/2024
Dr Chris Woollard	01/04/2022	01/04/2022-31/03/2026
Craig Hodges	18/05/2021	18/05/2021-31/03/2024
Karla Steen	18/05/2021	01/04/2022-31/03/2026
Kathryn Campbell	18/05/2021	01/04/2022-31/03/2026
Dr Sandra Rattenbury	18/05/2020	18/05/2021-31/03/2022

Table 3: Board Committee memberships and attendance

Name of Government body: Wide Bay Hospital and Health Board									
Act or instrument	*Hospital and Health Boards Act 2011*								
Functions	The Board appoints the Chief Executive of the Health Service and controls the financial management of the Hospital and Health Service, including the staff, land and buildings.								
Achievements	Funding for new Bundaberg Hospital as part of Queensland Health Capacity Expansion Program Hervey Bay Mental Health Inpatient Unit Hervey Bay Hospital expansion								
Financial reporting	The Board is responsible for preparing the financial report which gives a true and fair view in accordance with the *Financial Accountability Act 2009*, the *Financial and Performance Management Standard 2009* and Australian Accounting Standards and, as the Board determines is necessary, for internal control to ensure 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.								
Renumeration									
Position	Name	Meetings/sessions attendance					Approved annual fee	Approved sub-committee fees	Actual fees received
		Board	Board Executive	Safety and Quality	Finance	Audit and Risk			
Chair	Peta Jamieson	11/12	4/4	9/9	4/4	5/5	75,000 pa	**Board Executive** 4,000 pa **Safety and Quality** 3,000 pa **Finance** 3,000 pa **Audit and Risk** 3,000 pa	$88,000
Deputy Chair	Karen Prentis	12/12	4/4	–	4/4	5/5	40,000 pa	**Board Executive** 3,000 pa **Finance** 3,000 pa **Audit and Risk** 4,000 pa	$50,000

Position	Name	Meetings/session attendance					Approved annual fee	Approved sub-committee fees	Actual fees received
		Board	Board Executive	Safety and Quality	Finance	Audit and Risk			
Board Member	Trevor Dixon	11/12	4/4	–	4/4	5/5	40,000 pa	**Board Executive** 3,000 pa **Finance** 4,000 pa **Audit and Risk** 3,000 pa	$50,000
Board Member	Simone Xouris	11/12	4/4	7/9	–	5/5	40,000 pa	**Board Executive** 3,000 pa **Safety and Quality** 4,000 pa **Audit and Risk** 3,000 pa	$50,000
Board Member	Leon Nehow	12/12	–	7/9	4/4	–	40,000 pa	**Safety and Quality** 3,000 pa **Finance** 3,000 pa	$46,000
Board Member	Dr Chris Woollard	3/3	1/1	1/1	–	–	40,000 pa	**Board Executive** 3,000 pa **Safety and Quality** 3,000 pa	$10,000
Board Member	Craig Hodges	12/12	–	–	3/4	4/5	40,000 pa	**Finance** 3,000 pa **Audit and Risk** 3,000 pa	$46,000
Board Member	Karla Steen	12/12	–	9/9	–	5/5	40,000 pa	**Safety and Quality** 3,000 pa **Audit and Risk** 3,000 pa	$46,000

Position	Name	Meetings/session attendance					Approved annual fee	Approved sub-committee fees	Actual fees received
		Board	Board Executive	Safety and Quality	Finance	Audit and Risk			
Board Member	Kathryn Campbell	12/12	–	9/9	4/4	–	40,000 pa	**Safety and Quality** 3,000 pa **Finance** 3,000 pa	$46,000
Board Member	Dr Sandra Rattenbury	9/9	3/3	7/8	–	–	40,000 pa	**Board Executive** 3,000 pa **Safety and Quality** 3,000 pa	$35,000
No. scheduled meetings/sessions	12 Board 4 Board Executive 9 Board Safety & Quality 4 Board Finance 5 Board Audit & Risk								
Total out of pocket expenses	$4,626.42								

Note 1. The figures reported in the table above reflect the remuneration entitlement of Board members per *Remuneration Procedures for Part-Time Chairs and Members of Queensland Government Bodies*. Some Board members did not serve for the whole financial year, and were either appointed after the year commenced or retired before the year concluded. As such, figures reported in the Financial Statements on page FS-31 reflect the actual remuneration received and may differ due to pro-rata payments received in line with terms of service.

2. The figures reported in the table above reflect remuneration entitlements for Board membership, committee attendance and service as a committee chair. The figures reported in the Financial Statements on page FS-31 may differ from those reported here as they report total remuneration paid inclusive of motor vehicle and other applicable allowances.

Peta Jamieson
Chair

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

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

During her career, Peta was a driver of the microeconomic reform of local governments while working for the Queensland Government, with a focus on financial sustainability and capacity-building campaigns for all councils. Peta also led LGAQ negotiations on the development of the Queensland's first Environmental Protection Act.

Peta is a strong advocate for the Bundaberg and Wide Bay Burnett region through her management consultancy service, delivering a range of economic development, leadership and advocacy services for the public and private sectors.

Among her qualifications, 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 a Bachelor of Arts (Honours).

Peta is also a director for the Gladstone Ports Corporation and a member of its Governance and People Committee and Finance, Audit and Risk Committee.

Karen Prentis
Deputy Chair

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 extensive 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, chair 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.

Karen is the deputy chair of the Board, chairs the Audit and Risk Committee and is a member of the Finance Committee.

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 this time, 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 chief finance officer roles with a variety of large and smaller privately-owned businesses in the 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.

Trevor currently chairs the Board's Finance Committee and is a member of the Audit and Risk Committee.

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 CEO of RHealth, a not-for-profit primary healthcare organisation serving rural and remote communities, and also sits on the Fraser Coast, Southern Downs and Roma advisory groups for youth mental health organisation Headspace. She is a graduate of the Australian Institute of Company Directors.

Simone's previous roles have included practicing 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.

Simone chairs the Health Board's Safety and Quality Committee and is a member of the Audit and Risk Committee.

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 18 years and, in that time, has been a vocal and engaged participant in initiatives for the benefit of First Nations 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, 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.

While Leon has played a strong First Nations advocacy role throughout his career, he believes in a holistic approach that supports and serves the whole community.

Leon is a member of both the Safety and Quality Committee and the Finance Committee.

Karla Steen
Board Member

Karla is a communications and marketing strategist and social program developer with extensive experience within media, community and economic development organisations, government agencies and industry groups. As a former journalist, Karla has worked across radio and television outlets in north Queensland. She then served as a Queensland Government ministerial media advisor.

In recent years, Karla has developed a number of regional programs aimed at supporting women in areas of under-representation within STEM, small business, mining and sport. She currently works within the Hervey Bay Neighbourhood Centre to deliver programs aimed at addressing social isolation and improving mental health outcomes as part of COVID-19 recovery.

As a cancer survivor, Karla is a passionate advocate for regional and rural health service delivery and has previously served on the Mackay Hospital and Health Service Board. She has also completed research on regional participation on government boards.

Karla is a member of both the Audit and Risk Committee and the Safety and Quality Committee.

Kathy Campbell
Board Member

Kathy is an experienced non-executive director. She is also on the board of Brisbane North Primary Health Network (PHN) and previously served on the boards of Uniting AgeWell, UnitingCare Queensland and the Gladstone Area Water Board. Kathy held executive roles in the health sector including with public and private providers, consulting firms and vendors. She currently runs her own boutique digital health consulting firm.

Kathy is a qualified accountant (FCPA and FCA), is a Fellow of the Australian Institute of Company Directors (FAICD), a Fellow of the Australasian Institute of Digital Health and was the inaugural chair of their Precision Health Community of Practice (now Deputy Chair).

She has also completed Leadership Strategies for Information Technology in Health Care at Harvard University. She has an extensive network and knowledge of healthcare nationally and internationally and is well known for her capacity to contextualise her knowledge to specific settings.

Kathy's previous experience in the Wide Bay area includes her time as chief information officer for UnitingCare Health where she was instrumental in the visioning, planning, funding, contracting and design for St Stephen's Hospital, Hervey Bay, opening as Australia's first integrated digital (paperless) hospital.

Kathy is a member of both the Safety and Quality Committee and Board Finance Committee.

Craig Hodges
Board Member

Craig brings to the Wide Bay Hospital and Health Board extensive financial, risk and compliance, human resource management and corporate governance experience as a senior executive working in the health and technology sectors across Australia and New Zealand.

He is currently the global head of finance, legal and corporate affairs for a health care technology group and has served as a non-executive director and committee member across primary health care, clinical

governance, tertiary medicine, education/research and health support fields.

Currently Craig is a board member of the Australasian College of Emergency Medicine and chair of their board's finance and risk committee. He is a former chair of the Wide Bay Regional Electricity Council and has volunteered his time and expertise to a variety of community-based endeavours including hospital advisory committees, rural clinical training school, tertiary education and social support organisations.

Craig is a fellow of CPA Australia and the Australian Human Resources Institute and is a graduate of the Australian Institute of Company Directors.

Craig is a member of both the Finance Committee and the Audit and Risk Committee.

Dr Chris Woollard
Board Member

Chris has several years' healthcare experience across an extensive range of medical, academic, training and military roles.

He is currently a general practitioner and practice owner in Hervey Bay, holding a Fellowship of the Royal Australian College of General Practitioners. Chris has been a tutor with the University of Queensland Rural Clinical School, educating medical students, and a registrar supervisor with James Cook University general practice training.

Appointed as GP liaison officer of the Central Queensland, Wide Bay, Sunshine Coast Primary Health Network (PHN) in 2017, Chris went on to become the chair of the PHN Wide Bay Clinical Council for 2020 - 2021. He is also a GP representative on the Fraser Coast Local Medical Association.

During his military career Chris served as army medical officer in Australia and internationally, receiving an Australian Service Medal in addition to a Level Three Group Commendation for the development and delivery of specialised health training to the wider Australian Defence Force. He gained experience supporting a wide range of units and activities, as well as completing various courses such as aviation and underwater medicine, occupational health, and prehospital and early management of severe trauma. Chris remains an active reservist.

He is member of both the Safety and Quality Committee and Executive Committee. Growing up in rural NSW in a medical family, Chris has always been aware of, and keen to help tackle the challenges of delivering healthcare in regional and rural areas.

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 served as a staff specialist in emergency medicine at Bundaberg Hospital 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, New Zealand, which she established; and various medical officer and GP roles in acute and community settings in the United Kingdom, New Zealand 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 New Zealand College of General Practitioners.

Sandra completed her term on the Board on 31/3/2022.

Executive management

The Health Service Chief Executive (HSCE) 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 HSCE 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 over 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.

Deborah 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.

Michael Lewczuk
Chief Operating Officer

Michael has worked in healthcare for more than 20 years in both paediatric and adult health services across multiple hospital and health services in Queensland. Michael has a history in nursing, with extensive experience in paediatric intensive care and paediatric retrievals.

He has completed a Bachelor of Nursing, post graduate studies in paediatric intensive care and a Master of Nursing Leadership. Michael has worked in numerous operational management roles throughout his career and has a key focus of centring every decision around the patients and families requiring care.

Prior to joining WBHHS as COO in 2021 Michael was the executive director of Ipswich Hospital in West Moreton HHS and divisional director of clinical support with Children's Hospital Queensland.

Michael has developed and led numerous strategies significantly improving financial sustainability and patient flow within health services as well as leading the development of new services catering for the needs of populations across HHS's.

During 2022 and part of 2021, Michael has served as our COVID-19 incident controller and chaired WBHHS HEOC.

