



FINANCIAL AUDIT REPORT

16 December 2021

Health 2021

Report 12: 2021–22

As the independent auditor of the Queensland public sector, including local governments, the Queensland Audit Office:

- provides professional audit services, which include our audit opinions on the accuracy and reliability of the financial statements of public sector entities
- provides entities with insights on their financial performance, risk, and internal controls; and on the efficiency, effectiveness, and economy of public service delivery
- produces reports to parliament on the results of our audit work, our insights and advice, and recommendations for improvement
- supports our reports with graphics, tables, and other visualisations, which connect our insights to regions and communities
- conducts investigations into claims of financial waste and mismanagement raised by elected members, state and local government employees, and the public
- shares wider learnings and best practice from our work with state and local government entities, our professional networks, industry, and peers.

We conduct all our audits and reports to parliament under the *Auditor-General Act 2009* (the Act). Our work complies with the *Auditor-General Auditing Standards* and the Australian standards relevant to assurance engagements.

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The Honourable C Pitt MP
Speaker of the Legislative Assembly
Parliament House
BRISBANE QLD 4000

16 December 2021

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Report on a page

This report discusses the audit results of Queensland Health entities, which include the Department of Health (the department) and 16 hospital and health services (HHSs). It also summarises the audit results for 13 hospital foundations, four other statutory entities and three controlled entities.

Financial statements are reliable and internal controls are stronger

The financial reports prepared by Queensland Health entities, hospital foundations, and the other statutory bodies are reliable and comply with relevant laws and accounting standards. The systems and processes (internal controls) they use to prepare financial statements improved during the year, and they have resolved the weaknesses identified in 2019–20 relating to the implementation of the new finance system. None of the annual reports of the HHSs have been tabled by the statutory deadline of 30 September. We continue to find control deficiencies related to procurement and contract management processes within the department and HHSs.

Short-term sustainability has improved

The short-term financial position of the sector has improved in 2020–21, with the HHSs having a combined operating result (the difference between revenue and expenses) of \$33 million (2019–20: \$82 million loss). This was partly due to the Australian Government guaranteeing its funding in 2020–21, in recognition of the impact of COVID-19.

The total amount of unused staff leave is increasing. This indicates that HHSs face increasing demand, and their workforce is under significant pressure. The HHSs will face increasing employee and contractor costs in the coming year, and the majority of their revenue base is already fixed.

In 2020–21, the cost of anticipated maintenance needed to prevent an asset from deteriorating increased by \$65 million from 2019–20.

The ambulance service is facing increasing demand

The Queensland Ambulance Service (QAS) (which is part of the department) is also facing growing demand for all its services, including for the most urgent. The time it takes the ambulance crews to transfer patients into the care of emergency departments has increased significantly over the last five years. If this takes longer than 30 minutes, the extra time is considered to be 'lost' time for the QAS. In 2020–21, the QAS lost approximately 112,000 hours. However, the *Care4Q/d* strategy (which was announced in May 2021 and which aims to improve access to emergency services and unplanned care) has delivered some early improvements, but it is still too early to measure the sustained impact of this strategy.

Vaccine rates and quarantine debts need action

After a slow start largely due to supply issues beyond its control, Queensland vaccine rates increased over the second half of the year. More recently, the state has focused on achieving higher vaccination rates in the regions and remote communities, including in Aboriginal and/or Torres Strait Islander communities.

An associated challenge is the need to invoice and collect outstanding debts from the hotel quarantine program. Queensland Health is currently responsible for this, which detracts from its main focus of providing health care. It could work with other departments to meet this requirement.



Recommendations for entities

We have identified the following recommendations for the Department of Health and the 16 hospital and health services (HHSs).

Procurement and contracting controls need to be strengthened	
REC 1	<p>The Department of Health and 16 HHSs should:</p> <ul style="list-style-type: none"> • ensure they have appropriate contract management and procurement systems in place • provide training in procurement processes and procedures • maintain complete and up-to-date contract registers • ensure all documents relating to contracts are kept in a central location.
The Department of Health should arrange for another entity to manage hotel quarantine debts	
REC 2	<p>The Department of Health should pass the hotel quarantine invoicing and debt recovery functions to another government entity that is better suited to invoice processing and debt recovery, and is not as affected by COVID-19. This will allow the department to focus on the provision of health care.</p>

Status of recommendations made in *Health 2020* (Report 12: 2020–21)

The health entities have resolved one of the five recommendations made in *Health 2020* (Report 12: 2020–21). They have made progress on the other four, but further action is needed.

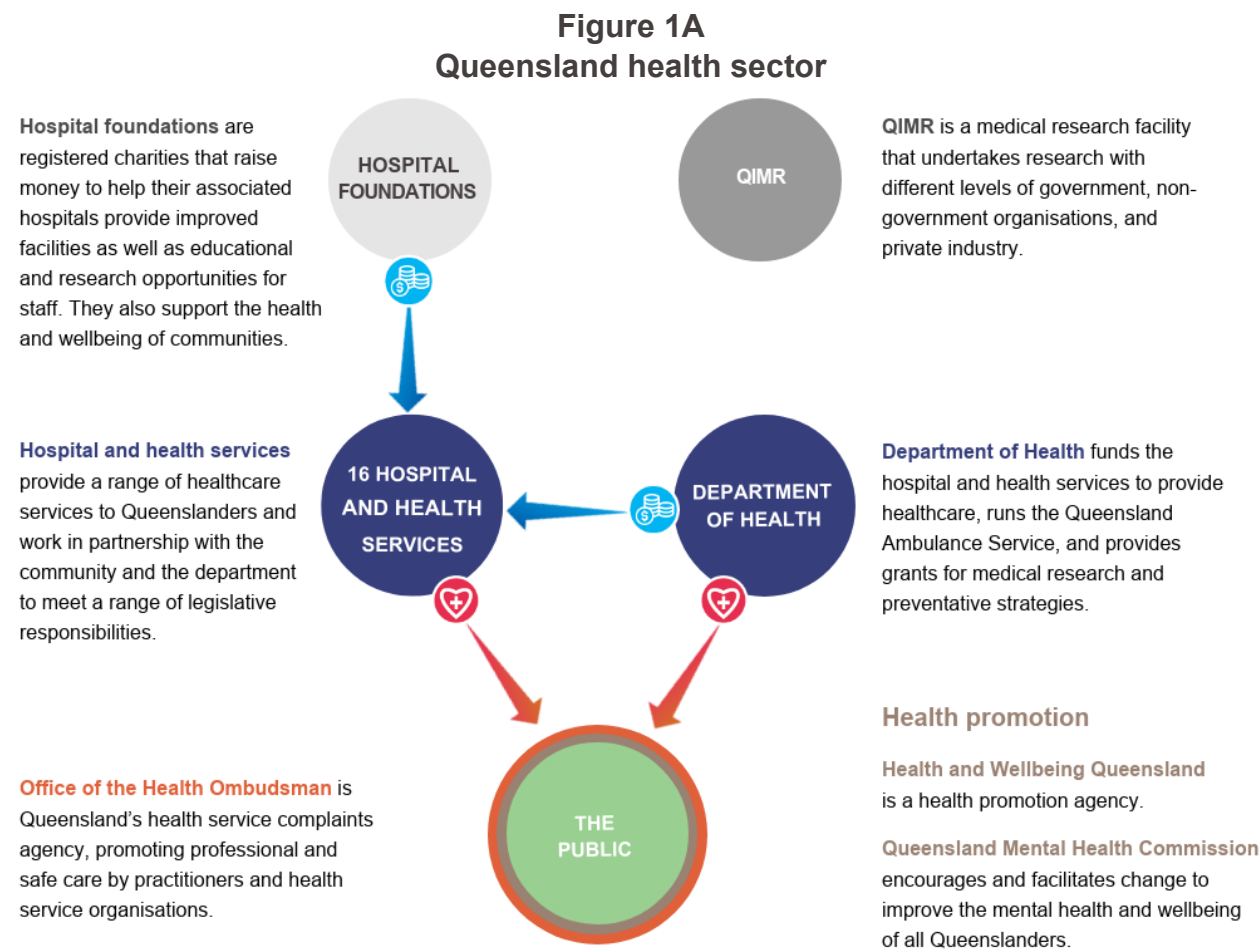
Despite the health sector continually improving the security of its digital platforms, the risk of cyber attacks has continued to increase. Entities have to ensure systems are secure enough to protect important government information and assets. All entities need strong security practices and must emphasise the importance of them in protecting against fraud or error and significant reputational damage.

This remains a recommendation for health entities in 2021. We have included a full list of prior year recommendations and their status in [Appendix C](#).

Reference to comments

In accordance with s.64 of the *Auditor-General Act 2009*, we provided a copy of this report to relevant entities. In reaching our conclusions, we considered their views and represented them to the extent we deemed relevant and warranted. Any formal responses from the entities are at [Appendix A](#).

1. Overview of entities in this sector

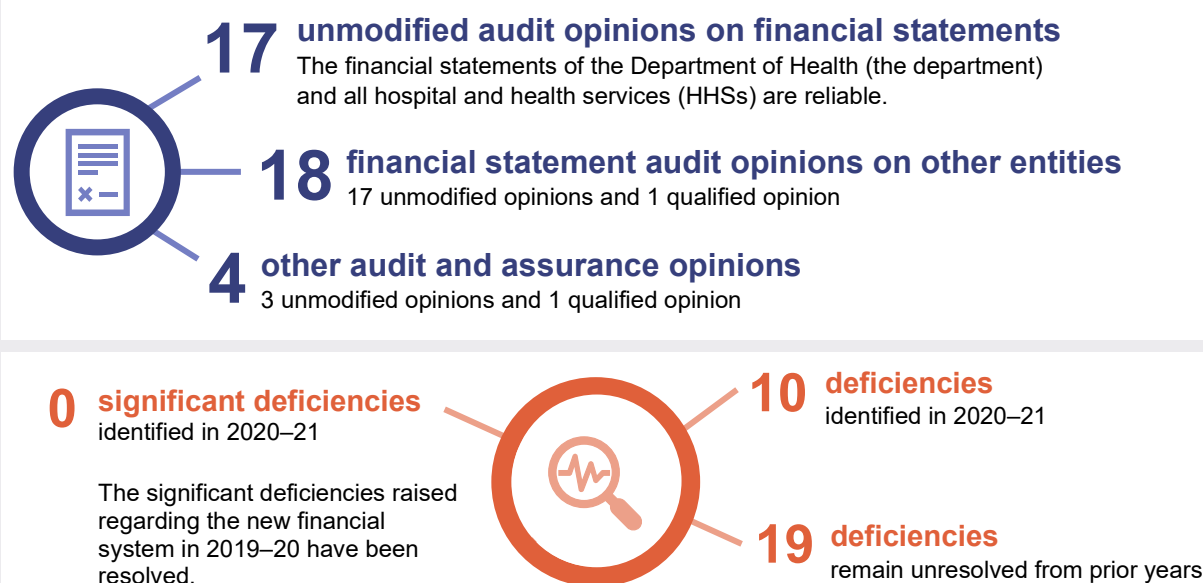


Source: Queensland Audit Office.

2. Results of our audits

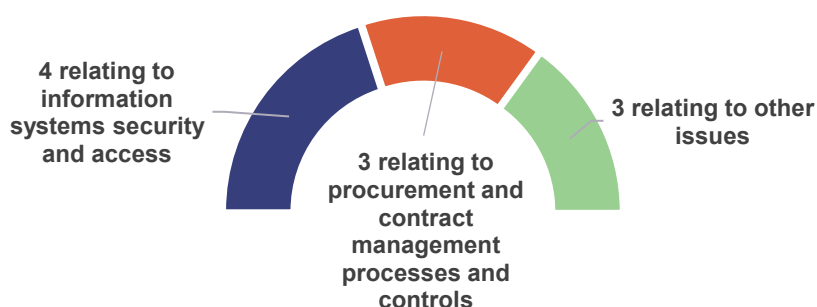
This chapter provides an overview of our audit opinions for the entities in the health sector. It also provides conclusions on the effectiveness of the systems and processes (internal controls) entities use to prepare financial statements.

Chapter snapshot



Types of deficiencies in internal controls identified in 2020–21

The figure below highlights the deficiencies across the sector by topic. We discuss the key deficiencies in this chapter.



DEFINITION

We express an **unmodified opinion** when financial statements are prepared in accordance with the relevant legislative requirements and Australian accounting standards.

We express a **qualified opinion** when the statements as a whole comply with the relevant accounting standards and legislative requirements, with the exceptions noted in the opinion.

Financial statements are reliable

We issued unmodified audit opinions to all 17 Queensland Health entities (the department and the 16 HHSs). Readers can rely on their audited financial statements.

All Queensland Health entities finalised their financial reports within their legislative deadlines. This is a good achievement given the impact of COVID-19 on staff and workloads.

Queensland legislation requires ministers to table their portfolio entities' annual reports in parliament by 30 September 2021—within three months after the end of the financial year. Only the Department of Health's annual report was tabled by this date. None of the HHSs' annual reports were tabled in parliament as at 9 December 2021. This is the third time in four years the HHSs' annual reports have been published after 30 September. Without timely public reporting, users of the HHSs' financial statements are unable to assess these entities' financial performance. This also creates a risk for the entities, that new facts may emerge which could impact on the financial statement audit opinion. If this did happen, we would have to re-issue our audit opinion.

We also audited 13 hospital foundations and five other statutory bodies. All 18 of these entities, except for the Townsville Hospital Foundation, received an unmodified opinion. We qualified our opinion for the Townsville Hospital Foundation on prior year comparative amounts, due to the lack of appropriate controls for ensuring all cash donations from the public and revenues from sales of goods were recorded.

Other audit and assurance opinions

[Appendix E](#) lists the other audit and assurance opinions we issued.

We issued a qualified audit opinion for the annual 'prudential compliance statement' for Queensland Health's aged care facilities across four HHSs.

In this statement, Queensland Health is required to outline to the Australian Government how it has managed refundable accommodation deposits, accommodation bonds, and entry contributions from aged care residents.

We qualified our audit opinion because of two non-compliance issues with financial regulations. For example, Queensland Health had not provided evidence that it had completed accommodation agreements with residents within the legislative time frame.

Entities not preparing financial statements

Not all entities in the health sector produce financial statements. [Appendix F](#) lists the entities not preparing financial statements and the reasons why.

Internal controls are generally effective

We assess whether the internal controls used by entities to prepare financial statements are reliable. We report any deficiencies in the design or operation of those internal controls to management for their action. Those simply rated as deficiencies are of lower risk and can be corrected over time. Those rated as significant deficiencies are of higher risk and require immediate action by management.

