Queensland Audit Office

Hospital and Health Services: 2014–15 financial statements

Report 5: 2015–16

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Queensland Audit Office

December 2015

The Honourable P Wellington MP
Speaker of the Legislative Assembly
Parliament House
BRISBANE QLD 4000

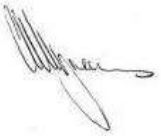
Dear Mr Speaker

Report to Parliament

This report is prepared under Part 3 Division 3 of the *Auditor-General Act 2009*, and is titled Hospital and Health Services 2014–15 financial statements.

In accordance with s.67 of the Act, would you please arrange for the report to be tabled in the Legislative Assembly.

Yours sincerely



Andrew Greaves
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Contents

Summary

This report summarises the results of our financial audits of the 16 Hospital and Health Services (HHSs) for the financial year ended on 30 June 2015.

Each HHS includes its financial statements, with our audit opinion, in its annual report. Our audit opinion provides assurance that these statements are reliable.

HHSs are statutory bodies, with most of them established from 1 July 2012. They are the principal providers of public health services across the metropolitan, regional and rural areas of Queensland. A local Hospital and Health Board governs each HHS independently. The board is accountable to the Minister for Health and Minister for Ambulance Services for the performance of the HHS.

Healthcare is expensive. In Queensland, public spending on healthcare consumed more than a quarter of the Queensland Budget in 2014–15. Advances in treatments mean that people are living longer, but they are spending more time in their later years with more complex medical conditions that require frequent and longer visits to hospital. Diet and lifestyle is also having a major impact on the health of Queenslanders through increased rates of heart disease and diabetes.

Demand for health services continues to grow. Across the state, the services provided by hospitals grew by 9.2 per cent over the previous year, but the funding for public health services in Queensland increased by 6.4 per cent over the same period. In this environment, HHSs must closely manage their costs and seek to maximise available revenues.

Conclusions

Users can rely upon HHS financial statements. We issued unmodified audit opinions for all HHS again this year.

They are also timely. For the third consecutive year, all HHSs achieved the two-month timeframe to prepare their financial statements and have them audited by us, thereby satisfying their legislative obligations.

Financial management at most HHS continues to improve. We raised fewer audit issues across the sector this year (37 per cent less than last year).

HHSs are financially sound and continue to operate sustainably. Our analysis of key financial ratios confirms that HHSs can meet their short-term obligations as they fall due. Strong net asset positions and no debt, also means all HHSs are presently sustainable over the longer term.

The Department of Health (DoH) and HHSs are acting jointly to maximise the external revenues that are available under the current activity based funding framework. However, the independent assurance over the data used by HHSs to calculate this funding lacks sufficient rigour.

Queensland hospitals continue to be amongst the most efficient in Australia when measured by the length of a patient's stay in hospital. Shorter stays in hospital mean additional beds to treat more patients. The costs they incur to deliver clinical services is also trending downwards, with most achieving the targets set by the department and improving their performance compared to last year. Nevertheless, the scope remains for some HHSs to improve their efficiency.

Patient access is also improving with reductions in the number of patients waiting longer than the clinically recommended time for a specialist consultation and a significant increase in the use of telehealth services.

Results of our financial audits

The timeliness of financial statements presented for audit continues to improve, with 75 per cent of HHSs (as compared to only 25 per cent in 2013–14) providing complete versions of financial statements for audit by the dates we agreed with them. While more timely, four HHSs had asset recognition and valuation issues that required late adjustments to their financial statements. This indicates the quality of statements requires further improvement. We encourage the early resolution of such issues to avoid potential delays in finalising statements.

Most HHSs made a reasonable attempt this year to bring greater clarity to their statements. On average, they reduced the number of notes in their statements by six. They achieved this despite needing to include an additional note disclosure for the first time this year explaining budget variations as required by AASB 1055 *Budgetary Reporting*.

While AASB 1055 requires that HHSs use their budgets from their service delivery statement (SDS), they typically compare their actual performance against the budget in their service agreements with the DoH. If the AASB 1055 disclosures are to be more meaningful, closer alignment is needed between the preparation and timing of the SDS budgets and the service agreements.

As a sector, the HHSs achieved a combined operating surplus of $18.778 million (down from $183.262 million last year). Despite the reduction in the overall operating surplus for the sector, the majority of HHSs achieved the generally accepted benchmarks for liquidity ratios. This indicates HHSs remain financially viable over the short term.

Seven HHSs reporting operating deficits in 2014–15 with another four reporting reduced operating surpluses compared to the prior year. The deficits and reduced operating surpluses arose because HHS funded the delivery of additional hospital activities.

HHSs have established sound internal management reporting practices that provide the right financial information, to the right people, at the right time. This allows management to track performance and make better-informed decisions. However, scope remains for HHSs to improve their practices further.

Revenue management

HHSs rely significantly on state and federal funding, with $10.156 billion received from government to provide health related services. Activity based funding drives the majority of this revenue.

While the state has implemented some controls to assure the integrity of activity based funding data submitted to the Australian Government, these controls are not robust, meaning the state may not be receiving funding for all the services that HHSs are delivering.

All but one HHS has a program of internal reviews of the accuracy of the coding of their activities, but only three complemented this self-assurance by obtaining independent assurance through an external review program.

The opportunity for HHSs to obtain additional funding from the Australian Government by increasing their level of activity will end on 1 July 2017, when the funding model changes from an activity model to one based on population growth.

Cost management

HHSs are managing their costs efficiently in providing their services. They met most of their service agreement targets for average length of stay (ALOS) outcomes across 16 diagnosis–related groups (DRGs). Nationally, Queensland achieved the shortest (or equal shortest) ALOS in 14 of 20 DRGs and continues to have the lowest reported relative stay index for public hospitals across the nation.

The majority of HHSs receiving activity based funding in 2014–15 had an average Queensland weighted activity unit (QWAU) cost below the Queensland efficient price; meaning their cost of providing services is equivalent to the funding they receive for these services. Most were able to reduce their average cost per QWAU from the prior year.

After staff salaries, spending on clinical supplies and drugs are amongst the most significant costs incurred by HHSs. Most HHSs are adequately controlling their spending in these areas having achieved the targets set by the department.

However HHSs are not managing their procurement contracts well:

- Many are yet to finalise their own procurement procedures that align with the requirements of the Queensland procurement policy. Most HHSs do not yet have fully updated contracts registers to record all contracts held.
- We identified a number of issues at various HHSs in relation to approving, documenting and managing procurement contracts, as well as an absence of formal evaluation of supplier performance when contracts expire.
- The nature and extent of these issues makes it difficult for HHSs to demonstrate that they have achieved value for money as required by the Queensland procurement policy.

Recommendations

As part of each audit we make a number of recommendations to individual HHSs about how to improve their financial management.

In addition to these, given the overall results of our audits, we further recommend that all Hospital and Health Services, in conjunction with the Department of Health:

1. formalise their shared service arrangements by documenting appropriate service level agreements
2. implement an overall framework that provides assurance over the completeness and accuracy of the data that drives activity based funding.

Reference to comments

In accordance with s.64 of the *Auditor-General Act 2009*, we provided a copy of this report to the Minister for Health and Minister for Ambulance Services; the Director-General, Department of Health; and the Board Chairs and Chief Executives of Hospital and Health Services with a request for comments.

We considered their views in reaching our audit conclusions and we have represented them to the extent relevant and warranted in preparing this report.

The comments received are included in Appendix A of this report.

1. Context

This chapter provides information on the financial reporting and auditing requirements and key sector events occurring in the Queensland hospital and health services environment.

To enable better comparisons in this report we have grouped Hospital and Health Services (HHSs) principally according to their size and location.

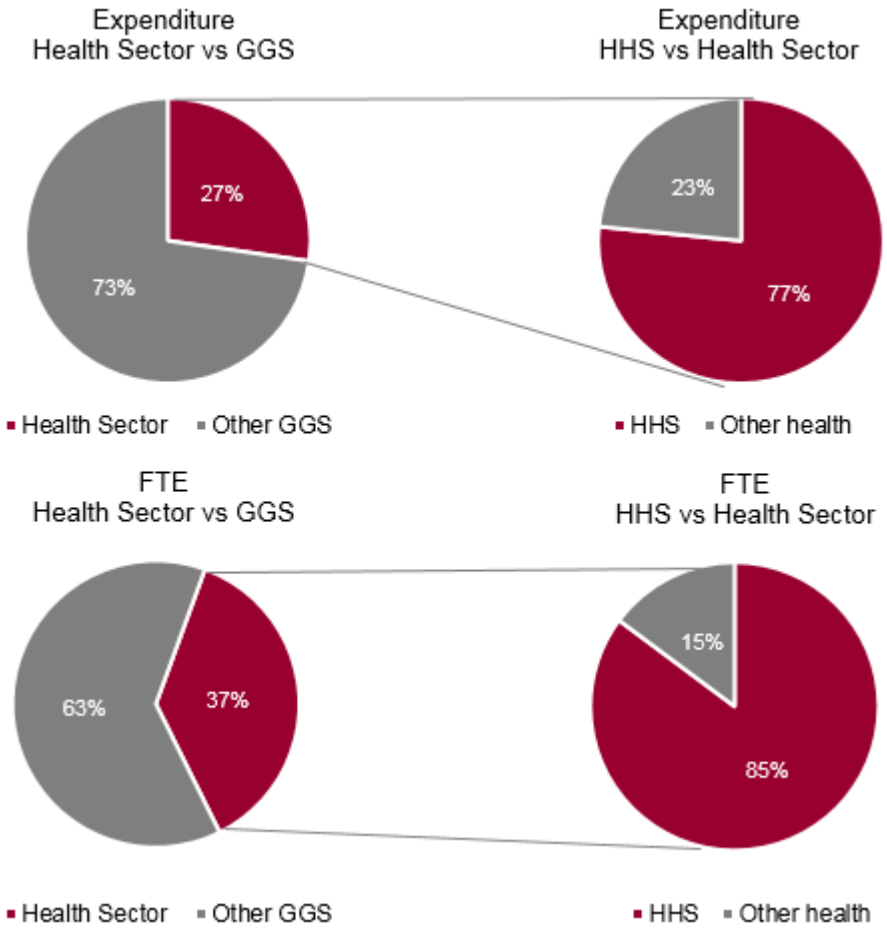
Hospital and Health Services within the Queensland health sector

Queensland health sector expenditure accounted for more than a quarter of the total 2014–15 budgeted expenditure of the Queensland Government's general government sector. In turn, HHSs accounted for 77 per cent of budgeted health sector expenditure.

The health sector also accounted for 37 per cent of full time equivalent employees within the general government sector. Similarly, the HHSs employ the majority of these full time equivalent employees.

The following figures demonstrate the significance of total expenditure and full time equivalent employees incurred by the HHSs.

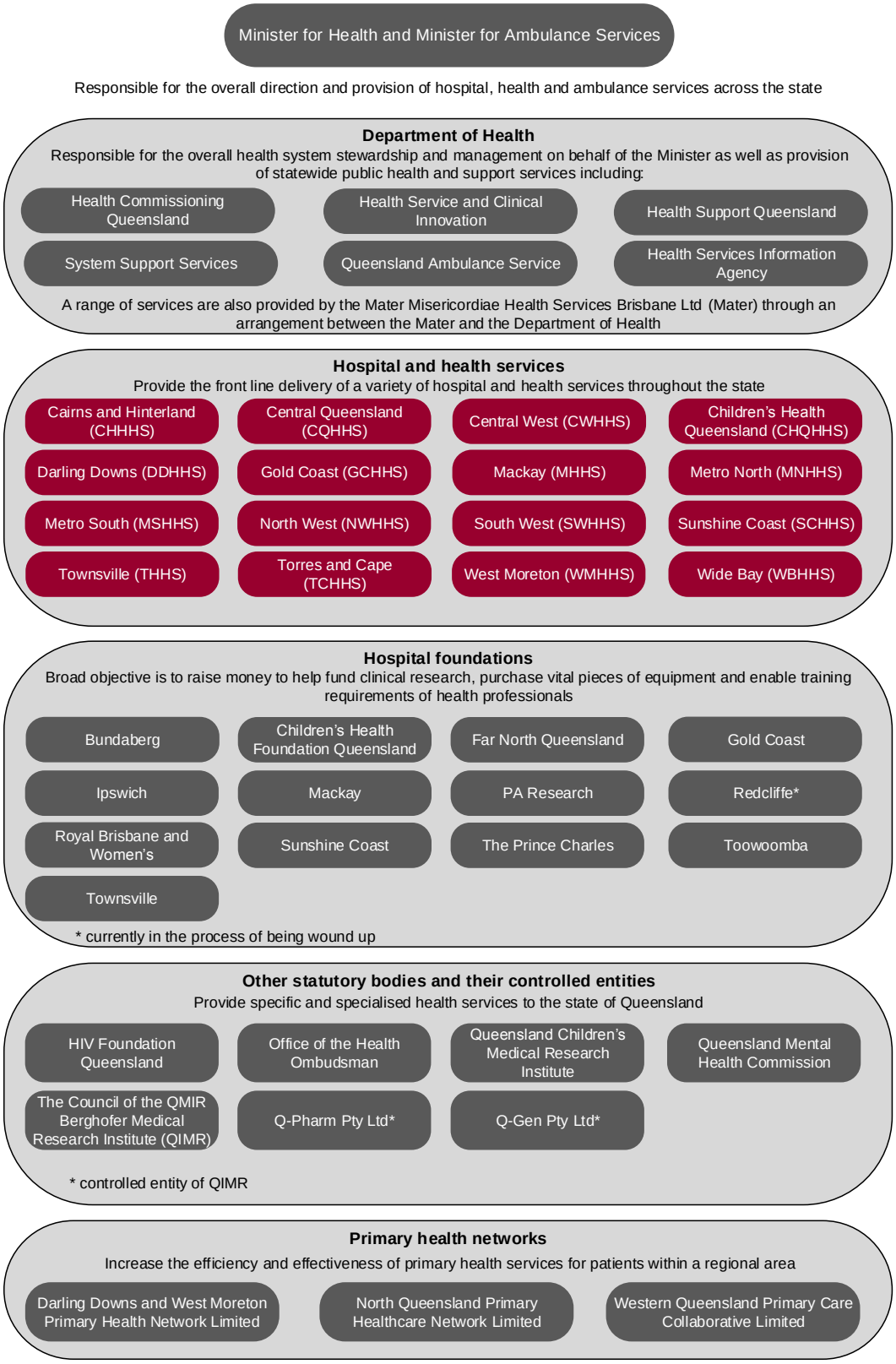
Figure 1A
Significance of HHS expenditure and full time equivalents



Source: Queensland Audit Office

Figure 1B provides an overview of all of the health related public sector entities in Queensland and their responsibilities. This report only includes results of audits for hospital and health services as highlighted. The results of all other entities are included in *State public sector entities: 2014–15 financial statements*.

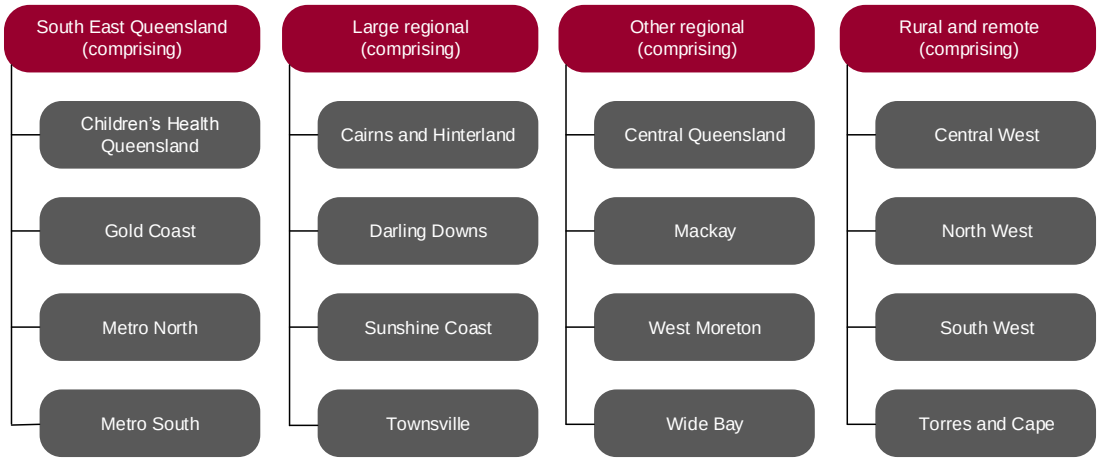
Figure 1B
Health entities in Queensland



Source: Queensland Audit Office

In previous reports, we compared relevant data and information across all HHSs. In order to provide better like for like comparisons in this report, we have grouped the HHSs into the following four categories.

Figure 1C
Grouping of HHSs for comparative purposes



Source: Queensland Audit Office

Key sector events

Creation of new hospital and health service

An amendment to the Hospital and Health Boards Regulation 2012 established the Torres and Cape HHS on 1 July 2014. The Torres and Cape HHS amalgamates the former Cape York HHS and former Torres Strait—Northern Peninsula HHS, which were both abolished on 30 June 2014. The former HHSs transferred their assets and liabilities to Torres and Cape HHS on 1 July 2014.

Prescribed employer

Prior to 1 July 2014, the Department of Health (DoH) was the employer of the majority of staff working at the HHSs with the exception of key management personnel. The HHSs negotiated with DoH for the provision of employee services via service agreements. On 1 July 2014, eight HHSs became prescribed employers meaning those HHSs became the employer of the staff working at the HHS.

The remaining eight HHSs were to become prescribed employers from 1 July 2015, however, the HHSs were advised that the prescribing would be delayed for 12 months until 1 July 2016.

On 4 August 2014, senior medical officers and visiting medical officers transitioned to individual employment contracts directly with the HHSs, irrespective of whether the HHS was a prescribed employer or not. In August 2015, the Director-General of DoH advised that relevant parties reached in-principle support for a medical officers' certified agreement covering both senior and resident medical officers. Subject to certifying the agreement, senior medical officers would revert to this award arrangement. The direct employment relationship with the HHSs is unchanged by the reversion to the award.

Transfer of land and building ownership

HHSs have recognised land and buildings assets in their financial statements since 1 July 2012 on the basis they control the assets—as they are subject to the risks and rewards of owning the assets. Prior to 1 July 2014, the legal title of these assets remained with DoH. During 2014–15, legal title for land and building assets transferred from DoH to eight HHSs. Legal title for the remaining HHSs were to transfer on 1 July 2015.

New hospitals and major redevelopments

DoH is responsible for the project management of hospital infrastructure construction throughout the state. DoH transfers assets to the relevant HHS through an equity transfer once they are constructed and are ready and fit for use. DoH transferred the following new hospitals and major redevelopments to HHSs during 2014–15:

- Children's Health Queensland HHS—Lady Cilento Children's Hospital located at South Brisbane
- Central Queensland HHS—redevelopment of Rockhampton Hospital
- Metro South HHS—Logan Hospital emergency department
- Townsville HHS—redevelopment of Townsville Hospital.

One of the major ongoing projects is the development of the Sunshine Coast Public University Hospital with commissioning expected in 2016–17.

Primary health networks

In the 2014–15 budget, the Australian Government announced the establishment of primary health networks (PHNs) to replace Medicare locals. The key objectives of PHNs are to:

- increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes
- improve coordination of care to ensure patients receive the right care in the right place at the right time.

To assist in achieving these objectives, PHNs will work directly with general practitioners, other primary health care providers, secondary care providers and hospitals to provide improved outcomes for patients.

In April 2015, the Commonwealth Government announced the successful applicants to run each PHN. PHNs officially commenced operations from 1 July 2015, but had an establishment and transition-in period of 1 June to 30 September 2015. Commonwealth Government funding transferred from Medicare locals to PHNs on 1 July 2015 with the creation of seven PHNs in Queensland. A listing of Queensland PHNs and their boundaries is included in Appendix F.

A number of HHSs have been involved in the establishment of three of the seven PHNs in Queensland. We deemed these PHNs to be public sector entities based on a review of their respective constitutions and memberships. HHSs in the respective regions created the following three PHNs.

Figure 1D
HHS involvement in Queensland primary health networks

Primary Health Network	Operator	HHSs involved
Darling Downs and West Moreton	Darling Downs and West Moreton Primary Health Network Limited	Darling Downs
Western Queensland	Western Queensland Primary Care Collaborative Limited	Central West North West South West
Northern Queensland*	North Queensland Primary Healthcare Network Limited	Cairns and Hinterland Mackay Torres and Cape

* The Minister for Health and Minister for Ambulance Services has requested Townsville HHS join the operators of this PHN

Source: Queensland Audit Office

A PHN performance framework (the framework) will outline the arrangements for monitoring, assessing and reporting on the performance of PHNs.

At the time of printing, the framework has not yet been finalised. The 2015–16 year will provide baseline data for monitoring, assessing and reporting of performance to occur in 2016–17.

We will monitor the progress of these PHNs to determine what, if any, impact they may have on the demand for services delivered by HHSs in future years.

Sunshine Coast Public University Hospital

On 1 July 2012, DoH entered into public private partnership contractual arrangements with a consortium to design, construct, commission, maintain and partially finance the Sunshine Coast Public University Hospital (SCPUH) for a period of 25 years. At the expiry of the agreement, management of the facility will transfer to DoH for nil consideration.

DoH will lease back SCPUH from the consortium and make lease payments as well as payments for the maintenance, refurbishment and other services to be provided by the consortium over the term of the agreement. The SCPUH public private partnership includes limited operational support services, closely linked to the hospital building and its systems—security, pest control and car parking services—but does not include clinical services.

DoH estimates outflows of the SCPUH public private partnership over a 25-year period of $3.259 billion (non-discounted cash flows) which includes a capital contribution of $820 million. As at 30 June 2015, DoH disclosed the estimated remaining outflows in respect of SCPUH of $2.8 billion in their financial statements.

The SCPUH project is currently on schedule with technical completion expected August 2016 and commercial acceptance November 2016. The asset will then transfer from DoH to the Sunshine Coast Hospital and Health Service (SCHHS) via an equity transfer.

SCHHS will receive approximately $193.5 million (over four years) for the ongoing transition and transformation program. This program will assist SCHHS to reconfigure services across the HHS, and commission and begin operating the new SCPUH.

Herston hospital site

With the opening of the Lady Cilento Children's Hospital in late 2014, the former children's hospital site, adjacent to the Royal Brisbane and Women's Hospital (RBWH), was identified for future development as a mixed use precinct for health, bio-medical research, residential and retail activity.

The Queensland Government endorsed the objectives for the Herston Quarter redevelopment project in July 2015 and invited the shortlisted proponents to participate in the request for proposal phase. Provision of detailed plans for the development of Herston Quarter followed by appointment of the successful developer is likely to occur in mid-2016.

As at 30 June 2015, the land asset resides with Metro North HHS. Effective as at 1 July 2015, buildings applicable to the site valued at $5.903 million, are to transfer to Metro North HHS from Children’s Health Queensland HHS.