Martin Clifford
Executive Director of Finance and Performance

Martin has worked in the health sector for almost 20 years and has held senior and executive leadership roles throughout Victoria. Appointed Executive Director Finance and Performance in February 2022, Martin brings to WBHHS substantial strategic direction in finance, health service and hospital executive skills.

Prior to joining WBHHS, Martin was chief financial officer for Albury Wodonga Health where he was executive sponsor for the new patient administration system project and was appointed as the chief procurement officer for the implementation of new state-wide procurement policies. He implemented a new budgeting process for the organisation built from a zero-base assumption and led the development of new recruitment approval process for the organisation incorporation finance sign-off for all recruitment actions.

Martin gained his Bachelor of Commerce degree at La Trobe University, Melbourne and a Graduate Diploma in Applied Finance and Investments through Securities Institute of Australia. He is a Fellow of CPA Australia and is an Associate Fellow of Australian College of Health Services Management.

Martin is passionate about leading high performing teams including identifying and developing talent across all levels of the organisation and leading by example in

recognising the contribution of individuals and teams in achievement of objectives supporting the strategic direction of the organisation.

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 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.

Robyn Scanlan
Executive Director of Governance

Robyn has more than 25 years of healthcare experience across a diverse array of clinical and leadership roles, including rural and remote nursing and midwifery, patient safety and clinical governance.

She has a strong track record in safety and quality improvement in health care, such as her leading role in introducing an Australian-first short notice accreditation pilot to WBHHS in 2017, which has since been adopted in multiple other locations across the country.

Robyn joined WBHHS as a clinical governance facilitator in 2013 and in subsequent years she took on more senior roles in the Clinical Governance Support Unit. She was appointed Director of Clinical Governance in 2017, and Executive Director of Governance in 2021.

She has been recognised with both a WBHHS Australia Day Award in 2016 and a WBHHS Excellence Award in 2018, for her pioneering work in hospital accreditation and associated research, and also presented on the topic at the 2018 World Hospital Congress.

Robyn is a Fellow of the International Society for Quality in Health Care, holds a Bachelor of Nursing, Graduate Diploma of Midwifery, and three Masters degrees in rural and remote health, business administration and project management. She is currently completing a PhD with a focus on quality and accreditation systems.

Dr Scott Kitchener
Executive Director of Medical Services

Scott has more than 35 years of healthcare experience across an extensive range of medical, academic, research, training and military roles.

Prior to joining WBHHS in October 2020, as the senior medical officer advising the Chief Medical Officer, he served as the COVID-19 Public Health Incident Controller in the Incident Management Team within the State HEOC Scott has also held other key medical leadership roles and has spent time as a rural GP, held academic and teaching posts with The University of Queensland's Rural Clinical School, and was the foundation professor of Griffith University's rural medicine program.

During a relatively long military career, Scott received several awards, including the Australian Active Service Medal, Australian Service Medals, InterFET Campaign Medal and Defence Service Medals, in addition to the Surgeon-General's Medal for Tropical Medicine contributions.

He holds extensive medical and research qualifications, including specialties in general practice, public health medicine and medical administration, doctorates in public health from James Cook University and in medicine from The University of Queensland.

During his time at WBHHS Scott has also supported the COVID-19 response as incident controller for part of 2021 and as the medical lead for the COVID-19 Vaccination Program. In the latter role he led research and evaluation of the program - demonstrating the effectiveness of the vaccination program in the Wide Bay.

Stephen Bell
Executive Director of Allied Health

Stephen 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 a Fellow of the Australasian College of Health Service Management.

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.

Fiona is the proud recipient of a WBHHS Australia Day Award 2021 for her outstanding leadership and tireless effort throughout our COVID-19 response, and the ABC Media and Emergency Services Outstanding Service Award in 2021 for her excellent and highly valued communication to the Wide Bay community.

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 United Kingdom and New Zealand. He is currently undertaking a Master of Business Administration.

The organisational restructure at the start of 2022 resulted in this position being replaced by three directors overseeing aspects of our services who report to the Chief Operating Officer. Peter now oversees our Fraser Coast facilities and services

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.

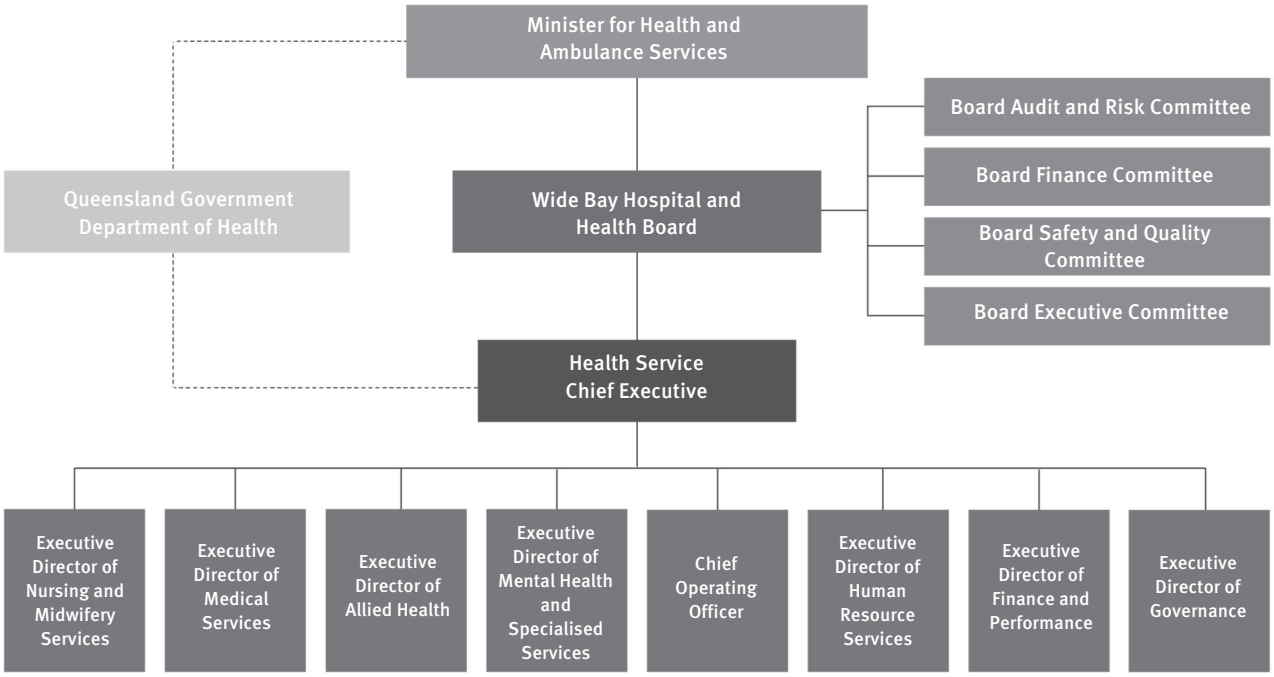
Peter has previously held senior HR roles with the Department of Employment, Economic Development and Innovation; the Department of Tourism, Regional Development and Industry; and the Environmental Protection Agency.

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.

Peter stepped down from the executive in June 2022 to take up further career opportunities.

Organisational structure and workforce profile

Organisational structure (as at 30 June, 2022)



WBHHS employed a total of 3,532 full-time equivalent staff in 2021-2022, an increase of 98 compared to 2020-2021.

Of that figure, more than 70 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 2022, WBHHS employed 96 people who identified as Aboriginal or Torres Strait Islander (13 per cent increase year-on-year), 445 CALD people (nine per cent increase year-on-year) and 101 people with a disability (23 per cent increase 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 2021-2022, 526 full-time equivalent staff separated employment from WBHHS. This equates to a permanent separation rate of 14.8 per cent, compared to 11.6 per cent in 2020-2021. The increase in separations from the previous year can be attributed to the introduction of mandatory COVID-19 vaccination for staff and other impacts on workforce movements due to COVID-19.

WBHHS continues to prioritise attraction strategies to reduce vacancy rates in critical roles and retention strategies to reduce turnover rates. The WBHHS turnover rate for 2021-2022 – which specifically measures the turnover rate of permanent roles – was 11.34 per cent which is higher than the 2020-2021 in line with the increase in permanent separations.

Table 4: More doctors and nurses*

* Workforce is measured in MOHRI – Full-Time Equivalent (FTE). Data presented reflects the most recent pay cycle at year's end, period ending 26 June 2022.

	2017–18	2018–19	2019–20	2020–21	2021-22
Medical staff[a]	360	387	425	437	440
Nursing staff[a]	1,290	1,377	1,433	1,481	1544
Allied Health staff[a]	336	343	345	477	482

Table 5: Increasing our First Nations workforce*

* Workforce is measured in MOHRI – Full-Time Equivalent (FTE). Data presented reflects the most recent pay cycle at year's end, period ending 26 June, 2022.

	2017–18	2018–19	2019–20	2020–21	2021-22
Persons identifying as being First Nations[b]	48	55	60	68	79

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

Table 6: **Greater diversity in our workforce^**

^ Headcount total and percentage in terms of the workforce headcount

Gender	Number	Percentage of Total Workforce
Male	1052	23.76%
Female	3340	75.45%
Non-Binary	35	0.79%
EEO Group	**Number**	**Percentage of Total Workforce**
Women	3340	75.45%
Aboriginal People and Torres Strait Islander Peoples	96	2.17%
People with a disability	101	2.28%
Culturally and Linguistically Diverse – Born overseas	102	2.30%
Culturally and Linguistically Diverse – Speak a language at home other than English (including Aboriginal and Torres Strait Islander languages and Australian South Sea Islander languages)	445	10.05%
	Number	**Percentage of Total Leadership Cohort**
Women in leadership roles[1]	31	58.54%

[1]W omen in Leadership Roles are considered those positions that are Senior Officer and equivalent and above.

Strategic workforce planning and performance

The WBHHS continues to strive to build a sustainable, educated and valued workforce to meet our current and future needs and to strive towards an organisational culture that reflects our values of Collaboration, Accountability, Respect and Excellence (CARE) Through patients' eyes.

WBHHS aligns its workforce strategies to the broader strategies outlined in the Public Service Commission's 10 year human capital outlook, 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*, the Public Service Commission's *Be healthy be safe be well framework*, and the Queensland Health *Workplace Mental Health Wellbeing Framework 2017*.

During the 2021-2022 year, attraction and retention initiatives continued including attendance at virtual online and in person at several job fairs and expos, including the Brisbane careers expo, Brisbane and Sunshine Coast TSExpos, Fraser Coast jobs expo, and the Rural Doctors Association of Queensland conference in Gladstone. WBHHS representatives also attended several local high school careers information sessions aligning to the Bundaberg jobs commitment program which provides for career advice, resume writing and mock job interview support for local high schools.

Promotional videos accompany all job advertisements on the Smart jobs website and other social media platforms such as LinkedIn and Facebook. Media materials promoting living and working in the Wide Bay are provided to all job applicants and specialised vacancy advertising materials are routinely developed for critical hard to fill vacancies.

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 management in alignment with the *Public Service Commission Positive Performance Management Directive 15/20*.

Leadership programs have continued to be delivered in partnership with the Centre for Leadership Excellence including the Step Up and Lead program, Lead for Performance program and Management Essentials program and other non-clinical personal development programs. The equivalent market value of these is over $400,000, not including participants in the state-wide programs. A refreshed performance appraisal and development tool has been implemented, the Performance and Development Plan (PDP) to continue to strive towards achieving the individual, team and organisational benefits and tangible value derived from high quality PDP practices which align to the core values of the WBHHS.

As at 30 June 2022, WBHHS's PDP compliance was 58%. In comparison, BPA Analytics data from national public health and Queensland health organisations demonstrate this is equal to these benchmarks. The COVID-19 pandemic response and significant workforce challenges have impacted on the compliance rate, however, the WBHHS continues to strive towards improving the PDP compliance rate.