Overall, to the extent that we tested them, we found the internal controls that health sector entities have in place to ensure reliable financial reporting are generally effective but can be improved. We identified no significant deficiencies and 10 deficiencies in the current financial year. Nineteen issues remain unresolved from prior years.

All health sector entities have either addressed their identified control deficiencies or are on track to do so by the agreed dates. Of the new deficiencies identified in our 2021 audits, six remain unresolved as of 31 August 2021.

Prior year issues have been largely resolved and internal controls have been improved

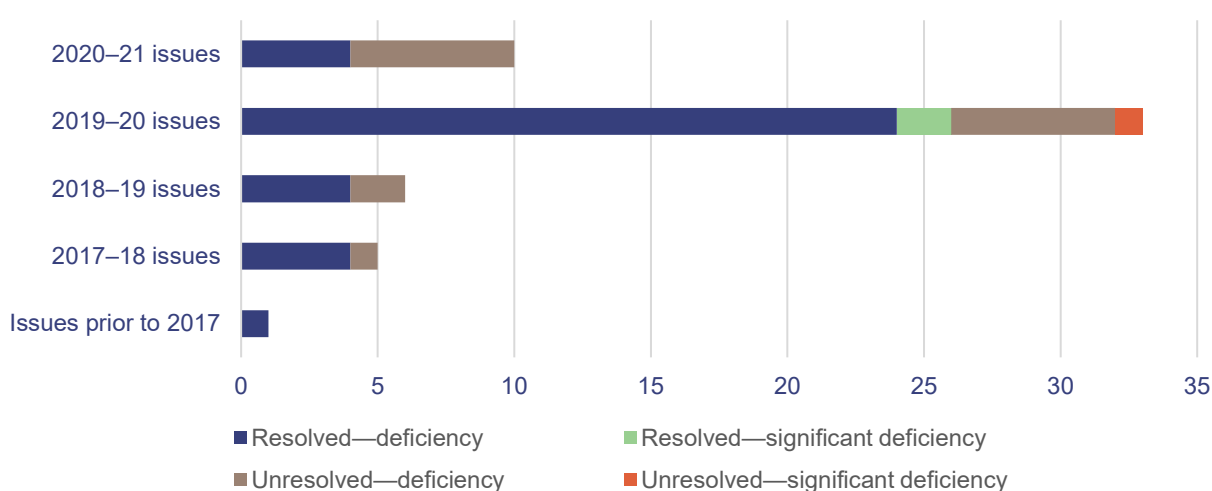
Health entities have resolved 39 issues we raised in previous years (2014 to 2020). Thirty of those issues resolved related to issues that were raised in the last two financial years.

We acknowledge that health entities have committed to resolving long-outstanding issues in 2021. There are indications the 19 issues remaining outstanding from previous years will be resolved within the agreed due dates.

There has been a significant decrease in the total number of deficiencies raised (2021: 10; 2020: 51). This indicates there has been an improvement in the effectiveness of systems and processes in the last year. The outstanding significant deficiency relates to our audit of the Annual Prudential Compliance Statement, which was qualified in 2019–20.

Figure 2A shows the number of internal control deficiencies we have raised in each of the last four financial years that were unresolved as at 1 July 2020 or were raised during 2020–21, and their status as at 31 August 2021.

Figure 2A
Status of internal control deficiencies at the department and HHSs unresolved as at 1 July 2020, and their status as at 31 August 2021



Source: Queensland Audit Office.

Information systems controls and cyber security

In our report to parliament—*Queensland Health's new finance and supply chain management system* (Report 4: 2020–21)—we found that Queensland Health entities' internal controls within the new finance system were not effective. Seven significant deficiencies identified in 2020 related to information technology (IT) general controls. These have now been resolved.

In November 2020, the Australian Cyber Security Centre reported a high-alert risk for cyber attacks on the Australian health sector. It recommended that all network owners review their controls against ransomware (malicious software that blocks access to computer systems or information until money is paid). Throughout 2020–21, cyber attackers targeted several health services within Australia, forcing hospital closures and IT system shutdowns.

It is anticipated that the COVID-19 pandemic will continue to affect the health sector and require increased use of digital solutions. Entities should continue to implement Recommendation 3 from our report *Health 2020* (Report 12: 2020–21), which was to strengthen the security of their information systems.

Procurement and contract management

Although we have seen significant improvements in terms of health entities resolving long-outstanding issues, we continue to find control deficiencies related to procurement and contract management processes within the department and HHSs.

Effective procurement processes ensure there is a fair and robust system in place to obtain goods and services. They also assist entities in obtaining value for money with their purchasing decisions.

To deliver good management of contracts, the individual entities should use centralised contract registers rather than individual business units having their own, which is currently the case in some instances. This ensures the necessary information is centrally stored and reduces the risk of suppliers not delivering on agreed terms. Contract registers can be used by the entities to monitor contract expiry dates and plan future procurement before a contract ends—to maximise the value for money achieved in new contracts.

There are currently 10 outstanding deficiencies relating to procurement processes and controls. They include issues to do with non-compliance with procurement procedures, a lack of contract registers, a lack of formal documentation, and a lack of supporting documents for contracts.

Recommendation for Queensland Health entities

Procurement and contracting controls need to be strengthened

The Department of Health and 16 HHSs should:

- ensure they have appropriate contract management and procurement systems in place
- provide training in procurement processes and procedures
- maintain complete and up-to-date contract registers
- ensure all documents relating to contracts are kept in a central location.

Assessment tools for internal controls

We are developing new assessment tools for internal controls relevant to public sector entities. They will provide the entities with greater insight into the strength of their internal control processes.

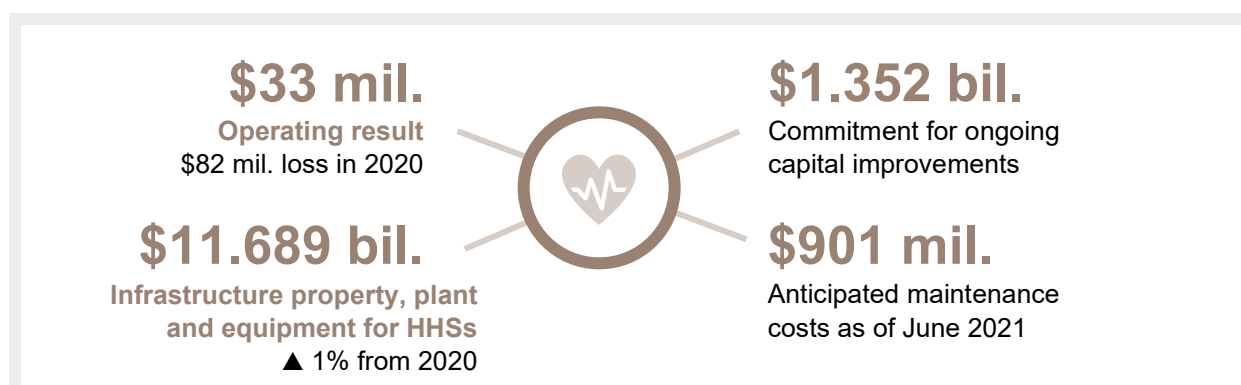
These tools focus on asset management, change management, culture, governance, grants management, information systems, monitoring, procure-to-pay (the whole procurement process), record keeping, and risk management.

We are currently consulting with our clients on these tools and intend to begin using them in our audits from 2021–22. Our reporting on internal control deficiencies will not change.

3. Ongoing financial sustainability

This chapter analyses the financial performance and position of health sector entities. We consider both financial sustainability and emerging issues relevant to the sector.

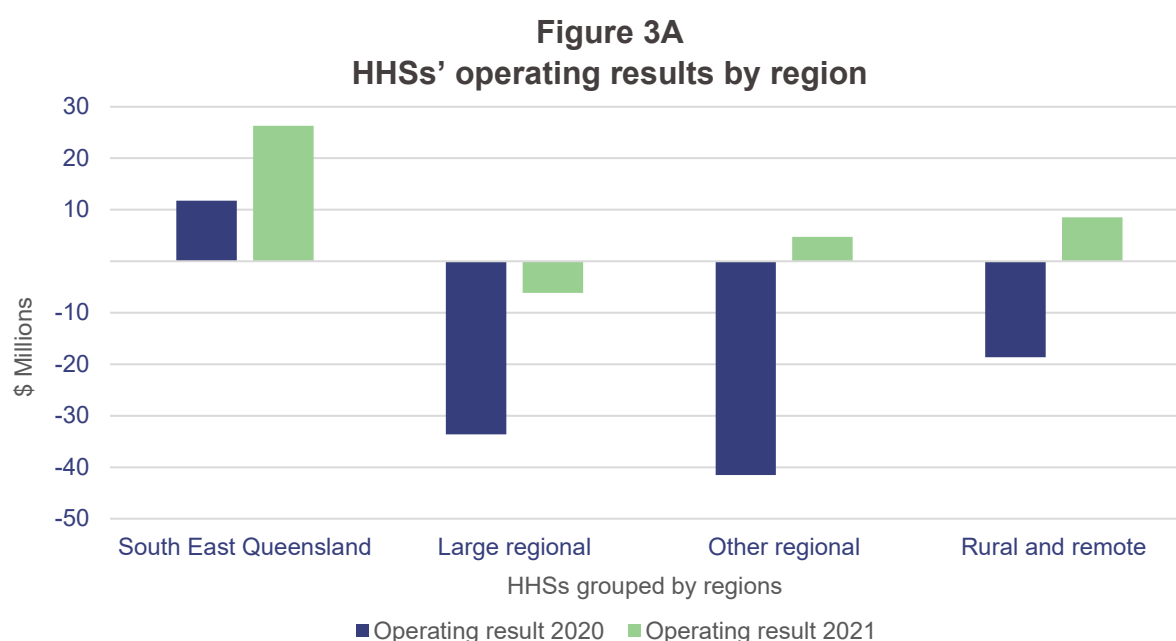
Chapter snapshot



The hospital and health services' operating results have improved

The combined operating result (the difference between revenue and expenses) of the HHSs in 2020–21 was a \$33 million surplus (2019–20: \$82 million loss). Fourteen of the 16 HHSs reported an operating surplus, and only two reported an operating loss (2019–20: 11 HHSs reported a loss). The 2020–21 state budget had only one HHS budgeted to make a deficit for the year—Sunshine Coast HHS. The other 15 HHSs were budgeted to achieve a zero operating result for the year.

Figure 3A shows the HHSs' operating results grouped by regions.



Notes: Appendix B shows how the HHSs are grouped into regions. See Appendix G for individual HHS financial results.

Source: *Hospital and health service financial statements 2019–20 and 2020–21*.

The Queensland and Australian governments fund 13 of the HHSs based on the number and complexity of clinical services provided to patients (known as activity-based funding—ABF). Three rural and remote HHSs are block funded (which means they are funded for services outside the scope of ABF), but they still have activity targets to be met, similar to activity-based funded-HHSs.

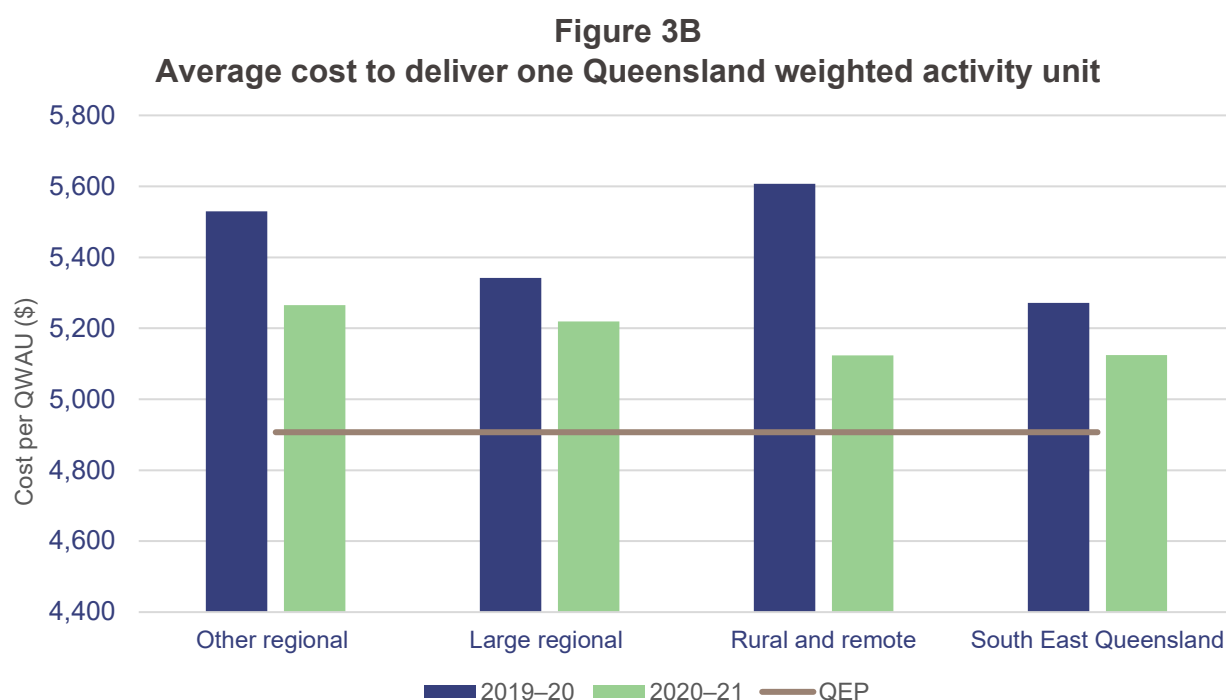
In 2019–20 and 2020–21, activity-based funding was guaranteed (which meant funding was received even if the state did not reach its activity targets for the year). On 5 November 2021, the Australian Government announced it was extending this guarantee for an additional year (to 30 June 2022) in recognition that COVID-19 is still having a significant impact on public hospitals. The Department of Health has not yet received confirmation of how much the state will receive, so it has not confirmed how this will affect HHS funding arrangements.

In 2020–21, guaranteed funding helped HHSs to achieve a surplus (although this was offset by increasing employee expenses). The department standardises health activity into Queensland weighted activity units (QWAU). For example, a HHS records a higher number of QWAUs for delivering complex surgery than for a simple day procedure.

While the HHSs were funded for \$4,895 per QWAU in 2020–21, the cost of delivering a QWAU in 2020–21 was, on average, \$5,108. The difference is related in some part to under-delivery of activity targets in six HHSs, and cost increases due to the management of the COVID-19 response. COVID-19 activity and expenditure is included in the reporting of the cost per weighted activity unit. HHSs need to cover the funding gap when their costs are above the funded rate.