Southport hospital site

Following the opening of the new Gold Coast University Hospital in 2013–14, the Gold Coast Hospital and Health Service vacated the former Gold Coast hospital site at Southport. Demolition work at the site is near completion with only in-ground remediation works continuing. DoH anticipates completion of this work by late 2015.

The site is located within the Southport Central Business District. Development of the site will likely include a mixed use of retail, offices, restaurants and apartments.

As at 30 June 2015, the asset resides with the DoH.

Financial reporting requirements

HHSs are statutory bodies under the *Hospital and Health Boards Act 2011.* Hospital and Health Boards are responsible for the operations of each of the HHSs. Each board is accountable to the Minister for Health and Minister for Ambulance Services.

As statutory bodies, HHSs are subject to the requirements of the *Financial Accountability Act 2009.* When preparing their financial statements, they are also required to have regard to the financial reporting requirements for Queensland government agencies, issued by Queensland Treasury.

In accordance with Australian accounting standards, HHSs are required to prepare general purpose financial statements. The *Financial and Performance Management Standard 2009* (the standard) requires HHSs to provide their financial statements for audit by an agreed date. The agreed timeframes should allow sufficient time to complete the audit and to issue the audit opinion by 31 August as required by the standard.

The *Financial Accountability Act 2009* requires that audited financial statements are included in the annual report of each HHS. The Act also requires that HHSs give their annual report to the minister by a date that allows tabling of the report in parliament by the minister within three months after the end of the financial year.

Audit responsibilities

Section 40 of the *Auditor-General Act 2009* (the Act) requires the Auditor-General to audit the annual financial statements of all public sector entities and to prepare an auditor's report.

The auditor's report, which includes the audit opinion, provides assurance about the reliability of the financial report, including compliance with legislative requirements. In accordance with Australian auditing standards, we will issue one or more of the following audit opinion types:

- an *unmodified* opinion is issued where the financial statements comply with relevant accounting standards and prescribed requirements
- a *qualified* opinion is issued when the financial statements as a whole comply with relevant accounting standards and legislative requirements, but with particular exceptions
- an *adverse* opinion is issued when the financial statements as a whole do not comply with relevant accounting standards and legislative requirements
- a *disclaimer* of opinion is issued when the auditor is unable to express an opinion as to whether the financial statements comply with relevant accounting standards and legislative requirements.

An *emphasis of matter* may be included with the audit opinion to highlight an issue of which the auditor believes the users of the financial statements need to be aware. The inclusion of an emphasis of matter does not modify the audit opinion.

The Act requires that, after the issue of the audit opinion, we provide a copy of the certified statements and the auditor's report to the chief executive of the HHS and the Minister for Health and Minister for Ambulance Services.

As an integral part of the financial audit, we assess the main components of each HHS's internal control framework to determine if financial reporting controls are operating effectively. We also assess the extent of compliance with legislative requirements.

We report deficiencies in controls identified during the audit and recommendations for improvements to the board chair and the chief executive of the HHS at a number of stages during the audit.

The Act also requires that the Auditor-General reports to parliament on each financial audit conducted. The report must state whether the audit was completed and the financial statements audited. It must also include details of significant deficiencies where financial management functions are not performed adequately or properly, along with any actions taken to improve deficiencies reported in previous reports.

This report satisfies these requirements.

Cost and structure of the report

The cost of preparing this report, including collation and confirmation of data that underpin matters reported, was $145 000.

The report provides an overview of the financial administration and reporting issues of the 16 HHSs. We have structured the report as follows:

Chapter	Description
Chapter 2	Provides the results of HHS audits including timeliness and quality of reporting, financial performance and other audit matters.
Chapter 3	Focuses on revenue management principally around activity based funding and also considering billing and debt management.
Chapter 4	Considers cost management through expenditure and asset management in addition to hospital efficiency considerations.
Appendix A	Contains comments from entities subject to this audit.
Appendix B	Details the management and audit certification dates for HHS financial statements.
Appendix C	Includes a high level summary of key statistics for each HHS.
Appendix D	Outlines the results of financial statements simplification.
Appendix E	Provides a map of the areas covered by the HHSs.
Appendix F	Details the recently created primary health networks and the areas covered by them.
Appendix G	Outlines the funding initiatives for 2014–15.
Appendix H	Contains a glossary of terms.

2. Results of audit

In brief

The 16 Hospital and Health Services (HHSs) located throughout Queensland are required to prepare financial statements each year and to include these statements in their annual reports. The financial statements provide a measure of their financial performance and position.

Conclusions

All 16 HHSs received unmodified audit opinions, confirming the reliability of HHS financial statements in reporting the results of financial position and performance for the financial year.

Most HHSs have continued to improve the quality and preparation processes of their financial statements with the majority making a reasonable attempt to simplify their financial statements in 2014–15.

Despite a number of HHSs incurring operating deficits during 2014–15, various financial ratios indicate HHSs are still sustainable in the short term. Appropriate monitoring is occurring where HHSs are not meeting ratio benchmarks.

All HHSs have established internal financial management reporting practices that meet their day-to-day requirements and allow them to respond to changes in user needs, but there is scope for HHSs to improve these practices.

Findings

- We issued unmodified audit opinions for all 16 HHSs by 31 August 2015.
- The timeliness of financial statements presented for audit have continued to improve for the majority of HHSs.
- Four HHSs still need to improve on the early resolution of year end asset recognition and valuation processes to avoid potential delays in the finalisation of their statements.
- On average, HHSs reduced the number of note disclosures by six, despite needing to include an additional note disclosure to meet the requirements of AASB 1055.
- To make the AASB 1055 disclosures included in the financial statements more meaningful, ideally there should be a closer alignment in the preparation processes and timing of original budgets and service agreements.
- The sector achieved an operating surplus of $18.778 million (2014: $183.262 million), with seven HHSs reporting operating deficits in 2014–15 with another four reporting reduced operating surpluses compared to the prior year.
- The majority of HHSs achieved the generally accepted benchmarks for liquidity ratios. One HHS has been below the benchmark for maintaining sufficient cash for three consecutive years.
- HHSs have established internal financial management reporting practices that meet their day-to-day requirements and allow them to respond to changes in user needs.

Recommendations

1. That Hospital and Health Services in conjunction with the Department of Health formalise shared service arrangements by documenting appropriate service level agreements.

Background

There are 16 Hospital and Health Services (HHSs) that prepared financial statements for 2014–15, one less than last year, with the amalgamation of the former Cape York HHS and former Torres Strait—Northern Peninsula HHS into one entity, the Torres and Cape HHS.

All HHSs have a 30 June balance date and are required under the Financial Management Performance Standard 2009 to have their financial statements audited by 31 August each year.

The financial statements provide a measure of their financial performance and position. To remain sustainable, HHSs must manage their financial risks and maintain the expected level of health services.

Conclusions

All 16 HHSs received unmodified audit opinions, confirming the reliability of HHS financial statements in reporting the results of financial position and performance for the financial year.

Issues associated with valuing and recognising assets are the major contributors to late adjustments to financial statements. This reinforces the need to complete asset revaluations early in the year, for the results to be scrutinised carefully by management and those charged with governance and to agree the accounting entries with audit teams.

HHSs—with the exception of Torres and Cape—are now in their third year of operation. The general improvement in the quality of their financial statements reflects this maturity. Most HHSs made good progress this year in reducing unnecessary disclosures in their financial statements, but there is more scope to simplify financial statements making them more succinct and readable.

Despite a number of HHSs incurring operating deficits during 2014–15, various financial ratios indicate HHSs remain sustainable over the short term. Where a HHS has been consistently below ratio benchmarks, they and the Department of Health (DoH) are monitoring the situation.

All HHSs have established internal financial management reporting practices that meet their day-to-day requirements and allow them to respond to changes in user needs. We have identified a number of improvement opportunities for HHSs to consider.

The absence of a service level agreement between each of the HHSs and DoH continues to be an unresolved issue. Both parties are continuing to work toward a resolution.

Audit opinions

We issued unmodified audit opinions for all 16 HHSs in 2014–15, confirming that financial statements have been prepared in accordance with relevant accounting standards and prescribed requirements. Details of the management and audit certification dates for all HHSs financial statements are included in Appendix B.

Timeliness and quality of financial statements

Timeliness

There was an overall improvement in the timeliness of the financial statements with 12 HHSs (four in 2013–14) meeting their agreed timeframe for having a complete set of financial statements ready for audit. We provided the audit opinions for all HHS's financial statements by the 31 August legislative timeframe.

Figure 2A
Milestones achieved by HHSs over three years

Milestone	Number of HHSs achieving milestone		
	2012–13	2013–14	2014–15
Final draft of financial statements provided for audit by the agreed date	10	4	12
Financial statements certified by management by agreed date	5	16	10
Audit opinion by 31 August*	17	17	16

* Two HHSs abolished at 30 June 2014, one new HHS established on 1 July 2014

Source: Queensland Audit Office

Investing time before 30 June to prepare 'pro forma' financial statement disclosures and have them agreed upon with audit teams reduces the effort required after year end to complete the final draft of the financial statements. By receiving and reviewing 'pro forma' statements we identified a number of disclosures that could either be eliminated or simplified, hence reducing the extent of disclosures included in the final draft financial statements.

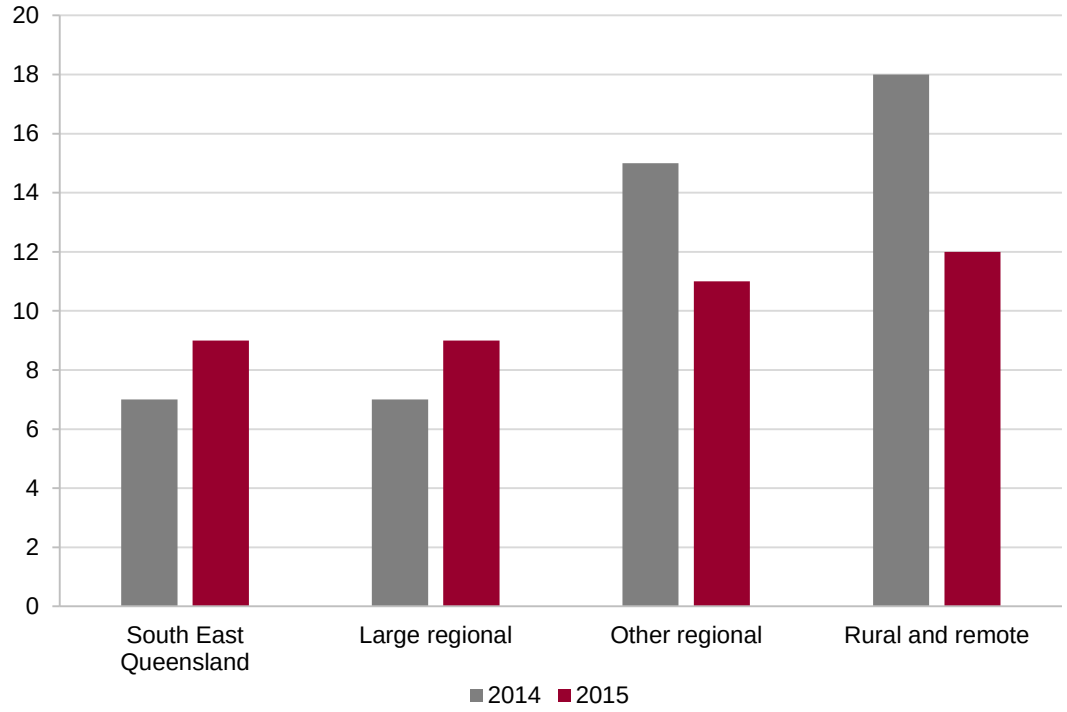
Quality

Even if HHSs provide financial statements for audit on time, unless the statements are of sufficient quality, the process to finalise the audit of the statements will not be efficient. Before audit review, the final draft statements should be quality checked to ensure they are complete, in accordance with management's understanding of operations for the year and comply with accounting and legislative requirements.

Ideally, each HHS would only prepare one set of financial statements and the audit of these statements would not result in any changes. No HHSs achieved this in 2014–15.

Overall HHSs did reduce the number of versions of financial statements from the prior year from 47 to 41. Figure 2B shows that movement in the number of versions of financial statements over the last two financial years.

Figure 2B
Number of versions of financial statements for each HHS category over two years



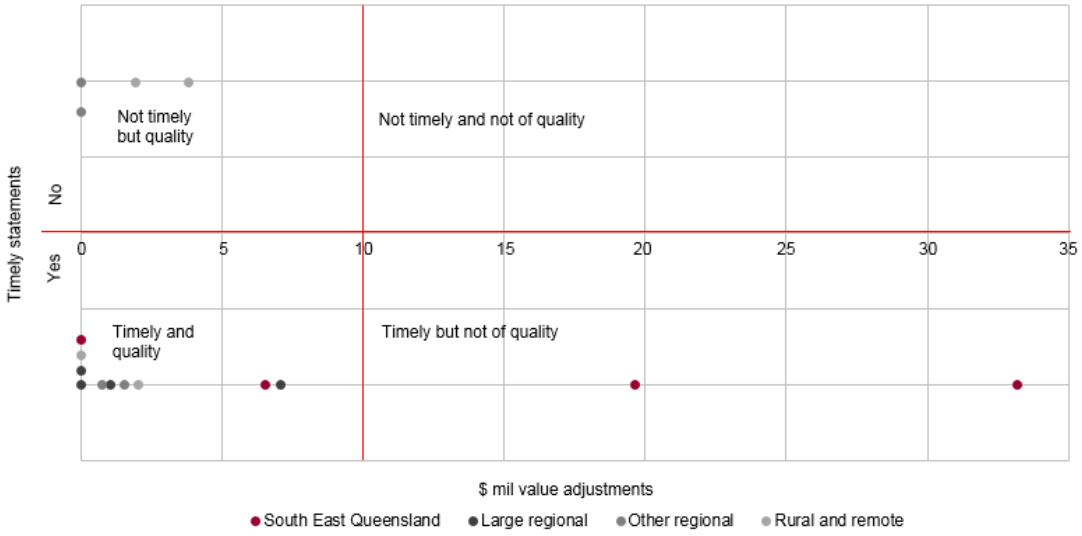
Source: Queensland Audit Office

In general, the south–east and large regional HHSs had the least number of versions, which reflects the stability and experience of financial staff in these locations. These regions however produced more versions, compared to last year, because we identified errors that required adjustment to the financial statements. There is notable improvement in the reduced number of statement versions at other regional, and rural and remote HHSs.

Of the 12 HHSs that met their agreed timeframes to provide complete financial statements for audit, five required no adjustments to the financial results, which is a good outcome. For those HHSs that did require adjustments, these were principally due to asset recognition or asset valuation errors. This indicates that some HHSs still need to improve the early resolution of year end asset recognition and valuation processes to avoid potential delays in the finalisation of their statements. HHSs should engage with audit teams early to resolve these types of issues before providing draft statements for audit.

Figure 2C shows the correlation between the timely provision of draft statements for audit and the value of adjustments required.

Figure 2C
Timeliness and quality of financial statements by HHS category in 2014–15



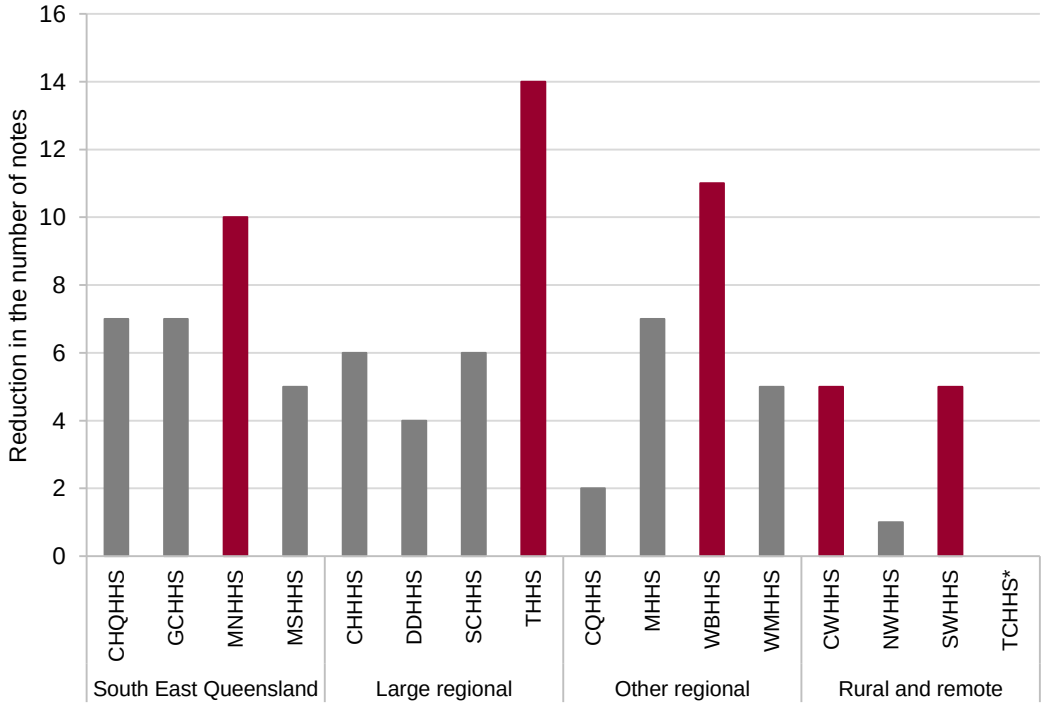
Source: Queensland Audit Office

Simplified financial statements

There is a growing movement in the accounting profession to simplify financial statements to increase their usefulness for readers. This year, we worked closely with the HHSs to streamline their statements so they focused on the things that matter.

All HHSs reduced the size of their financial statements with an average decrease of 18 per cent in the number of note disclosures compared to the prior year. They achieved this reduction despite the requirement to include an additional disclosure for AASB 1055 *Budgetary Reporting* for the first time in 2014–15. Seven HHSs also disclosed an additional note describing their interest in primary health networks.

Figure 2D
Reduction in the number of notes disclosed by HHS from 2013–14 to 2014–15



* First year of operation therefore no reduction in notes.

Source: Queensland Audit Office

The emphasis will now be on challenging the presentation and format of statements, as well as rewriting notes to make the statements succinct and readable.

Future considerations include:

- materiality and relevance of disclosures by placing the most relevant information for the reader up front
- grouping relevant accounting policies, explanations of estimates and judgements within each quantitative note to provide all key information in one place
- including a summary of key performance measures that correlate to the financial results
- using plain language to improve reader understanding.

Implementation of AASB 1055

AASB 1055 *Budgetary Reporting* became effective from reporting periods beginning on or after 1 July 2014. Under this accounting standard, HHSs must compare their actual results against their original budget. The standard prescribes the original budget as that published in the service delivery statement (SDS), which forms part of the Queensland Budget. HHSs must explain material variances in the statement of comprehensive income, statement of financial position and statement of cash flows.

A variance is material where it exceeds:

- five per cent of the budgeted figure for employee expenses, supplies and services and payments for property, plant and equipment
- ten per cent of the budgeted figure for all other material line items.

While AASB 1055 requires the use of the SDS budget, HHSs typically compare their actual performance against the budget agreed with DoH under the service agreement. As the state budget cycle is earlier than that of the service agreement, HHSs needed to explain a number of material variances for situations that were unknown at the time the state budget was prepared.

To make the comparisons between budget and actual more meaningful, there would ideally be closer alignment between the service agreements and the state budget process.

The quality of AASB 1055 disclosures was adequate, but there are opportunities for HHSs to improve this disclosure in the following areas:

- Materiality—consider if a line item is material to the financial statements and require an explanation. Many HHSs included explanations for variances that were greater than 10 per cent of balances that were not material to the financial statements.
- Aggregation—consider the relationships between line items and consolidate explanations. There is a high level of correlation between the statement of comprehensive income and the statement of cash flows. Explanations that relate to variances on both statements can be included as a single comment rather than duplicated.
- Dissection—consider whether the explanation adequately explains the significant elements of the variance. Explanations should not just describe the variance but explain the underlying cause of the variance.

Financial performance and position

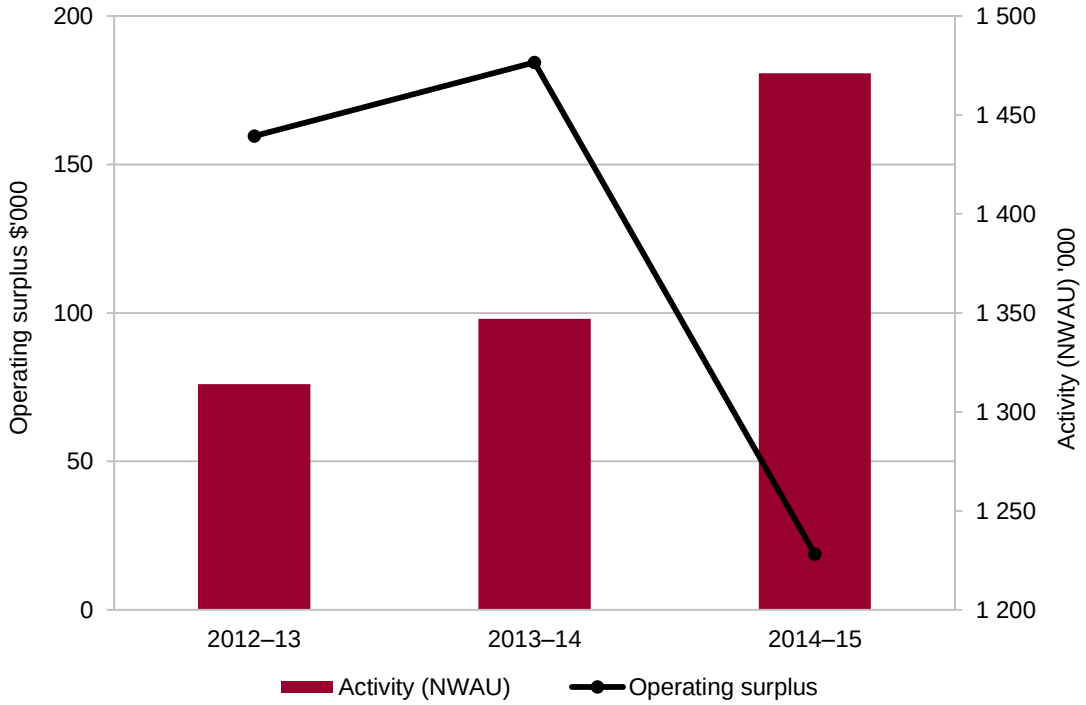
Financial performance is measured by the operating result—the difference between operating revenue and operating expense. The three-year 2014–2016 service agreements for HHSs set a target operating result that is balanced or in surplus. Amendments to service agreements in 2014–15 allowed for HHS to agree with DoH to make an operating deficit. This enabled HHSs to spend surplus monies built up in prior years to deliver additional health related services this year.