Throughout 2021-2022, WBHHS has continued its health, safety and wellbeing journey with initiatives aimed at continuing to improve safety and on staff wellbeing

Whilst current efforts are focused on pandemic response, staff wellbeing is a key responsibility of the organisation and has driven establishment of a Staff Wellbeing Group to deploy immediate and longer term supports for our staff under challenging pandemic conditions.

To date initiatives developed following staff feedback have included expansion of outdoor break spaces for staff, distribution of care packages to work units, and additionally the organisation has reconvened a Fatigue Working Group in response to unprecedented pressures the pandemic has placed on our organisation. The group will apply a systems-focused lens to better understand how our operations and actions impact the functioning and subsequent fatigue of all staff.

Management of contractors within the organisation has been a priority area. Workplace Safety and Wellbeing have partnered with Building Engineering Maintenance Services (BEMS) to expand the use of the existing online Contractor Management System (Rapid Global) to our rural sites at Mundubbera, Gayndah, Monto, and Biggenden with additional kiosks proposed for Gin Gin, Eidsvold and Childers over the next 12 months. This innovation utilises a data driven platform to capture and manage contractor documentation and activity, allowing preauthorised workers to interact with the CMS via a kiosk terminal at entry to a facility, enter details of work being performed and provide details of any high-risk work permits required.

The organisation actively encourages the reporting of all workplace incidents to reinforce identification and management of risk. As a critical control of Occupational Violence, WBHHS continues to train frontline staff in MAYBO, the preferred occupational violence reduction methodology, which is based on prevention and control through improved communication and situational awareness. Staff in higher-risk areas receive more intensive training in assault avoidance and/or physical intervention as we continue to strive towards making our workplaces as safe as possible for our staff and to provide our staff the appropriate tools to respond when confronted with occupational violence.

It was pleasing to see continued safety improvements in most divisions across the WBHHS with less incidents and lower WorkCover average leave rates. This positive improvement in our safety record ensured that WBHHS secured a further reduction of 0.5% in its WorkCover premium for the 2021-2022 year against wages increase (which premium is calculated against).

Our Employee Assistance Provider, Converge International, has continued to partner with the WBHHS to deliver confidential personal coaching and short-term counselling services to all staff covering a range of personal and work issues. Converge International also partnered with the WBHHS towards planning the 2022-2023 delivery of monthly webinars covering a range of staff wellbeing topics which staff can access via live Webinars or via recorded sessions at a time convenient to them.

WBHHS has continued its commitment to training and graduate programs, including:

- Nursing graduate intake program across WBHHS facilities, including rural facilities
- Allied Health Rural Generalist Pathway
- Medical graduate intake program across Bundaberg, Hervey Bay and Maryborough 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

During the 2020-21 year, WBHHS engaged with its workforce through several initiatives such as the Your Voice, Our Future staff engagement survey and the Working for Queensland survey. From these initiatives it was identified that staff held a strong desire for further opportunities to contribute to the development of the WBHHS.

Using this knowledge, WBHHS held a number of Showcases for staff over the 2020-2021 year. Following collation of the feedback and themes from the Showcases and subsequent consultation on a proposed new organisational structure, a new organisational leadership structure was implemented in March 2022 realigning the structure and leadership positions to a facilities-based leadership model which was overwhelmingly supported by staff.

Early retirement, redundancy and retrenchment

No early retirement, redundancy or retrenchment packages were paid during the 2021-2022 period.

Our risk management

WBHHS recognises that risk management is an essential element of good corporate governance to ensure that strategic and operational objectives can be achieved. It is committed to pursuing a positive risk culture through a top-down approach which seeks to embed risk management principles and practices into strategic planning, governance reporting, business decisions and operational processes.

WBHHS has established a contemporary risk management framework which is supported by an integrated policy designed in accordance with 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.

The risk management framework describes the intent, roles and responsibilities and implementation requirements. It defines the processes for risk identification, assessment, treatment, monitoring, review, recording and reporting of risks.

Operational and Strategic Risks are regularly monitored and reported to the Board through various committees, but particularly via the Audit and Risk Committee and the Safety and Quality Committee.

Key accountability bodies within the risk management framework include:

- The Board that is responsible for setting objectives, key deliverables and identification of strategic risks. It appoints the Board Audit and Risk Committee and sets limits of acceptable behaviour through the organisation's values and defining and approving the Risk Appetite Statement.
- The Board Audit and Risk Committee that reviews and oversees systems of risk management, internal controls and legal compliance.

Key achievements during 2021-2022 include:

- Conducting comprehensive risk reviews of strategic and operational risks across the WBHHS to ensure risks remain current and assist with embedding risk management maturity within the organisation.
- Regular risk deep dive reporting to the Executive and Board to provide greater oversight and assurance.
- Development of an assurance map that outlines risks and associated assurance activities and was utilised in the development of the Internal Audit Plan.
- Providing a greater risk focus and oversight across Executive, Board and sub-committees.
- Continued development of in-house capability and knowledge

The *Hospital and Health Boards Act 2011* requires annual reports to state each direction given by the Minister to the HHS during the financial year, and the action taken by the HHS as a result of the direction. During the 2021-2022 period, no directions were given by the Minister for Health and Ambulance Services to WBHHS.

Internal audit

The primary role of internal audit is to conduct independent, objective and risk-based assurance activities. It provides assurance to the WBHHS Executive, Board Audit and Risk Committee and Board through evaluating the adequacy and effectiveness of WBHHS governance, risk management and internal controls, including whether resources are used in an efficient, effective and ethical manner.

The function operates under a Board approved Internal Audit Charter that is consistent with the International Professional Practices Framework that was developed by the Institute of Internal Auditors.

During the 2021-2022 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 2021-2022 was delivered through the outsourced 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.

The *Annual Internal Audit Plan* was developed to ensure adequate coverage over WBHHS strategic risks. Internal audits are undertaken utilising a risk-based methodology with recommendations made to further enhance the internal control environment where weaknesses are identified. The implementation and status of recommendations arising from audits is

monitored and reported to the Executive and Board Audit and Risk Committee.

Key achievements during 2021-2022 include:

- Completing internal audits on Information Security Management System (ISMS), S4/Hana Effectiveness, Contracts Management, and Patient Flow.
- Implementing 23 internal audit recommendations.
- Matured the internal audit function through the enhancement of an Internal Audit application to accommodate monitoring and communication requirements through the full program of work lifecycle
- Increased engagement and facilitation between relevant stakeholders and KPMG throughout the internal audit lifecycle.

External scrutiny, information systems and recordkeeping

WBHHS operations are accountable to external oversight bodies that regularly review and scrutinise our health service. These external bodies include but are not limited to the Queensland Audit Office, Crime and Corruption Commission, Office of the Health Ombudsman, Australian Council on Healthcare Standards, Queensland Ombudsman, and the Coroner.

Recommendations made from external agencies are acted on through existing WBHHS that monitor and report on corrective actions.

The *Public Records Act 2002* and *Queensland State Archives (QSA) Records Governance Policy April 2019 v1.0.2* provide 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 provide additional resources and tools to support administrative records governance.

WBHHS has training 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.

WBHHS 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 (IGF)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 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, hospitals 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 2021-22, the WBHHS continued to embed the objectives of the Act including continuation of the dedicated Human Rights Act intranet site with information and links for staff, a human rights training module incorporated into the WBHHS mandatory training program, and mandatory assessments of all policies, procedures and complaints received against the Act.

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:

- Human rights considerations built into development of all new or reviewed policies and procedures.
- Ongoing review of contractual and partnership arrangements.
- Embedding human rights consideration into strategic direction the development of the WBHHS Strategic Plan 2022-2026.
- Maturing feedback processes to increase accessibility, including providing publicly available information, accepting feedback through a variety of mediums, offering access to an interpreter or other translating services and offering child-friendly feedback mechanisms.
- Utilisation of risk management system to comprehensively record and report to ensure compliance with the reporting aspects of complaints and the Act.

While responding to the ongoing COVID-19 pandemic, WBHHS has ensured our actions were compatible with the *Human Rights Act 2019*, balancing physical distancing requirements with humane treatment where liberty was restricted.

In 2021-2022, WBHHS received 111 human rights complaints from staff, all resolved locally and resulting in no further action. It was up from the previous year, with COVID-19 mandatory vaccination requirements contributing to the increase.

Between July 2021 - June 2022 there were 22 patient complaints identifying relevance to the Human Rights Act. All were resolved locally.

The WBHHS Consumer Feedback Management Procedure has been reviewed (published 15 June 2022) with clear guidance around consent, privacy and human rights. A severity assessment scale identifies issues related to denial of rights as 'major': requiring escalation to Directors of Clinical Governance, Professional streams, or Human Resources. The procedure also includes avenues for referral of complaints to the Queensland Human Rights Commission.

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.

No releases of confidential information under section 160 of the Act were required by the Chief Executive during the 2021-2022 year.

Performance

Service standards

Table 7: Service Standards — Performance 2021-2022

Wide Bay Hospital and Health Service	2021-22 Target	2021-22 Actual
Effectiveness measures		
Percentage of emergency department patients seen within recommended timeframes[1]		
• Category 1 (within 2 minutes)	100%	99%
• Category 2 (within 10 minutes)	80%	61%
• Category 3 (within 30 minutes)	75%	51%
• Category 4 (within 60 minutes)	70%	58%
• Category 5 (within 120 minutes)	70%	88%
Percentage of emergency department attendances who depart within 4 hours of their arrival in the department[1]	>80%	61%
Percentage of elective surgery patients treated within the clinically recommended times[2]		
• Category 1 (30 days)	>98%	96%
• Category 2 (90 days)[3]	..	88%
• Category 3 (365 days)[3]	..	91%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days[4]	<2	1.0
Rate of community mental health follow up within 1-7 days following discharge from an acute mental health inpatient unit[5]	>65%	59.3%
Proportion of re-admissions to acute psychiatric care within 28 days of discharge[6]	<12%	9.1%
Percentage of specialist outpatients waiting within clinically recommended times[7]		
• Category 1 (30 days)	98%	96%
• Category 2 (90 days)[8]	..	74%
• Category 3 (365 days)[8]	..	81%
Percentage of specialist outpatients seen within clinically recommended times[7]		
• Category 1 (30 days)	98%	94%
• Category 2 (90 days)[8]	..	63%
• Category 3 (365 days)[8]	..	81%
Median wait time for treatment in emergency departments (minutes)[1]	..	28
Median wait time for elective surgery treatment (days)[2]	..	28
Efficiency measure		
Average cost per weighted activity unit for Activity Based Funding facilities[9]	$5,210	$5,006
Other measures		
Number of elective surgery patients treated within clinically recommended times[2]		
• Category 1 (30 days)	2,145	1,935
• Category 2 (90 days)[3]	..	1,195
• Category 3 (365 days)[3]	..	727
Number of Telehealth outpatients service events[10]	6,911	8,074
Total weighted activity units (WAU)[11]		
• Acute Inpatients	58,772	55,978
• Outpatients	15,453	13,402
• Sub-acute	7,360	14,974
• Emergency Department	18,743	15,384
• Mental Health	5,512	4,734
• Prevention and Primary Care	3,648	3,516
Ambulatory mental health service contact duration (hours)[12]	>34,523	33,360
Staffing[13]	3,428	3,532

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

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. Progress in 2021-2022 towards achieving the strategic directions:

Enhance holistic healthcare	• Establishing RaSS, which gives residents the option of receiving safe clinical support in their own environment rather than a hospital setting. • Launching of SPACE service which educates and supports aged care staff and general practitioners (GP) to manage residents with complex palliative needs. • Development of the draft FNHES by our First Nations led project team in consultation with key stakeholders. The draft is due to be presented for community consultation in July 2022. • Proportion of re-admissions to acute psychiatric care within 28 days of discharge improved from 10 per cent in 2020-2021 to 9.1 per cent in 2021-2022 – within Queensland Health benchmark of <12 per cent. • Working alongside Queensland Health's Preventative Health Branch to roll out initiatives supporting local pregnant women to quit smoking – addressing a 2019 survey which found 20 per cent of Wide Bay women smoked during their pregnancy. • Provided COVID-19 fever clinics, vaccination hubs, pop up vaccine clinics and virtual ward for positive patients ensuring equity of access across the region. • Exceeded our 80 per cent target for resolving complaints within 35 days with 83.4 per cent complaints resolved in this timeframe. • Exceptionally high complaints acknowledged within five days rate of 99.81 per cent (close to target of 100 per cent). • Continue to meet accreditation standards under our national leading Short Notice Accreditation . • Across the 2021-2022 year, 65 per cent of patients who completed a Patient Reported Experience Measures survey rated their overall care Very Good. A further 20 per cent rated their overall care Good. • WBHHS facebook page had 22,370 followers at June 30, 2022, (up 28 per cent compared to previous year). Overall audience reach was 318,987 during the financial year (down 11 per cent). The average audience for individual posts is increasing with 134 posts exceeding 10,000 reach and five posts exceeding 20,000 reach including two exceeding 30,000. • Consumers and clinicians are represented on key committees across WBHHS • Youth representation on our CRGs, the Bundaberg CRG now has four student members and the Fraser Coast CRG has two student members, bringing a youth perspective to their contributions. • Clinical incidents being thoroughly investigated and where possible within targets with a Severity Code Assessment Code (SAC) 1 closure within 90 days of 58.3 per cent (below target of 70 per cent). • Let's talk health community consultation campaign saw more than 350 people engage through public forums and online surveys through the Expression of Interest and draft plan feedback stages.

	• Held First Nations Family Days and clinics to support COVID-19 vaccination as well as a targeted proactive media and social media campaign to support this program.
Deliver more care locally	• 100 per cent KPI met for patients on the general dental waiting list within the recommended two-year wating time. This KPI has been sustained for 2.5 years. • A 60 per cent reduction in the denture waiting list in the last 12 months from 2,242 patients in July 2021 to 908 patients in June 2022. • Establishing a local rheumatology outpatient clinic to the region at Hervey Bay Hospital which sees Metro North HHS specialists visit to provide in-person outpatient clinics with telehealth follow up. • Wide Bay HHS achieving a 99 per cent first dose rate and more than 96 per cent second dose rate within 12 months of the COVID-19 vaccination rollout beginning. • 99 per cent of category 1 emergency department patients seen within clinically recommended waiting time. • Expansion of Wide Bay Hospital and Health Service's Mobile Women's Health Service clinics into Maryborough and Miriam Vale. • Overnight junior medical coverage commenced at Maryborough Hospital in February 2022, allowing for closer monitoring of higher acuity patients. • 8,131 telehealth outpatient service event significantly exceeding target of 6,911. • Despite the disruption and postponement of non-urgent elective surgery during the COVID-19 pandemic, WBHHS treated 88 per cent of category 2 and 91 per cent of category 3 patients within their clinically-recommended waiting times. • Application submitted for aged care places under the Australian Government's 2022-22 Flexible Residential Aged Care Places (Multi-purpose Services) Allocations Round for the Discovery Coast.
Plan today for future infrastructure	• Securing the $1.2 billion Bundaberg Hospital following the successful submission of a detailed business case to the Queensland Government. This will be the largest health infrastructure investment that the Wide Bay region has seen. • Continuation of the Fraser Coast Mental Health Service project, which involves building a new 22-bed acute mental health inpatient unit at Hervey Bay and refurbishment of the existing Maryborough inpatient unit into a 10-bed specialist sub-acute unit for older persons. Increasing mental health capacity by 18 beds. • Opening the refurbished Ward 1 at Maryborough Hospital in February 2022 to increase inpatient capacity by 18 beds and enhance service delivery across the Fraser Coast. • Continuing upgrades 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. Our performance in this area has led to a significant increase in funding. • Almost $1.4 million funding secured for minor capital works at Biggenden, Eidsvold and Mundubbera to improve the aged care service environment and support daily living, providing a more homelike environment and promoting residents' independence, dignity and choice. • Continuing planning and design work in collaboration with the Department of Health for a 28-bed alcohol and other drug residential rehabilitation and withdrawal management service facility in Bundaberg.

	• Securing $40 million funding for the Hervey Bay Hospital Expansion project to increase inpatient capacity at the hospital by up to 35 beds. • Extensive work on Bundaberg Hospital's HVAC systems to create negative pressure treatment areas that included 24 medical beds, seven intensive care beds, six renal treatment spaces, 12 medical clinical decision unit beds, two paediatric beds and one birthing suite at a cost of $2.8 million. • A continued agile and flexible approach to modifying infrastructure and assets to reduce risks associated with the COVID-19 pandemic, such as segregating clinical areas, improving ventilation along with establishing onsite and offsite fever and vaccination clinics.
Develop and support our staff	• WBHHS standing up of a Staff Wellbeing Group to develop and supports for our staff under challenging pandemic conditions. The program is supported by senior leadership and reinforced with a robust framework and communications strategy. • The 2022 graduate nursing intake was one of the largest in WBHHS history with more than 80 registered nurses joining our teams across the region. • The diversity of our workforce has improved in 2021-2022 with 13 per cent increase in employees who identify as Aboriginal or Torres Strait Islander, a nine per cent increase in people who are culturally and linguistically diverse and a 23 per cent increase in staff with a disability. • Six junior oral health line managers undertaking Women In Leadership program under mentorship of their director. The program challenges participants to value add to their roles and then act as future mentors of participants. • The 2021-2022 WBHHS Rehabilitation performance has been our best to date with the average first days return to work for injured staff 18 days (31 per cent reduction), total average incapacity days reducing to 31 days (37 per cent decrease) and partial incapacity days now averaging 51 days (31 per cent decrease). Injured staff are given meaningful roles and being supported to a positive recovery in the workplace. • Staff displaying WBHHS values and outstanding work performance recognised through awards such as annual Excellence Awards, Allied Health Awards and Australia Day Awards. The Excellence Awards received 130 nominations. • BPA Analytics Staff Survey completed in April and May 2022 providing a comprehensive overview of the views of our workforce – with a response rate of 43 per cent of our staff which exceeded our target. Survey results will be analysed and released in the next reporting period. • Our Employee Assistance Provider, Converge International is partnering with WBHSS to provide a series of self-guided wellness sessions for staff to access, commencing in July 2022 covering a variety of topics including mental wellbeing, nutrition, financial wellness and resilience. • PDP compliance was 58 per cent, which is equal to benchmark data across national public health and Queensland health organisations according to BPA analytics. This was achieved as COVID-19 pandemic response and significant workforce challenges impacted on the compliance rate. • Inclusion of WBHHS organisational values into PDPs to ensure workplace culture reflects our values.
Excellence through innovation	• The first intake of the Regional Medical Program, in collaboration with University of Queensland, CQUniversity Australia and Central Queensland HHS, with students starting their first year of learning at the Bundaberg campus. • The RISE pilot program was launched as part of the Frail Older Persons Healthy Ageing Model of Care.

- Opening the Oasis Crisis Support Space at Hervey Bay Hospital which provides high-quality and timely after-hours crisis care to people in distress, as an alternative to the emergency department.
- Wide Bay Oral Health is adopting the Dental Laboratory Module in ISOH after the successful pilot in Metro North. This will track denture units effectively to ensure swift turn arounds from one clinic to another, provide an efficient pathway of communication between clinicians and technicians, and allow for accurate statistics tracking both a clinic and technician level output.
- Installation of sign in/out kiosks for contractors at Mundubbera, Gayndah Monto and Biggenden. This will end the need for contractors to sign in remotely via Bundaberg and improve support to rural partners.
- Annual WBHHS Excellence Awards which recognise and reward innovation of our staff which drives better patient outcomes.
- Ongoing WBHHS involvement in clinical trials that investigate new medications and increasing WBHHS principal investigators pursuing research that benefits our patients.
- Continued partnerships for the provision of interim care with Mater, Friendlies, St Stephens and Residential Aged Care Facilities.
- Partnerships in place with local health providers to enhance access to specialist services closer 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 Central Queensland – onsite and offsite radiologist services including interventional and consultancy services (Hervey Bay, Bundaberg and Maryborough)
    - 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 Ltd – cardiac and pulmonary rehabilitation programs
    - Wide Bay Nuclear Medicine - offsite

Financial summary

2021–2022: in review

WBHHS ended the 2021-2022 financial year with an operating deficit of $2.4 million, which equates to 0.3 per cent of its operating revenue of $767 million. This is contrast with the $3.1 million operating surplus reported for the 2020-2021 financial year. The deficit is largely attributable to penalties associated with an under-delivery of activity for the period July to December 2021. WBHHS made the necessary service preparations for a COVID-19 surge that did not occur in the volume we anticipated, and this was the major contributor to the under-delivery of activity.

Due to ongoing demands associated with the COVID-19 pandemic, the Commonwealth Government agreed to provide a guaranteed Activity Based Funding envelope for the 2021-2022 financial year under the National Health Reform Agreement.

For the period July 2021 to December 2021, a partial guarantee applied to funding sources outside of those exclusively funded by the state, with 45% of the calculated penalty associated with underdelivered activity being guaranteed. For the months of January to June, a full guarantee applied to both the state and commonwealth portion of funding, resulting in no financial adjustments for under-delivery or over-delivery associated with this period against ABF targets.

In relation to COVID-19 costs, the National Partnership Agreement remained in force through 2021-2022 and supported the reimbursement of all eligible costs.

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.

As at 30 June 2022, WBHHS had a reported total anticipated maintenance of $26.83 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.

2021–2022: an outlook

Financial sustainability remains a critical challenge and is a key strategic risk to WBHHS, given the continued tightening financial pressures and growing demand whilst continuing to experience the impact of a worldwide pandemic.

The Board and Executive are committed to delivering productivity and efficiency improvements to meet increasing demand for services without compromising patient and staff safety and the quality of health care provided to our community.

Wide Bay Hospital and Health Service

Financial Statements - 30 June 2022

Wide Bay Hospital and Health Service

Wide Bay Hospital and Health Service

STATEMENT OF COMPREHENSIVE INCOME

for the year ended 30 June 2022

OPERATING RESULT	Notes	2022 $'000	2021 $'000
Income from Continuing Operations			
User charges and fees	A1-1	**57,241**	60,826
Funding for public health services	A1-2	**688,827**	636,586
Grants and other contributions	A1-3	**11,277**	10,714
Other revenue	A1-4	**9,627**	8,697
Total Revenue		**766,972**	716,823
Gain on disposals		**104**	75
Total Income from Continuing Operations		**767,076**	716,898
Expenses from Continuing Operations			
Employee expenses	A2-1	**80,052**	75,229
Health service employee expenses	A2-2	**432,828**	404,479
Supplies and services	A2-3	**222,588**	203,260
Interest on lease liabilities	B8-1	**252**	267
Depreciation and amortisation	B5-1,B8-1	**24,648**	22,772
Impairment losses / (reversals)	B2-2	**924**	494
Other expenses	A2-4	**8,209**	7,314
Total Expenses from Continuing Operations		**769,501**	713,815
Operating Result for the Year		**(2,425)**	3,083
Other Comprehensive Income			
Items that will not be reclassified subsequently to profit or loss			
Increase / (decrease) in asset revaluation surplus	B9-2	**23,153**	843
Total Other Comprehensive Income		**23,153**	843
Total Comprehensive Income		**20,728**	3,926

The accompanying notes form part of these statements.