The department has applied efficiency and productivity dividends on HHSs. Efficiency dividends encourage HHSs to identify cost savings by reducing how much the department funds them, without reducing their target level of QWAUs. With productivity dividends, the department increases the HHSs' expected activity output without a corresponding increase in the funding it provides.

As Figure 3B shows, none of the regions (defined in [Appendix B](#)) have been able to achieve sufficient savings to close the gap between the cost and funding to deliver a QWAU. However, 10 HHSs have reduced their costs to narrow this gap over the last two years.



Notes: Rural and remote—only one HHS is included in this figure (North West HHS) as the other three are block funded. QEP—Queensland Efficient Price, which is based on the average cost to deliver a QWAU, averaged over two years.

Source: Queensland Audit Office.

The HHSs are facing increasing demand for their services and will need to meet the Queensland weighted activity units (QWAU) targets within the constraints of their budgets. To assist, the Department of Health has provided funds for additional beds to meet the increasing demand and to decrease the waitlists in order to target key performance indicators.

Workforce under pressure

The health sector in Queensland has had a challenging task during the months since COVID-19 emerged. Even before it had to cope with the challenges the pandemic presented, it was dealing with increasing demand for its services. This has continued, with demand exceeding supply in some cases.

One effect of this is the growth in the unused leave balances of our frontline health workers since 2020–21.

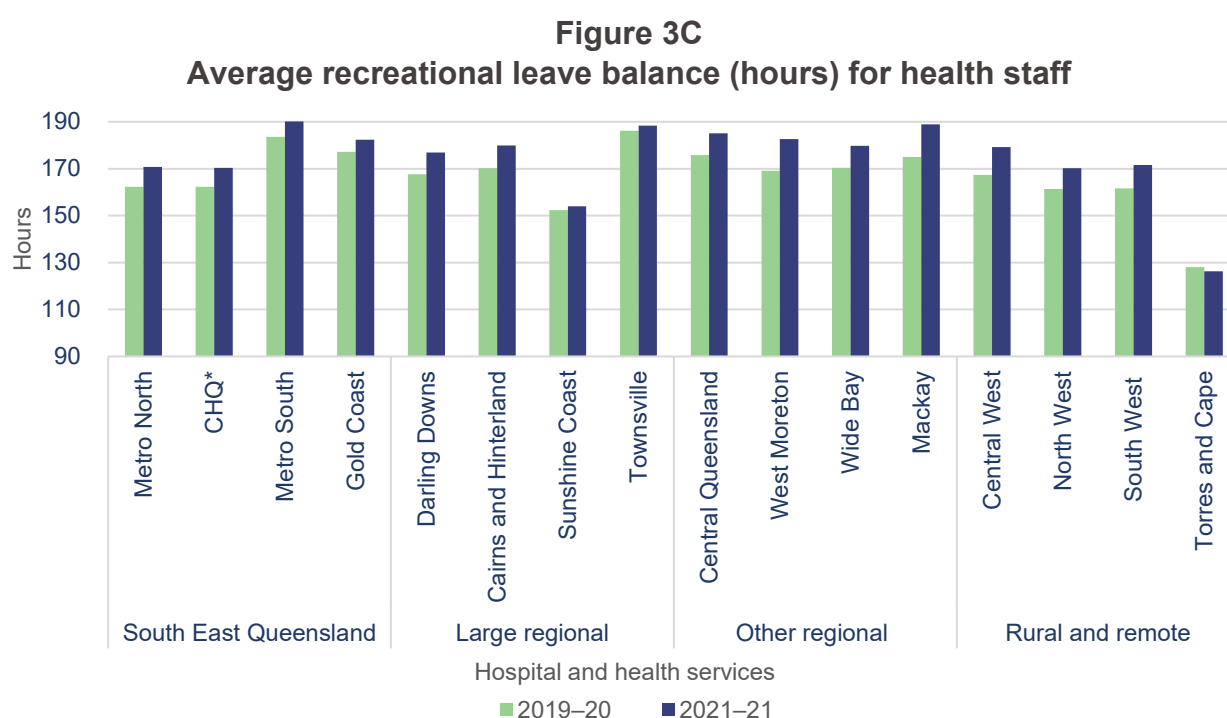
The wellbeing of the workforce is a significant issue that could impact on the sustainability of the health sector. This will be a major challenge for the Department of Health when Queensland's borders open in December 2021.

It is important to have enough hospital beds to manage demand. It is even more important that we have a highly energised health workforce to cope with the risk of a COVID-19 outbreak. High leave balances indicate the workload of our health workers may be unsustainably high.

Increasing leave balances

Recreation leave balances (total hours) have increased by about 7.8 per cent in 2020–21 in comparison to 2019–20. This indicates there has been an impact on health staff's ability to take leave due to diversions to COVID-19-related activities and the overall increase in demand for health services during 2020–21.

Figure 3C shows the increase in average recreation leave hours per staff for HHSs. Fifteen out of 16 HHSs had an increase in average recreation leave balances in 2020–21. On average, the highest increase in leave balances was in the 'Other regional' HHSs where it was approximately 11.5 hours per employee. The other three regions all had an average increase of between five and eight hours per employee.



Note: * CHQ—Children's Health Queensland Hospital and Health Service.

Source: Queensland Audit Office from Department of Health data.

The growing leave balances will lead to an increase in expenses in the future, as staff take leave and temporary roles are filled to meet the workforce requirements.

Border closures have contributed to the increase in recreation leave balances (hours). This is a significant issue for regional HHSs and rural and remote HHSs, which have traditionally relied on medical and nursing support from staff who live outside of Queensland and on visiting medical officers (VMOs), who provide the sole specialty service in several disciplines in many of these HHSs. HHSs have reduced their use of VMOs as they have not been able to access them from other jurisdictions or internationally.

DEFINITION

Visiting medical officers (VMOs) enhance full-time specialist services by providing specialty input in several disciplines throughout the state and advanced specialities at major metropolitan and regional hospitals.

Increasing employee expenses

Increasing employee expenses are mostly responsible for the increasing cost per QWAU in HHSs. In 2020–21, employee expenses increased by 4.8 per cent to \$11.476 billion, and they make up 68 per cent of total HHS expenses.

With the Queensland borders currently closed (as at 18 November 2021) to a number of national and international arrivals, the ability of the HHSs—especially those in rural and remote areas—to access temporary staff at a cost-effective rate is limited. The costs of contractors are increasing, which further impacts on the sector's bottom line. Contracted expenses may also increase if the HHSs need to hire additional resources to backfill positions due to the suspension of unvaccinated staff.

COVID-19 pandemic leave

In November 2020, the Queensland Government announced two days of pandemic leave for health staff in recognition of the effects of COVID-19 on staff wellbeing. This leave is separate to an employee's existing leave entitlements and must be taken within two years, or the leave is lost.

The 2020–21 leave data also shows that health staff have not fully used this leave. As at 30 June 2021, 49 per cent of staff had not taken any of their pandemic leave.

This indicates the health workforce is under significant stress and the extra leave provided has not been used due to the increasing demands on it. Failure to take leave during the pandemic will lead to a fatigued workforce, and the increasing demands will become unsustainable.

Future capital requirements to meet changing service delivery needs

Future capital requirements

Queensland makes up 20 per cent of the Australian population. The state's population has been rising steadily, and in 2021, it has had the highest growth of any state or territory in Australia (as shown in Figure 3D).

This will add additional pressure on the health system and the services it needs to deliver. The health sector budget for 2021–22 and future years includes a number of capital projects and investments to increase its capacity to meet the growing demand.

Figure 3D
Population growth for the states and territories for the year ending 31 March 2021



Source: Population estimates: States and territories—Queensland Government Statistician's Office (qgso.qld.gov.au).

The current state budget announced \$1.352 billion for health-related capital projects. These include:

- \$283.7 million as a part of the Building Better Hospitals program (redeveloping and expanding a number of hospitals)
- \$233.6 million for the Sustaining Capital Program (enhancing and optimising existing infrastructure to ensure facilities and equipment are fit for purpose)
- \$105 million for the Satellite Hospitals Program (enabling hospitals in South East Queensland to manage demand and free up capacity while continuing to safely manage patients through alternative models of care)
- \$61.8 million invested in the Queensland Ambulance Service (QAS) for capital purchases.

Not all of these programs will be delivered in the 2021–22 year. Related operational costs will need to be included in future budgets to ensure these assets can be effectively and efficiently used.

Anticipated maintenance

HHSs continue to face significant challenges in funding the anticipated maintenance of their assets.

DEFINITION

Anticipated maintenance is defined as maintenance that is necessary to prevent the deterioration of an asset or its function, but which has not yet been carried out.

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

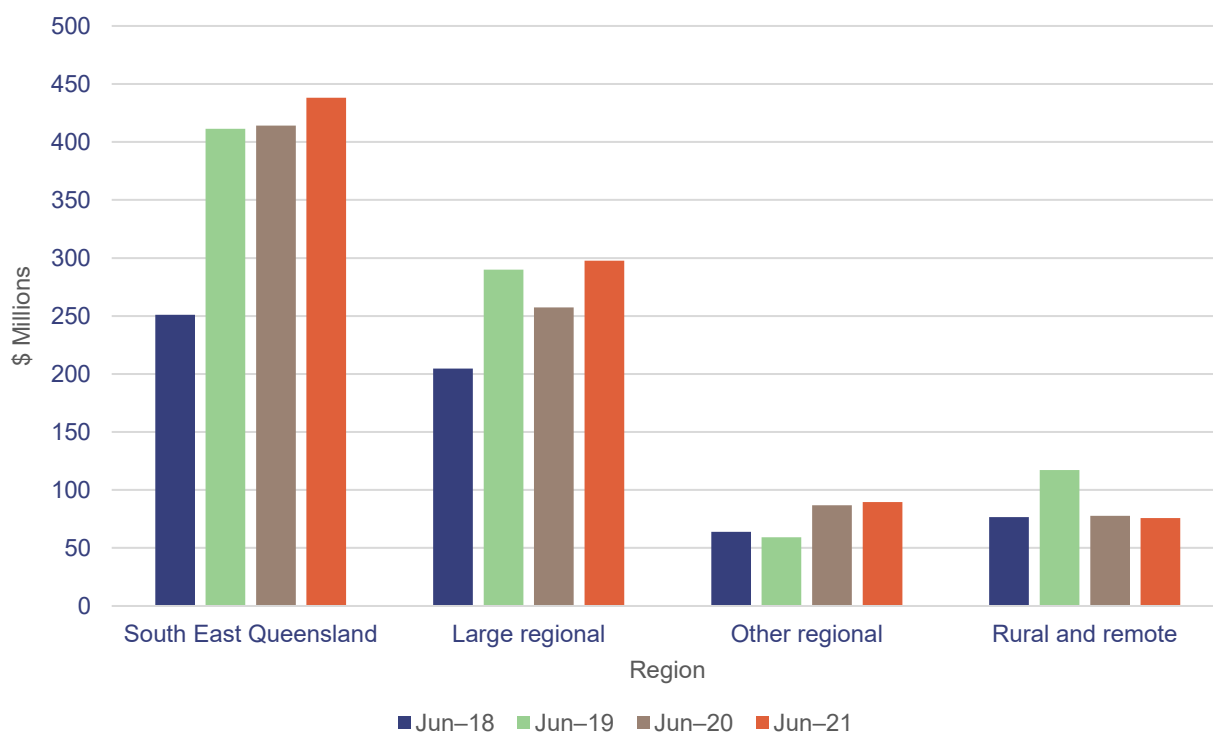
The Department of Health has a service level agreement with all the HHSs in Queensland that states a minimum of 2.81 per cent of each HHS's building portfolio is required to be spent annually on maintenance to sustain the building assets to achieve expected life cycles. While newer buildings may not require this level of maintenance, older buildings require more, so on average, the 2.81 per cent reflects what is expected at a portfolio level.

Currently, all the HHSs spend below this target—between one per cent and 2.5 per cent for the 2019–20 and 2020–21 years. There is a risk that building assets that do not receive maintenance when required will deteriorate. This will increase the anticipated maintenance required to keep the buildings in the condition they are required to be in.

In 2020–21, across the state's HHSs, the current cost of anticipated maintenance is \$901 million, which is an increase of \$65 million from 2019–20.

Figure 3E shows, by HHS regions, the growth in anticipated maintenance for the last four financial years.

Figure 3E
Growth in anticipated maintenance



Source: Queensland Audit Office from signed financial statements of the HHSs.

All 17 entities should continue work on addressing Recommendation 5 from our report *Health 2020* (Report 12: 2020–21), which was to prioritise high-risk maintenance.

4. Ambulance services

The Queensland Ambulance Service (QAS) (which is part of the department) continues to be directly impacted by COVID-19 and by increasing demand for health services. In addition to its usual work, the QAS has taken on extra, non-business-as-usual work, including:

- rapid deployment of seven fever clinics—QAS staff provided over 12,000 staff hours in 2020–21 to operate seven QAS fever clinics. This was in addition to business-as-usual activity and was resourced through redeployment of staff and using overtime as a rostering method
- hotel quarantine relocation transports
- assistance/attendance at vaccination centres.

In our *Forward work plan 2021–24*, we indicated we would be undertaking an audit to examine how well Queensland Health is addressing the root causes affecting ambulance response times. Two of the key issues are the difficulty in moving patients from ambulance stretchers into emergency departments and hospitals within the required time frames; and the continuing increase in demand for QAS's services.

In this chapter, we analyse Queensland Health's performance against ambulance response times, patient off stretcher times (the percentage of patients transferred to the care of an emergency department within 30 minutes), and ambulance 'lost' time (the amount of time greater than 30 minutes that a patient remains on QAS stretchers). We also compare the demand for QAS's services and its response times to that in other Australian jurisdictions.

Based on the findings of this chapter—which includes commentary on the root causes affecting ambulance response times—we do not see value in conducting a detailed performance audit on ambulance services in 2021–22. We will, however, provide a further update in our Health 2022 report and will consider the impact of the *Care4Qld* strategy announced in May 2021 in our assessment of the value of any future audit.

Chapter snapshot (key measures 2020–21)



Notes: The increase/decrease in numbers in this snapshot show the variation between the 2020–21 and 2019–20 financial years. Lost time and patient off stretcher figures are reported against Queensland's top 26 public hospitals (refer to Appendix H). Data includes priority codes 1 and 2 (emergency and urgent cases). ~ means approximately.