Operating results

The HHS sector achieved a combined operating result of $18.78 million ($184.38 million in 2013–14). Total revenues were $11.07 billion ($10.25 billion in 2013–14) and expenses of $11.05 billion ($10.06 billion in 2013–14). Total expenses grew by 9.8 per cent, faster than revenue, which increased by 8.0 per cent compared to 2013–14.

The decrease in operating surplus is because prior year surpluses were used to deliver additional activity and because some asset values needed to be written down. Figure 2E shows that operating surplus has declined and activity delivered by the sector (measured in national weighted activity units) has increased significantly over the past three years.

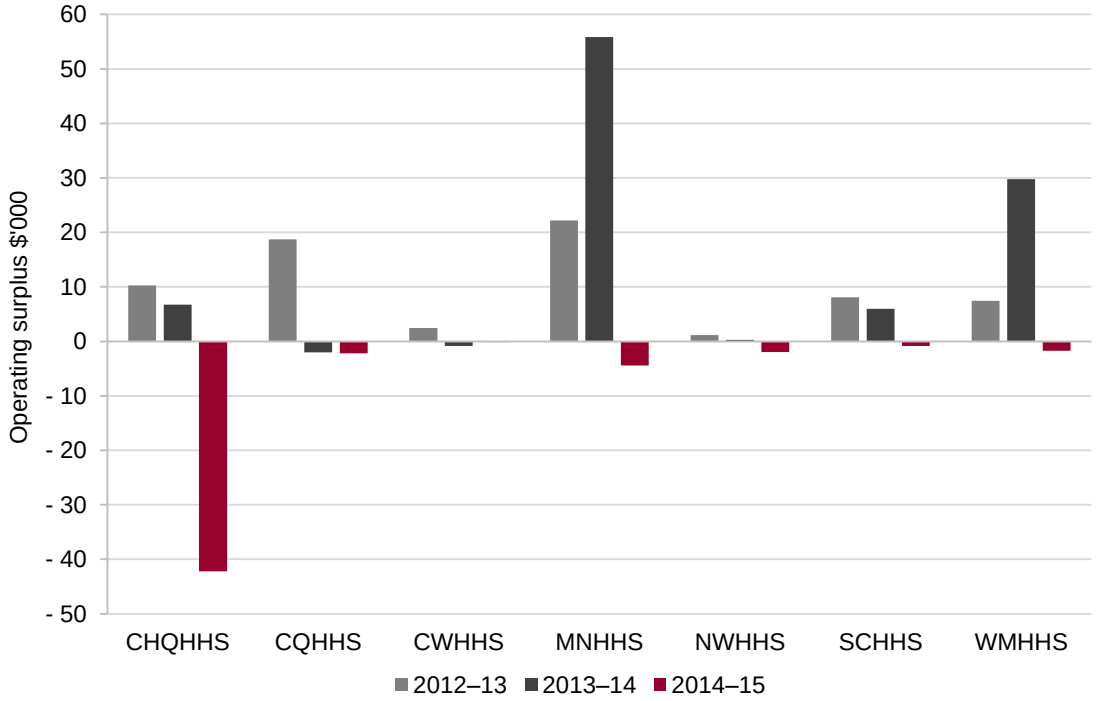
Figure 2E
Operating surplus for the HHS sector over the last three financial years



Source: Queensland Audit Office

Figure 2F shows the seven HHSs that reported operating deficits, with Children's Health Queensland (CHQ) reporting the largest deficit of $42.2 million. However, this deficit arose mainly because of the write down of $35.1 million in the book values of buildings on the former Royal Children's Hospital (RCH) site, and was outside the direct control of the HHS. The write down reflects the 'value in use' remaining at the RCH site that was forgone by the state when the CHQ moved to the new Lady Cilento Children's Hospital.

Figure 2F
HHSs with operating deficits in 2014-15



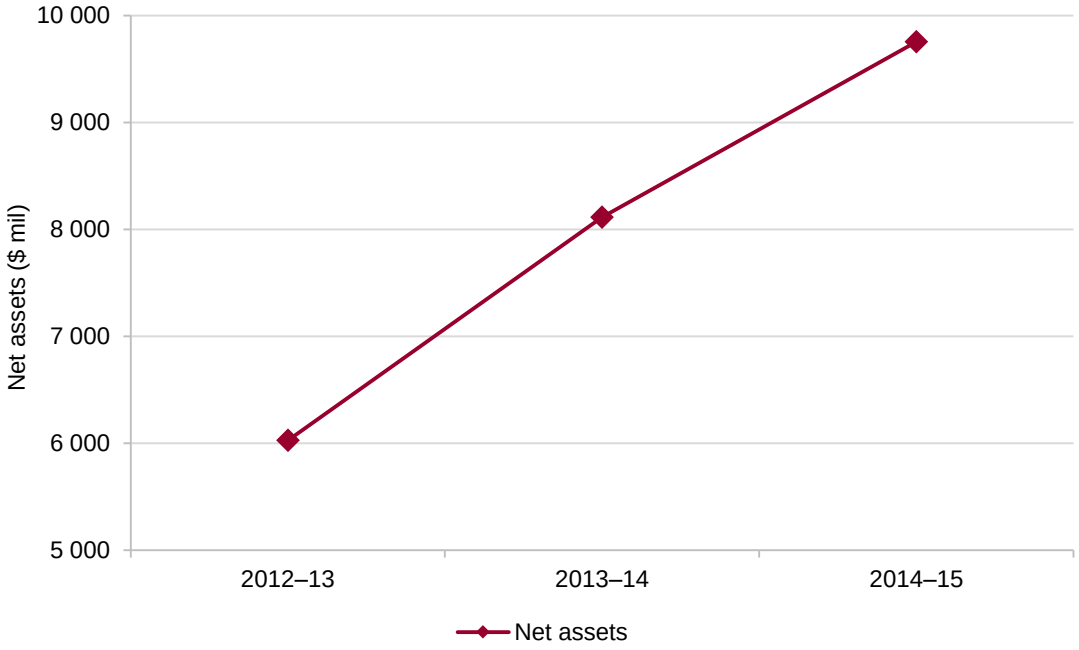
Source: Queensland Audit Office

Financial position

We measure the financial position of HHSs by reference to their net assets, the difference between total assets and liabilities. Over time, the financial position can indicate whether financial health is improving or deteriorating. A growing positive net asset position indicates that a HHS will have greater capacity to meet an increase in future service demands. All HHSs have strong net assets positions and have no long-term liabilities. Details of total assets and liabilities for each HHS are included in Appendix C.

Figure 2G shows the growth in net assets for the sector since 2012–13. As at 30 June 2015, the combined net asset position of HHSs totalled $9.75 billion, increasing by $1.64 billion (20.2 per cent) compared to the prior year.

Figure 2G
Net assets for the HHS sector over the last three financial years



Source: Queensland Audit Office

The growth in net assets is primarily due to the contribution of infrastructure assets from DoH. DoH is responsible for funding and constructing all major infrastructure projects. The Department transfers assets, in the form of land and buildings, to HHSs at no cost once they are completed and ready for use. HHSs are responsible for the ongoing maintenance of these assets upon transfer.

Significant assets transferred to the HHSs in 2014–15 included:

- Children's Health Queensland HHS—Lady Cilento Children's Hospital $1.28 billion
- Townsville HHS—Townsville Hospital Redevelopment $167.6 million
- Central Queensland HHS—Rockhampton Hospital Redevelopment $149.0 million
- Metro South HHS—Logan Hospital Emergency Department $115.0 million.

Financial sustainability indicators

Financial sustainability examines the HHSs ability to meet current and future expenditures as they arise and the capacity to absorb foreseeable changes and emerging risks.

Three financial sustainability ratios were calculated using information from the financial statements of the HHSs. We have not assessed whether HHSs generate adequate funding to cover long-term debt and to replace assets, as no HHS has any long-term borrowings. DoH manages the construction of major infrastructure assets and transfers them to HHSs at no cost. DoH provides HHSs funding for asset maintenance and depreciation.

Appendix C details the ratios for all HHSs.

Current ratio

The current ratio measures the ability to pay existing short-term liabilities with current liquid assets (cash, inventories and receivables). A ratio of one or more indicates that a HHS has sufficient liquid assets to meet its short-term liabilities as they fall due.

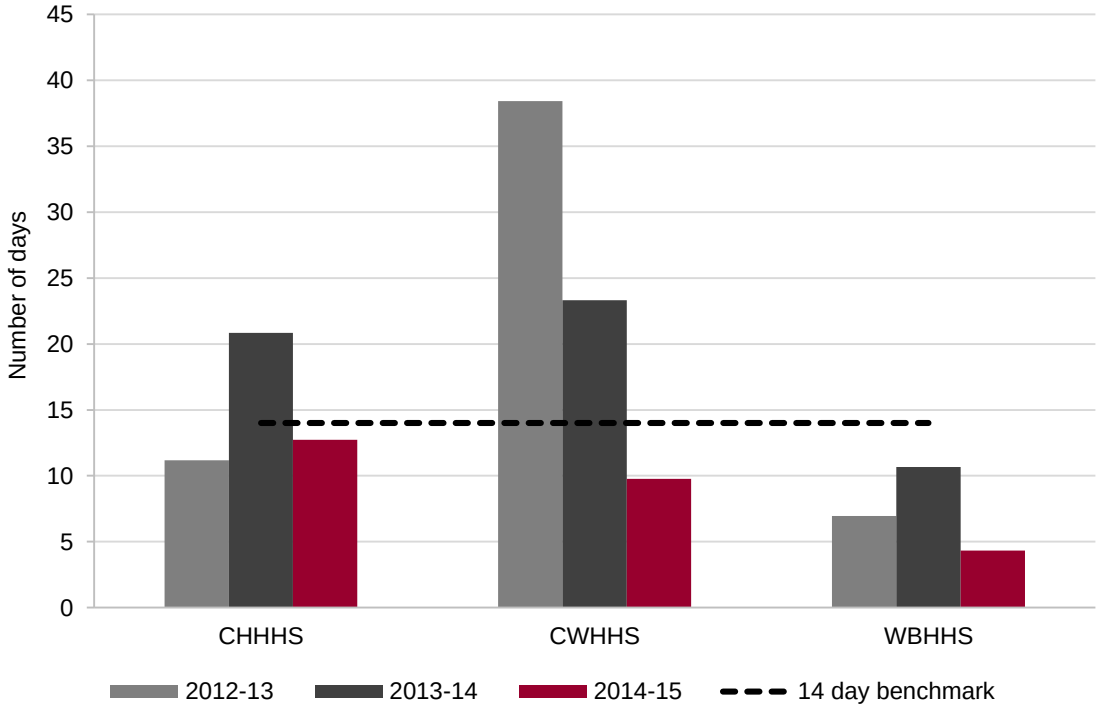
All HHSs, except for Central West HHS, have a current ratio of one or more. The current ratio for Central West HHS is slightly below one at 0.96. This does not necessarily indicate that the HHS is unable to meet its debts. The timing of cash in-flows from DoH with the cash outflows for expense affects the ratio, which measures liquidity at a point in time. Central West HHS has an established financial management reporting process that monitors and forecasts financial performance. This process enables the HHS to manage its resources so that it is able to meet its ongoing financial and service obligations.

Number of days cash available

Each HHS is responsible for its own cash management. Dependency on the fortnightly funding payments from DoH affects the HHS's ability to manage cash prudently. This is because a HHS is heavily reliant on this funding to deliver its activities. DoH benchmarks require a HHS to have unrestricted cash holdings equivalent to 14 days to cover their cash outflows.

Most HHSs had unrestricted cash holdings equivalent to or in excess of 14 days as at 30 June 2015 with the exception of Wide Bay, Cairns and Hinterland and Central West HHSs. Figure 2H shows the cash available days for these three HHSs since their establishment.

Figure 2H
Cash available (days) by HHS



Source: Queensland Audit Office

Not meeting the cash availability benchmark in any one single year is not a significant cause for concern. However, Wide Bay HHS has been consistently below the benchmark for the last three years. Wide Bay management needs to exercise greater discipline and visibility of cash flow forecasts for a forward period of at least twelve months. DoH is also monitoring the cash availability concerns at the HHS.

Operating surplus ratio

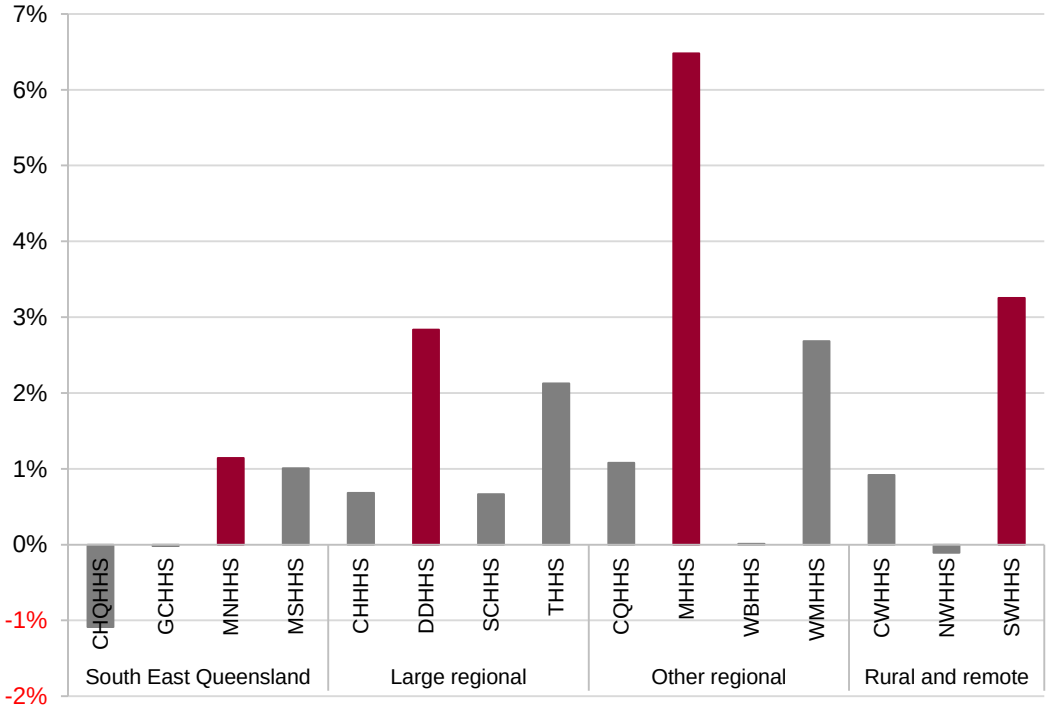
The operating surplus ratio is an indicator of the extent to which revenue covers operational expenses or is available for capital funding purposes. A positive ratio indicates the HHS is able to cover operational expenses and generate savings to help fund additional activity or proposed capital expenditure on plant and equipment and minor building refurbishments.

The operating surplus ratio is a long-term indicator, so we use the average ratio over the last three years when considering the HHS's overall financial sustainability risk rather than using the 2014–15 results in isolation.

Minor deficits are not a concern in the short term but HHSs need to break-even over the long term to be financially sustainable. Continually running operating deficits makes it difficult for HHSs to generate sufficient funds to maintain service levels and renew essential assets.

The three-year average demonstrates all HHSs, except Children's Health Queensland, are performing well with positive or neutral ratios. While negative, the Children's Health Queensland result is not cause for concern, as this is an outcome of the $35.1 million write down in the value of the former Royal Children's Hospital at Herston, which has distorted the three-year average.

Figure 2I
Operating surplus ratio—three-year average



Note: Ratio not calculated for TCHHS due to first year of operation.

Source: Queensland Audit Office

HHS sustainability modelling

Healthcare is the largest area of the state spend, representing 27.6 per cent of the Queensland Government's 2014–15 Budget increasing to 28.5 per cent of the Budget in 2015–16. The financial sustainability of the sector is dependent on the ability of HHSs to plan in the short, medium and long-term, and manage financial risks while delivering the expected level of activity to their communities.

In an environment where health spending is growing faster than the consumer price index and government revenues are declining, HHSs must make optimal asset management decisions without compromising their service delivery model and level of service provided.

Debt may be a viable option for financing asset renewal or replacement in the future. However, current Queensland legislation prohibits HHSs from borrowing. Before considering debt as a funding option, HHSs would need to demonstrate a capacity to repay borrowings without any adverse financial or operational impact on their business. To achieve this, they need to develop a financial sustainability framework with the ability to forecast revenues and expenses over the long term.

Queensland Treasury Corporation (QTC) is developing a forecasting model for HHSs. The objectives of the model are to:

- develop robust 'bottom-up' revenue forecasts derived from expected activity levels
- improve long-term planning by understanding financial implications of strategic decisions
- improve the ability to conduct scenario analysis in a complex and dynamic funding and policy environment
- understand the financial sustainability impact of asset management plans.

QTC developed the model in conjunction with Gold Coast HHS, which is being trialled by eight HHSs. It will be subsequently rolled out to interested parties from December 2015. QTC expects that this model will assist in informing or providing greater clarity and uniformity around what a financial sustainability framework may look like for the HHS sector.

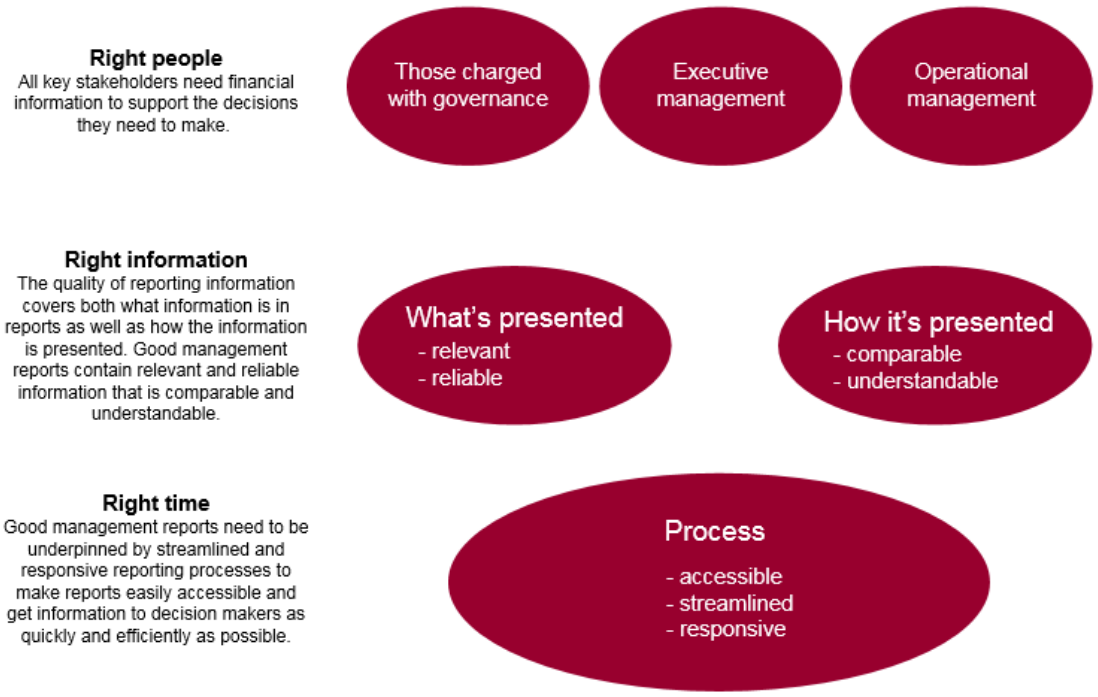
Key audit matters

Internal management reporting

Sound internal financial reporting is essential to the efficient and effective management of an entity. Internal financial management reports (IFMR) provide managers with reliable, regular information on how the entity is performing which supports good decision-making.

Good management reporting is about getting the right information to the right people at the right time to allow managers to manage their business effectively. These three principles for good management reporting are summarised in Figure 2J below.

Figure 2J
Principles of management reporting



Source: Queensland Audit Office

Our objective was to assess the effectiveness of IFMR at HHSs against the three principles for good management reporting.

We considered the application of these principles and reporting practices across three tiers of management at each HHS. The three tiers reflect that users at different levels have different information needs due to the different types of decisions they make and their assigned responsibilities. Figure 2K summarises the responsibilities and needs for the three tiers of users.

Figure 2K
Internal reporting—tiers of users

Level	Responsible for	Information needs	Examples
Tier 1 HHS Board	Setting strategic direction, including program and service delivery. Fiduciary accountability.	Is the HHS doing the right things, doing them well and achieving its objectives?	▪ HHS financial position and performance. ▪ Performance by service streams, facilities or divisions. ▪ Strategic and service agreement key performance indicators (KPIs). ▪ Accrual based accounting.
Tier 2 Executive Management Team	Delivering services and programs.	Are services and functions delivered efficiently and economically in accordance with HHS objectives?	▪ Performance by service or divisions. ▪ Breakdown by project or activity. ▪ Service agreement KPIs. ▪ Accrual based accounting.
Tier 3 Service / Divisional Management Team	Implementing projects and activities.	Are projects and activities meeting budgets and targets?	▪ Budget to actual financial performance. ▪ Operational KPIs. ▪ Accrual based accounting.

Source: Queensland Audit Office

We scored each HHS against the three principles of IFMR to arrive at an overall capability maturity assessment of between one and five. Figure 2L describes the assessment scores.

Figure 2L
Internal financial management reporting—maturity assessment

Score	Criteria
5 – Optimised	The HHS has in place internal financial reporting practices that are leading edge. These allow it to anticipate both changing user needs and key opportunities in order to optimise performance.
4 – Integrated	The HHS has in place professional internal financial reporting practices that enable effective response to changing user needs and identify some opportunities to improve performance.
3 – Established	The HHS has in place internal financial reporting practices that meet day-to-day requirements and enable it to respond adequately to changing user needs.
2 – Developing	The HHS has in place internal financial reporting practices that are adequate to meet the day-to-day requirements of the business under stable conditions and enable it to develop. They will not be sufficient in challenging times.
1 – Basic	The HHS has in place internal financial reporting practices that are basic and allow it to function on a day-to-day basis. They do not support development.

Optimised Source: Queensland Audit Office, developed in reference to: 'Financial Management Maturity Model', National Audit Office, January 2010, United Kingdom; and the Portfolio, Programme, and Project Management Maturity Model (P3M3) 'P3M3 Maturity Model' (www.axelos.com)

Fifteen HHSs have established internal financial management reporting practices that meet their day-to-day requirements and allow them to respond to changes in user needs (maturity assessment score of 3). One HHS, Torres and Cape, is in the developing phase (maturity assessment score of 2). This is largely due to the organisational change resulting from the amalgamation of two former HHSs.

Right people

The structure of the IFMR function varies depending on the size and complexity of the HHS. Most HHSs had a decentralised structure with a central corporate finance team responsible for preparing Tier 1 and Tier 2 reports and service or divisional business teams responsible for Tier 3 reports.