Wide Bay Hospital and Health Service

STATEMENT OF FINANCIAL POSITION

as at 30 June 2022

	Notes	2022 $'000	2021 $'000
Current Assets			
Cash and cash equivalents	B1	**37,905**	35,016
Receivables	B2	**15,303**	9,592
Inventories	B3	**5,887**	5,503
Other assets	B4	**4,315**	5,196
Total Current Assets		**63,410**	55,307
Non-Current Assets			
Property, plant and equipment	B5-1	**334,183**	302,741
Right-of-use assets	B8-1	**9,295**	9,368
Intangible assets		**281**	-
Total Non-Current Assets		**343,759**	312,109
Total Assets		**407,169**	367,416
Current Liabilities			
Payables	B6	**54,263**	44,432
Lease liabilities	B8-1	**1,944**	1,818
Accrued employee benefits		**1,019**	709
Other liabilities	B7	**2,682**	2,174
Total Current Liabilities		**59,908**	49,133
Non-Current Liabilities			
Lease liabilities	B8-1	**7,844**	7,904
Total Non-Current Liabilities		**7,844**	7,904
Total Liabilities		**67,752**	57,037
Net Assets		**339,417**	310,379
Equity			
Contributed equity	B9-1	**231,813**	223,503
Accumulated surplus / (deficit)		**4,677**	7,102
Asset revaluation surplus	B9-2	**102,927**	79,774
Total Equity		**339,417**	310,379

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 2022

	Notes	Contributed equity $'000	Asset revaluation surplus $'000	Accumulated surplus/ (deficit) $'000	Total equity $'000
Balance as at 1 July 2020		231,039	78,931	4,019	313,989
Operating Result					
Operating result from continuing operations		-	-	3,083	3,083
Other Comprehensive Income					
Increase in asset revaluation surplus	B9-2	-	843	-	843
Total Comprehensive Income for the Year		-	843	3,083	3,926
Transactions with Owners as Owners:					
Non-appropriated equity asset transfers	B9-1	508	-	-	508
Non-appropriated equity injections - capital works	B9-1	14,728	-	-	14,728
Non-appropriated equity withdrawals - depreciation funding	B9-1	(22,772)	-	-	(22,772)
Net Transactions with Owners as Owners		(7,536)	-	-	(7,536)
Balance at 30 June 2021		**223,503**	**79,774**	**7,102**	**310,379**
Balance as at 1 July 2021		223,503	79,774	7,102	310,379
Operating Result					
Operating result from continuing operations		-	-	(2,425)	(2,425)
Other Comprehensive Income					
Increase in asset revaluation surplus	B9-2	-	23,153	-	23,153
Total Comprehensive Income for the Year		-	23,153	(2,425)	20,728
Transactions with Owners as Owners:					
Equity asset transfers	B9-1	1,831	-	-	1,831
Non-appropriated equity injections - capital works	B9-1	31,128	-	-	31,128
Non-appropriated equity withdrawals - depreciation funding	B9-1	(24,649)	-	-	(24,649)
Net Transactions with Owners as Owners		8,310	-	-	8,310
Balance at 30 June 2022		**231,813**	**102,927**	**4,677**	**339,417**

The accompanying notes form part of these statements.

Wide Bay Hospital and Health Service

STATEMENT OF CASH FLOWS

for the year ended 30 June 2022

	Notes	2022 $'000	2021 $'000
Cash flows from operating activities			
Inflows			
User charges and fees		**53,695**	39,106
Funding from public health services		**664,178**	636,586
Grants and other contributions		**5,680**	4,822
GST input tax credits from ATO		**15,345**	12,948
GST collected from customers		**779**	676
Other receipts		**9,627**	8,375
Outflows			
Employee expenses		**(81,095)**	(77,561)
Health service employee expenses		**(418,827)**	(416,593)
Supplies and services		**(220,107)**	(179,149)
GST paid to suppliers		**(15,493)**	(12,904)
GST remitted to ATO		**(704)**	(820)
Other payments		**(7,784)**	(7,369)
Net cash provided by operating activities	CF-1	**5,294**	8,117
Cash flows from investing activities			
Inflows			
Sales of property, plant and equipment		**104**	84
Outflows			
Payments for property, plant and equipment		**(31,431)**	(15,047)
Net cash used in investing activities		**(31,327)**	(14,963)
Cash flows from financing activities			
Inflows			
Equity injections		**31,128**	16,306
Outflows			
Lease payments	CF-2	**(2,206)**	(2,073)
Net cash provided by financing activities		**28,922**	14,233
Net increase in cash and cash equivalents		**2,889**	7,387
Cash and cash equivalents at the beginning of the financial year		**35,016**	27,629
Cash and cash equivalents at the end of the financial year	B1	**37,905**	35,016

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

	2022 $'000	2021 $'000
Operating result	**(2,425)**	3,083
Non-cash items:		
Depreciation and amortisation funding	**(24,648)**	(22,772)
Depreciation and amortisation expense	**24,648**	22,772
Donations below fair value	**(6,265)**	(5,807)
Services below fair value	**6,265**	5,807
Gain on disposal of assets	**(105)**	79
Loss on disposal of non-current assets	**366**	(11)
Donated non-cash assets	**252**	267
Changes in assets and liabilities:		
(Increase) / Decrease in receivables	**(5,711)**	(2,838)
(Increase) / Decrease in inventories	**(384)**	(949)
(Increase) / Decrease in contract assets	**193**	1,148
(Increase) / Decrease in prepayments	**688**	(1,296)
Increase / (Decrease) in trade payables	**11,602**	8,352
Increase / (Decrease) in contract liabilities and unearned revenue	**508**	2,614
Increase / (Decrease) in accrued employee benefits	**310**	(2,332)
Net cash provided by operating activities	**5,294**	8,117

CF-2 Change in liabilities arising from financing activities

	2022 $'000	2021 $'000
Lease Liabilities		
Balance at 1 July	**9,722**	10,332
Non-cash movements:		
New leases acquired during the year	**2,010**	1,196
Lease interest	**252**	267
Cashflows:		
Lease repayments	**(2,206)**	(2,073)
	9,778	9,722

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 39 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 Financial Reporting Requirements for the year ended 30 June 2022*, 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' where they are due to be settled within 12 months of the reporting date or where WBHHS does not have an unconditional right to defer settlement beyond 12 months of 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

	2022 $'000	2021 $'000
Revenue from contracts with customers		
Pharmaceutical Benefit Scheme Reimbursements	**34,979**	30,192
Sales of goods and services	**3,377**	7,124
Hospital fees	**17,265**	22,051
Other user charges and fees		
Sales of goods and services	**1,620**	1,459
Total	**57,241**	60,826

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 goods 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	Accounting 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, attending outpatient day clinics, or 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, 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

	2022 $'000	2021 $'000
Revenue from contracts with customers		
Activity based funding	**508,415**	469,801
Other funding for public health services		
Block funding	**79,610**	75,579
Department of Health funding	**100,802**	91,206
Total	**688,827**	636,586

A1 REVENUE *(Continued)*

Accounting policy – Funding for the provision of public health services

Funding is provided predominantly from the Department of Health for specific public health services purchased by the Department in accordance with a service agreement. The Australian Government pays its share of National Health funding directly to the Department of Health, for on forwarding to the Hospital and Health Service. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by WBHHS. Cash funding from the Department of Health is received fortnightly for State payments and monthly for Commonwealth payments and is recognised as revenue as the performance obligations under the service level agreement are discharged. Commonwealth funding to Wide Bay in 2022 was $247 million (2021: $232.0 million).

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

Ordinarily, activity based funding and Department of Health funding is recognised as public health services are delivered, however, due to the impacts of COVID-19, activity based funding was guaranteed by the Commonwealth government for 2020-21 under the National Health Reform Agreement. As such, the Department of Health did not make any adjustments for under delivery against activity-based funding targets during 2020-21. The Commonwealth government has applied a partial guarantee for the 2021-22 financial year. Further details of the guarantee are disclosed under note C4 Impact of COVID-19 on the Financial Statements.

Note A1-3: Grants and other contributions

	2022 $'000	2021 $'000
Revenue from contracts with customers		
Australian Government - specific purpose payments	**4,738**	4,784
Other grants and contributions		
Other grants	**36**	25
Donations - other	**238**	98
Donations below fair value	**6,265**	5,807
Total	**11,277**	10,714

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

	2022 $'000	2021 $'000
Revenue from contracts with customers		
Contract staff recoveries	**7,813**	6,937
General recoveries	**989**	935
Other revenue		
General recoveries	**589**	652
Interest	**11**	18
Other revenue	**225**	155
Total	**9,627**	8,697

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. 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, and the Australian and New Zealand College of Anaesthetists. 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 is recognised over time 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.	Revenue is recognised over time 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 Full Time Equivalents (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 is recognised as performance obligations are met in accordance with AASB 15.

A2 EXPENSES

Note A2-1: Employee expenses

	2022 $'000	2021 $'000
Employee benefits		
Wages and salaries	**67,617**	64,089
Annual leave levy	**4,698**	4,072
Employer superannuation contributions	**5,289**	4,792
Long service leave levy	**1,654**	1,488
Employee related expenses		
Workers' compensation premium	**794**	788
Total	**80,052**	75,229

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).

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.

Pandemic Leave

An additional 2 days of leave was granted to all non-executive employees of the Department of Health and HHS's in November 2020 based on set eligibility criteria as recognition of the effects of the COVID-19 pandemic on staff wellbeing. This leave must be taken within 2 years or eligibility is lost. Total value of the leave equates to $2.58m. Half of this was paid in advance by WBHHS to the Department of Health during 2020-21 with the remaining balance paid in 2021-22. The leave is expensed in the period it which it is taken, and the remaining balance treated as a pre-payment to the Department of Health.

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 Enterprise Bargaining Agreement (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. 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 employees' service each pay period. WBHHS's obligations are limited to those contributions paid.

A2 EXPENSES *(Continued)*

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.

Full time equivalent employees

	2022	2021
Number of WBHHS Employees (FTE) *	**162**	157

* 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.

	2022	2021
Number of Health Service Employees (FTE) *	**3,371**	3,277

	2022	2021
	$'000	$'000
Health Service employee expenses	**432,828**	404,479

* 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))*

Note A2-3: Supplies and services

	2022	2021
	$'000	$'000
Clinical supplies and services	**28,660**	28,781
Outsourced clinical services	**37,014**	28,594
Clinical contractors and consultants *	**23,233**	20,317
Other contractors and consultants	**642**	507
Drugs	**42,317**	37,088
Pathology	**18,914**	14,899
Repairs and maintenance including minor capital works	**11,858**	12,108
Catering and domestic supplies	**5,752**	6,701
Patient travel	**11,263**	10,955
Other travel	**3,592**	2,949
Electricity and other energy	**4,398**	4,212
Lease expenses	**1,844**	1,693
Motor vehicles	**743**	412
Communications	**5,025**	4,895
Computer services	**7,323**	6,784
Services below fair value	**6,265**	5,807
Other	**13,745**	16,558
Total	**222,588**	203,260

***** *Clinical contractors and consultants includes $15.3 million (2021: $14.9 million) for locum medical staff.*

A2 EXPENSES *(Continued)*

Note A2-4: Other expenses

	2022 $'000	2021 $'000
Insurance premiums QGIF *	**6,177**	5,815
Other insurance	**263**	127
Inventory written off	**252**	177
Losses from the disposal of non-current assets	**114**	161
Other legal costs	**445**	292
Advertising	**356**	227
Other **	**602**	515
	8,209	7,314

***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 medical indemnity payments above a $20,000 threshold and associated legal fees. Premiums are calculated on a risk assessment basis.