Summary of findings

The QAS is facing increasing demand for all its services, including for the most time-sensitive categories. There is more demand for ambulances in this state than in others. One reason for this is because in Queensland, the ambulance is a publicly funded service that users do not have to pay for. Other factors which also influence Queensland's demand for ambulance services include Queensland's geography, population density in South East Queensland and popular regional areas, and Queensland's decentralised nature.

Despite the demand pressure, in 2020–21 QAS met its key performance indicators for time critical (Code 1A) incidents. However, it did not achieve its targets for Code 1B and Code 1C incidents, and its performance for Code 2A incidents declined from 2019–20 to 2020–21.

This parallels with a significant increase in the time it takes the ambulance crews to transfer a patient into emergency departments. The QAS lost approximately 112,000 hours in 2020–21. Making more beds available through the *Care4Qld* strategy (which was announced in May 2021, and which aims to improve access to emergency services and unplanned care) is helping to ease pressure on this issue.

Demand for ambulance services is increasing

The demand for ambulance services has grown significantly in the last five years, particularly for more complex and priority cases. Since 2016–17, the number of:

- code 1 incidents (emergency) attended by QAS have increased by 18 per cent
- code 2 incidents (urgent) have increased by 19 per cent.

Several factors are increasing the demand for ambulance services, including:

- Queensland's population growth—in 2021, Queensland had the highest population growth of any state or territory in Australia (see Figure 3D, in Chapter 3)
- an ageing population—the demand for ambulance services increases with age. QAS advises that while people over 65 years of age account for 15 per cent of the population, this age group makes up about 36.7 per cent of QAS's total caseload.

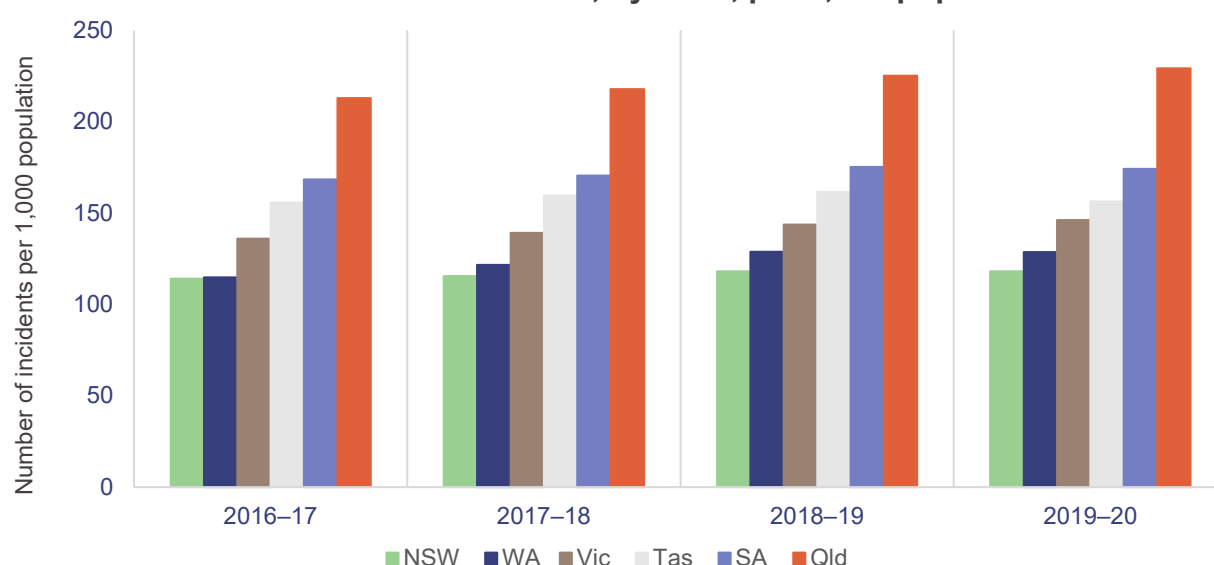
In the Gold Coast, Sunshine Coast and Wide Bay regions, QAS's workload for people over 65 years accounts for about 40 per cent of total caseload. The top five dispatch categories for people over 65 years are Medically Authorised Ambulance Transports (for example, transfers from general practitioners (GPs), interfacility patient transfers, or pre-scheduled appointments), sick persons (when the caller indicates the patient is generally unwell), falls, chest pain (non-traumatic), and breathing problems. QAS reports that cases referred from GPs have the highest dispatch growth rate

- the complexity of cases—the QAS is dealing with more complex cases, such as people with mental health issues, and falls (by the ageing).

Queensland has the highest number of ambulance incidents (events that result in one or more responses by a QAS resource) per 1,000 population compared to the rest of Australia, as shown in Figure 4A. A key reason for this is that QAS is a publicly funded service compared to New South Wales, which has adopted a user pays model, and to Victoria, South Australia, and Western Australia, which use subscriber-based models.



Figure 4A
Ambulance service demand, by state, per 1,000 population



Notes:

- Data is for all hospitals across the states. Latest available information is up to the 2019–20 financial year.
- Population rates are derived using the 31 December estimated resident population of the relevant financial year.
- NSW—New South Wales; WA—Western Australia; Vic—Victoria; Tas—Tasmania; SA—South Australia; Qld—Queensland.

Source: Productivity Commission, *Report on Government Services 2021 Part E Section 11 Ambulance Services*.

Ambulance response times

Ambulance response times measure how long it takes from when a call to triple zero is answered to when an ambulance arrives at the scene of an emergency. The performance targets are set for code 1 (emergency cases) only.

Code 1 response times

In 2020–21, QAS met its response time performance targets for Code 1A (actual time-critical) incidents but not for codes 1B (emergent time-critical), and 1C (potential time-critical), as shown in Figure 4B.

Figure 4B
Queensland ambulance response times performance—2020–21

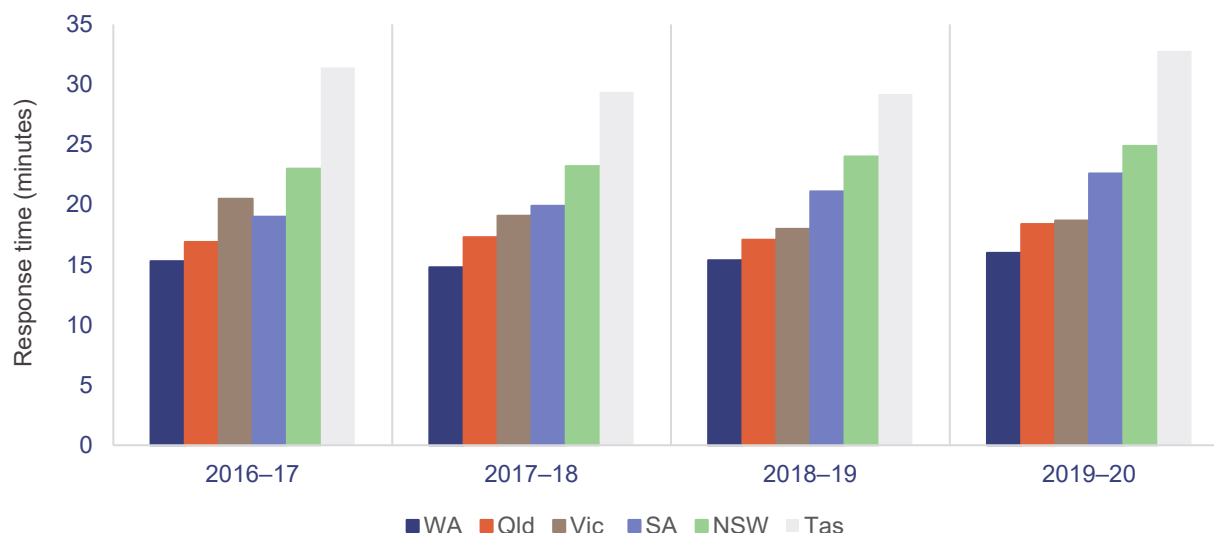
Priority	50th percentile		90th percentile	
	Actual (minutes)	Target (minutes)	Actual (minutes)	Target (minutes)
Code 1A	8	8.2	15.8	16.5
Code 1B	9.9	8.2	19.8	16.5
Code 1C	11	8.2	22.1	16.5

Note: Response times are calculated across Australia and measure the time (in minutes) within which 50 per cent and 90 per cent of the first responding ambulance resource arrives at the scene of an emergency code 1.

Source: Queensland Audit Office from QAS Service Delivery Statements 2020–21.

Despite having the highest number of responses in Australia in proportion to the state's population, QAS has managed to achieve better response times for emergency cases (code 1) than most other jurisdictions, as shown in Figure 4C.

Figure 4C
Ambulance service response times (minutes) for code 1, by state, 90th percentile



Notes:

- Data is for all hospitals across the states. Latest available information is up to the 2019–20 financial year.
- Differences across states in the topography, road/transport infrastructure, dispersion of the population, personnel mix, and response systems and processes affect statewide response times data.
- In New South Wales, Queensland, and Western Australia, response times are calculated from triple zero transfer to dispatch. Victoria, South Australia and Tasmania calculate them from the first key stroke.

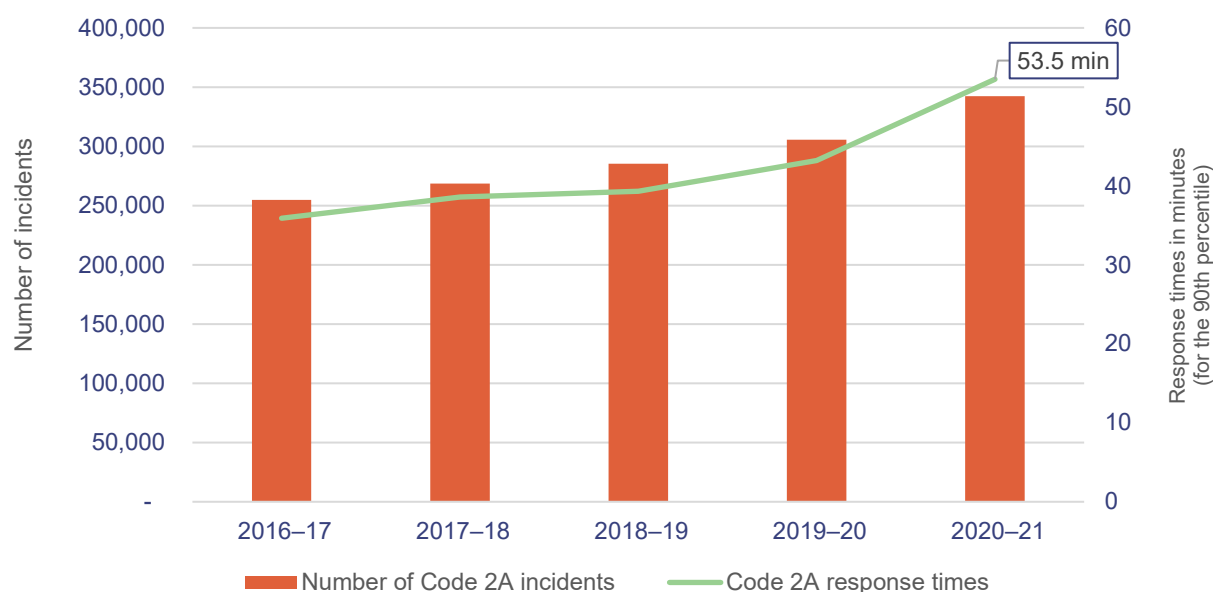
Source: Productivity Commission, *Report on Government Services 2021 Part E Section 11 Ambulance Services*.

Code 2 response times

There are no performance targets in QAS's service delivery statements for code 2 incidents.

Figure 4D shows the demand (number of incidents) for Code 2A (urgent response) against the respective response times in minutes (for the 90th percentile) for the last five years.

Figure 4D
Increasing demand and response times for QAS's services for Code 2A incidents



Source: Queensland Audit Office from data received from the Queensland Ambulance Service.

The increase in code 2 response times in 2020–21 reflects the ambulance lost time in 2020–21 due to not being able to get patients off stretchers within the expected 30 minutes. QAS does not have an internal performance measure on code 2 response time performance and there are no performance targets in its service delivery statements. This is because QAS's focus is on ensuring it is responding to the most urgent cases.

We recognise that code 2 response times are an indicator of the effect of ambulance lost time at hospitals and a system-wide issue that QAS cannot solve on its own.

Moving patients off ambulance stretchers

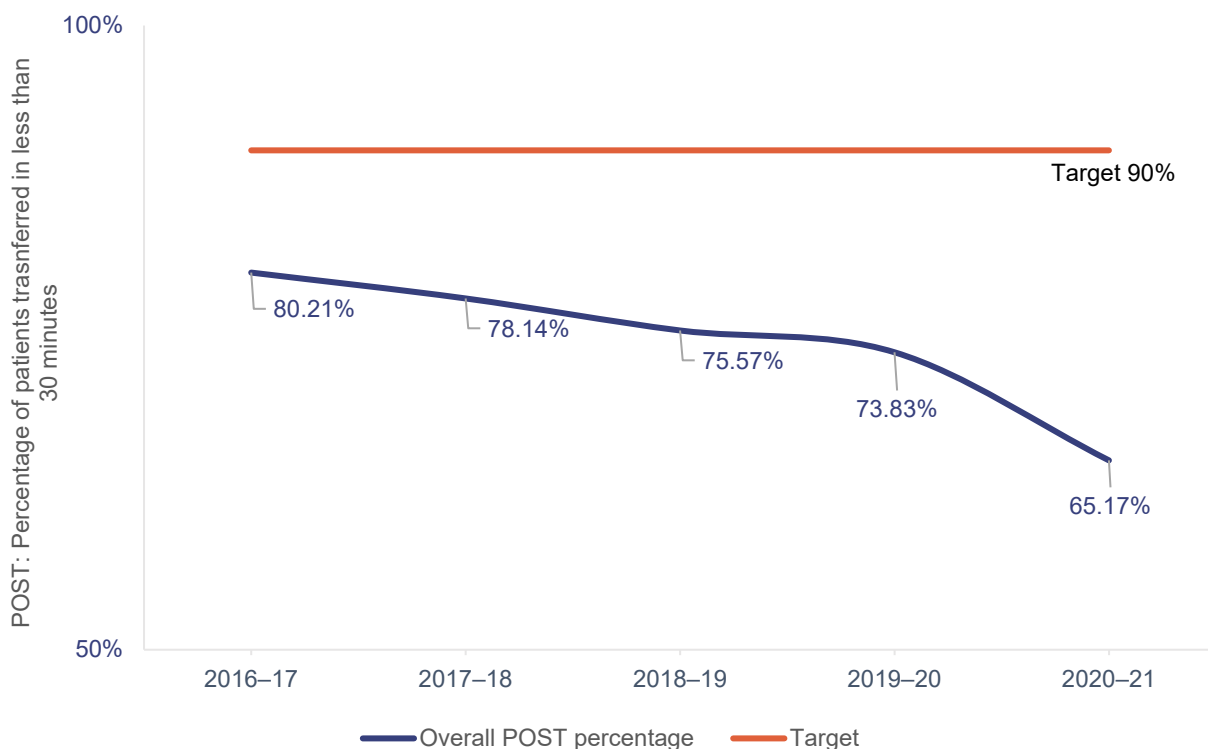
In *Measuring emergency department patient wait time* (Report 2: 2021–22), we reported that the patient off stretcher time (POST) performance measure had not been met at the statewide level in the past seven years. Queensland's target for POST is to have 90 per cent of patients transferred off stretchers into the care of an emergency department within 30 minutes.