We found users and preparers of reports were clear about financial management roles and responsibilities. Financial management practice manuals (FMPMs), board and committee terms of reference and charters, and other guidance material defines the internal financial reporting frameworks.

We also found that management reports aligned with organisational structure and service delivery structure. Preparers consult with users on whether management reports meet their needs on an informal ad-hoc basis, and feedback is actioned.

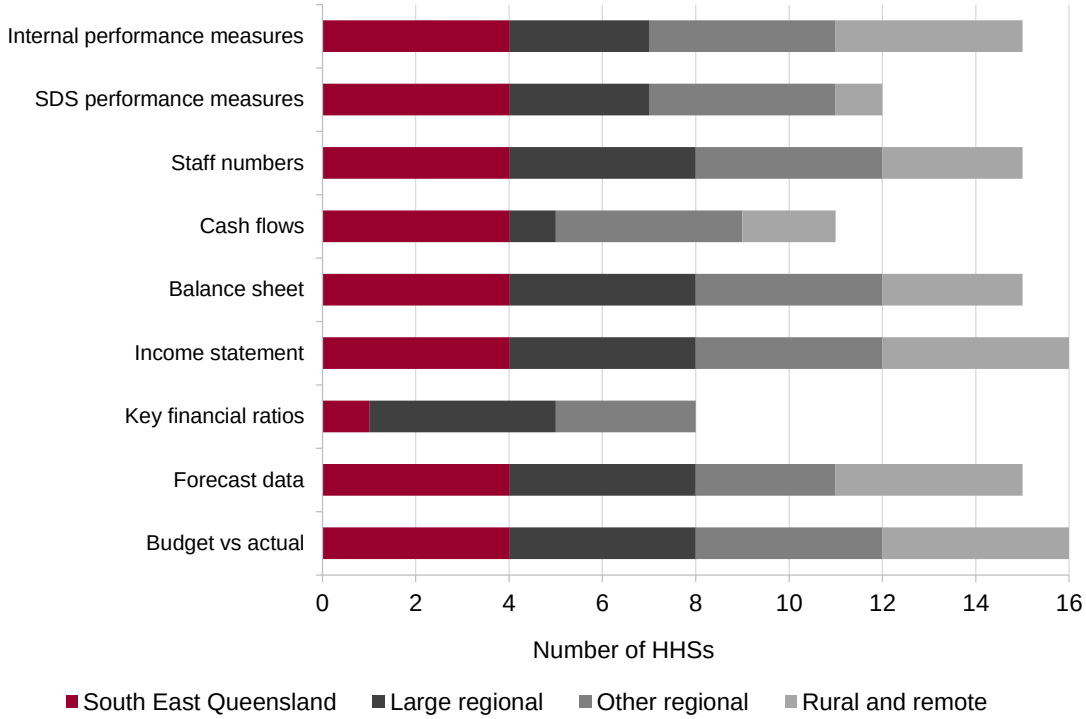
All HHSs had the following best practice in place:

- strong working relationships between preparers and users
- tailored reports to support time-critical decisions.

Right information

All HHSs prepare reports using full accrual information across all tiers of management. Management reports typically include financial information associated with revenue, expense, assets and liabilities, with actual results measured against budgets, prior year information or forecasts. Non-financial information supplement these reports providing users with a universal view of the achievements of the HHS against strategic and operational objectives. Figure 2M benchmarks the level of financial and non-financial information provided to HHS boards.

Figure 2M
Financial and non-financial information provided to HHS boards on a monthly basis



Source: Queensland Audit Office

Opportunities exist for rural and remote HHS to report additional information in relation to the cash flows, SDS financial and non-financial measures and financial ratios.

The reports we reviewed showed some variability in the format, level of detail and depth of reports at all tiers of management. Where reports did not contain much commentary, users relied on verbal commentary from the preparer of the report. Narrative analysis, where provided, was mainly retrospective (identifying the cause), with some perspective (impact/actions required in the short term) and prospective (impact to year end forecast and emerging issues or trends) analysis.

Training or guidance on understanding the management reports and financial management roles and responsibilities is largely ad hoc and informal, and conducted by finance officers as needed.

We identified the following examples of best practice at some HHSs:

- internal financial management reports that are consistent with the format and accounting concepts used in annual statutory financial statements
- integration of financial and non-financial measures, with internal benchmarking across services or divisions
- strong commentary within the management report that provided retrospective, perspective and prospective analysis of financial and non-financial measures
- induction program and company director training for HHS board members.

Right time

All HHSs provide management reports on a monthly basis to all tiers, based on the previous month cut-off. The turnaround time for management reports reflects the level of automation, degree of efficiency, depth of analysis and quality review processes in place. In general, we saw some degree of automation and use of business intelligence tools, however, the process of preparing management required manual intervention to consolidate information from different systems.

We identified the reports at some HHSs reflected the latest financial and non-financial information available.

Improvement opportunities

We made a number of recommendations to HHSs to increase their level of capability maturity in IFMR. Common themes for HHSs include:

- Establishing an overarching financial reporting framework that covers all three tiers of management. The reporting framework should identify the nature and description of financial reporting including financial and non-financial data required to assess performance, users of such reports, timing, and responsibilities for preparation and review.
- Providing opportunities for formal feedback from report users. Given sufficient time, users can consider the content and presentation of their reports and the timing and method of communication. Different methods for facilitating formal feedback include annual surveys, workshops and annual agenda items at board or committee meetings.
- Providing more non-financial performance information to enable Tier 1 and 2 users to consider their financial results in the context of their achievement of the HHS strategic and operational objectives. Consider opportunities for external benchmarking to peer HHSs in Queensland and other Australian jurisdictions.
- Including comprehensive retrospective, prospective and perspective comments to support financial and non-financial results.
- Assessing users' and preparers' training needs and implementing a formal training program to address them.

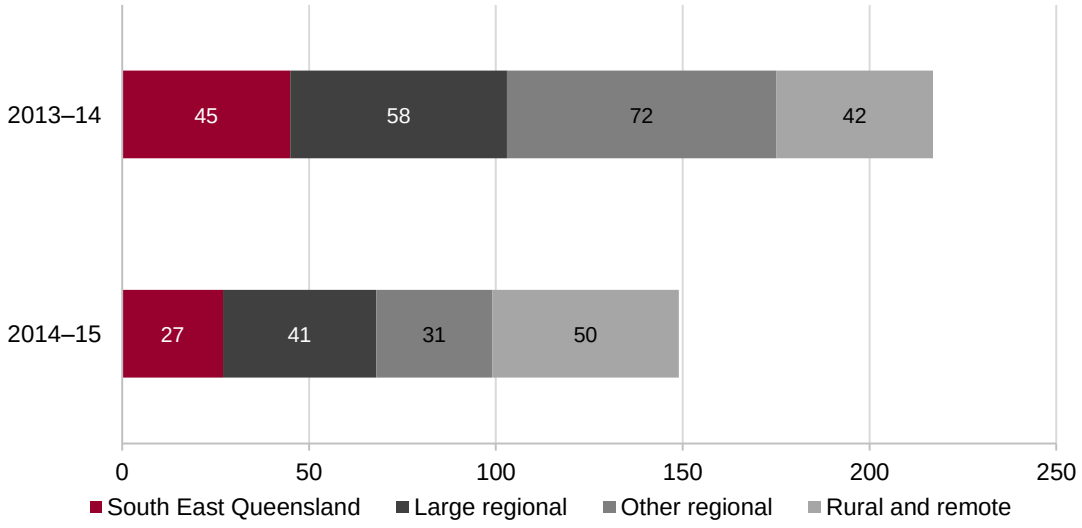
Audit financial control and reporting issues raised

When we identify weaknesses in controls or financial reporting issues, we report those to management with recommendations to address the identified concerns.

During 2014–15, we reported 149 issues to the 16 HHSs compared to 236 issues reported to the 17 HHSs in the prior year. This represents a significant reduction of 37 per cent, which we attribute to the ongoing improvement in controls and processes as the HHSs continue to mature—this being their third full year of operation.

Figure 2N shows the number of issues raised for each HHS category over two years.

Figure 2N
Audit issues by HHS category over the last two financial years



Source: Queensland Audit Office

In previous years, we classified audit issues as either high, moderate or low risk or as business improvement opportunities. This year we revised the classification of our issues to align these with the requirements of the Australian Auditing Standards. The revised categories are: material deficiency; significant deficiency; deficiency or other matter.

This change in classification makes it difficult to compare the number of issues by significance between the years. Consequently, we have only made comparisons based on the number of issues raised. Appendix C details the number of issues raised per HHS.

One issue that exists at all of the HHSs is the absence of a service level agreement between each of the HHSs and DoH as their shared service provider. The absence of such an agreement can result in:

- ambiguity and gaps in the internal control framework
- increasing the risk of error or fraud
- untimely identification and resolution of errors
- implementing of non-standard processes that may increase the cost of services.

We raised this issue in last year's report to Parliament *Results of audit: Hospital and Health Service entities 2013–14* (Report 5: 2014–15). DoH and the HHSs are continuing to work towards establishing an appropriate service level agreement.

Other audit issues raised that were common across many of the HHSs include:

- internal management report (refer section above in this Chapter)
- activity based funding coding and counting (refer Chapter 3)
- contract procurement (refer Chapter 4).

Recommendation

1. We recommend that the Hospital and Health Services in conjunction with the Department of Health formalise their shared service arrangements by documenting appropriate service level agreements.

3. Revenue management

In brief

The demand for and the costs associated with providing Hospital and Health Services (HHSs) continue to rise. To assist in meeting these increasing costs, HHSs need to maximise the revenue streams available to them.

Conclusions

Current controls over the integrity of activity based funding data submitted to the Australian Government are not robust. As a result, the state may not be obtaining funding for all the services it is delivering.

The opportunity for HHSs to obtain additional Commonwealth funding by increasing their level of activity will end on 1 July 2017, when the funding model changes to one based on population growth.

Findings

- All but one HHS had a program of internal reviews of coding accuracy, but only three received independent assurance through an external program.
- HHSs certify an annual reconciliation of costing data to the general ledger.
- Most HHSs have been successful in securing additional Australian Government funding for the growth in their publicly delivered health services.
- The Department of Health estimates changes to the funding method from the Australian Government will mean reduced future funding to Queensland of $11.8 billion over the period 2017–18 to 2024–25.

Recommendations

2. We recommend that the Hospital and Health Services, in conjunction with the Department of Health, implement an overall framework that outlines how they obtain assurance over the completeness and accuracy of the data that drives activity based funding.

Background

In 2014–15, Hospital and Health Services (HHSs) received income totalling $11.073 billion, an increase of $988 million over the previous year. Of this amount, they received $10.156 billion from the Australian and Queensland Governments for the provision of hospital and health services.

The demand for, and the costs associated with, providing hospital and health services continue to rise. To assist in meeting these increasing costs, HHSs need to maximise the revenue streams available to them.

The majority of their government funding is based on of activity based funding (ABF). To maximise this revenue, HHSs need to ensure the integrity of ABF data, which is dependent on the accurate coding, counting and costing of hospital activity. HHSs are continuing to look at how they can maximise their other revenue streams.

Conclusions

While the state has implemented some controls to assure the integrity of ABF data submitted to the Australian Government, these controls are not robust, meaning the state may not be obtaining funding for all the services they are delivering.

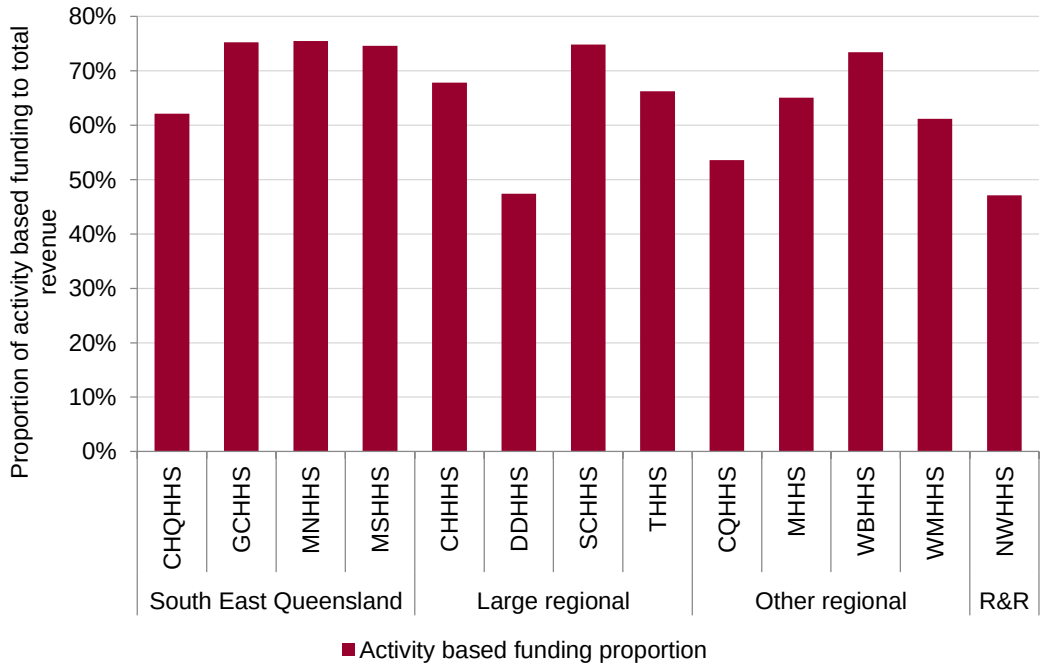
The opportunity for HHSs to obtain additional Commonwealth funding by increasing their level of activity will end on 1 July 2017, when the funding model changes to one based on population growth.

Activity based funding

The funding basis for most public hospital services is the level of hospital activity through a payment system called activity based funding (ABF). Thirteen of the 16 HHSs receive ABF (across 34 hospitals) with the remaining three HHSs (Central West, South West, Torres and Cape) being solely block funded with no direct link to the level of activity delivered.

The proportion of ABF to total revenue for those 13 HHSs varied from 47 per cent to 75 per cent in 2014–15 as shown in Figure 3A.

Figure 3A
Proportion of activity based funding to total revenue for selected HHSs in 2014–15



Source: Hospital and Health Services

The Independent Hospital Pricing Authority (IHPA) assesses each public hospital service for its clinical complexity. The average hospital service is worth one weighted activity unit (WAU). More intensive and expensive activities are worth multiple WAUs, the simpler and less expensive are worth fractions of a WAU. IHPA (an Australian Government body) determines a fixed national efficient price (NEP), which represents the average cost for a WAU across all Australian hospitals. The Australian Government contribution to most public hospital services is the number of WAUs multiplied by the NEP.

Providing the right amount of ABF depends on accurately coded, counted and costed activity data. Under the *National Health Reform Agreement 2011* the state is responsible for the data within their systems and to establish appropriate independent oversight mechanisms for data integrity. These obligations are to provide certainty to the Australian public about the actual performance of hospitals. The *Hospital and Health Boards Act 2011* gives the Department of Health (DoH) the responsibility to 'receive and validate performance data and other data' provided by HHSs.

We examined what controls were in place at HHSs and DoH to meet these responsibilities in the ABF context. DoH and the HHSs have not documented an overall framework that outlines how they obtain assurance over the completeness and accuracy of the data that drives ABF. Instead, they have implemented individual control activities over the areas of coding, counting and costing.

Coding

Nationally consistent coding standards exist to ensure that all health services delivered across the country are comparable. These standards cover six health service areas: inpatient; outpatient; emergency; procedures and interventions; sub-acute and non-acute, and mental health. We focused on the coding for services for inpatients, procedures and interventions and mental health as these areas comprised more than 67 per cent of WAUs delivered by HHSs in 2014–15.

We observed the following:

- Most HHSs have developed guides and instructions to help ensure accurate and consistent coding.
- Logic checks within computer systems help ensure accurate coding.
- Processes to check patient documentation with clinicians assist to provide accurate and complete coding.
- All but one HHS has a program of internal reviews of coding accuracy, but only three received independent assurance through an external program facilitated by an outside party, and a further two through a program coordinated by the statewide Health Information Management-Clinical Coding Network.
- Some HHSs perform targeted audits of patient episodes whilst others perform a random sample of all patient episodes (excluding simple episodes where the risk of error is low). In all cases, the HHSs do not take a statistically valid approach meaning they cannot project any errors identified across the remainder of the population.
- Reporting to board committees comparing actual to budget performance helps to identify trends but is rarely used to question whether coding contributes to the variances. Executive management does not often receive the results of internal coding audits.
- Eleven HHSs participate in a national health roundtable that benchmarks hospital performance and provides insights in potential coding errors.

We see opportunities to improve the efficiency and accuracy of coding processes by:

- implementing a statewide program of independent audits of coding accuracy that takes a statistically valid approach
- refining methods to clearly capture coded data at its source thereby reducing the need to retrospectively clarify items with clinicians.

The ability for coders to classify accurately the services provided depends on the completeness and quality of clinical documentation, often manually written in patient records. If HHSs do not fully capture the information required for coding, the diagnosis-related groups (DRG) allocation may be incorrect and affect the amount of funding received. Case study 1 illustrates this fact on a small scale.

Case study 1

Data analysis to identify uncoded conditions

The former Office of Data Integrity and Patient Safety within DoH performed data analysis during 2014–15 to identify episodes of care with possibly incomplete coding. They used pathology test results to identify likely cases where a patient had an uncoded metabolic disorder.

They identified over 92 000 episodes of care across Queensland between 1 July 2014 and 30 April 2015 that met their criteria. They estimated that, by adding the missing diagnosis codes, approximately 8 750 episodes may have a different DRG and $40.65 million of additional revenue may be due to HHSs (0.4 per cent of total revenue).

One HHS has reviewed 2 100 episodes in detail and identified 822 episodes (39 per cent) where the DRG required change. This resulted in an additional 1 014 WAUs worth $2.10 million being identified for the HHS (0.1 per cent of total revenue for the HHS).

Source: Department of Health, Hospital and Health Service

Audit program in Victoria

The Victorian Department of Health and Human Services undertakes an annual clinical coding audit program facilitated by an external contractor. The program uses a statistically significant sample to express a 95 per cent confidence in the findings. The rate of DRG change has been decreasing over the years of the audit program from approximately 10 per cent in 2007–08 to approximately six per cent in 2013–14. The resultant impact on funding to their hospitals each year is less than two per cent.

Counting

Counting all health services delivered allows complete reporting of WAUs and calculation of funding. Counting the amount of activity delivered requires the collection of data from various clinical systems. A medical record in electronic or paper form supports each health service activity recorded by the HHS.

We observed the following:

- Computer systems capture most activity delivered by HHSs.
- DoH performs high level validation checks of admitted and non-admitted patient data submitted by HHSs.
- DoH has commenced a project in conjunction with HHSs to improve the collection of non-admitted patient data. HHSs collectively earned an additional $2.4 million (out of a possible $2.8 million) in funding through providing improved quality data.

We see opportunities to improve the accuracy of counting processes by:

- moving activity remaining on manual systems and spreadsheets to standardised computer systems
- clarifying the process for counting outreach patient activity (refer to case study 2).

Case study 2

Counting of outreach patient activity
Medical staff from urban HHSs provide outreach services in rural and remote locations throughout Queensland. There is a lack of clarity between HHSs on who should count activity at outreach services. The 2014–15 service agreements between HHSs and DoH state that 'activity should be recorded at the HHS where the service is being provided'. This suggests the location of the service dictates who should count the activity. Five HHSs believe that, as the costs of delivering the service (in terms of salary expenses) are with the provider HHS, they should count the activity. Conversely, the other HHSs believe that the location of the service dictates who counts the service. This lack of clarity may result in services being counted twice (once at the providing HHS and once at the receiving HHS) or not at all, leading to incorrect funding being provided. We recommended that those five HHSs confirm with DoH the responsibility for counting outreach services.

Source: Queensland Audit Office

Costing

Each HHS must allocate all costs that it incurs in delivering an episode of care. Costing should include all costs for services to a patient, including direct costs (such as clinical staff salaries and clinical supplies) and indirect costs (such as administration staff salaries and administrative overheads).

Correct cost allocation is essential under ABF. If the allocation of full costs is inappropriate, assessments against published benchmarks will be incorrect. The NEP will not reflect true costs and HHSs will not receive adequate funding.

We observed the following:

- Most HHSs perform a monthly reconciliation between the costing system and the general ledger to ensure they match.
- DoH performs an annual reconciliation of the costed data to the general ledger prior to submission to IHPA, allowing for very small variances. The chief executive of the HHS certifies this reconciliation.

We see opportunities to improve the accuracy of costing processes:

- Perform benchmarking of the split between ABF and non-ABF for each cost centre. HHSs advised this is difficult due to differences between cost centres at each HHS.
- Four HHSs did not review the split between ABF and non-ABF for each cost centre on a regular basis. Performance against the average cost per weighted activity unit for ABF facilities may be over/understated without such a review.

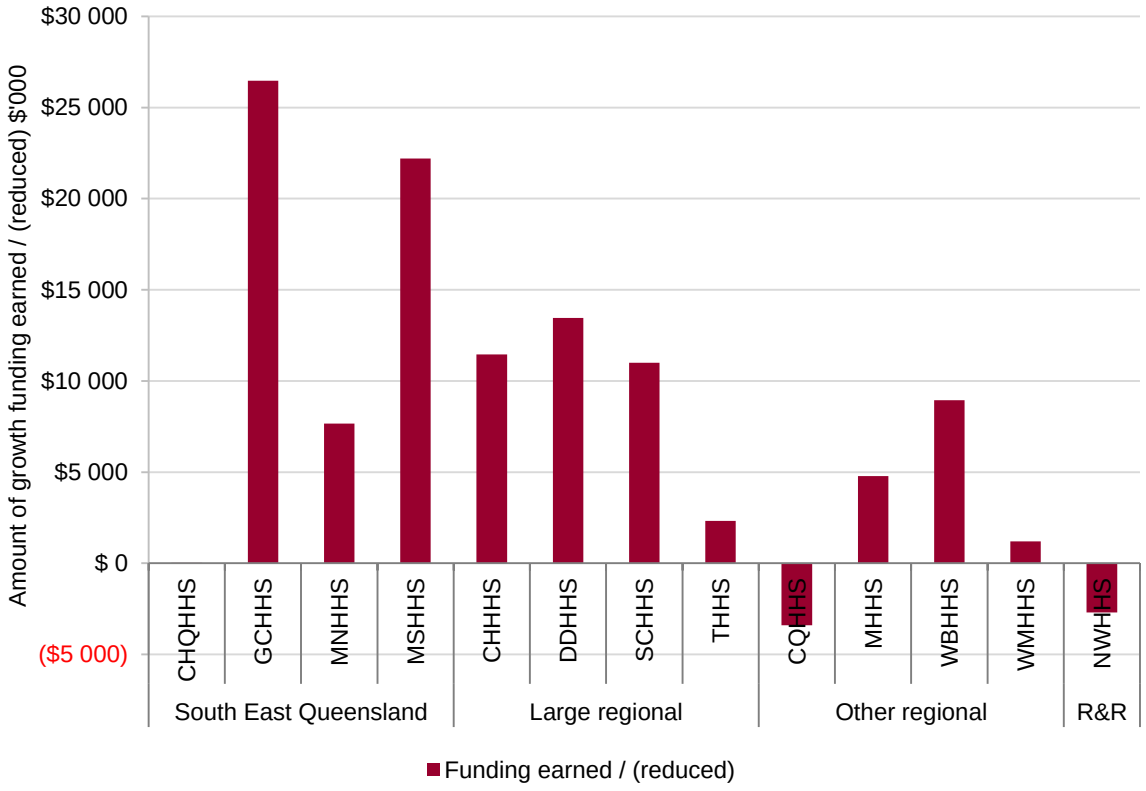
Growth funding

Since 1 July 2014, the Australian Government contributes directly to the growth in public hospital activity delivered by the state. The additional contribution is the number of additional WAUs delivered to public patients when compared to the prior year, multiplied by the NEP. The National Health Funding Administrator (NHFA) will determine during 2015–16 the final amount of funding due to the state from growth in 2014–15 activity.