****Other:** Other includes audit fees paid or payable and special payments.
Audit fees: of $169 thousand to the Queensland Audit Office (2021: $169 thousand). There are no non-audit services included in this amount.
Special payments: of $6 thousand (2021: $10 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 setting out details of all special payments greater than $5,000. As at 30 June there were no special payments greater than $5,000.

NOTES ABOUT FINANCIAL POSITION

B1 CASH AND CASH EQUIVALENTS

	2022 $'000	2021 $'000
Cash at bank and on hand	**36,391**	33,718
General trust at call deposits*	**1,514**	1,298
Total	**37,905**	35,016

* 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 2022, the amount of $1.5 million (2021: $1.3 million) was in General Trust. Included in this was $503 thousand (2021: $506 thousand) for excess earnings from private practice clinicians.

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 facilities.

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.

B2 RECEIVABLES

Note B2-1: Trade and other receivables

	2022 $'000	2021 $'000
Trade receivables	**8,685**	5,036
Less: Loss allowance	**(773)**	(384)
	7,912	4,652
GST receivable	**1,643**	1,552
GST payable	**(105)**	(48)
	1,538	1,504
Accrued health service funding	**5,422**	2,493
Other DoH receivables	**431**	943
Total	**15,303**	9,592

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, industry 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 as at 30 June mainly related to overseas / ineligible patients.

Disclosure – Receivables

The closing balance of receivables arising from contracts with customers at 30 June 2022 is $3.5 million (2021: $4.3 million).

B2 RECEIVABLES *(Continued)*

Note B2-2: Impairment of Receivables

(i) Ageing of trade receivables

	2022			2021		
	Gross receivables	Loss rate	Expected credit loss	Gross receivables	Loss rate	Expected credit loss
	$'000	%	$'000	$'000	%	$'000
Trade receivables						
Current	**2,090**	**5%**	**(105)**	1,536	8%	(118)
1 to 30 days overdue	**1,745**	**7%**	**(122)**	1,333	9%	(120)
31 to 60 days overdue	**1,153**	**15%**	**(173)**	562	11%	(62)
61 to 90 days overdue	**2,745**	**4%**	**(110)**	185	11%	(20)
Greater than 90 days	**952**	**28%**	**(263)**	1,420	5%	(64)
Total	**8,685**		**(773)**	5,036		(384)

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

	2022	2021
	$'000	$'000
Balance at 1 July	**384**	345
Amounts written off during the year	**(535)**	(455)
Increase/(decrease) in allowance recognised in operating result	**924**	494
Balance at 30 June	**773**	384

B3 INVENTORIES

	2022	2021
	$'000	$'000
Inventories		
Pharmaceuticals	**2,203**	1,998
Clinical supplies	**3,581**	3,434
Catering and domestic	**92**	60
Other	**11**	11
Total	**5,887**	5,503

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

	2022	2021
	$'000	$'000
Current		
Prepayments	**1,409**	2,097
Contract assets*	**2,906**	3,099
	4,315	5,196

**Contract assets includes $0.6 million (2021: $0.8 million) associated with the Department of Health and $2.3 million (2021: $2.3 million) 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 2021						
Opening net book value	**14,921**	**262,764**	**27,011**	**19**	**2,568**	**307,283**
Acquisitions	-	94	5,882	-	9,095	15,071
Disposals	-	-	(179)	-	-	(179)
Transfers from / (to) DoH / Other HHS	485	-	23	-	-	508
Transfers between classes	-	1,460	-	-	(1,460)	-
Revaluation increments/(decrements)	8	835	-	-	-	843
Depreciation charge for the year	-	(15,795)	(4,990)	-	-	(20,785)
Carrying amount at 30 June 2021	**15,414**	**249,358**	**27,747**	**19**	**10,203**	**302,741**
At 30 June 2021						
At cost/fair value	15,414	581,562	60,898	20	10,203	668,097
Accumulated depreciation	-	(332,204)	(33,151)	(1)	-	(365,356)
Carrying amount at 30 June 2021	**15,414**	**249,358**	**27,747**	**19**	**10,203**	**302,741**
Year ended 30 June 2022						
Opening net book value	**15,414**	**249,358**	**27,747**	**19**	**10,203**	**302,741**
Acquisitions	-	-	6,581	-	22,511	29,092
Disposals	-	-	(117)	-	-	(117)
Transfers from / (to) DoH / Other HHS	-	-	1,831	-	-	1,831
Transfers between classes	-	14,410	-	-	(14,410)	-
Revaluation increments/(decrements)	2,100	21,053	-	-	-	23,153
Depreciation charge for the year	-	(17,033)	(5,484)	-	-	(22,517)
Carrying amount at 30 June 2022	**17,514**	**267,788**	**30,558**	**19**	**18,304**	**334,183**
At 30 June 2022						
At cost/fair value	17,514	648,720	66,538	20	18,304	751,096
Accumulated depreciation	-	(380,932)	(35,980)	(1)	-	(416,913)
Carrying amount at 30 June 2022	**17,514**	**267,788**	**30,558**	**19**	**18,304**	**334,183**

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.

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

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.

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)	0.83% - 4.55%
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.

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

Impairment of non-current assets

Key Judgement and Estimate: All non-current physical assets are assessed for indicators of impairment on an annual basis, or where the asset is measured at fair value, for indicators of a change in fair value / service potential since the last valuation was completed. 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 Impairment of Assets, where such assets are measured at fair value under AASB 13 Fair Value Measurement, 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 Request for Quote process to cover a full four-year rolling revaluation program up to financial year 30 June 2025. The successful quote was endorsed by the Board Audit and Risk Committee.

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.

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

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

Land

During the 2021-22 year, WBHHS engaged the services of the State Valuation Service (SVS) to provide an indexation report for the 2021-22 financial year. The last comprehensive valuation of land was undertaken by SVS in the 2020-21 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 2021-22 resulted in a revaluation adjustment of $2.10 million to the carrying value of land (2021: $8 thousand). The next comprehensive revaluation is scheduled to occur in 2025-26. Indexation will occur in the intervening years in line with Queensland Treasury's Non-Current Asset Policy.

Buildings

A new 4 year rolling building valuation program commenced in 2021-22 based on major geographical locations of building and land improvement assets (i.e. Bundaberg, Hervey Bay, Maryborough 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. In 2021-22 WBHHS engaged independent quantity surveyors AECOM to undertake the building valuations for a period of four years.

In 2021-22 Bundaberg building and land improvement assets were valued, reflecting 31% of NBV of the building portfolio at the time of valuation. Those buildings which were not subject to comprehensive valuation (accounting for 67% 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 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 comprehensive valuation for 2021-22 resulted in a net increment to the building portfolio of $16.21 million (2021: $0.84 million increment) and to the asset revaluation surplus account. This is an increase of 8.94% to the fair value of buildings as at 30 June 2022. An adjustment was made to the remainder of buildings not subject to independent valuation due to the index rate of 8.0% being material. (cumulative rate 10.16%).

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 business case is due to be presented to the Queensland Government in the later part of 2022 for consideration. The business case, informed by compressive analysis of the social, economic, environmental and financial impacts of the proposed hospital, will assist the Queensland Government to make informed decisions about the future design, staging and funding of the project. Useful lives associated with existing assets will be reviewed once a decision has been made on the outcome of the detailed business case. As part of the detailed business case, Queensland Health has purchased land from the Department of Resources in Bundaberg for the site of the proposed new hospital for $250 thousand (excl. GST). This land asset will be transferred to the HHS once the new hospital is operational.

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

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

	2022 $'000	2021 $'000
Trade payables	**23,043**	24,652
Accrued expenses	**14,983**	14,086
Department of Health payables	**16,237**	5,694
Total	**54,263**	44,432

Payables are recognised for amounts to be paid in the future for goods and services already received. Trade payables 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.

B7 OTHER LIABILITIES

	2022 $'000	2021 $'000
Current		
Contract liabilities *	**2,014**	2,174
Unearned revenue	**668**	0
	2,682	2,174

** Contract liabilities includes $1.7 million (2021: $1.7 million) associated with Department of Health and $0.3 million (2021: $0.5 million) associated with contracts with other customers.*

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

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.

B8 RIGHT OF USE ASSETS AND LEASE LIABILITIES

Note B8-1: Leases as a lessee

Right-of-use assets

	Buildings $'000	Plant and equipment $'000	Total $'000
Year ended 30 June 2021			
Opening balance 1 July	**10,159**	**-**	**10,159**
Additions	1,196	-	1,196
Disposals	-	-	-
Depreciation charge for the year	(1,987)	-	(1,987)
Other adjustments	-	-	-
Closing balance at 30 June 2021	**9,368**	**-**	**9,368**
Year ended 30 June 2022			
Opening balance 1 July	**9,368**	**-**	**9,368**
Additions	1,970	40	**2,010**
Depreciation charge for the year	(2,076)	(7)	**(2,083)**
Disposals	-	-	**-**
Other adjustments	-	-	**-**
Closing balance at 30 June 2022	**9,262**	**33**	**9,295**

Lease liabilities

	2022 $'000	2021 $'000
Current		
Lease liabilities	**1,944**	1,818
Non-current		
Lease liabilities	**7,844**	7,904
	9,788	9,722

Accounting policies – Leases as lessee

Right-of-use assets

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

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

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

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

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.

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

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

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 not to separate lease and non-lease components and instead accounts for them as a single lease component.

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.

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

Disclosures – Leases as lessee

(i) Residential Accommodation Leases

WBHHS has 55 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.

(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) Office equipment

WBHHS has 1 equipment lease with an external party which has been recognised as an ROU asset and lease liability in line with AASB 16.

(v) Amounts recognised in profit or loss

	2022 $'000	2021 $'000
Interest expense on lease liabilities	**252**	267
Breakdown of 'Lease expenses' included in Note A2-3		
- Expenses relating to short-term leases	**127**	95
- Expenses relating to internal-to-government arrangements that are no longer leases	**1,718**	1,598
	2,097	1,693

(vi) Total cash outflow for leases

	2022 $'000	2021 $'000
Lease Payments	(2,206)	(2,073)

B9 EQUITY

Note B9-1: Contributed Equity

	2022 $'000	2021 $'000
Opening balance at beginning of year	**223,503**	231,039
Non-appropriated equity injections		
Capital funding	**31,128**	14,728
Non-appropriated equity withdrawals		
Non-cash depreciation funding returned to Department of Health as a contribution towards capital works program	**(24,649)**	(22,772)
Equity asset transfers		
Land	**-**	485
Other	**1,831**	23
Balance at the end of the financial year	**231,813**	223,503

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

	2022 $'000	2021 $'000
Land		
Balance at the beginning of the financial year	**2,123**	2,115
Revaluation increments/(decrements)	**2,100**	8
Total Land	**4,223**	2,123
Buildings		
Balance at the beginning of the financial year	**77,651**	76,816
Revaluation increments/(decrements)	**21,053**	835
Total Buildings	**98,704**	77,651
Balance at the end of the financial year	**102,927**	79,774

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	2022 $'000	2021 $'000
Financial assets at amortised cost			
Cash and cash equivalents	B1	**37,905**	35,016
Receivables	B2	**15,303**	9,592
Total		**53,208**	44,608
Financial liabilities at amortised cost			
Payables	B6	**47,073**	43,927
Lease liabilities	B8-1	**9,788**	9,722
Total		**56,861**	53,649

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 2022 comprise $3.8 million from Health Funds (2021: $3.2 million), and $4.1 million other external debtors (2021: $1.5 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 (2021: $8.5 million) to manage any short-term cash shortfalls. This facility has not been drawn down as at 30 June 2022 (2021: 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 (2022: $1.5 million, 2021: $1.3 million)

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:

	2022 Number of cases	2021 Number of cases
Supreme Court	**2**	4
District Court	**2**	1
Tribunals, commissions and boards	**3**	1
	7	6

Medical Indemnity 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 2022, WBHHS has 6 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

Capital expenditure commitments

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

	2022 $'000	2021 $'000
Plant and Equipment		
No later than 1 year	**23,861**	18,300
Later than 1 year but no later than 5 years	**651**	10,509
Total	**24,512**	28,809

C4 IMPACT OF COVID-19 ON THE FINANCIAL STATEMENTS

The impact of the global COVID-19 pandemic continues across the globe. 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 $20.0 million (2021: $9.5 million) was provided through the COVID National Partnership Agreement. In addition to this, expenses associated with COVID-19 vaccination clinics were reimbursed by the State in the amount of $11.4 million (2021: $1.7 million), as well as funding of $1.3 million (2021: nil) to cover backfill expenses for staff on mandatory vaccination leave.