The percentage of patients transferred off stretchers in less than 30 minutes has decreased further since that report, and as at 30 June 2021, the overall POST performance was 65.17 per cent—a decrease of about nine percentage points since 2019–20. In 2020–21, none of the 14 hospital and health services (HHSs) with a top 26 reporting hospital met its POST target, except for North West HHS.

The COVID-19 pandemic has placed further pressure on emergency departments, affecting POST performance. For example, hospitals have had to adopt new infection control measures for the safety of staff and patients, such as social distancing and personal protective equipment. These requirements increase the time required to provide treatment and affect patient flow. Several Queensland hospitals also provide COVID-19 fever clinics from their emergency departments.

Figure 4E shows the POST performance for the top 26 Queensland hospitals over the last five years. We note that POST is not a performance measure for QAS—it is a measure of the performance of HHSs. However, since the results of this measure indicate hospitals do not have sufficient capacity at present, this is a system-wide issue.

Figure 4E
POST performance for the top 26 Queensland public hospitals
from 2016–17 to 2020–21



Source: Queensland Audit Office, from data received from Queensland Ambulance Service reporting system.

Ambulance patient off stretcher delays occur when paramedics are unable to complete transfer of care or handover of a patient to an emergency department within 30 minutes (which is the clinically appropriate time frame recommended by Queensland's Metropolitan Emergency Department Access Initiative in July 2012).

The inability to meet this target is due to several reasons, including volume and complexity of patients presenting for treatment (both walk-ins and ambulance presentations), availability of ward beds, efficiency of hospital discharge processes, and the limited availability of specialists to attend patients in emergency departments.

When there is a patient off stretcher delay, patients are looked after by QAS paramedics until formal transfer of care to the emergency department takes place. Faster off stretcher times ensure ambulances are available to respond to those patients waiting unseen in the community.

Ambulances are losing time

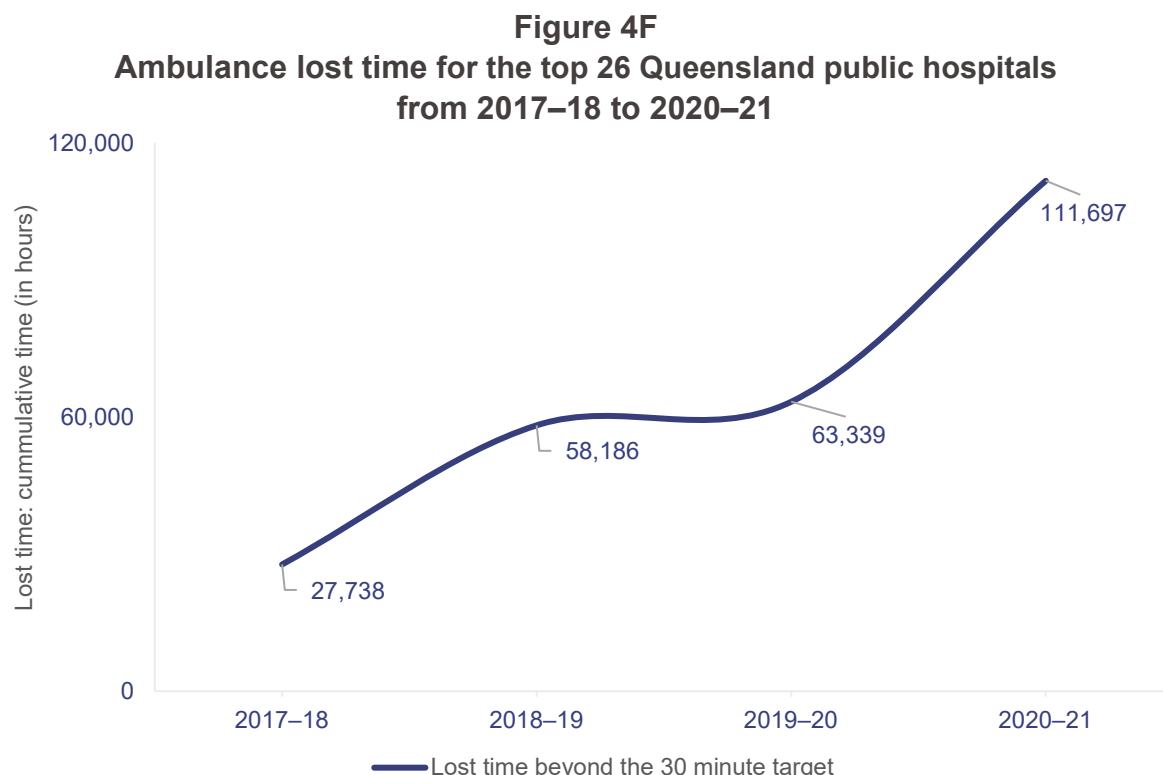
Ambulance 'lost' time measures the cumulative amount of time greater than 30 minutes that a patient remains on a QAS stretcher, inclusive of formal handover and transfer of the patient to an available bed within the emergency department. Hospitals assume responsibility for overall patient care from the time of triage; but, as mentioned previously, when QAS paramedics are unable to offload their patients due to flow constraints, they provide care until the formal transfer takes place.

Lost time is not reported as a performance indicator in the Department of Health annual reports. It is, however, internally measured by QAS.

Overcrowded emergency departments affect ambulance services. If an overcrowded emergency department is unable to receive more patients, ambulance services are not able to transfer them.

In 2020–21, ambulance lost time for the top 26 hospitals was 111,697 hours—an increase of 76 per cent from 2019–20.

Figure 4F shows the ambulance lost times in total hours for the last four financial years for the top 26 hospitals for codes 1 and 2 incidents. There was minimal increase in ambulance lost time from 2018–19 to 2019–20 due to the impact of COVID-19 lockdowns and a reduction in demand during this period.



Note: QAS began recording ambulance lost time in 2017–18.

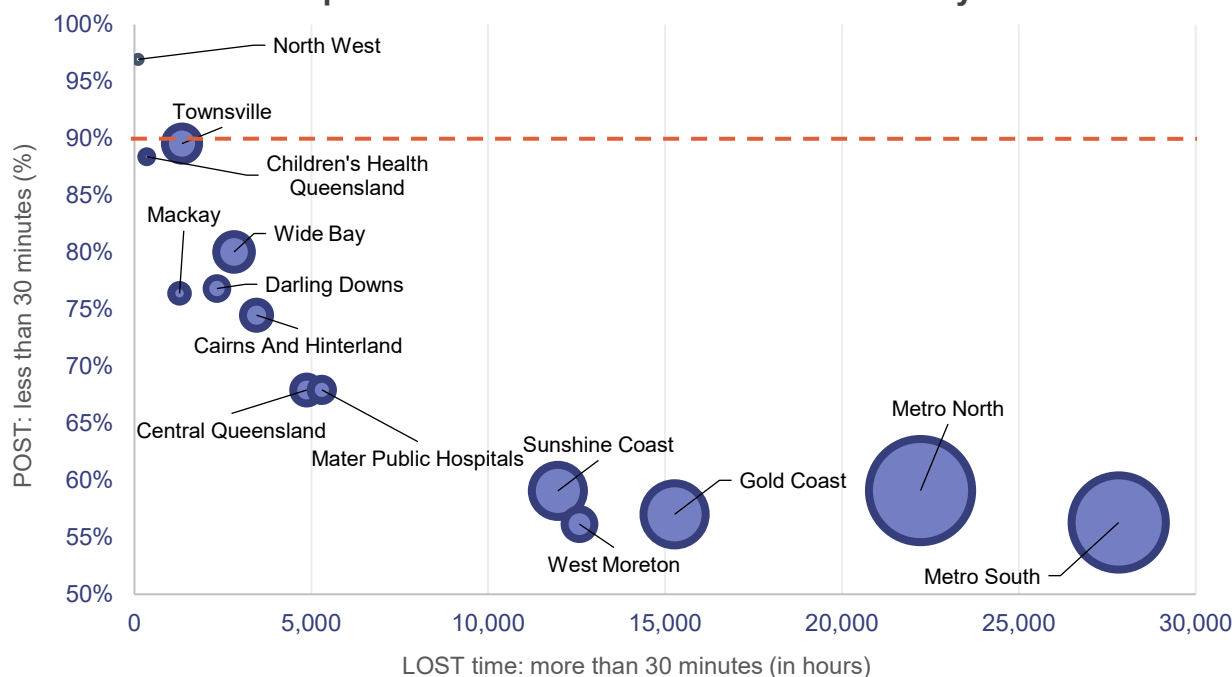
Source: Queensland Audit Office, from data received from Queensland Ambulance Service reporting system.

A key factor in the increase in ambulance lost time is the increase in emergency department demand for both ambulance patients and walk-in patients. As noted in our *Measuring emergency department patient wait time* report, ambulance presentations to emergency departments increased by 45.8 per cent between July–September 2014 and October–December 2020. Walk-in presentations increased by 20.5 per cent during the same period.

This has led to significant increases in the time it takes to transfer a patient to an emergency department.

Figure 4G shows, by HHS, the POST performance against accumulated ambulance lost time for the top 26 hospitals for codes 1 and 2 incidents. The HHSs serving heavily populated areas have the lowest performance when it comes to moving patients off stretchers within 30 minutes, and they have the highest amount of ambulance lost time as a result.

Figure 4G
Ambulance POST performance and accumulated lost time by HHS—2020–21



Note: The size of the circles corresponds to the number of patients transferred to emergency departments by QAS. The orange line represents the POST target.

Source: Queensland Audit Office from QAS reporting system.

The department is currently working on improving emergency services. In this, it is supported by the Queensland Government's *Care4Qld* strategy announced in May 2021, which aims to improve access to emergency services and unplanned care across Queensland. Of the 351 beds announced as part of this program, the department has indicated that 266 were operational as at October 2021.

The code 1 and 2 lost time has improved recently, following initiatives implemented as part of the *Care4Qld* strategy. According to the data from QAS's reporting system, there has been a 31 per cent decrease over the five months from May to October 2021. POST has also improved by 4.6 percentage points to 62.73 per cent over the same period. We note it is still too early to measure the sustained impact of the *Care4Qld* strategy as ambulance lost time can vary over a 12-month period due to seasonal fluctuations on demand such as flu seasons and heat waves.

Assisting patients with mental health issues

In 2020–21, the QAS attended 58,213 cases of mental health (patients under triage category psychiatric/abnormal behaviour/suicide attempt). This represents an increase of 3.2 per cent compared to the previous year and an increase of 70.2 per cent over the last five years.

In addressing the increase in demand in mental health incidents, the QAS has implemented several strategies including:

- the Mental Health Liaison Service. This engages senior mental health clinicians to provide support and assistance to QAS personnel statewide through the provision of information and advice to crews before and on scene, or by providing intervention to people who call triple zero
- the Mental Health Co-responder program. This is a collaboration between the QAS and participating HHSs, enabling specialised mental health care. The program includes a physical and mental health assessment and preparation of an appropriate treatment plan.

In 2020–21, the program was operational in six HHSs (Metro South, Metro North, Gold Coast, Sunshine Coast, West Moreton, and Cairns). Due to the success of the program, it was extended to Townsville HHS in July 2021.

QAS's evaluation of its pilot Mental Health Co-responder program found that:

- 68 per cent of the patients seen by the teams stayed at home, with individually tailored assessments and interventions offered
- 55 per cent of the cases seen were for suicide-related incidents
- the average patient case cycle from a triple zero call to the provision of treatment was approximately 120 minutes
- the QAS mental health co-responder was the first responder 70 per cent of the time
- paramedics who have worked with the co-responders have reported increased skills, knowledge, and confidence in the provision of mental health crisis interventions.

Increasing budget for QAS

In the 2021–22 Queensland state budget service delivery statements, QAS is budgeted to:

- recruit 114 full-time equivalent staff. These are mainly additional ambulance operatives to assist with the increasing demand for ambulance services and pre-hospital emergency medical care
- commission 136 new and replacement ambulance vehicles
- progress the planning and construction phases for six new ambulance stations and for replacement of the North Rockhampton Ambulance Station
- undertake planning and construction phases for the redevelopment of the Cairns Ambulance Station and Operations Centre, the Southport Ambulance Station and Gold Coast Operations Centre, and refurbishment of the Rockhampton Ambulance Station and Operations Centre
- progress the implementation of technology to make best use of available resources across acute emergency dispatch, resource planning, and non-emergency patient transport.

However, if paramedics are unable to transfer their patients into the hospital system, within specified time targets, the additional infrastructure and employees may not lead to a corresponding improvement in the patient off stretcher time and the time lost by the paramedics waiting at the emergency departments.