DoH sets a public Queensland WAU (PQWAU) target for each HHS. DoH provides additional funding to HHSs that exceeds this target to recognise the additional Australian Government contribution. The amount of the contribution is 45 per cent of the Queensland efficient price (QEP) per additional PQWAU delivered above target. HHSs must meet any additional costs from delivering higher activity from their existing funding allocation. Conversely, HHSs have their funding reduced by the same measure where they do not achieve the target.

Figure 3B shows the amount of growth funding DoH estimates HHSs will have earned or had reduced in 2014–15. Two HHSs (CQHHS and NWHHS) did not exceed their activity target. The opening of the Lady Cilento Children's Hospital affected the performance of Children's Health Queensland (CHQHHS). Total net growth funding across all HHSs is $103.4 million.

Figure 3B
Estimate of growth funding earned by HHSs in 2014–15



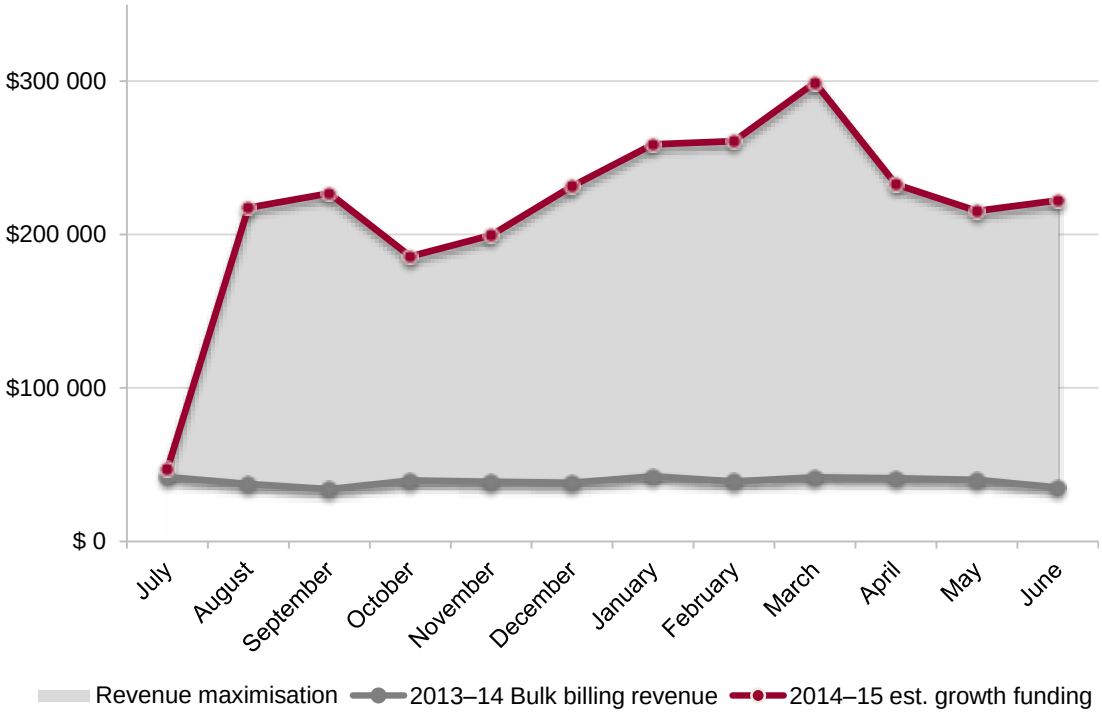
Source: Department of Health

The growth funding is generally attributable to increases in demand for services, but the manner by which HHSs offer these services may also contribute. Under the current arrangements, certain services attract a higher level of funding when delivered as public inpatient service, as opposed to a bulk billed outpatient service.

A number of HHSs sought to maximise their revenue by altering the way they deliver services. Four HHSs converted bulk billed outpatient services to public inpatient services, with chemotherapy being the most common service converted. The HHSs advised that the impact for patients in terms of this conversion was limited and in most cases simply required the completion of a different administration form.

Figure 3C shows the estimated revenue increase for one HHS through converting chemotherapy services to inpatients in 2014–15. Over the 12 months, the HHS received an additional $2.1 million in funding whilst treating a similar number of patients (2015: 7 382 and 2014: 7 225). The estimated growth funding this year is approximately $352 per hospital departure, compared to $65 per departure in 2013–14.

Figure 3C
Revenue growth through conversion of patients for one HHS in 2014–15



Source: Queensland Audit Office

Data matching by the National Health Funding Administrator

The NHFA is currently working collaboratively with states and territories to identify an appropriate means for enforcing clauses A6 and A7 of the National Health Reform Agreement (the agreement). These clauses preclude Australian Government funding for public hospital services where the Australian Government already funds a service (or component of a service) under the Medicare Benefits Schedule (MBS) and/or the Pharmaceutical Benefits Schedule (PBS).

Under the proof of concept method currently being trialled, the Australian Government's Department of Human Services matches public hospital activity data against Medicare patient records. Where a match occurs, the department provides the relevant state or territory with the record for further analysis and validation.

Should this project by the NHFA proceed, it may result in HHSs reimbursing the Commonwealth for any services funded under the agreement and claimed under either the MBS or PBS.

Future Australian Government funding changes

Until 30 June 2017, the Australian Government will continue to provide growth funding to the states for increases in health service activity. After this date, the Australian Government will index its funding contribution for public hospitals by the consumer price index and population growth.

The Australian Government Treasury estimated in the 2014–15 Budget that this change would result in a reduction in future Australian Government public hospital funding over the period 2017–18 to 2024–25 of $57 billion across Australia. This would rise from $1 billion in 2017–18 to $15 billion in 2024–25.

DoH estimates that based on Queensland's share of the Australian population (per Australian Bureau of Statistics population projections), Queensland's future funding will be lower by $11.8 billion over the period 2017–18 to 2024–25. The state will need to cover any shortfall between Commonwealth funding levels and the costs of services.

Audit of the National Health Funding Pool

The Queensland and Australian Governments primarily fund the activities of HHSs. ABF is pooled and allocated through a state pool bank account which is part of the National Health Funding Pool. The pool account received ABF of $2.60 billion (2014: $2.38 billion) from the Australian Government and $5.15 billion (2014: $4.77 billion) from the Queensland Government during 2014–15.

The state also maintains a separate state managed fund to manage Queensland and Australian Government contributions and payments for block funding. The Australian Government also contributes funding for various public health programs including essential vaccines, child health and youth services.

Each financial year, the administrator of the National Health Funding Pool prepares special purpose financial statements for each state pool account for audit by each respective state and territory Auditor-General. These statements detail the receipts into and payments from the state pool account. We issued an unqualified opinion on the 2014–15 statements with an emphasis of matter drawing attention to the special purpose basis of accounting (the same opinion issued in 2013–14).

Recommendation

2. We recommend that the Hospital and Health Services, in conjunction with the Department of Health, implement an overall framework to provide assurance over the completeness and accuracy of the data that drives ABF.

4. Cost management

In brief

In 2014–15, Hospital and Health Services (HHSs) expenses increased by more than 11 per cent over the previous year. The demand for hospital and health services and the costs of providing these services continue to rise. HHSs need to manage their costs effectively to maximise their limited available resources.

Conclusions

Queensland hospitals continue to be amongst the most efficient in Australia when measured by the length of a patient's stay in hospital. The costs they incur to deliver clinical services are trending downwards, with most achieving the targets set by the department and improving their performance compared to last year. Scope remains for some HHSs to improve their efficiency.

Patient access to specialist consultations is also improving with reductions in the number of patients waiting longer than the clinically recommended time and significant increases in the use of telehealth services.

HHSs are not effectively managing their procurement contracts. Many HHSs are yet to finalise their own procurement procedures and most do not have a fully updated contracts register.

Findings

- HHSs met most targets in the service agreement with the Department of Health (DoH) for average length of stay (ALOS) outcomes across 16 diagnosis related groups (DRGs).
- Queensland achieved the shortest (or equal shortest) ALOS in 14 of 20 DRGs measured nationally and continues to have the lowest nationally reported relative stay index for public hospitals.
- Ten of the 13 HHSs receiving activity based funding had an average Queensland weighted activity unit (QWAU) cost below the Queensland efficient price. Nine HHSs reduced their average cost per QWAU from 2013–14.
- Spending by HHSs on clinical supplies and drugs was within five per cent of the targets per weighted activity unit (WAU) set by the department. Non-ABF funded HHS also demonstrated savings.
- No rural and remote HHS met the service agreement target for potentially preventable hospitalisations.
- The proportion of patients waiting longer than clinically recommended for an initial specialist outpatient appointment improved for all HHSs except Children's Health Queensland (CHQHHS).
- The number of telehealth consultations across the state increased by 116 per cent compared to last year
- Six of the 16 HHSs have developed procurement procedures that align with the Queensland procurement policy. Only one HHS has a complete contract register.
- Documentation supporting the approval and ongoing management of new contracts, especially those without a competitive tender process, was lacking at a number of HHSs.
- Four of the sixteen HHSs formally evaluate supplier performance on contract completion.
- HHSs manage buildings worth $11.8 billion.
- All HHSs use a computerised maintenance management system (CMMS) to plan for asset maintenance, but only half use this data as an input to their asset valuation processes.

Background

In 2014–15, Hospital and health Services (HHSs) incurred expenses totalling $11.055 billion, an increase of $1.153 billion over the previous year. The demand for hospital and health services and the costs associated with providing these services continue to rise.

HHSs need to manage their costs effectively to maximise their limited available resources. These costs are wide ranging and include employee expenses and supplies and services as well as the opportunity cost of not managing these purchases effectively and the cost of maintaining hospital infrastructure.

To determine whether HHSs are managing the cost of their services effectively, they measure a range of performance indicators against established benchmarks at a state and national level.

Conclusions

Queensland hospitals continue to be amongst the most efficient in Australia when measured by the length of a patient's stay in hospital. Shorter stays in hospital means additional beds to treat more patients. The costs they incur to deliver clinical services (measured in weighted activity units) is trending downwards with most achieving the targets set by the department and improving their performance compared to last year. Scope remains for some HHSs to improve their efficiency.

These results are also evident in their spending in high costs areas such as drugs and clinical supplies, with most HHSs either meeting or being within five percent of targets set by the department.

Patient access to specialist consultations is also improving with reductions in the number of patients waiting longer than the clinically recommended time and significant increases the use of telehealth services.

HHSs are not effectively managing their procurement contracts however. Many HHSs are yet to finalise their own procurement procedures and most do not have a fully updated contracts register.

Hospital efficiency

Queensland government expenditure on public hospitals was an estimated $4.7 billion in 2013–14, an increase of $0.5 billion (12 per cent) since 2011–12. HHSs aim to deliver patient care in hospitals at the lowest possible cost without compromising the quality of health care outcomes.

Key performance indicators (KPIs) measure hospital efficiency at a state and national level. Hospital and Health Boards are accountable for their performance and publish information about their performance in their annual reports. The Department of Health (DoH) publishes information about the performance of HHSs on its website.

We have examined selected KPIs that DoH, HHSs or national bodies use to measure hospital efficiency.

Average length of stay in public hospitals

Information about the average length of stay (ALOS) by patients offers insight into the efficiency of hospitals. The length of time a patient spends in hospital affects overall health system costs. A shorter stay makes beds available to provide care for more patients and reduces the cost per patient. Although longer hospital stays can be due to factors outside a hospital's control, opportunities taken to reduce longer hospital stays can increase efficiency with services provided at the lowest possible cost.

Length of stay outcomes are particularly important for HHSs funded via activity based funding (ABF) as the price paid for each Australian Refined Diagnosis-Related Group (DRG) varies depending on the length of stay. Each DRG has an allocated average length of stay. If the length of stay is:

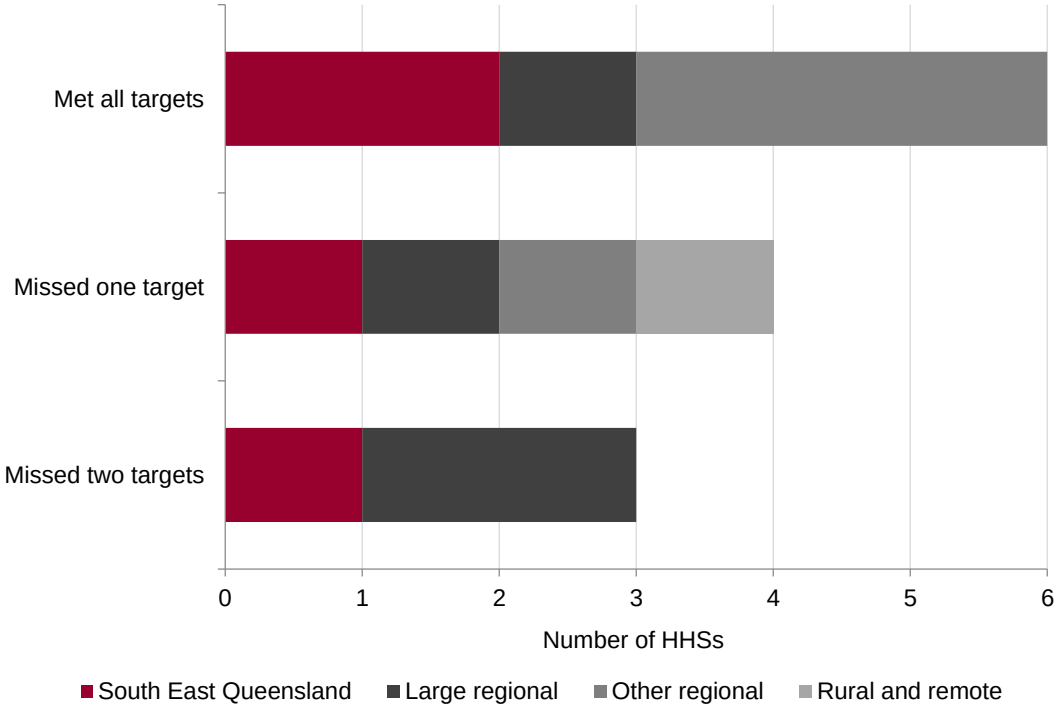
- lower than the average, the funding paid to a HHS will be higher than the cost incurred
- higher than the average, then a HHS will be in a 'shortfall' position.

Overall, each HHS needs to be at or below the average length of stay for each DRG to provide cost efficient services.

A new KPI introduced in the 2014–15 HHS service agreements is 'length of stay in public hospitals'. This measures the ALOS for 16 DRGs where the patient stayed one or more nights in hospital. The 13 HHSs that receive ABF measure themselves against consistent statewide targets for each DRG.

Figure 4A shows HHS performance in 2014–15 against the 16 DRGs. HHSs met most targets with no apparent difference in performance between HHS regions. Performance was consistent across most DRGs except for gall bladder removal procedures (laparoscopic cholecystectomy) where five HHSs missed the target of 1.8 days.

Figure 4A
HHS performance against average length of stay targets for selected DRGs 2014–15



Source: Department of Health

Analysing data for long stay patients within selected high cost DRGs can help to identify inefficient practices at the HHS. Eliminating these practices helps to reduce the average cost of providing health services, improve efficiency and provide better quality health care. Other Australian jurisdictions that analysed high cost DRGs identified that long patient stays contribute to high cost outcomes. Unpacking and addressing the cause of unnecessarily long hospital stays, such as variances in clinical practice or discharge process inefficiencies, reduced the average cost.

National comparisons

The Australian Institute of Health and Welfare (AIHW) selects 20 DRGs to measure the average length of stay outcomes for patients. Eight of the DRGs are in common with the KPI in the HHS service agreements in Queensland.

The latest available national data published by the AIHW in relation to the average length of stay is from 2013–14. Across the 20 selected DRGs Queensland achieved the:

- shortest (or equal shortest) ALOS in 14 DRGs (the same as 2012–13)
- second shortest ALOS for a further five DRGs (up from three in 2012–13)
- third shortest ALOS for the remaining DRG (down from three in 2012–13).

This means, for these DRGs, Queensland hospitals are more likely to be providing cost-efficient services.

Relative stay indexes measure the length of stay for admitted patients. The relative stay index for all Australian hospitals (public and private) is one. A relative stay index greater than one indicates that an average patient's length of stay is higher than expected. A low or decreasing relative stay index is desirable if it is not associated with poorer health outcomes or significant extra costs outside the hospital systems.

The latest available national data published in relation to relative stay indexes by the AIHW is from 2013–14. Queensland continues to have the lowest reported relative stay index for public hospitals of all Australian states and territories.

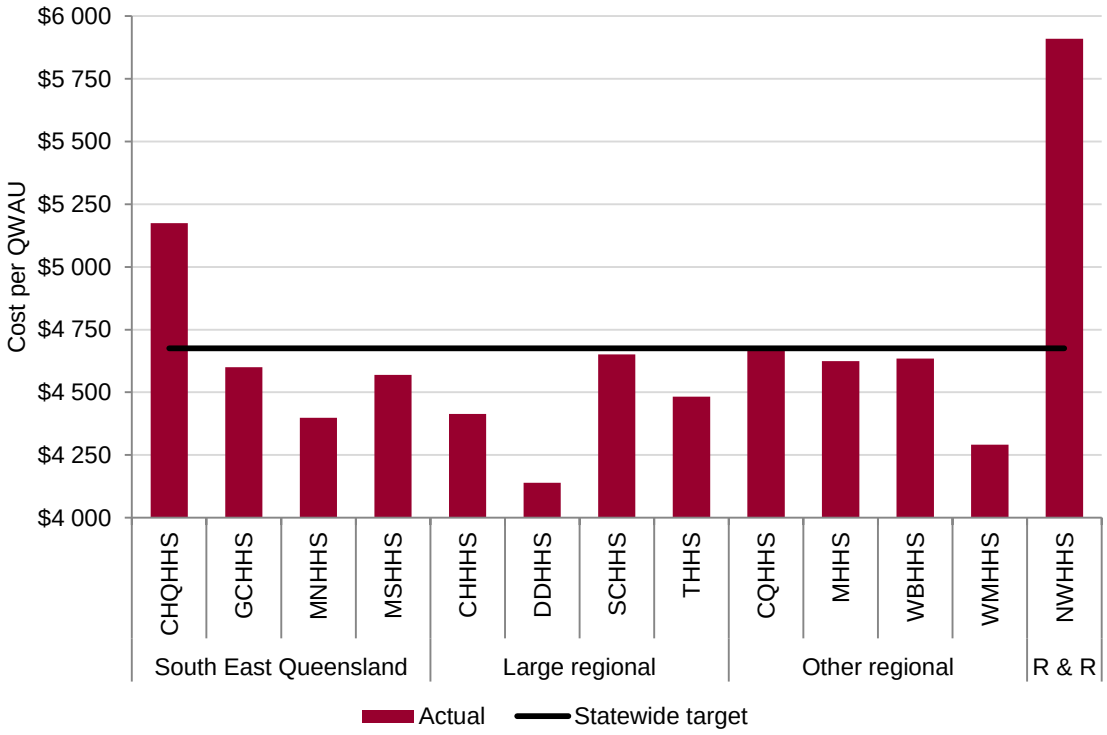
Over the same period, Queensland's reported performance against safety measures reported by the AIHW were generally in line with the national average. The data showed:

- A slight deterioration from 2012–13 in the proportion of patients with a condition arising during an overnight inpatient hospital stay but an improvement for same day patients.
- Unplanned or unexpected readmissions higher than the national average for six out of seven procedure groups reported, but four procedure groups showed an improvement from 2012–13.
- The rate of falls resulting in patient harm also declined from 2012–13 and Queensland remains better than the national average.
- The rate of infection (Staphylococcus aureus bacteraemia) per 10 000 days of patient care was in line with the national average and less than half the national target.

Average cost of delivering hospital services

DoH measures HHSs that receive ABF against the average cost of delivering one Queensland weighted activity unit (QWAU). An efficient HHS will deliver their services at or below the Queensland efficient price (QEP). Figure 4B shows the actual average QWAU cost for each HHS that received ABF in 2014–15 compared to the statewide target.

Figure 4B
Average cost per QWAU for each HHS that received ABF in 2014–15



Source: Department of Health

Ten of the 13 HHSs funded by ABF in 2014–15 had an average QWAU cost below the QEP of $4 676 (2013–14: seven). Nine HHSs reduced their average cost per QWAU from 2013–14. CQHHS was only $9 over the QEP in 2014–15.

Children's Health Queensland Hospital and Health Services (CHQHHS) and North West Hospital and Health Services (NWHHS) remain above the QEP, the same situation as the previous year. CHQHHS delivers care in a specialised paediatric hospital with increased supervision, children needing more support for interventions, family support and lower economies of scale. NWHHS services patients in a remote location with a proportionally high indigenous population. These circumstances increase the cost of care.