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 market based land valuation which is updated on advice from Queensland Treasury and State Valuation Services at 30 June 2022.

Due to the COVID-19 pandemic, the Commonwealth Government has agreed to provide a guaranteed Activity Based Funding (ABF) envelope for the 2021-22 financial year under the National Health Reform Agreement (commonly known as a Minimum Funding Guarantee MFG). For the period July 2021 to December 2021, a partial MFG has been applied to funding sources outside of those exclusively funded by the state or funding listed as specific funding investment within the service agreement. The MFG for this period is 45% of the calculated penalty associated with underdelivered activity for the period. For the months of January to June 2022, a full MFG has been applied to both the state and commonwealth portion of funding, resulting in no financial adjustments for under-delivery or over-delivery associated with this period against ABF targets.

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 Yvette D'Ath, Minister for Health and 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 2021-22. 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.	Karen Prentis	Hospital and Health Boards Act 2011 Section 25 (1) (b)	18/05/2017 Appointed as Deputy Chair 21/10/2021
Non-executive Board Member - Provide strategic leadership, guidance and effective oversight of management, operations and financial performance.	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
	Sandra Rattenbury	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2020 Resigned: 31/03/2022
	Leon Nehow	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2020
	Craig Hodges	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2021
	Karla Steen	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2021
	Kathy Campbell	Hospital and Health Boards Act 2011 Section 23 (1)	18/05/2021
	Chris Woollard	Hospital and Health Boards Act 2011 Section 23 (1)	01/04/2022

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.	Deborah Carroll	s24 / s70 Appointed by Board under *Hospital and Health Board Act 2011 (Section 7 (3))*	02/12/2014 (Appointed to Chief Executive 27/04/2020)
Chief Operating Officer - Reports to the Chief Executive and provides strategic leadership, direction, and day to day management of the Wide Bay Hospital and Health Service to optimise quality health care and business outcomes.	Michael Lewczuk	HES3 Appointed by Chief Executive (CE) under s74 Hospital and Health Boards Act 2011	30/08/2021
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.	Martin Clifford	HES2 Appointed by Chief Executive (CE) under s74 *Hospital and Health Boards Act 2011*	07/02/2022
	Martin Heads (Acting)	Employed under short term contract arrangement	11/01/2021 Contract end date: 07/02/2022
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 Resignation: 26/06/2022
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.	Scott Kitchener	MMOI2 Appointed under Medical Officers (Queensland Health) Award - State 2015	25/01/2021
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.	Cameron Duffy (Acting)	NRG13-2 Appointed under Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012	16/06/2021
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.	Robyn Scanlan	HES2 Appointed by Chief Executive (CE) under s74 *Hospital and Health Boards Act 2011*	13/04/2020 (Acting) Permanently appointed: 30/08/2021
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

Wide Bay Hospital and Health Service (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 arrangements 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
2021-2022				
Peta Jamieson	92	-	9	**101**
Karen Prentis	51	-	5	**56**
Trevor Dixon	53	-	5	**58**
Simone Xouris	52	-	5	**57**
Sandra Rattenbury	35	-	4	**39**
Leon Nehow	47	-	5	**52**
Craig Hodges	48	-	5	**53**
Kathy Campbell	46	-	5	**51**
Karla Steen	48	-	4	**52**
Chris Woollard	10	-	1	**11**

Name	Short Term Employee Expenses		Post employment benefits	Total remuneration
	Monetary benefits	Non-monetary benefits		
	$'000	$'000	$'000	$'000
2020-2021				
Peta Jamieson	91	-	8	**99**
Bryan Burmeister	36	-	4	**40**
Karen Prentis	49	-	4	**53**
Anita Brown	42	-	4	**46**
Trevor Dixon	49	-	4	**53**
Simone Xouris	48	-	4	**52**
Emeritus Professor Phillip Clift	42	-	4	**46**
Sandra Rattenbury	41	-	4	**45**
Leon Nehow	41	-	4	**45**
Craig Hodges	5	-	1	**6**
Kathy Campbell	5	-	1	**6**
Karla Steen	5	-	1	**6**

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
2021-2022						
Deborah Carroll	291	-	7	29	-	**327**
Michael Lewzcuk	206	-	4	19	-	**229**
Martin Clifford	89	-	2	7	-	**98**
Martin Heads *	-	-	-	-	-	**-**
Peter Heinz	198	-	4	17	1	**220**
Robyn Bradley	210	-	5	20	-	**235**
Scott Kitchener	604	-	14	43	-	**661**
Fiona Sewell **	-	-	-	-	-	**-**
Cameron Duffy	245	-	5	21	-	**271**
Robyn Scanlan	203	-	5	20	-	**228**
Stephen Bell	196	-	4	20	-	**220**

**Martin Heads was employed by Deloitte Financial Advisory Pty Ltd (Deloitte) and contracted to WBHHS on a short term contract arrangement to act in the role of Executive Director Finance and Performance while a formal recruitment process was undertaken. Total contract payments made to Deloitte during 2021-22, in relation to the provision of this service, amounts to $278 thousand (2021: $207 thousand).*

*** Fiona Sewell was acting in the role of COVID Responsible Lead Officer role during 2021-22. Fiona returned to her substantive position of Executive Director Nursing Services on 27/06/2022. Cameron Duffy was acting in the Executive Director Nursing Services position in 2021-22.*

D1 KEY MANAGEMENT PERSONNEL DISCLOSURES (C*ontinued*)

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
2020-2021						
Deborah Carroll	296	-	6	30	-	**332**
Scott McConnel	111	-	2	10	2	**125**
Peter Heinz	196	-	4	20	-	**220**
Robyn Bradley	209	-	4	21	-	**234**
Katrina Mathies	66	-	1	2	1	**70**
Fiona Sewell	266	-	6	28	-	**300**
Jennifer King	151	-	3	13	-	**167**
Stephen Bell	193	-	4	19	-	**216**
Peter Wood	217	-	5	20	-	**242**
Robyn Scanlan	200	-	4	16	-	**220**
Martin Heads *	-	-	-	-	-	**-**
Scott Kitchener	358	-	8	27	-	**393**

**Martin Heads was employed by Deloitte Financial Advisory Pty Ltd (Deloitte) and contracted to WBHHS on a short-term contract arrangement to act in the role of Executive Director Finance and Performance while a formal recruitment process was undertaken. Total contract payments made to Deloitte during 2020-21, in relation to the provision of this service, amounts to $207 thousand.*

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 2021-22 (2020-21 $nil).

WBHHS employs 4 staff which are close family members of Key Management Personnel and were employed through an arm's 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 2021-22 is $688.8 million (2020-21: $636.6 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 2021-22 is $432.8 million (2020-21: $404.0 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 2022		As at 30 June 2022	
Revenue Received $'000	**Expenses incurred $'000**	**Assets $'000**	**Liabilities $'000**
$691,691	**$343,338**	**$5,209**	**$39,822**

D3 RELATED PARTY TRANSACTIONS (Continued)

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

	2022 $'000	2021 $'000
Receipts		
Billings from SMOs and VMOs	**2,710**	7,535
Interest	**4**	9
Total receipts	**2,714**	7,544
Payments		
Payments to SMOs and VMOs	**(258)**	(269)
Payments to HHS under assignment model (including transfer of excess earnings to general trust – refer to note B-1)	**(3,068)**	(8,372)
Hospital and Health Service recoverable administrative costs	**(142)**	(173)
Total payments	**(3,468)**	(8,814)
Increase/decrease in net granted private practice assets	**(755)**	(1,272)
Granted private practice assets opening balance	**1,159**	2,431
Granted private practice closing balance	**404**	1,159
Granted private practice assets		
Current assets		
Granted private practice cash at bank	**404**	1,159
Total	**404**	1,159

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.

	2022 $'000	2021 $'000
Patient Trust receipts and payments		
Receipts		
Receipts from patients	**81**	81
Total receipts	**81**	81
Payments		
Payments to patients	**(75)**	(113)
Total payments	**(75)**	(113)
Increase/decrease in net patient trust assets	**6**	(32)
Patient trust assets opening balance	**16**	48
Patient trust assets closing balance	**22**	16
Patient trust assets		
Current assets		
Patient Trust cash at bank	**22**	16
Total	**22**	16

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.

	2022 $'000	2021 $'000
Restricted assets		
Opening balance	**1,515**	1,517
Income	**485**	420
Expenditure	**(471)**	(422)
Closing balance	**1,529**	1,515

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 considers specific financial impacts relating to climate related risks by identifying and monitoring material accounting judgements and estimates used in preparing the financial report. This includes potential for changes in asset useful lives, changes in the fair value of assets, provisions or contingent liabilities and changes in expenses and revenue.

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.

No adjustments to the carrying value of recorded assets or other adjustments to the amounts recorded in the financial statements were recognised during the financial year.

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 2021-22.

Accounting standards early adopted for 2021-22

No Australian Accounting Standards have been early adopted for the 2021-22 financial year.

Accounting Standards Applied for the First Time in 2021-22

No new accounting standards with material impact were applied for the first time in 2021-22.

Accounting Standard Interpretations in 2021-22

International Financial Reporting Interpretations Committee (IFRIC) agenda decision in April 2021 relating to Software as a Service (SaaS), clarified that an entity is not entitled to capitalise the cost of any configuration or customisation costs incurred in relation to software accessed under a SaaS arrangement. In accordance with this decision, WBHHS has undertaken a review of all purchased and developed software and software work in progress to determine whether any amounts previously capitalised, or currently in work in progress, were related to SaaS arrangements. WBHHS’s assessment is that there are no intangible assets that would meet the criteria of a SaaS and hence no accounting adjustments are required if in 2021-22.