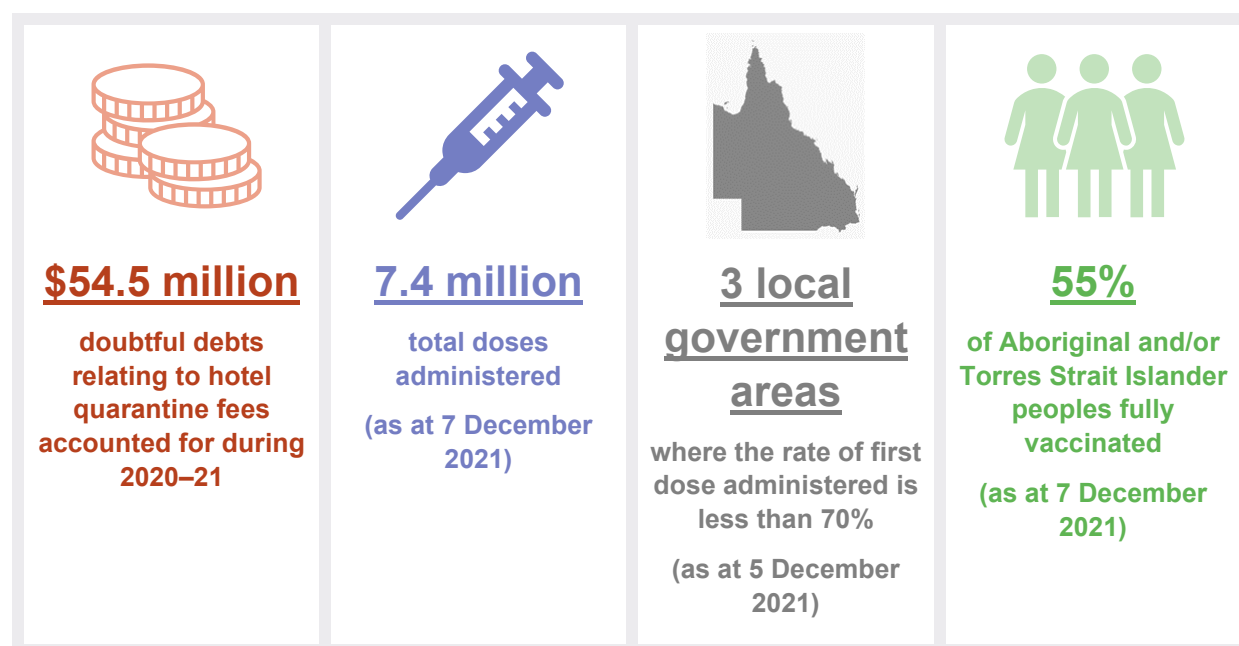
5. COVID-19 vaccine rollout and recovery of hotel quarantine fees

One of the most pressing issues for our state and nation at this time is the COVID-19 vaccine rollout. The Australian National Audit Office is currently conducting an audit to assess the effectiveness of the Australian Government's planning and implementation of this.

In this report, we provide an overview of the rollout in Queensland as at 7 December 2021, covering key statistics at significant dates, the responsibilities of the Queensland and Australian governments, and the recovery of hotel quarantine fees.

The Queensland COVID-19 vaccine program began on 22 February 2021, with the aim that every Queenslanders who wants to be vaccinated against the virus will be.

Chapter snapshot



The rollout of the vaccine is a joint state and Australian Government responsibility

Queensland Health provides vaccinations via the 16 HHSs and the Australian Government provides them via the Primary Health Networks, which include general practitioners, pharmacists, Aboriginal community controlled health services, aged care, and disability support.

The Australian Government is responsible for obtaining the vaccines, and has made agreements with four providers—Pfizer-BioNTech; University of Oxford—Astra Zeneca; Moderna; and Novavax. The rollout began primarily with Pfizer-BioNTech and Astra Zeneca, both of which were approved for use by the Therapeutic Goods Administration (TGA) in early 2021. Moderna was approved for use on 9 August 2021, and rollout of this vaccine by Queensland pharmacists began on 22 September 2021. The TGA is currently evaluating the Novavax vaccine.

Figure 5A shows the responsibilities of the Australian and Queensland governments for the vaccine rollout.

Figure 5A
Australian and Queensland governments' responsibilities for the COVID-19 vaccine rollout

Australian Government	Queensland Government
<ul style="list-style-type: none"> Transporting vaccine doses to storage and administration sites within Queensland and transferring between sites where necessary Specifying minimum training requirements for the immunisation workforce Specifying types of and minimum requirements for vaccination locations Setting data collection requirements in collaboration with the Queensland Government. <p>If the site is a Primary Health Network site, the Australian Government is also responsible for:</p> <ul style="list-style-type: none"> ensuring that immunisation providers remain compliant at all times with their safety, ethical, and reporting obligations managing stock, including storage, wastage, and stock security. 	<ul style="list-style-type: none"> Establishing an appropriately qualified and trained workforce to support the vaccine rollout and perform immunisations Ensuring immunisation providers remain compliant at all times with their safety, ethical, and reporting obligations Managing stock, including storage, wastage and stock security, at Queensland Health sites Collaborating with the Australian Government to set data collection requirements Providing up-to-date data to relevant coordinating bodies.

Source: Adapted from the Australian COVID-19 Vaccination Policy, 13 November 2020, Australian Government.

Vaccine sentiment and demand versus supply

The Australian Government monthly 'Vaccine Sentiment' report shows the percentage of Australian people intending to get vaccinated or already vaccinated increased from 66 per cent in May, to 70 per cent in June and July, to 84 per cent in October 2021.

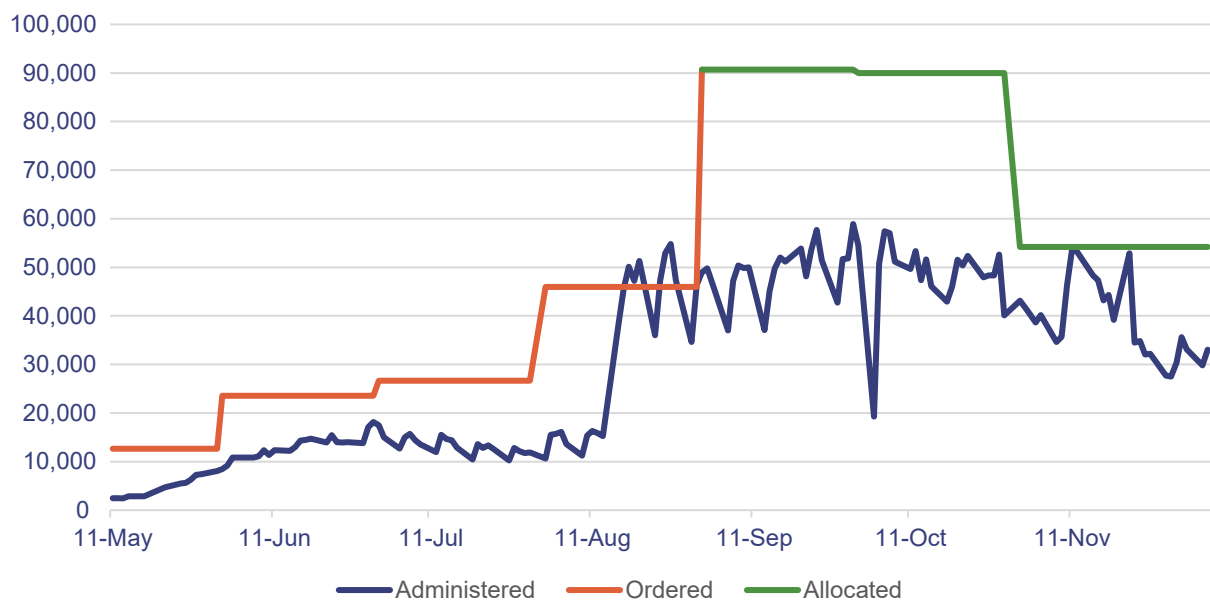
The low percentage in May 2021 followed the initial announcement that the AstraZeneca vaccine was no longer available for the population under 50 years old. The increase in October coincided with the Delta strain outbreaks in Victoria and New South Wales.

We do not have access to any sentiment data specifically for Queensland.

The number of doses available to the state and the primary care providers is determined by the Australian Government, and the estimated weekly doses have been stated in the *COVID Vaccination Allocations Horizons* document prepared by the Australian Government Department of Health.

Figure 5B shows the number of doses administered, overlaid with the total stock ordered by Queensland Health and primary care providers for the period July 2021 to August 2021 and vaccines allocated by the Australian Government from September onwards. The doses administered were limited by availability of stock, especially in the earlier months. However, vaccine uptake has not kept pace with the significant increase in supply since late August 2021.

Figure 5B
Number of vaccine doses administered per day compared to average stock orders/allocations per day—11 May–7 December 2021



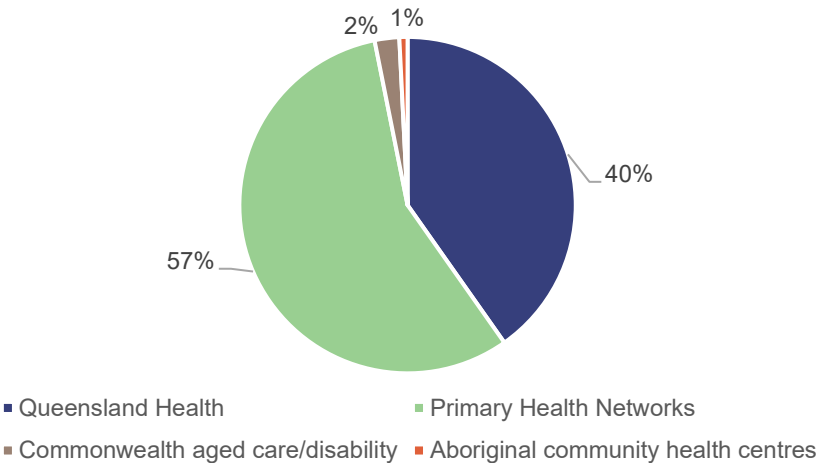
Note: Ordered = total doses delivered to sites. Allocated = total doses available to the sites.

Source: Australian Government Department of Health—Daily report data Monday to Friday between May and December 2021; and Australian Government Department of Health—COVID Vaccination Allocations Horizons report—24 September 2021.

Vaccine doses administered in Queensland

Figure 5C shows the doses administered via Queensland Health and various primary care providers. The state has administered 40 per cent of total doses at 7 December 2021, with the remainder administered by the Australian Government (through the Primary Health Networks, Commonwealth aged care and disability services, and Aboriginal community health centres).

Figure 5C
Doses administered in Queensland



Source: Australian Government Department of Health—Daily report data as at 7 December 2021.



Vaccination rates by location

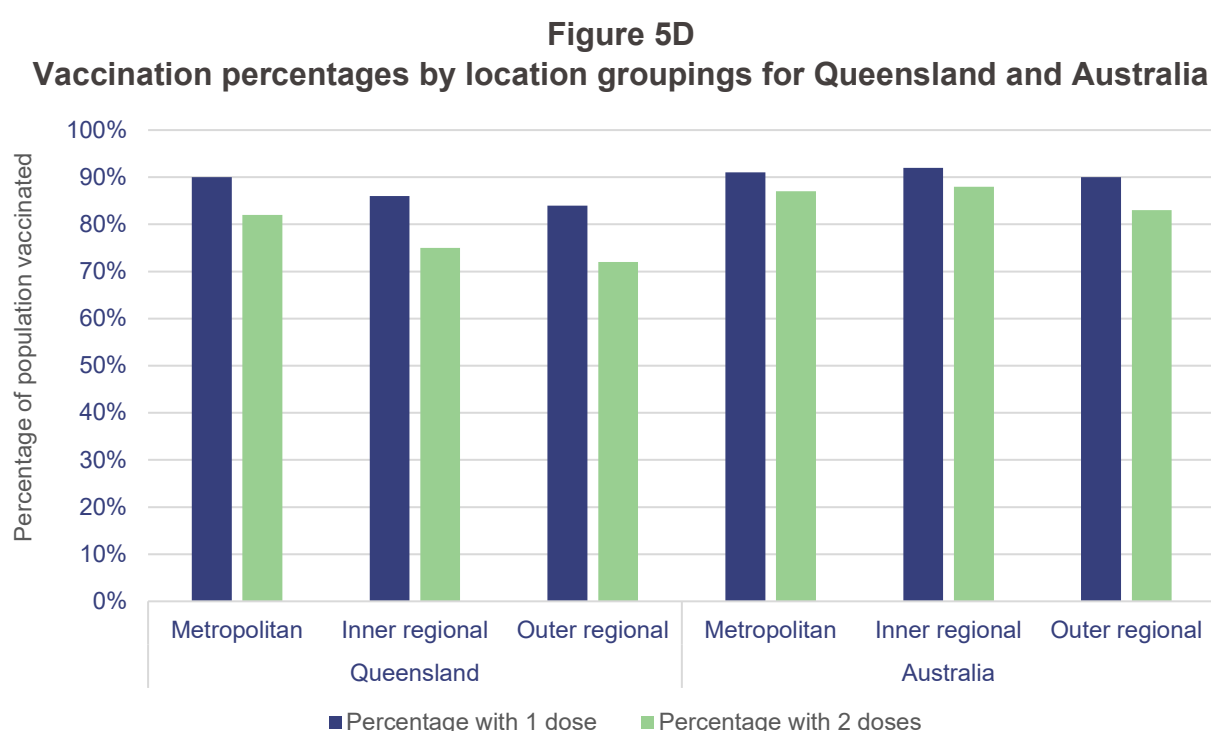
We have considered the vaccination rates based on the level of remoteness of location within Queensland, compared to the national data for the same levels of remoteness. The Australian Government information excludes some areas that are very remote due to issues with collecting data. The percentage of areas excluded due to this is 1.5 per cent of the total Queensland population.

As can be seen in Figure 5D, the vaccination rates in the Queensland metropolitan areas are ahead of those in regional areas. This is in line with the national data, although we note the rates for inner regional areas in the national data appear to be closer in percentages to the rates for metropolitan areas than in Queensland. This could in part be due to the size of Queensland compared to other states who are further ahead in their vaccine rollout and the fact our regional areas have been largely unaffected by COVID-19 outbreaks.

DEFINITION

Areas in Queensland have been divided into five **classes of remoteness** on the basis of a measure of relative access to services. Metropolitan areas include major cities such as Brisbane, Gold Coast, Sunshine Coast, and Ipswich. Inner regional includes Toowoomba, Bundaberg, Rockhampton, and similar. Outer regional includes Cairns, Townsville, Goondiwindi, and similar.

The Australian Government excluded remote and very remote areas from its data due to issues with locating addresses and linking vaccine data for those individuals.



Source: Australian Government Department of Health—Local government authority data as at 5 December 2021.

There are three local government areas in Queensland—Cherbourg, Yarrabah, and Isaac—where the rate for the first dose of the vaccine is less than 70 per cent. Cherbourg and Yarrabah are both Indigenous councils, and both Yarrabah and Isaac are classified as outer regional areas.

Aboriginal and/or Torres Strait Islander peoples

The Australian Government is responsible for leading the rollout to Aboriginal and/or Torres Strait Islander peoples, in collaboration with state and territory governments. Aboriginal and/or Torres Strait Islander peoples were also included in Phase 1B of the rollout, which commenced on 22 March 2021.

As at 7 December 2021, 69 per cent of the Aboriginal and/or Torres Strait Islander peoples in Queensland had received their first dose, which was well below the state average. In two local government areas—Woorabinda and Tablelands—less than 55 per cent have received their first dose. There are a further seven local government areas where their first dose vaccination rates are less than 60 per cent.

Figure 5E shows the vaccine rollout progress for Aboriginal and/or Torres Strait Islander peoples compared to all people in Queensland.