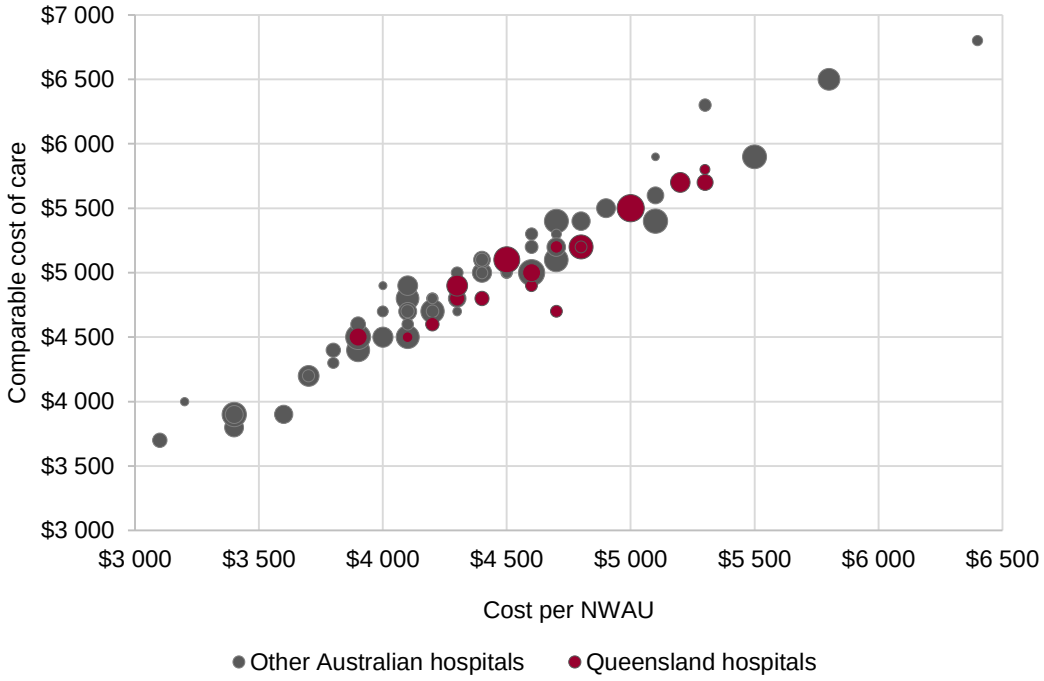
DoH recognises this through a variable increase in funding per DRG for specialised paediatric care in an acute admitted setting (and a 96 per cent loading for sub-acute care) and provides additional funding for indigenous and remote patients (four per cent and 15 to 21 per cent respectively for acute admitted care).

National comparisons

The National Health Performance Authority (NHPA) issued a report in April 2015 on the costs of acute admitted patients in public hospitals in 2011–12. It compares the relative efficiency of public hospitals in Australia. This report shows the high variability between hospitals in the cost of providing comparable care, with some hospitals costing twice as much as their peers to deliver the same procedure.

Figure 4C shows the variability in the cost of care, measured in cost per weighted activity unit (WAU) and comparable cost of care, in 80 Australian hospitals across metropolitan and large regional areas. The size of each dot signifies the number of services delivered in that hospital.

Figure 4C
Variability in the cost of care in Australian public hospitals 2011–12



Source: National Health Performance Authority

This demonstrates the large variability in costs between hospitals that existed in Queensland in 2011–12. HHSs and DoH have been working over the last three years to improve the cost relativity of Queensland hospitals—the increasing number of HHSs meeting the QEP and low average length of stay outcomes reflects this effort. There is no more recent comparable publicly available data to determine whether this has resulted in improvements when compared to their interstate peers.

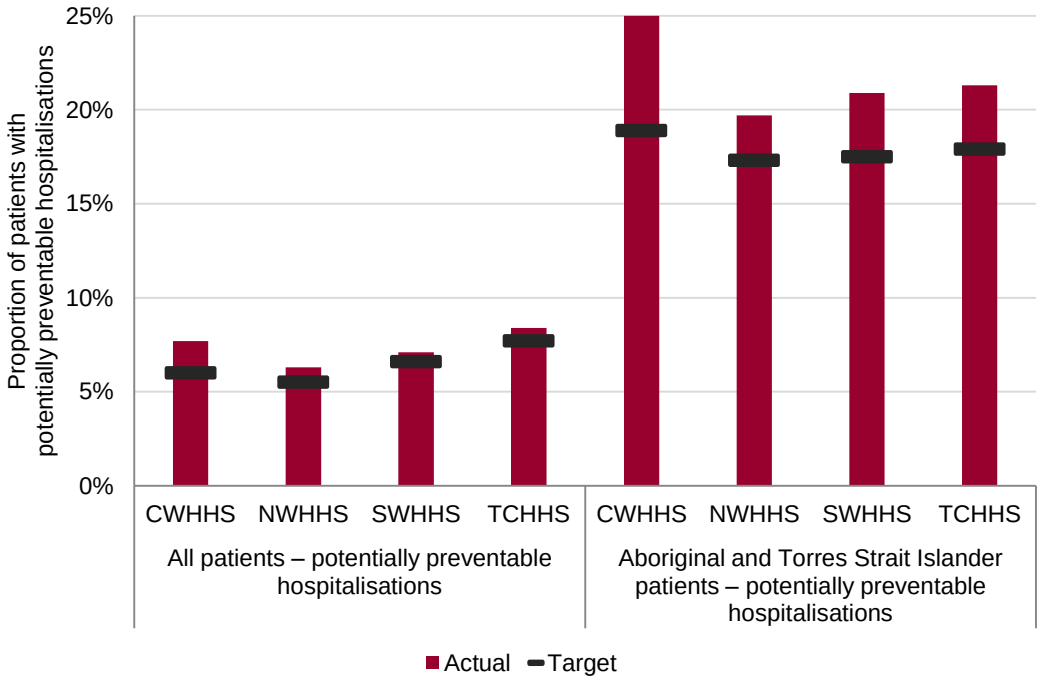
Potentially preventable hospitalisations

The service agreement for rural and remote HHSs contains a KPI that measures the proportion of potentially preventable admissions (PPH) for chronic conditions through the provision of appropriate non-hospital health services. Chronic conditions include diabetes, hypertension and chronic obstructive pulmonary disease. Treating these conditions prior to hospitalisation can help to reduce the overall costs for a HHS.

This KPI measures conditions where hospitalisation may be avoidable through timely and adequate provision of non-hospital care. The KPI focuses only on chronic conditions as this area has the greatest opportunity to influence health outcomes, through either effective community care and/or collaboration with other primary or community care providers.

Figure 4D shows the performance of the rural and remote HHSs against the target set by DoH for both PPH across all patients and PPH for Aboriginal and Torres Strait Islander patients. Targets for PPH and PPH for Aboriginal and Torres Strait Islander patients were set based on a 0.5 per cent and two per cent respective improvement on the 2013–14 performance at each HHS. Each HHS aims to be lower than the target.

Figure 4D
Potentially preventable hospitalisations for all patients and Aboriginal and Torres Strait Islander patients in 2014–15



Source: Department of Health

No HHS met the target set by DoH for either category of patients.

The AIHW publishes national comparative results of PPH per 1 000 people for chronic conditions. The latest available data from 2013–14 shows that Queensland has the second highest rates of PPH behind the Northern Territory. This may be attributed to Queensland's higher proportion of Indigenous people in the population (Indigenous patients are almost four times more likely than non-Indigenous patients to have a PPH) and remoteness of its population (patients in remote locations around Australia are two times more likely than patients in metropolitan locations to have a PPH).

Rural and remote HHSs will need to create strong partnerships with the new primary health networks to be able to achieve better performance against this KPI.

Funding initiatives focused on patient care

Service agreements between DoH and HHSs contain funding initiatives that focus on improvements to patient care. Each initiative does not apply to all HHSs as it depends on the HHS's funding arrangements, patient mix, and services provided. DoH provides incentives to HHSs by either granting additional revenue for meeting minimum threshold targets or reducing funding for adverse outcomes. DoH assesses HHS performance against each initiative on a monthly, quarterly or half-yearly basis.

The initiatives for 2014–15 are broadly categorised in Figure 4E, which shows the amount of funding made available and actually paid to or reduced from HHSs. Appendix C provides further detail on the initiatives in each category.

Figure 4E
Funding initiatives for HHSs in 2014–15

Initiative category	Additional/ reduced funding	Funding available 2014–15 $ mil	Funding paid / (reduced) 2014–15 $ mil
Payment for outcomes	Additional	83.5	37.4
Quality improvement payments	Additional	19.3	12.1
Other initiatives^	Additional	18.9	13.9
Adverse events	Reduced	N/A	(10.2)
'Never' events	Reduced	N/A	Nil
	Total	**121.7**	**53.2**

^ Telehealth funding made available in this category was uncapped.

Source: Department of Health

The initiative with the lowest performance relative to its target is the payment for outcomes measure to provide timely access to specialist outpatient care for new appointments. The minimum threshold to receive funding was 34 per cent of patients waiting within the clinically recommended time with full payment made for 90 per cent of patients waiting within the clinically recommended time. DoH assessed performance on a monthly basis.

HHSs collectively only received 37 per cent of funding available under this initiative. HHS performance varied considerably with one HHS receiving 98 per cent of available funding whilst one HHS received eight per cent.

Management of outpatient waiting lists

Over 207 500 patients were waiting for their first appointment in a specialist outpatient clinic across Queensland at 30 June 2015, although the actual number that need an appointment may be less than that.

Fifteen out of 16 HHSs undertook waiting list audits in 2014–15 to ensure they have the most accurate waiting list information possible. The audit generally involves contacting patients by letter or phone to ensure they still require treatment and are appropriately categorised, and to update patient administrative information. A benefit of waiting list audits is a reduction in the rate of patients failing to attend their scheduled appointment, freeing up appointment times for other patients.

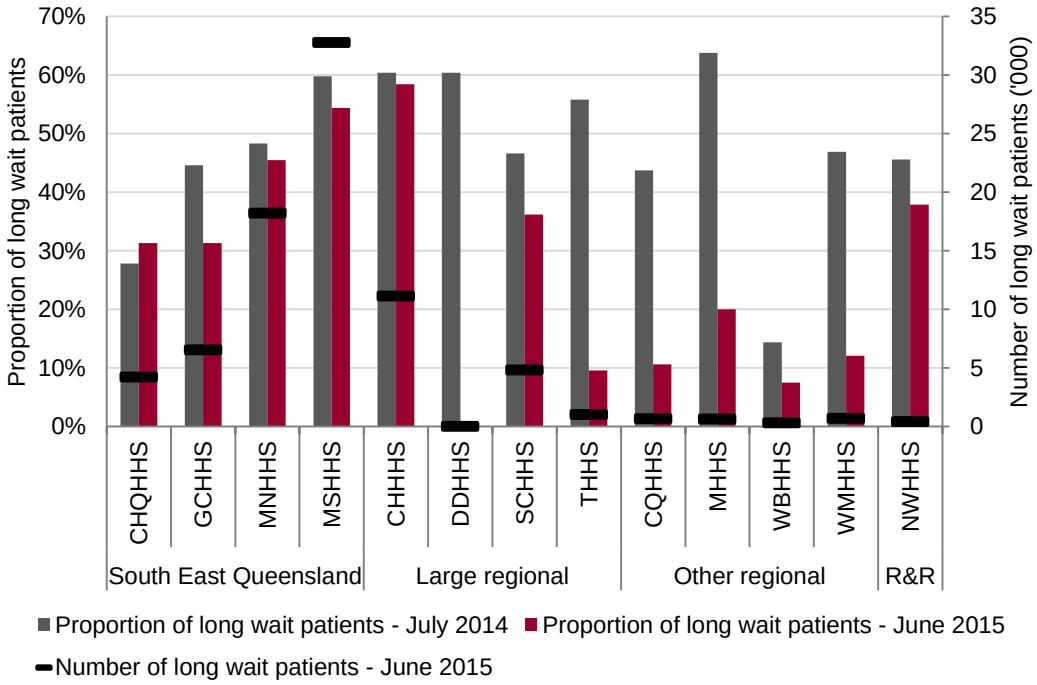
Four HHSs that were able to provide statistics removed 13 500 patients from the waiting list from these audits. These HHSs removed between 17 per cent and 32 per cent of the patients audited. Fourteen out of 16 HHSs have stated that they will be undertaking more waitlist audits in 2015–16. This activity should assist in validating the true number of patients that require an appointment.

Proportion of patients waiting longer than clinically recommended

Service agreements between DoH and HHSs contain a KPI that focuses on reducing the number of specialist outpatients waiting longer than the clinically recommended timeframe. Each HHS was required to agree an individual target with DoH. However, three HHSs in South East Queensland were unable to reach an agreement on a 2014–15 target.

Figure 4F shows the proportion of patients waiting longer than clinically recommended at the end of July 2014 and June 2015. Collectively HHSs reported 82 088 patients across Queensland who were waiting longer than clinically recommended at 30 June 2015 (39.6 per cent of all patients waiting).

Figure 4F
Patients waiting longer than clinically recommended for a specialist outpatient appointment across all urgency categories in 2014–15



Royal Brisbane and Women's Hospital performance at MNHHS and Princess Alexandra Hospital performance at MSHHS was only included from November 2014 and February 2015 respectively, due to system limitations.

Source: Department of Health

The proportion of patients waiting longer than clinically recommended improved for all HHSs except CHQHHS between July 2014 and June 2015. Darling Downs Hospital and Health Services (DDHHS) achieved the most improvement in the proportion of long waiting patients with a reduction of 60 per cent to almost nil.

DoH is providing HHSs with additional funding to reduce outpatient waiting lists. HHSs received $30 million in late 2014–15 for specific programs under their service agreements with DoH. Any activity not delivered in 2014–15 must occur in 2015–16. The 2015–16 Queensland budget provided an additional $361.2 million over four years (including $71.3 million in 2015–16) to reduce the number of patients waiting longer than clinically recommended for a specialist outpatient appointment.

Telehealth

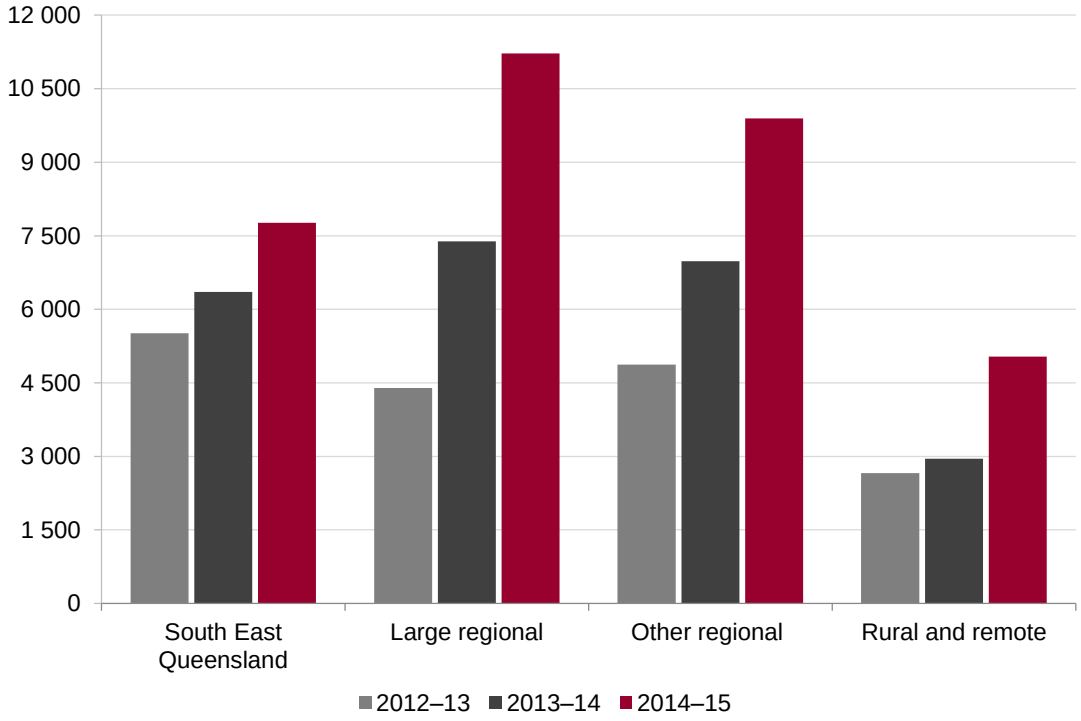
Telehealth is the delivery of health-related services and information via audio and video-active linkages. It provides access to health services for patients closer to home, reduces the cost and inconvenience of travelling to access treatment and reduces waiting times for treatment.

Clinical services delivered by telehealth fall into two categories: non-admitted specialist services such as endocrinology, oncology, paediatrics and general medicine; and admitted patient services such as intensive care, geriatrics and surgical care.

In emergency services, Retrieval Services Queensland uses telehealth to support aero-medical transfer of critical patients.

In 2013–14, the Queensland Government announced funding of $30.9 million over four years to establish rural telehealth services. Figure 4G shows the results of this investment with an increase of 116 per cent in the provision of non-admitted telehealth services across all HHS areas. In 2014–15, large regional HHSs delivered the highest volume of telehealth services, followed by other regional HHSs. The greatest benefits are to those patients in rural and remote HHSs.

Figure 4G
Non-admitted telehealth occasions of service by HHS region



Source: Department of Health

Supplies and services

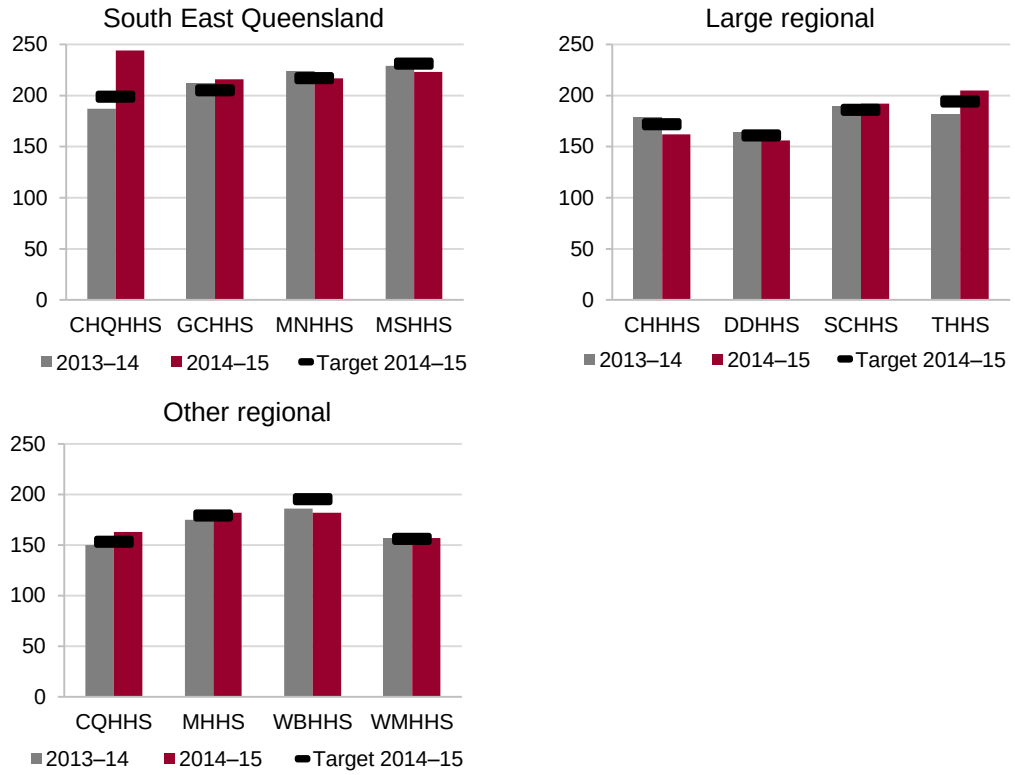
HHSs collectively spent more than $385 million on clinical supplies and $395 million on drugs from DoH and external suppliers during 2014–15. In 13 HHSs, clinical supply and drug costs were both within the top five recurring expenses, excluding salaries and depreciation.

Usage targets per WAU for clinic services and drug usage are calculated based on the HHSs annual budgets, however, these targets are not included as part of the department's performance assessments of the HHSs. The review and monitoring of the results varied across the HHSs.

Clinical supplies and usage

HHSs procured more than 85 per cent of their clinical supplies from DoH. Figure 4H provides an overall summary of the target vs actual cost of clinical supplies per WAU for the South East Queensland, large regional and other regional HHSs as all of these HHSs received activity based funding.

Figure 4H
Clinical supplies per WAU

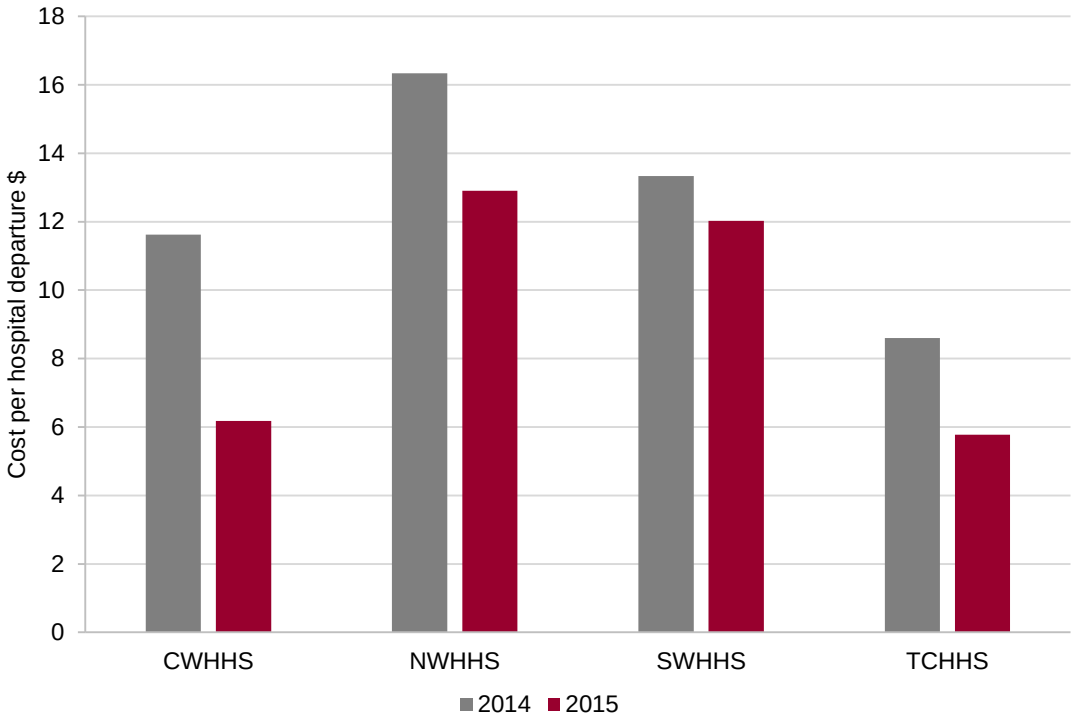


Source: Department of Health

Across the three groups, four HHSs met their targets; four were within five per cent of their target; and a further three were within 10 per cent of the target. CHQHHS was 20 per cent above its target of $199 per WAU. After the opening of the new Lady Cilento Children's hospital, procurement for clinical supplies increased on average by 85 per cent per month compared to the five months operating under the former Royal Children's Hospital (RCH). The basis of this increase was the expectation of an increased number of WAUs for the larger hospital. However, for the new hospital's first three months of operating, the HHS did not achieve its targeted WAUs.

The four rural and remote HHSs are predominately block-funded and not driven by activity or the related WAUs. For these HHSs, we measured clinical supplies based on departures from hospital as outlined in Figure 4I.