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 2022 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 2021-22 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 2022 $'000	Actual Result 2022 $'000	Variance $'000
OPERATING RESULT				
Income				
User charges and fees	1	53,784	**57,241**	3,457
Funding for public health services	2	653,312	**688,827**	35,515
Grants and other contributions		10,478	**11,277**	799
Other revenue	3	7,326	**9,627**	2,301
Total Revenue		724,900	**766,972**	42,072
Gain on disposals		10	**104**	94
Total Income		724,910	**767,076**	42,166
Expenses				
Employee expenses		74,357	**80,052**	5,695
Health service employee expenses	4	417,128	**432,828**	15,700
Supplies and services	5	196,481	**222,588**	26,107
Interest on lease liabilities		270	**252**	(18)
Depreciation and amortisation		23,529	**24,648**	1,119
Impairment losses	6	414	**924**	510
Other expenses	7	12,731	**8,209**	(4,522)
Total Expenses		724,910	**769,501**	44,591
Operating Results for the year		-	**(2,425)**	(2,425)
Other Comprehensive Income				
Items that will not be reclassified subsequently to profit or loss				
Increase / (decrease) in asset revaluation surplus		-	**23,153**	23,153
Other comprehensive income for the year		-	**23,153**	23,153
Total comprehensive income for the year		-	**20,728**	20,728

1. The increase relates to additional Pharmaceutical Benefits Scheme revenue of $3.3m in line with increased drug expenditure at note 5. The increase in drug expenditure is mostly a result of the original budget not being aligned with expected activity and increases in the volume of respiratory and cancer care related drugs.

2. The increase relates to amendments during the year to the service agreement with the Department of Health, including the provision of additional specific funding initiatives to help manage activity related impacts as a result of COVID-19, increased pressure over flu season, and to support unprecedented demand being experienced across Queensland public hospitals. Major amendments include $31.4m for reimbursement of direct costs associated with COVID-19, $1.4m for enterprise bargaining increases, $6.0m interim care beds under the Care4Qld Program, $9.6m to support an extension of outsourced service activity, offset by ABF activity penalty of ($3.3m) and ($10.0m) for end of year technical adjustments (including clawback/deferrals for specific initiatives not fully delivered/performed).

3. The increase relates to a higher number of junior doctor placements recovered via a contract arrangement with a tertiary institution of $1.9m plus $0.4m in inter-entity charging for recoveries with the Department and other Health Services as a result of new contracts entered into.

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

4. Total increase across employee and health services expenses relates to COVID-19 activity of $19.0m plus additional labour spend associated with amendments to the service agreement with the Department of Health as reported at note 2 of $3.9m, offset by labour associated with end of year technical adjustments with the Department of Health ($3.6m), also reported at note 2.

5. Increases relate primarily to COVID-19 expenditure of $12.2m, temporary medical and nursing labour of $10.9m as a result of recruitment and retention challenges, pathology not budgeted in line with expected activity of $1.9m, and increased drug expenditure of $3.9m (offset by PBS drug revenue as reported in note 1). These amounts are offset by savings in patient travel ($2.9m) and other supplies and services ($1.5m) as a result of reduced activity during periods of COVID-19 uplift.

6. Variance to budget relates to increased write-offs and doubtful debt provisions associated with an increased number of Medicare Ineligible patients. COVID-19 related write-offs amount to $0.2m, which are reimbursable under the National Partnership Agreement (NPA). The remainder of the increase relates to a higher than expected doubtful debt provision for Medicare Ineligible patients.

7. The positive variance to budget relates primarily to $3.4m in funding parked in centrally managed budget for initiatives not commenced during the year as a result of delays associated with recruitment, planning and focus on COVID-19 related activity. Some of this variance relates to clawbacks/deferrals recognised as part of the end of year technical adjustment process with the Department of Health as reported at note 2.

F3 BUDGET TO ACTUAL COMPARISON – STATEMENT OF FINANCIAL POSITION

	Variance Notes	Original Budget 2022 $'000	Actual Result 2022 $'000	Variance $'000
Current Assets				
Cash and cash equivalents	8	26,953	**37,905**	10,952
Receivables	9	10,747	**15,303**	4,556
Inventories		5,021	**5,887**	866
Other assets	10	866	**4,315**	3,449
Total Current Assets		43,587	**63,410**	19,823
Non-Current Assets				
Property, plant and equipment	11	316,663	**334,183**	17,520
Right-of-use assets	12	7,244	**9,295**	2,051
Intangibles		(24)	**281**	305
Total Non-Current Assets		323,883	**343,759**	19,876
Total Assets		367,470	**407,169**	39,699
Current Liabilities				
Payables	13	36,911	**54,263**	17,352
Lease liabilities		2,131	**1,944**	(187)
Accrued employee benefits		841	**1,019**	178
Other liabilities	14	66	**2,682**	2,616
Total Current Liabilities		39,949	**59,908**	19,959
Non-Current Liabilities				
Lease liabilities	12	5,636	**7,844**	2,208
Total Non-Current Liabilities		5,636	**7,844**	2,208
Total Liabilities		45,585	**67,752**	22,167
Net Assets		321,885	**339,417**	17,532
Equity				
Contributed equity		217,910	**231,813**	13,903
Accumulated surplus / (deficit)		4,020	**4,677**	657
Asset revaluation surplus		99,955	**102,927**	2,972
Total Equity		321,885	**339,417**	17,532

8. The increase relates primarily to additional funding provided throughout the Service Agreement with the Department of Health not factored into the original budget.

9. The majority of the increase relates to invoices raised for contract staff recoveries and inpatient accounts $3.6m and uplift in Medicare Ineligible patient accounts.

10. Increase relates to contract assets not factored into budget as a result of Contracts with Customers, including funding revenue payable from the Department of Health.

11. The increase relates to the 2020-21 revaluation results being higher than budgeted plus higher value of assets transferred from work in progress throughout the year.

12. New leases under AASB 16 entered during period resulted in a higher value of Right-of-use assets and Lease Liabilities than budgeted.

13. The increase relates primarily to timing difference between budget and actuals for accrued labour of and non-labour expenses at year-end plus $11.4m in unbudgeted funding payables to the Department of Health at year-end.

14. Unearned revenue associated with new capital grants issued during year of $0.7m plus $1.7m in contract liabilities with the Department of Health associated with funding deferrals under AASB 15 Contracts with Customers.

F4 BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOWS

	Variance Notes	Original Budget 2022 $'000	Actual Result 2022 $'000	Variance $'000
Cash flows from operating activities				
Inflows				
User charges and fees	15	706,658	**717,873**	11,215
Grants and other contributions		4,674	**5,680**	1,006
GST input tax credits from ATO		13,991	**15,345**	1,354
GST collected from customers		-	**779**	779
Other receipts	16	7,326	**9,627**	2,301
Outflows				
Employee expenses	17	(74,357)	**(81,095)**	(6,738)
Health service employee expenses		(417,128)	**(418,827)**	(1,699)
Supplies and services	18	(195,404)	**(220,107)**	(24,703)
GST paid to suppliers		(14,000)	**(15,493)**	(1,493)
GST remitted to ATO		-	**(704)**	(704)
Other payments		(7,197)	**(7,784)**	587
Net cash from / (used by) operating activities		24,563	**5,294**	(19,269)
Cash flows from investing activities				
Inflows				
Sales of property, plant and equipment		10	**104**	94
Outflows				
Payments for property, plant and equipment	19	-	**(31,431)**	(31,341)
Net cash from / (used by) investing activities		10	**(31,327)**	(31,337)
Cash flows from financing activities				
Inflows				
Equity injections	20	1,358	**31,128**	29,770
Outflows				
Lease payments	21	(1,616)	**(2,206)**	(590)
Equity withdrawals	22	(23,529)	**-**	23,529
Net cash from / (used by) financing activities		(23,787)	**28,922**	52,709
Net increase / (decrease) in cash and cash equivalents		786	**2,889**	2,103
Cash and cash equivalents at the beginning of the financial year		26,167	**35,016**	8,849
Cash and cash equivalents at the end of the financial year		26,953	**37,905**	10,952

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

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

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

18. Consistent with movement in Statement of Comprehensive Income (note 5).

19. Increase relates to capital projects managed by the Department of Health not included in the original budget (included in the Department of health's consolidated budget).

20. Increase relates primarily to capital project costs paid for by the HHS and reimbursed by the Department of Health which were not included in the original budget (included in the Department of Health's consolidated budget).

21. Consistent with movement in Statement of Financial Position (note 12).

22. 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 2009* (the Act), Section 38 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 2022 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
24 August 2022

Deborah Carroll
Chief Executive
24 August 2022

Martin Clifford
Chief Financial Officer
24 August 2022

Queensland Audit Office
Better public services

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 2022, and its financial performance and cash flows for the year then ended

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

The financial report comprises the statement of financial position as at 30 June 2022, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

Basis for opinion

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

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

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

Key audit matter

Valuation of buildings ($267.8 million)

Refer to note B5 in 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 within the Bundaberg region this year as part of the rolling revaluation program. All other buildings were assessed using relevant indices.	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

Key audit matter	How my audit addressed the key audit matter
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 balance date using unit prices that required significant judgements for: • identifying the components of buildings with separately identifiable replacement costs • developing a unit rate for each of these components, including: – estimating the current cost for a modern substitute (including locality factors and oncosts), expressed as a rate per unit (e.g. $/square metre) – identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference. The measurement of accumulated depreciation involved significant judgements for determining condition and forecasting the remaining useful lives of building components. The significant judgements required for gross replacement cost and useful lives are also significant judgements for calculating annual depreciation expense. Using indexation required: • significant judgement in determining changes in cost and design factors for each asset type since the previous revaluation • reviewing previous assumptions and judgements used in the last comprehensive valuation to ensure ongoing validity of assumptions and judgements used.	• 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 • for unit rates, on a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the: – modern substitute (including locality factors and oncosts) – 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 – testing that no building asset still in use has reached or exceeded its useful life – enquiring of management about their plans for assets that are nearing the end of their useful life – 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.

Responsibilities of the entity for the financial report

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

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

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

Queensland Audit Office
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Statement

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2022:

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

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

Prescribed requirements scope

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

26 August 2022

David Adams
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 breastscreen 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.
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 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 per cent 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.
Integrated Care	Focuses on the transition between the hospital and the community enhancing a safe continuum of care for the client.
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 tumors
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 on-line 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	3
Non-financial performance	• Government's objectives for the community whole-of-government plans / specific initiatives	ARRs – section 11.1	1
	• Agency objectives and performance indicators	ARRs – section 11.2	31
	• Agency service areas and service standards	ARRs – section 11.3	29
Financial performance	• Summary of financial performance	ARRs – section 12.1	35
Governance – management and structure	• Organisational structure	ARRs – section 13.1	22
	• Executive management	ARRs – section 13.2	19
	• Government bodies (statutory bodies and other entities)	ARRs – section 13.3	13
	• Public Sector Ethics	*Public Sector Ethics Act 1994* ARRs – section 13.4	27
	• Human Rights	*Human Rights Act 2019* ARRs – section 13.5	28
	• Queensland public service values	ARRs – section 13.6	27
Governance – risk management and accountability	• Risk management	ARRs – section 14.1	26
	• Audit committee	ARRs – section 14.2	11
	• Internal audit	ARRs – section 14.3	26

Summary of requirement		Basis for requirement	Annual report reference
	• External scrutiny	ARRs – section 14.4	27
	• Information systems and recordkeeping	ARRs – section 14.5	27
	• Information Security attestation	ARRs – section 14.6	N/A
Governance – human resources	• Strategic workforce planning and performance	ARRs – section 15.1	24
	• Early retirement, redundancy and retrenchment	Directive No.04/18 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	25
Open Data	• Statement advising publication of information	ARRs – section 16	i
	• Consultancies	ARRs – section 31.1	https://data.qld.gov.au
	• Overseas travel	ARRs – section 31.2	https://data.qld.gov.au
	• Queensland Language Services Policy	ARRs – section 31.3	https://data.qld.gov.au
Financial statements	• Certification of financial statements	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	FS-43
	• Independent Auditor's Report	FAA – section 62 FPMS – section 46 ARRs – section 17.2	After FS-43

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2019*

ARRs *Annual report requirements for Queensland Government agencies*

ANNUAL REPORT 2021–2022
Wide Bay Hospital and Health Service
www.health.qld.gov.au/widebay