Figure 5E
Comparison of vaccine rollout progress between Aboriginal and/or Torres Strait Islander peoples and all of Queensland

Group	Percentage with dose 1	Percentage with dose 2
Aboriginal and/or Torres Strait Islander peoples (over the age of 15)	69.4%	55.3%
Queensland (total)	87.7%	79.6%

Source: Australian Government Department of Health—Daily report data as at 7 December 2021.

To assist Aboriginal and/or Torres Strait Islander peoples in receiving their vaccinations, throughout October and November 2021, HHSs have been providing:

- mobile vaccination vans
- transport to assist people to attend appointments
- door-to-door vaccinations in remote communities
- pop-up clinics at schools and youth centres
- designated First Nation vaccination days at existing clinics.

They have also been providing t-shirts, footballs, food vouchers and other incentives to encourage people to get vaccinated in areas with low vaccination rates. A 'Make the Choice' campaign has been rolled out via various media outlets including websites, radio, TV, social media, and events, to educate and advocate for people who may be hesitant to receive their vaccinations.

Vaccine wastage has been minimal to date

Queensland Health records and monitors wastage by HHSs. Since the beginning of the rollout, 7,195 doses have been reported as significant wastage events—5,143 doses of Pfizer and 2,052 doses of AstraZeneca. Wastage as a percentage of doses administered is 0.24 per cent. We do not have wastage data for other Australian jurisdictions.

While vaccine wastage has been minimal to date, the risk from this point forward increases due to supply levels exceeding demand.

Hotel quarantine fees

The Queensland Government announced that, from 17 June 2020, hotel quarantine fees were payable by travellers arriving in the state. As at 30 June 2021, there had been 100,993 stays in hotel quarantine. On average, 19 per cent of applications received for an invoice to be waived were approved for various reasons, including booking prior to the announcement of fees, financial hardship or vulnerability.

In 2020–21, the Department of Health recognised income from quarantine fees totalling \$179.4 million. Of this total:

- \$82.5 million was yet to be invoiced. As at 30 June 2021, over 25,000 quarantine invoices had not been processed, due in part to a lack of staff within the section processing these invoices and the time required to validate the traveller information. The Department of Health is currently working to obtain additional staff resources to help clear the backlog of invoice processing
- the department recognised \$54.5 million for doubtful debts relating to hotel quarantine fees accounted for during 2020–21. This includes \$21.4 million the department estimated may not be recoverable and may have to be written off from the quarantine revenue yet to be invoiced (\$82.5 million).

The department recognised associated expenses of \$118 million in its 2020–21 financial statements representing the cost of the hotel quarantine program. The surplus from quarantine fees and costs is used to support the broader COVID-19 response such as fever clinics, procurement of protective personal equipment, health service provision at hospitals, and the vaccine rollout.

Not included is the full cost of the administration burden on Queensland Health to manage the hotel quarantine system and payroll expenditure for Queensland Health employees working within the system.

Queensland Health could focus on health service delivery and work with other government entities for pursuing outstanding debt. Other entities, such as Queensland Treasury's State Penalties Enforcement Registry unit, are better placed to handle debt recovery, and other government entities are not under as much pressure from the pandemic as Queensland Health.

There would be value in the Department of Health arranging for another entity to take responsibility for pursuing recovery of debts associated with hotel quarantine.

Recommendation for Department of Health

The Department of Health should arrange for another entity to manage hotel quarantine debts

The Department of Health should pass the invoicing and hotel quarantine debt recovery functions to another government entity that is better suited to invoicing and debt recovery, and is not as affected by COVID-19. This will allow the department to focus on the provision of health care.

Appendices

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A. Full responses from entities

As mandated in Section 64 of the *Auditor-General Act 2009*, the Queensland Audit Office gave a copy of this report with a request for comments to the Department of Health.

We also provided a copy of the report to the following and gave them the option of providing a response:

- Minister for Health and Ambulance Services
- board chairs of the 16 hospital and health services
- chief executive officers of the 16 hospital and health services.

We provided a copy of this report to the Premier and Minister for the Olympics, and the Director-General, Department of the Premier and Cabinet for their information.

This appendix contains the detailed responses we received.

The heads of these entities are responsible for the accuracy, fairness and balance of their comments.

Comments received on 10 December 2021 from Director-General, Department of Health



Queensland Health

+Enquiries to:

Telephone:
Our ref:
Your ref:

Mr Brendan Worrall
Auditor-General
Queensland Audit Office
Level 14, 53 Albert Street
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Email: qao@qao.qld.gov.au

Dear Mr Worrall

Thank you for your letter dated 19 November 2021, regarding Queensland Audit Office's (QAO) proposed report to Parliament titled 'Health 2021'.

I acknowledge receipt of the report and the contents proposed to be included in this report. I am responding on behalf of the Department of Health and the 16 Hospital and Health Services (HHSs) to provide a single health system response to your report.

It is pleasing to note that the Department and all 16 HHSs received unmodified opinions on their annual financial statements for the 2020-21 financial year. This has been achieved within the legislative deadlines, despite the impact of COVID-19 pandemic on staff and workloads.

Noted below are our responses to matters raised in the proposed report.

Recommendation 1: Procurement and contracting controls need to be strengthened
Queensland Health recognises the need for continuous improvement and development of systems and system controls. Initiatives are underway for the continued strengthening of procurement and contracting controls. Appropriate training has been developed and is continuously subject to review for content and delivery enhancements. Options for a more centralised contract register and storage system are currently under review.

Recommendation 2: The Department of Health should arrange for another entity to manage hotel quarantine debts
I appreciate QAO recognising the considerable additional administrative demands that the quarantine fee invoicing, management and collection processes have imposed on the Department. Your noting of the unaccounted administrative burden and associated payroll costs highlights some of the additional costs arising as a consequence of the pandemic. We agree that Queensland Health's resources are better directed toward the provision of health services. Alternative possibilities for the management, invoicing and collection of quarantine fees are currently under review.

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Information systems controls and cyber security

Queensland Health continues to be vigilant about information systems controls and cyber security risks. The resolution, in 2021, of significant deficiencies highlighted in your 2020 report is evidence of our continued focus on strengthening cyber security. We have in place a continuous program to manage cyber security risks including ransomware. The program includes training, awareness and targeted campaigns and cultural practice improvement initiatives to ensure a cyber aware workforce. The IT department is constantly working on cyber security strategies for the prevention, detection, response and recovery from any cyber-attacks or other threats to information systems.

Future capital requirements to meet changing service delivery needs

Queensland Health is very aware of the steadily increasing Queensland population and the related demand this places on future capital requirements and asset maintenance. Your proposed report notes that HHSs continue to face significant challenges in funding the anticipated maintenance of their assets. QAO recommends that all 17 entities should continue work on addressing Recommendation 5 from the QAO report Health 2020 (Report 12: 2020–21), which is to prioritise high-risk maintenance.

The Department and HHSs continue to work together on strategies to better manage anticipated maintenance and the whole of life cycle cost, including the level of maintenance investment required to sustain the built environment. The Department continues to work with HHSs to categorise items recorded in the anticipated maintenance register based on the type of expenditure (for example deferred operational maintenance, capital maintenance, etc.) and projected year for completion. The processes in place provide a mechanism for the identification and prioritising of high-risk maintenance within the constraints of available financial resources.

Financial sustainability

QAO has again commented on health entities' ongoing financial sustainability. It is pleasing to note the improved performance of most HHSs. The proposed report notes that while the HHSs have a combined operating surplus of \$33 million (2019–20: \$82 million operating loss) that this was partly due to the Australian Government guaranteeing its funding in 2020–21 in recognition of the impact of the COVID-19 pandemic. Fourteen of the 16 HHSs reported an operating surplus, and only two reported an operating loss (2019–20: 11 HHSs reported a loss).

Queensland Health recognises the challenges for financial sustainability which remains a key focus of all Queensland Health leadership teams and their staff. As noted in your report the Department has applied efficiency and productivity dividends on HHSs. Efficiency dividends encourage HHSs to identify cost savings by reducing how much the department funds them, without reducing their target service levels. In 2021–22, the savings generated through the application of efficiency dividends have been reinvested back into front line care across the state. Queensland Health continues to focus on efficiency dividend strategies to increase productivity and deliver required service levels.

The ambulance service is facing increasing demand

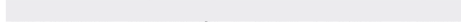
I appreciate QAO recognising the constantly increasing demand for all services provided by the Queensland Ambulance Service (QAS), and the challenges presented by the COVID-19 pandemic. In addition to the impact of COVID-19, your proposed report notes that QAS continues to experience constantly increasing demand arising from Queensland's increasing population. Your report further notes that increased demand also arises from the supply of new services, such as the rapid deployment of seven fever clinics, hotel quarantine

relocation transportation and assistance/attendance at vaccination centres. Queensland's ageing population is another factor in the increasing demand for QAS services. QAS have noted that while people over 65 years of age account for 15 per cent of the population, this age group makes up 36.7 per cent of QAS total workload. Workloads are also being affected by increasingly complex cases, including mental health issues.

QAO have recognised that despite having the highest number of responses in Australia, in proportion to the state's population, QAS have managed to achieve better response times for emergency cases (Code 1) than most other jurisdictions. The proposed report notes that the increasing demand for all QAS services has contributed to the increased time it takes the ambulance crews to transfer patients into the care of emergency departments. The proposed report recognises that the COVID-19 pandemic has placed further pressure on emergency departments. Hospitals have had to adopt new infection control measures for the safety of staff and patients. These requirements increase the time taken to provide treatment and affect patient flow.

Queensland Health are constantly reviewing processes to reduce the time that it takes to transfer the care or handover of a patient to an emergency department. As noted in your proposed report, a key factor in the time it takes to transfer a patient, is the increase in emergency department demand for both ambulance patients and walk-in patients. The Department is currently working on improving emergency services. In this, it is supported by the Queensland Government's Care4Qld Strategy announced in May 2021, which aims to improve access to emergency services and unplanned care across Queensland. As noted in your proposed report the Code 1 lost time has improved recently, following initiatives implemented as part of the Care4Qld Strategy.

As noted in your proposed report, QAS have also addressed the increased demand in mental health incidents. This strategy includes programs such as the Mental Health Liaison Service and the Mental Health Co-responder Program. Both these programs provide for early QAS engagement and cooperation with senior mental health clinicians and relevant HHS staff.

Thank you again for seeking our comments. Should you require further information, the Department of Health's contact is 

Yours sincerely



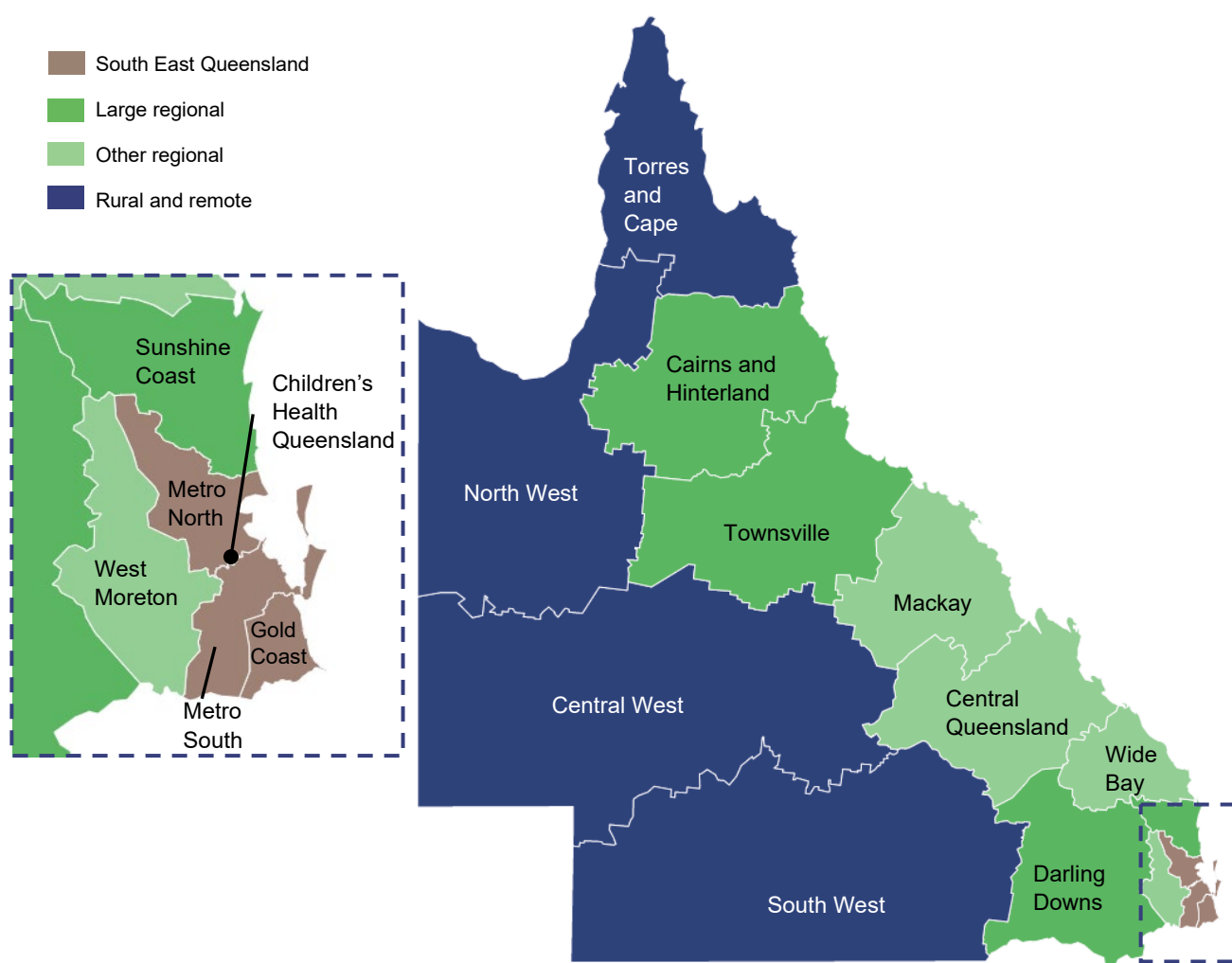
Dr John Wakefield PSM
Director-General

B. Queensland hospital and health service regions

Hospital and health services (HHSs) provide health services across metropolitan, regional, and rural areas of Queensland. They are grouped into the following regions:

Figure B1
Queensland hospital and health service regions

South East Queensland	Large regional	Other regional	Rural and remote
Children's Health Queensland HHS	Cairns and Hinterland HHS	Central Queensland HHS	Central West HHS
Gold Coast HHS	Darling Downs HHS	Mackay HHS	North West HHS
Metro North HHS	Sunshine Coast HHS	West Moreton HHS	South West HHS
Metro South HHS	Townsville HHS	Wide Bay HHS	Torres and Cape HHS



Source: Queensland Audit Office from Queensland Health.