Figure 4I
Rural and remote—clinic supplies costs per hospital departure



Source: Queensland Audit Office

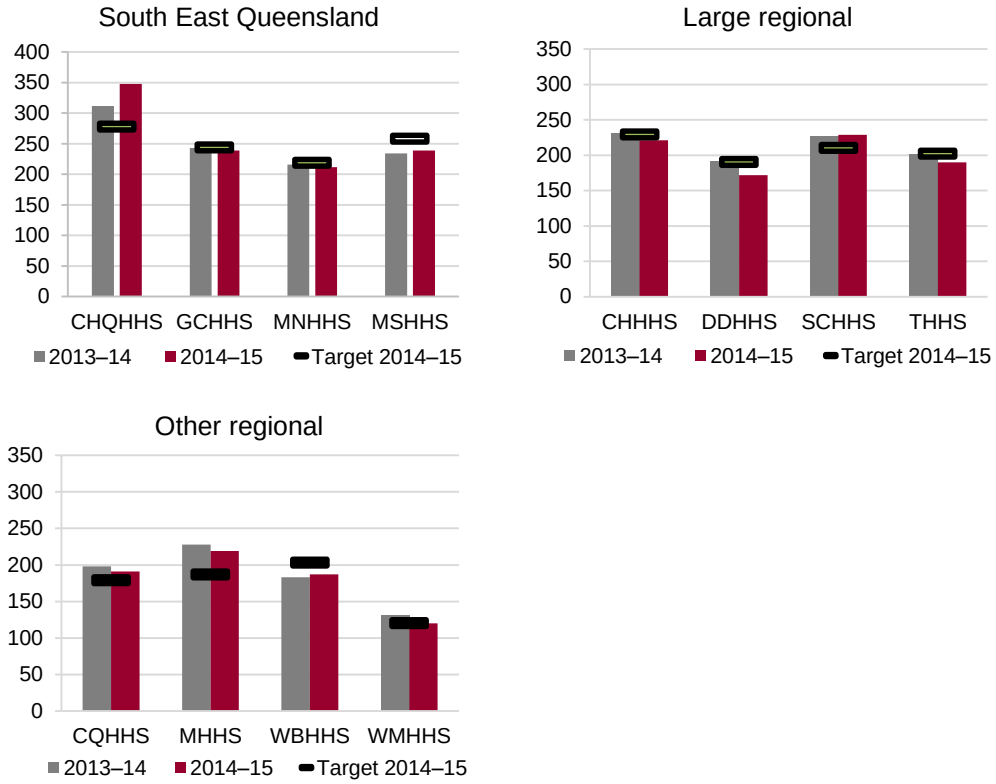
Across the four HHSs, there has been a reduction in the average cost per hospital departure when compared to the previous year. These reductions are due to a combination of an increase in the number of departures and a decrease in the overall procurement costs incurred by the HHSs.

Drug procurement and usage

With the exception of Torres and Cape, HHSs procure between 90 per cent and 99 per cent of their drugs from DoH. Torres and Cape HHS only procures 54 per cent of its drugs from DoH or the Cairns and Hinterland HHS. They procured the remaining 46 per cent of their drug requirements from local pharmacies within the region. These pharmacies have been engaged to fill patient scripts using the Webster-Pak service. This is an easy to use pre-packaging system which ensures that patients take the right prescribed medication dosages at the right times of the day.

Figure 4J provides a summary of the target vs. actual cost of drug procurement per WAUs for South East Queensland, large regional and other regional HHSs—those that receive activity based funding.

Figure 4J
Drug costs per WAU



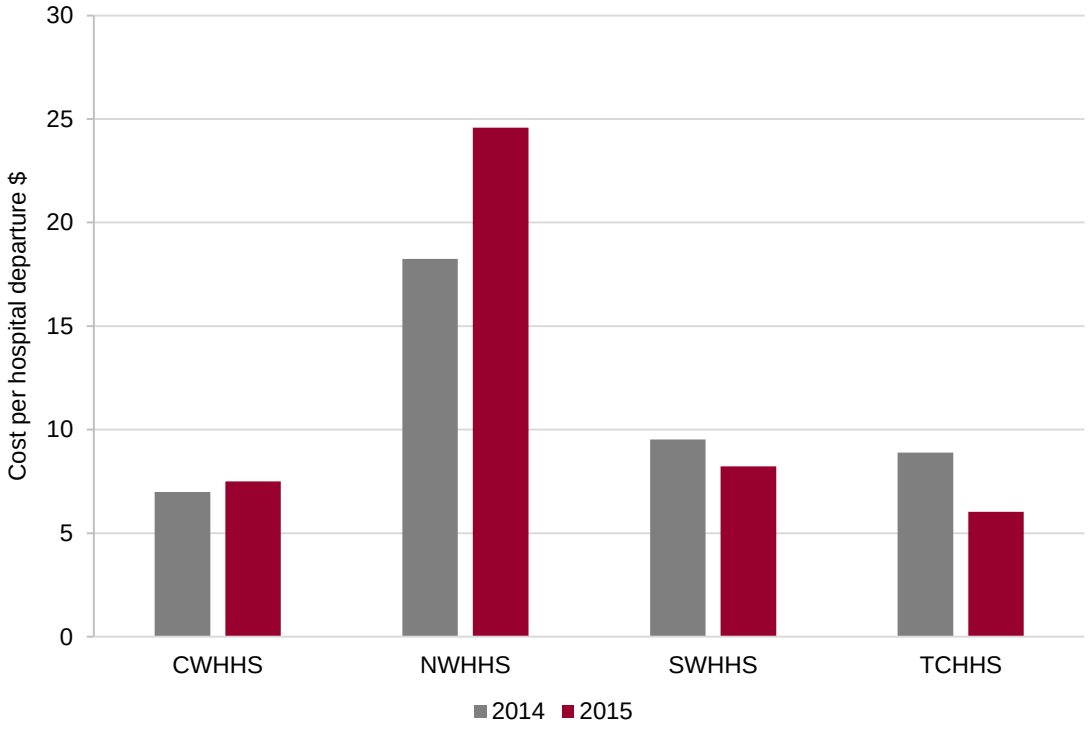
Source: Department of Health

Across the sector, seven HHSs met their targets; one was within five per cent of the target and a further two were within 10 per cent of the target. Mackay HHS was 17 per cent above its target of $186 per WAU. The main reason for this variance is due to the purchase of new and more expensive cancer drugs. These are claimable against the Pharmaceutical Benefits Scheme.

CHQHHS was 25 per cent above its target of $277 per WAU. On the expectation of increased activity in the larger hospital, drug procurement increased on average by 100 per cent per month compared to the five months operating under the former RCH. This resulted in an increase in drug stock levels held by the HHS at year end.

Again, because the four rural and remote HHS are block funded, we have measured drug costs for these HHSs based on departures from hospital as represented in Figure 4K.

Figure 4K
Rural and remote—drug costs per hospital departure



Source: Queensland Audit Office

NWHHS drug costs per hospital departure were significantly larger than those of the other rural and remote HHSs, as 2014–15 saw a substantial increase in high cost cancer treatment drugs. The HHS also implemented other services and activities with higher cost drugs during the year, which also contributed to the increase.

Contract procurement

As statutory bodies, HHSs are required to comply with the requirements of the Queensland procurement policy. In addition, the One Government contract management framework issued by the Department of Housing and Public Works also applies to HHSs.

During the year, we received external referrals relating to contract procurement practices at two HHSs. In response, we undertook a broader review of contract procurement and contract management practices across all HHSs.

Our review did not test full compliance with the policy or the framework but assessed whether:

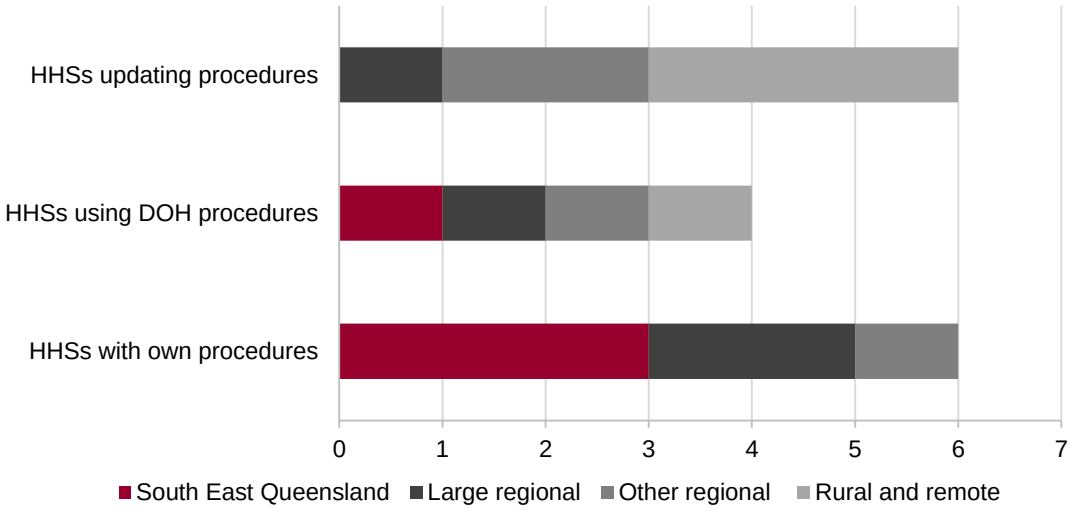
- HHS's procurement processes align with the procurement principles in the policy
- HHSs have a contracts register or contracts management system to record all contracts and key management and reporting data
- new contracts comply with procedures, decisions were appropriately documented and approved and KPIs identified
- contracts exempt from procurement procedures (on the basis of sole supplier, genuine emergency or limited supply) were adequately supported and appropriately documented
- existing contracts were appropriately and actively monitored and managed
- completed contracts were adequately assessed to determine the overall performance and suitability of the supplier for future contracts.

Alignment with Queensland procurement policy

The *Financial and Performance Management Standard 2009* (the standard) requires HHSs to comply with the Queensland procurement policy in developing their expense management system. The policy outlines six key principles to assist in delivering excellence in government procurement outcomes with the primary principle being to drive value for money in procurement.

We assessed whether HHS procurement procedures aligned with the principles of the policy with the results included in Figure 4L.

Figure 4L
Status of procurement procedures



Source: Queensland Audit Office

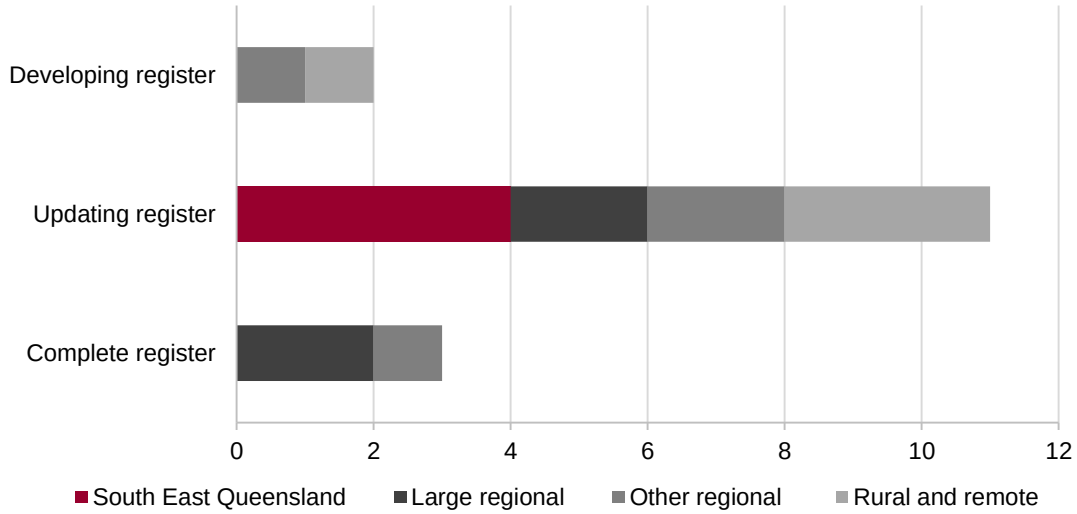
Without documented procedures to guide procurement staff, the six HHSs that are developing or updating their procedures may not be achieving value for money in their procurement, which is the overriding principle in the policy. By not having their own procurement procedures and continuing to follow the department's procurement policy, four HHSs are not complying with the requirements of the standard. In addition, these HHSs adopted the department's procurement procedures at the time they were established (1 July 2012). Given the Queensland procurement policy was re-issued in 2013, these HHSs are using outdated procedures that need to be re-assessed in light of the principles in the current policy. These HHSs need to develop and tailor their procurement procedures to meet their own specific circumstances.

Contracts register

HHSs should maintain a central contract register to record all contracts and capture all key information to support contract management activities and reporting.

Only three HHSs had central contract registers that included all contracts and the required supporting information. Eleven HHSs were in the process of updating their contracts register with the majority of these using the QContracts system. The remaining two HHSs are in the process of developing a central contract register.

Figure 4M
HHSs with central contract register



Source: Queensland Audit Office

Incomplete contract registers increase the risk that HHSs do not monitor contracts for compliance with performance obligations, cannot identify expiring contracts and commitments reported in the financial statements will not be complete.

Due to the general lack of completeness of contract registers, we were not able to obtain any detail of the level or nature of contract expenditure incurred by the HHSs.

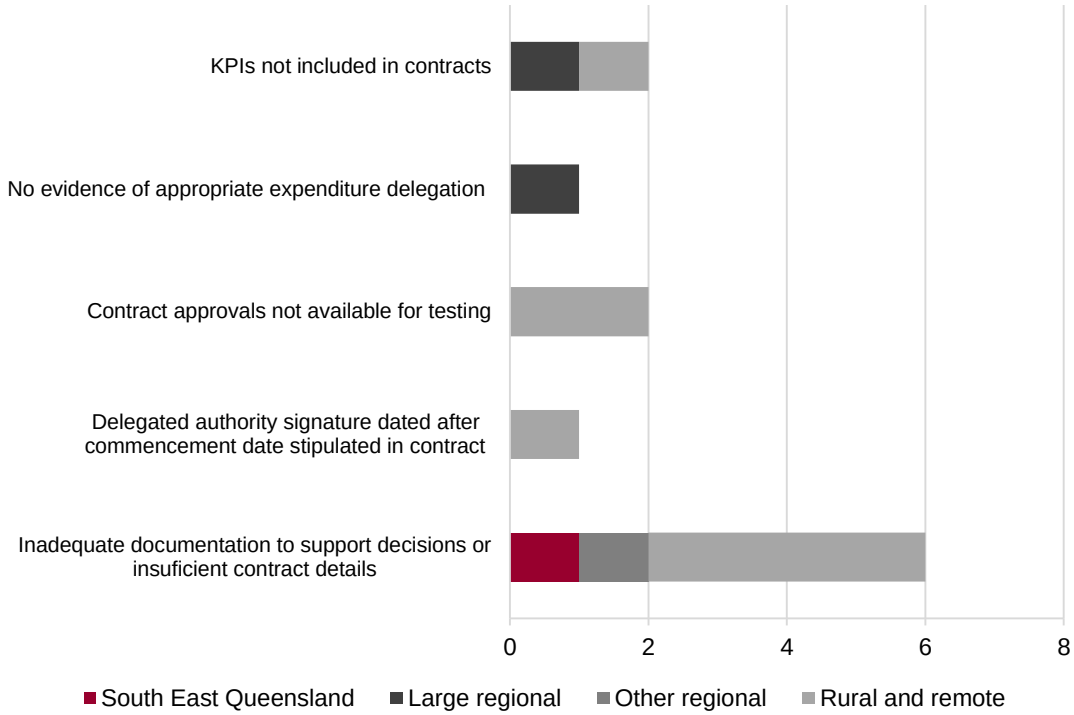
Approval of new contracts

New procurement contracts entered into by HHSs should:

- be undertaken in accordance with the HHS's procurement procedures
- be supported by adequately documented and appropriately approved procurement decisions
- be signed by the appropriate contract signing delegate
- include KPIs (e.g. timeliness, quality, cost) which establish the HHS's expectations of supplier performance.

Generally, HHSs have complied with the above requirements. The following issues were evident at six of the HHSs.

Figure 4N
Issues in new contracts



Source: Queensland Audit Office

The above figure highlights that the majority of issues raised are in rural and remote HHSs. Generally, these smaller HHSs have limited resources to be able to implement fully an appropriate procurement framework. The nature and extent of these issues indicate that there is poor documentation and support for some of the procurement decisions made by these HHSs. This makes it difficult for them to demonstrate that they have achieved value for money as required by the Queensland procurement policy.

Exempt contracts

HHSs are exempt from needing to comply with the full requirements of their procurement procedures where only one supplier can provide goods or services or there is limited supply or a genuine emergency. These are often referred to as type four contracts. The awarding of exempt contracts carries a higher risk that the HHS may not obtain value for money due to favouritism or bias toward particular suppliers. For this reason, approval to restrict the procurement to one or limited suppliers is required up front, before approaching the potential suppliers.

Almost half of the HHSs were not able to identify their exempt contracts or did not have processes in place to monitor such contracts. Despite the absence of controls over such contracts at these HHSs, we were able to identify and test a number of exempt contracts through other means. Generally, the basis for the exemption was adequately supported (evidence of market research or basis for urgency) and documented and the contract approved by an appropriately delegated officer. However, it was not always clear that HHSs obtained approval to undertake exempt contracts before engaging with suppliers. Improvement in the documentation of the decision making process is required for four HHSs.

Given the higher risk nature of these contracts, they should be recorded in the HHS's contract register and be readily identifiable for monitoring and scrutiny by senior management and those charged with governance.

Management of contracts

Contract management is important to:

- effectively deliver contracted goods and services at agreed specifications, terms, conditions and timeframes
- ensure ongoing contractor compliance and performance
- maintain relationship with suppliers without formal mediation or litigation
- effectively deliver contracts at or under agreed costs/rates.

Generally, HHSs were effectively managing their procurement contracts. However, a number of individual HHSs require some improvement in their contract management processes as demonstrated by the following matters identified at different HHSs:

- absence of key documentation and information supporting contracts (two HHSs)
- contract not in place before the provision of services
- absence of review to ensure contractor terms were suitable to the HHS
- value of orders exceeding the contract value
- inadequate monitoring of the expiry date of the contract requiring an extension of the contract without going back to market
- absence of a formal basis for monitoring performance given differences in practices noted
- absence of any formal contract management processes.

Performance assessments on completed contracts

A contractor's performance on completed contracts should be a key input into whether to engage that supplier in future.

HHSs performed poorly in this area with ten HHSs not performing any formal evaluations of suppliers on completion of contracts. A further two HHSs did evaluate supplier performance, but this was either not formalised or there was no mechanism to make the feedback available to others within the HHS.

Formal evaluations of performance should be completed and documented in a timely manner on the expiry of a contract. The evaluation should be readily available to assist in assessing the reliability of the contractor for future contract engagements.

Maintenance of hospital infrastructure

On 1 July 2012, HHSs gained control of their assets from DoH by way of a lease arrangement between the department and the HHS. In 2014–15, legal ownership of land and buildings progressively transferred from the department to the HHSs, with all legal titles transferred by 1 July 2015.

At 30 June 2015, HHSs were the custodians of $11.1 billion of buildings at their gross asset value. The effective maintenance of these assets is critical for HHSs to be able to deliver high quality health services to the people of Queensland and to ensure the safety of staff.

Regular maintenance

The service agreement between DoH and the HHSs provides funding for the regular maintenance of buildings and infrastructure. The department sets a target of 2.15 per cent of the gross asset value of the building portfolio as the annual budget for regular maintenance expenditure. Figure 4O shows that across the sector, building maintenance expense as a percentage of gross asset value is below this target despite the fact that HHSs spending on asset maintenance has been increasing steadily over the same period.

Figure 4O
Building maintenance expense as a percentage of gross asset values

	2012–13	2013–14	2014–15
Gross asset value of buildings ($'000)	7 426 160	9 012 513	11 139 593
Actual building maintenance expense ($'000)	120 575	144 024	172 990
Building maintenance expense as a percentage of gross asset value	1.62%	1.60%	1.55%

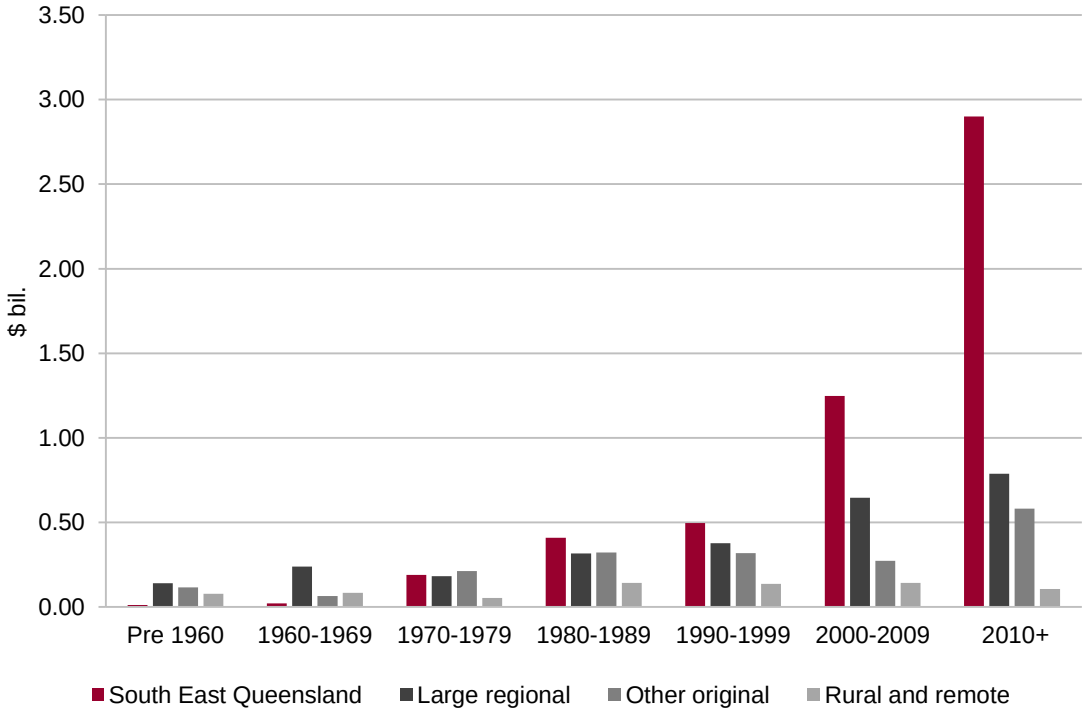
Source: Hospital and Health Services

This is not an immediate cause for concern as the significant investment in new assets over the last three years will require little maintenance in the early years of use, but HHSs do need to develop long-term asset management plans to ensure they maintain these assets over their life.