C. Status of recommendations made in *Health 2020* (Report 12: 2020–21)

In *Health 2020* (Report 12: 2020–21), we identified the following recommendations for health sector entities. These entities have taken appropriate action for one of the five recommendations. They have also made progress on the other four, but they still need to take further action.

Automate manual financial reporting processes (Queensland Health entities)		Appropriate action has been taken
REC 1	Queensland Health entities should improve the efficiency of their reporting by automating manual processes, where possible.	Management at the Queensland Health entities have improved their reporting through the automation of processes where applicable.
Resolve outstanding audit issues (Queensland Health entities)		Further action needs to be taken
REC 2	Queensland Health entities and their audit committees should continue to regularly review the status of outstanding audit issues and ensure they are resolved in a timely manner.	<p>We note significant improvements in the resolution of long-outstanding issues (the longest outstanding issue is from 2018; previously, it was 2014).</p> <p>There are currently 19 issues that remain outstanding from prior years (one significant deficiency and 18 deficiencies). This recommendation is partially implemented, as issues remain outstanding.</p>

Strengthen the security of information systems (all entities)		Further action needs to be taken
REC 3	<p>We recommend all entities strengthen the security of their information systems. They rely heavily on technology, and increasingly, they have to be prepared for cyber attacks. Any unauthorised access could result in fraud or error, and significant reputational damage.</p> <p>Their workplace culture, through their people and processes, must emphasise strong security practices to provide a foundation for the security of information systems.</p> <p>Entities should:</p> <ul style="list-style-type: none"> • provide security training for employees so they understand the importance of maintaining strong information systems, and their roles in keeping them secure • assign employees only the minimum access required to perform their job, and ensure important stages of each process are not performed by the same person • regularly review user access to ensure it remains appropriate • monitor activities performed by employees with privileged access (allowing them to access sensitive data and create and configure within the system) to ensure they are appropriately approved • implement strong password practices and multifactor authentication (for example, a username and password, plus a code sent to a mobile), particularly for systems that record sensitive information • encrypt sensitive information to protect it • patch vulnerabilities in systems in a timely manner, as upgrades and solutions are made available by software providers to address known security weaknesses that could be exploited by external parties. <p>Entities should also self-assess against all of the recommendations in <i>Managing cyber security risks</i> (Report 3: 2019–20) to ensure their systems are appropriately secured.</p>	<p>Six significant deficiencies were raised in 2020. These were resolved in 2021.</p> <p>Cyber security remains an area of focus for all the entities. The recommendation to strengthen the security of information systems remains.</p>
Approve service agreements for shared services (Queensland Health entities)		Further action needs to be taken
REC 4	<p>The Department of Health and the hospital and health services should work together to approve and sign service level agreements with each other for the purchasing and payroll services the department performs on behalf of the HHSs. The agreements should clearly identify the roles and responsibilities of each party, including the quality and scope of services and the respective costs.</p>	<p>The department and HHSs continue to work together to approve and sign the service level agreements that are outstanding.</p>
Address backlog of asset maintenance (Queensland Health entities)		Further action needs to be taken
REC 5	<p>Queensland Health entities should continue to prioritise high-risk maintenance.</p> <p>The hospital and health services should work with the department to find ways to mitigate the operational, clinical, and financial risks associated with anticipated maintenance.</p>	<p>The anticipated maintenance has increased by \$57 million in 2020–21.</p>

Source: Queensland Audit Office.

Status	Definition	
Fully implemented	Recommendation has been implemented, or alternative action has been taken that addresses the underlying issues and no further action is required. Any further actions are business as usual.	
Partially implemented	Significant progress has been made in implementing the recommendation or taking alternative action, but further work is required before it can be considered business as usual. This also includes where the action taken was less extensive than recommended, as it only addressed some of the underlying issues that led to the recommendation.	
Not implemented	Recommendation accepted	No or minimal actions have been taken to implement the recommendation, or the action taken does not address the underlying issues that led to the recommendation.
	Recommendation not accepted	The government or the agency did not accept the recommendation.
No longer applicable	Circumstances have fundamentally changed, making the recommendation no longer applicable. For example, a change in government policy or program has meant the recommendation is no longer relevant.	

If a general recommendation has been made for all entities to consider, we assess action on issues reported to specific entities in the prior year, as well as any further issues identified in the current year. On this basis, we have concluded whether *appropriate action has been taken* across the sector, or if *further action needs to be taken* to address the risk identified.

Status	Definition	
Appropriate action has been taken	Recommendations made to individual entities have been implemented, or alternative action has been taken that addresses the underlying issues, and no further action is required. No new issues have been identified across the sector that indicate an ongoing underlying risk to the sector that requires reporting to parliament.	
Further action needs to be taken	Recommendations made to individual entities have not been fully implemented, and/or new recommendations have been made to individual entities, indicating further action is required by entities in the sector to address the underlying risk.	

D. Audit opinions for entities preparing financial reports

Queensland state government financial statements

Each year, Queensland state public sector entities must table their audited financial statements in parliament.

These financial statements are used by a broad range of parties including parliamentarians, taxpayers, employees, and users of government services. For these statements to be useful, the information reported must be relevant and accurate.

The Auditor-General's audit opinion on these entities' financial statements assures users that the statements are accurate and in accordance with relevant legislative requirements.

We express an *unmodified opinion* when the financial statements are prepared in accordance with the relevant legislative requirements and Australian accounting standards. We *modify* (qualify) our audit opinion when financial statements do not comply with the relevant legislative requirements and Australian accounting standards and are not accurate and reliable.

Sometimes we include an *emphasis of matter* in our audit reports to highlight an issue that will help users better understand the financial statements. It does not change the audit opinion.

The following table details the types of audit opinions we issued for the 2021 financial year in accordance with Australian auditing standards.

Figure D1
Audit opinions issued

Entity type	Entity	Date audit opinion issued	Type of audit opinion issued
Department	Department of Health	31.08.2021	Unmodified
Statutory bodies —hospital and health services (HHS)	Cairns and Hinterland	26.08.2021	Unmodified
	Central Queensland	31.08.2021	Unmodified
	Central West	30.08.2021	Unmodified
	Children's Health Queensland	27.08.2021	Unmodified
	Darling Downs	31.08.2021	Unmodified
	Gold Coast	19.08.2021	Unmodified
	Mackay	31.08.2021	Unmodified
	Metro North	31.08.2021	Unmodified
	Metro South	30.08.2021	Unmodified
	North West	31.08.2021	Unmodified

Entity type	Entity	Date audit opinion issued	Type of audit opinion issued
	South West	27.08.2021	Unmodified
	Sunshine Coast	30.08.2021	Unmodified
	Townsville	23.08.2021	Unmodified
	Torres and Cape	25.08.2021	Unmodified
	West Moreton	18.08.2021	Unmodified
	Wide Bay	30.08.2021	Unmodified
Statutory bodies —hospital foundations	Bundaberg Health Services Foundation	31.08.2021	Unmodified
	Central Queensland Hospital Foundation	25.08.2021	Unmodified
	Children's Hospital Foundation Queensland	30.08.2021	Unmodified
	Far North Queensland Hospital Foundation	31.08.2021	Unmodified
	Gold Coast Hospital Foundation	24.08.2021	Unmodified
	Ipswich Hospital Foundation	31.08.2021	Unmodified
	Mackay Hospital Foundation	30.08.2021	Unmodified
	PA Research Foundation	31.08.2021	Unmodified
	Royal Brisbane and Women's Hospital Foundation	31.08.2021	Unmodified
	Sunshine Coast Health Foundation	31.08.2021	Unmodified
	The Prince Charles Hospital Foundation	31.08.2021	Unmodified
	Toowoomba Hospital Foundation	31.08.2021	Unmodified
	Townsville Hospital Foundation	31.08.2021	Qualified [#]
Other statutory bodies	Queensland Mental Health Commission	28.07.2021	Unmodified
	Office of the Health Ombudsman	10.08.2021	Unmodified
	The Council of The Queensland Institute of Medical Research (QIMR)	26.08.2021	Unmodified
	Health and Wellbeing Queensland	11.08.2021	Unmodified
Controlled entities	Sunshine Coast Health Institute (SCHI)*	22.04.2021	Unmodified
	genomiQa Pty Ltd [^] (controlled entity of QIMR)		
	Endpoint Pty Ltd [^] (controlled entity of QIMR)		

Notes: * SCHI is a joint venture collaborative partnership between the Sunshine Coast Hospital and Health Service, University of the Sunshine Coast, TAFE Queensland and Griffith University.

[^] Did not previously prepare financial statements but will for 2021; not certified as at 9 December 2021.

[#] The qualification relates to comparative amounts 2019–20.

Source: Queensland Audit Office.



E. Other audit and assurance opinions

We issued the following opinions for other audit and assurance engagements performed in the Queensland public health sector. To provide assurance, an auditor must confirm whether specific information is correct, so users of the information can confidently make decisions based on it.

Figure E1
Other audit and assurance opinions issued

Type of engagement	Subject	Date opinion issued	Type of opinion issued
Department of Health			
Audit of a special purpose financial report	National Health Funding Pool Queensland State Pool Account—the cash receipts from the Australian and Queensland governments to fund Queensland public health services	08.09.2021	Unmodified
Compliance audit	Annual Prudential Compliance Statement for Queensland Health's aged care facilities that collect refundable deposits and accommodation bonds	28.10.2021	Qualified
Assurance audit	ASAE 3402 Assurance Report for the period 25 November 2019 to 31 March 2020 (Type 2)—covering the design, implementation, and effectiveness of key financial controls	04.06.2021	Unmodified
Assurance audit	ASAE 3402 Assurance Report as at 30 June 2020 (Type 1)—covering the design and implementation of key financial controls	22.07.2021	Unmodified

Source: Queensland Audit Office.

F. Entities not preparing financial reports

For each state public sector company, other than government owned corporations, the board of directors considers the requirements of the *Corporations Act 2001* to determine whether financial statements need to be prepared. The board must revisit the assessment every three years or whenever a significant change occurs.

When entities are part of a larger group and are secured by a guarantee with other entities in that group (that they will cover their debts), the Australian Securities and Investments Commission allows them to not prepare a financial report. In addition, dormant or small companies that meet specific criteria under the *Corporations Act 2001* are not required to prepare financial statements. If entities form part of a larger group that reports to the Australian Charities and Not-for-profits Commission, the commissioner may allow the group to jointly report under subsection 60–95(1) of the *Australian Charities and Not-for-profits Commission Act 2012*.

Accordingly, the Auditor-General will not issue audit opinions for the following controlled public sector entities for 2021, as they were not required to produce financial statements.

Figure F1
Health sector entities not preparing financial reports in 2020–21

Public sector entity	Reason for not preparing financial statements
Controlled entities of The Council of The Queensland Institute of Medical Research (QIMR)	
Q-Gen Pty Ltd	Dormant
Vaccine Solutions Pty Ltd	Non-reporting

Source: Queensland Audit Office.



G. Financial results

Figure G1
Department of Health and hospital and health services—for the year ending
30 June 2021

Amounts in \$'000						
Health entity	Total assets	Total liabilities	Total income	Total expenses	Operating result	Accumulated operating result
Department of Health	4,550,526	2,759,335	29,801,958	29,796,574	5,384	1,335,890
Cairns and Hinterland HHS	922,964	70,332	1,110,558	1,110,530	28	-66,641
Central Queensland HHS	469,714	39,750	698,395	701,096	-2,701	-15,112
Central West HHS	106,134	7,327	92,900	92,755	145	-337
Children's Health Queensland HHS	1,182,972	65,497	923,886	920,978	2,908	44,763
Darling Downs HHS	543,038	65,440	945,504	934,878	10,626	64,053
Gold Coast HHS	1,785,298	161,572	1,808,003	1,797,369	10,634	16,779
Mackay HHS	419,041	33,132	529,998	526,669	3,329	24,790
Metro North HHS	2,496,065	787,410	3,380,369	3,368,666	11,703	161,314
Metro South HHS	1,471,404	238,406	2,773,105	2,772,053	1,052	-515
North West HHS	130,861	19,527	206,702	206,336	366	-9,538
South West HHS	262,512	17,832	179,052	173,360	5,692	23,195
Sunshine Coast HHS	1,979,926	739,342	1,355,175	1,376,457	-21,282	-31,812
Torres and Cape HHS	261,155	37,191	262,248	259,919	2,329	6,797
Townsville HHS	915,312	78,197	1,135,454	1,130,979	4,475	81,379
West Moreton HHS	315,627	72,618	747,544	746,539	1,005	-6,234
Wide Bay HHS	367,416	57,037	716,898	713,815	3,083	7,102
Total	18,179,965	5,249,945	46,667,749	46,628,973	38,776	1,635,873

Source: Queensland health entities' 2020–21 audited financial statements.

H. Queensland's top 26 reporting hospitals

The figures and data presented in Chapter 4 are for the top 26 reporting public hospitals in Queensland, unless otherwise specified. These hospitals treated 77 per cent of emergency department presentations in 2018–19.

Figure H1 lists the top 26 hospitals grouped by hospital and health service.

Figure H1
Top 26 reporting hospitals

Hospital and health service (HHS)	Hospital
Cairns and Hinterland HHS	Cairns Hospital
Central Queensland HHS	Gladstone Hospital Rockhampton Hospital
Children's Health Queensland HHS	Queensland Children's Hospital
Darling Downs HHS	Toowoomba Hospital
Gold Coast HHS	Gold Coast University Hospital Robina Hospital
Mackay HHS	Mackay Base Hospital
Mater Health Services	Mater Hospital Brisbane Public Hospital
Metro North HHS	Caboolture Hospital Redcliffe Hospital Royal Brisbane and Women's Hospital The Prince Charles Hospital
Metro South HHS	Logan Hospital Princess Alexandra Hospital QEII Jubilee Hospital Redland Hospital
North West HHS	Mount Isa Hospital
Sunshine Coast HHS	Gympie Hospital Nambour Hospital Sunshine Coast University Hospital
Townsville HHS	Townsville University Hospital
West Moreton HHS	Ipswich Hospital
Wide Bay HHS	Bundaberg Base Hospital Hervey Bay Hospital Maryborough Hospital

Source: Queensland Audit Office report *Measuring emergency department patient wait time (Report 2: 2021–22)*.



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