Hospital infrastructure profile

Figure 4P shows the growth in the cumulative value of buildings across the sector over time. It highlights the substantial investment in buildings in South East Queensland, large regional and other regional HHSs since the 1980s and especially in the last five years. These results also reflect the regular revaluation of the building assets over the last 20 years.

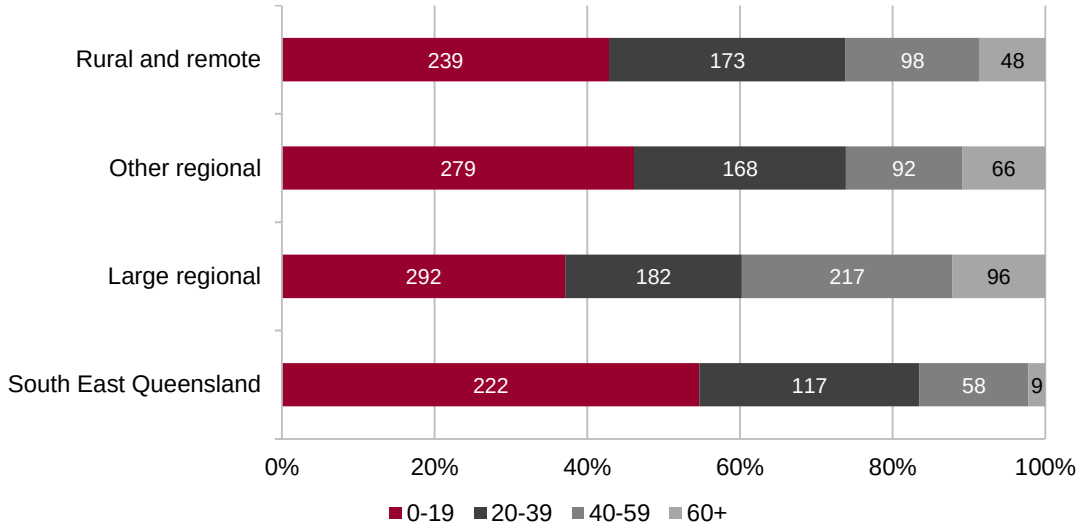
Figure 4P
Cumulative value of buildings



Source: Queensland Health

Ageing infrastructure is one of the challenges for HHSs in managing their buildings. Generally, the older the building, the more maintenance and functionality issues it will have. This will affect the ability of the HHS to support not only existing service levels but also future demand for services and the delivery of contemporary models of care. Figure 4Q illustrates the age of HHS buildings. Approximately 56 per cent of HHS buildings are older than 20 years (1 324 buildings out of 2 356). It also shows that large regional HHSs have a disproportionately large number of older buildings.

Figure 4Q
HHS buildings by age



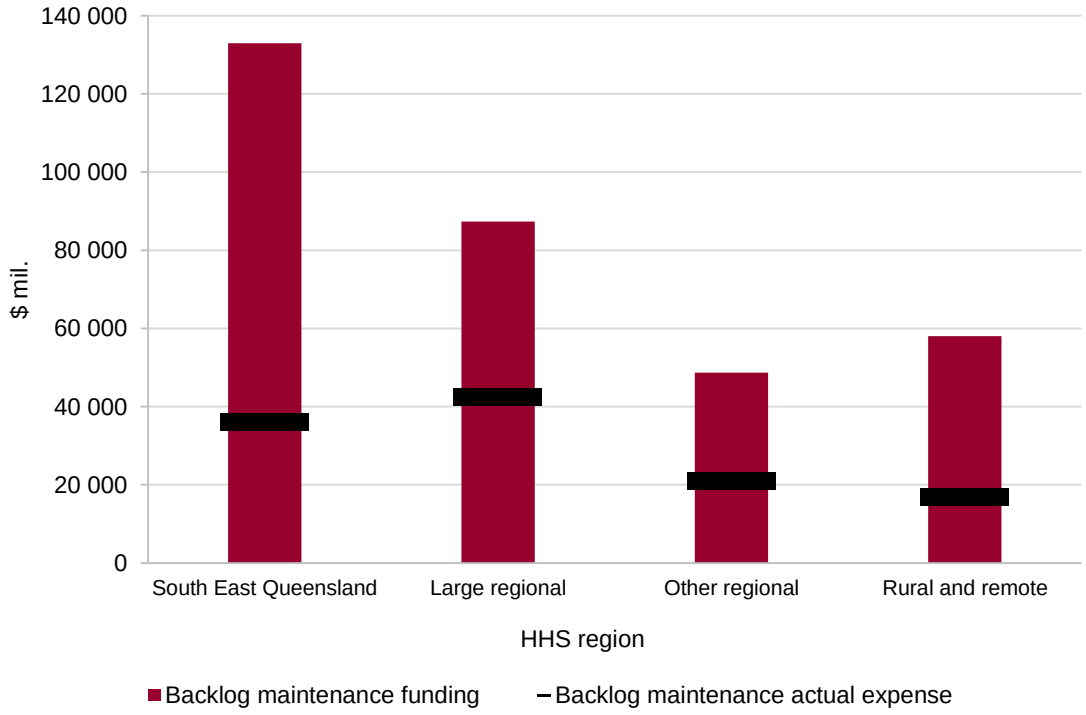
Source: Queensland Audit Office

Backlog maintenance program

An outcome of under expenditure in regular building maintenance is the build-up in backlog maintenance requirements.

The government announced the backlog maintenance remediation program (BMRP) in the 2013–14 State Budget to provide $327 million over four years to address the under investment in asset maintenance. Figure 4R shows the BMRP funding to HHSs however require a significant amount of lead-time to plan and implement their backlog maintenance program, resulting in timing differences between the state funding cycle and the HHS planned backlog remediation cycle.

Figure 4R
Backlog maintenance—funding v actual



Source: Hospital and Health Services

At the completion of the BMRP, the challenge for the HHSs is to maintain regular maintenance at the appropriate threshold for optimising asset utilisation without accumulating significant backlog. To assist HHSs with asset management decisions, HHSs need good supporting systems and processes.

In our report to parliament *Maintenance of public schools* (Report 11: 2014–15), we identified that good asset data, in particular condition assessments, is essential for the development of long-term and preventative asset maintenance plans. All 16 HHSs use the computerised maintenance management system (CMMS) for asset maintenance purposes, with 13 HHSs using the system for condition assessments.

However, only half of the HHSs use data on CMMS as input for asset valuations. This could result in the use of incomplete and inaccurate data for asset valuations, affecting asset values reported in the financial statements.

Delivery of e-Health investment strategy

In previous reports to parliament, we have identified the risks posed by Information and communications technology (ICT) systems that are old and no longer have vendor support. However, to date there has been limited progress made to replace these systems. While there has been significant investment in new hospitals, investment in the supporting ICT has fallen behind.

In September 2015, Queensland Health announced its eHealth Investment Strategy, which outlines the future ICT requirements over the next 20 years for the state's health system.

DoH and the 16 HHSs adopted a co-design approach in the development of the strategy resulting in the collaborative identification, selection and review of ICT investment priorities. Figure 4S identifies the strategy's investment priorities and their indicative cost.

Figure 4S
eHealth investment priorities

Category	Priorities	Indicative cost
Digital future	Information interoperability eHealth foundations	$130 million
ICT infrastructure	Infrastructure utility Contemporary desktop	$300 million
Clinical systems	Patient administration system Integrated Electronic Medical Record and digital hospitals Pathology system replacement Primary and community care Digital imaging and transmission	$730 million
Business systems	Financial system replacement	$100 million
Total indicative cost		**$1 290 million**

Source: Queensland Health eHealth Investment Strategy

The eHealth investment priorities include the replacement of two major systems in use by the HHSs—FAMMIS, the financial management system and HBCIS, the patient administration system. While the planned investment in new ICT is a positive step, replacing existing systems creates risks that require careful management by DoH and the HHSs collectively. These risks include:

- long lead times to initiate planning studies and project start-ups due to complex and time-consuming governance processes resulting in longer times for benefit realisation and less return on the investment
- long lead times to initiate procurement processes resulting in delays in the delivery of the project
- solutions that are not compatible with other systems or platforms leading to isolated systems and wasted investment.

Financial system replacement project

FAMMIS has been out of vendor support since December 2006. In the event of a major system failure, DoH and the HHSs may not be able to access financial information from the system. In addition, DoH and the HHSs are unable to make any changes to FAMMIS to suit their operational needs.

DoH has twice attempted to replace FAMMIS. In February 2015, DoH, Metro South Hospital and Health Service (MSHHS) and Metro North Hospital and Health Service (MNHHS) established the financial system replacement (FSR) project to replace FAMMIS. Subject to the Investment Review Committee approval of the FSR business case, a pilot project will commence in 2016 with progressive rollouts to the HHSs in 2017 and 2018.

Patient administration system

The replacement of the patient administration system, known as HBCIS, is a long-recognised priority for the sector, with the system being in use since 1991. Vendor support for HBCIS, which originally ended in 2015, now extends to 2023. Numerous attempts to develop a business case for HBCIS replacement have not resulted in any solutions.

HBCIS is a core system with significant clinical and administrative inter-dependencies. Its replacement needs to be well considered and well planned to mitigate risks to patients and HHS operations.

DoH established a project board for HBCIS replacement in September 2015. An implementation planning study has commenced to support the development of a detailed plan and a preliminary business case.

Integrated electronic medical record (ieMR) and digital hospitals

The digital hospital program will introduce electronic medical records (EMR) and a range of new integrated digital devices and updated systems at two hospitals—Princess Alexandra Hospital in December 2015 followed by Cairns Base Hospital in February 2016. Once implemented, health professionals will access patient information and clinical data from integrated devices in real time.

Governance

The Digital Hospital Program Board (DHPB) provides overarching program governance for the deployment of the integrated electronic medical record (ieMR) system. The chair of the DHPB is the chief health information officer of the DoH. Program board membership also includes the chief executives from Cairns and Hinterland, Central Queensland, Children's Health Queensland, Mackay, Metro North, Metro South and Townsville HHSs. HHS chief executives are accountable to their own boards for the benefits committed to in their own business case.

Risks

Digital hospital implementation presents risks to the HHSs including:

- High rate of change, putting pressure on clinicians and support staff to learn and adopt new ways of working. This could result in resistance to organisational change and prevent the transformation of services to new models of care.
- Hybrid of paper and electronic records that could result in missing patient information. This could result in increases in clinical incidents, length of stay and re-admissions.

The Digital Hospital Program Board and the HHSs are carefully managing these risks as the Digital Hospital Project progresses towards implementation in late 2015.

Appendices

Appendix A—Comments

In accordance with s.64 of the Auditor-General Act 2009, copies of this report were provided to the Chairperson and Chief Executive Officer of each Hospital and Health Service as well as the Director-General of the Department of Health with a request for comment.

Responsibility for the accuracy, fairness and balance of the comments rests with the head of these agencies.

Comments received from Chair, Metro North Hospital and Health Board

Queensland Government

Office of the
Metro North Hospital and Health Board

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Herston QLD 4029
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E metro_north_board@health.qld.gov.au

Ref: J15/15580

RECEIVED
23 NOV 2015
QUEENSLAND AUDIT OFFICE

Mr Andrew Greaves
Auditor-General
Queensland Audit Office
PO Box 15396
City East QLD 4002

Dear Mr Greaves

Results of audit: Hospital and Health Services' financial statements 2014-15

Thank you for the opportunity to comment in relation to the above draft report to Parliament.

I have read and considered the findings and recommendations contained in your report. I believe that your report accurately portrays a balanced view of the results of your financial audit in relation to Metro North Hospital and Health Service.

Metro North staff have reviewed the report thoroughly and have provided direct feedback to Mr Joe Rapisardi, the acting Director of the Queensland Audit Office, in relation to any anomalies or concerns with the accuracy of the report. Mr Rapisardi has acknowledged this feedback and advised that corrections have been made to the report as a consequence.

It is pleasing to note that Queensland Hospitals continue to be amongst the most efficient in Australia and that Metro North HHS compares favourably to its South East Queensland peers in terms of operating surplus ratios, average cost per QWAU, and clinical supplies and drug costs per WAU. Just as important is the contribution that Metro North is making to improving patient access, through significant reductions in the number of patients who have had to wait longer than clinically recommended for treatment in this jurisdiction and across the state.

However, it is also noted that Metro North, as do other HHSs, can continue to improve in a number of areas, including optimising receipts from all available revenue sources and improving the performance and effectiveness of its procurement processes.

The Board and the Chief Executive are committed to excellence in governance and sound financial management practices. Whilst Metro North can be proud of its achievements to date, as noted in your letter, we also take seriously your recommendations for improved financial management.

Comments received from Chair, Metro North Hospital and Health Board

As such, the findings and recommendations of your report will be presented for consideration to the Board Risk and Audit Committee once your report is tabled in Parliament.

Yours sincerely

Dr Paul Alexander AO
Chair
Metro North Hospital and Health Board

23 / 11 / 2015

Comments received from Acting Chief Executive, Cairns and Hinterland Hospital and Health Board

Queensland Government

Telephone: (07) 4226 3205
Email: CE_Office_CHHHS@health.qld.gov.au

Office of the Chief Executive
Cairns and Hinterland
Hospital and Health Service

Mr Andrew Greaves
Auditor-General
Queensland Audit Office
PO Box 15396
CITY EAST
QLD 4002

Dear Mr Greaves,

I refer to your letter of 4 November 2015 and accompanying draft Report to Parliament on the results of the 2014-15 Hospital and Health Services' financial statements.

I would be grateful if you would consider appending the following comment within Appendix A of your report.

> *The Cairns and Hinterland Hospital and Health Service (CHHHS) Executive notes the reference of the Auditor General to the CHHHS cash position, and specifically the "number of days cash available". The CHHHS agrees the underlying cash position is a critical factor in long term financial sustainability, and both the CHHHS Executive and CHHH Board actively monitor the cash position on a weekly and monthly basis. Mitigating circumstances unique to the CHHHS with respect to a timing mismatch between payment and funding for the Digital Hospital Program temporarily affected the cash position in 2014/15 and have now been resolved.*

It is unfortunate the timing of the reimbursement for the Digital Hospital was not resolved and received in cash in 2014/15, for it would have taken CHHHS cash position out past the 14 days. In saying that, the CHHHS and the Board absolutely agree with the need to ensure sufficient cash reserves are maintained to ensure financial sustainability.

Thank you for bringing this matter to my attention.

Yours sincerely,

Dr Neil Beaton
A/Chief Executive
Cairns and Hinterland Hospital and Health Service

26 / 11 / 2015

Comments received from Board Chair, Children's Health Queensland Hospital and Health Board

Queensland Government

Children's Health Queensland
Hospital and Health Service

Enquiries To: Loretta Seamer
Chief Finance Officer
Children's Health Queensland
Telephone: 07 3068 5568
Email: CHQ_CFO@health.qld.gov.au
File Number: CHQB15138

RECEIVED
26 NOV 2015
QUEENSLAND AUDIT OFFICE

Mr Andrew Greaves
Auditor-General
Queensland Audit Office
PO Box 15396
CITY EAST QLD 4002

Dear Mr Greaves

Re: Results of audit - Hospital and Health Services' financial statements 2014-15

I refer to your correspondence dated 4 November 2015 regarding the results of the audit of Children's Health Queensland Hospital and Health Services' financial statements for the 2014-15 financial year.

Please find attached my response to the findings of this audit. Thank you for the opportunity to provide a response.

Should you have any queries about this response please contact Loretta Seamer, Chief Finance Officer on 3068 5568.

Yours sincerely

Rachel Hunter
Board Chair
Children's Health Queensland
Hospital and Health Board
26/11/2015

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Comments received from Board Chair, Children's Health Queensland Hospital and Health Board

A fair summary of the overall response received on 26 November 2015:

…

<table>
<tr>
<td>Section 4 Cost Management, Hospital Efficiency

Page 39

Comments on CHQ Average Length of Stay for Certain DRG's</td>
<td>1. It should be noted that the Statewide targets set for each DRG are primarily adult focussed and do not reflect the different models of care and requirements of a Specialist Paediatric quaternary hospital. This has been raised with the DoH in the relationship management meetings and the parties have agreed that the measures should be adjusted to reflect Paediatric DRG's and relative length of stay targets benchmarked with similar hospitals.
2. The example below shows the performance of CHQ is comparable with other Specialist Paediatric hospitals.

<table>
<tr><th>DRG & Description</th><th>13/14 ALOS for Australasian Specialist Paediatric Hospitals*</th><th>14/15 QH Target</th><th>CHQ 14/15 Actual Performance</th></tr>
<tr><td>E65A Chronic Obstructive Airways Disease W Catastrophic CC</td><td>14.1</td><td>9.0</td><td>13.7</td></tr>
<tr><td>E65B Chronic Obstructive Airways Disease W/O Catastrophic CC</td><td>8.8</td><td>5.4</td><td>9.1</td></tr>
</table>
*excluding CHQ</td>
</tr>
<tr>
<td>Section 4 Cost Management, Hospital Efficiency

Page 40-41
Average cost per QWUA</td>
<td>The 2014-15 result was also impacted by a 3.6% underperformance to the QWAU target for the year. The lower activity was due to the reduction in activity to enable the move to LCCH in November 2014. Services then ramped up over a period of 4 months, hence the lower activity. CHQ is currently exceeding the QWAU targets for the period July to October 2015.</td>
</tr>
</table>

…

Appendix B—HHS financial statements audit opinions

Audit	Financial statements signed	Opinion issued	Opinion	Certified by 31 August legislated timeframe
Cairns and Hinterland Hospital and Health Service	19.08.2015	26.08.2015	U	✓
Central Queensland Hospital and Health Service	25.08.2015	31.08.2015	U	✓
Central West Hospital and Health Service	27.08.2015	28.08.2015	U	✓
Children's Health Queensland Hospital and Health Service	27.08.2015	31.08.2015	U	✓
Darling Downs Hospital and Health Service	24.08.2015	31.08.2015	U	✓
Gold Coast Hospital and Health Service	20.08.2015	21.08.2015	U	✓
Mackay Hospital and Health Service	27.08.2015	31.08.2015	U	✓
Metro North Hospital and Health Service	28.08.2015	31.08.2015	U	✓
Metro South Hospital and Health Service	19.08.2015	26.08.2015	U	✓
North West Hospital and Health Service	21.08.2015	28.08.2015	U	✓
South West Hospital and Health Service	31.08.2015	31.08.2015	U	✓
Sunshine Coast Hospital and Health Service	18.08.2015	21.08.2015	U	✓
Torres and Cape Hospital and Health Service	26.08.2015	31.08.2015	U	✓
Townsville Hospital and Health Service	28.08.2015	31.08.2015	U	✓
West Moreton Hospital and Health Service	28.08.2015	31.08.2015	U	✓
Wide Bay Hospital and Health Service	28.08.2015	31.08.2015	U	✓

Opinion Key:
U = unmodified
Q = qualified
A = adverse
E = emphasis of matter
D = disclaimer

Source: Queensland Audit Office

Appendix C—HHS health check

Figure C1
HHS health check

	South East Queensland				Large regional			
	CHQHHS	GCHHS	MNHHS	MSHHS	CHHHS	DDHHS	SCHHS	THHS
Financial performance								
Total revenue ($'000)	501 488	1 155 756	2 195 379	1 990 907	727 781	643 401	742 930	805 184
Total expenditure ($'000)	543 683	1 149 202	2 199 795	1 980 681	718 941	623 267	743 755	797 382
Operating result ($'000)	-42 195	6 554	-4 416	10 226	8 840	20 134	-825	7 802
Total assets ($'000)	1 376 298	1 884 427	1 412 547	1 404 849	688 712	395 772	357 971	823 557
Total liabilities ($'000)	54 482	75 235	121 508	125 272	45 932	35 905	55 664	46 850
Ratios								
Current ratio ● > 1.00 | ● < 1.00	1.26	1.29	1.73	1.69	1.21	2.62	1.31	2.03
Number of days cash available ● > 14 days | ● < 14 days	22.92	14.67	21.83	24.56	12.72	43.74	21.11	34.41
Audit matters								
Number of audit issues	4	5	11	7	12	10	14	3
Operational performance								
Safety measures								
Healthcare associated Staphylococcus (Including MRSA) Bacteraemia cases per 10 000 bed days ● ≤ 2 cases | ● > 2 cases	1.67	0.60	1.19	1.00	0.49	0.44	0.44	1.14
Access measures								

	South East Queensland				Large regional			
	CHQHHS	GCHHS	MNHHS	MSHHS	CHHHS	DDHHS	SCHHS	THHS
National emergency access target (NEAT) – full year ● ≥ 90.0% | ● ≥ 85.0% < 90.0% | ● < 85.0%	78.7%	76.1%	73.9%	73.7%	69.3%	82.5%	76.8%	88.0%
Queensland emergency access target (QEAT) – full year ● ≥ 90.0% | ● ≥ 85.0% < 90.0% | ● < 85.0%	78.7%	76.1%	73.9%	74.6%	81.2%	90.4%	76.8%	90.5%
Elective surgery patients treated within the clinically recommended time								
Category 1 – full year ● ≥ 98.0% | ● ≥ 95.0% < 98.0% | ● < 95.0%	98.1%	99.9%	94.4%	98.9%	98.9%	99.9%	96.8%	100.0%
Category 2 – full year ● ≥ 95.0% | ● ≥ 92.0% < 95.0% | ● < 92.0%	65.4%	99.9%	93.0%	93.2%	98.6%	99.8%	96.8%	100.0%
Category 3 – full year ● ≥ 95.0% | ● ≥ 92.0% < 95.0% | ● < 92.0%	87.8%	99.8%	96.9%	98.4%	99.5%	99.9%	99.7%	100.0%
Proportion of long waiting specialist outpatients								
Category 1—June 2015 (targets vary per HHS)	36.5%	39.3%	42.0%	54.4%	43.7%	1.8%	16.4%	0.0%
Category 2—June 2015 (targets vary per HHS)	54.0%	46.5%	56.5%	64.8%	67.6%	0.9%	42.5%	15.0%
Category 3—June 2015 (targets vary per HHS)	8.6%	12.9%	34.8%	45.5%	50.2%	0.1%	33.3%	5.9%
Increase in number of non-admitted patient telehealth service events ● ≥ 10.0% | ● ≥ 5.0% < 10.0% | ●< 5.0%								
*Efficiency measures^*								
Total targets met for average length of stay per DRG applicable to the HHS	4 / 6	13 / 13	15 / 16	16 / 16	14 / 16	14 / 16	15 / 16	16 / 16
Individual results for average length of stay (days) for DRGs where a HHS missed the target:								
DRG E65A lung conditions affecting flow of air through the airways with complications ● ≤ 9.0 days | ● > 9.0 days < 10.0 days | ● ≥ 10.0 days	13.0	4.5	6.9	5.8	7.5	4.5	7.2	6.1

	South East Queensland				Large regional			
	CHQHHS	GCHHS	MNHHS	MSHHS	CHHHS	DDHHS	SCHHS	THHS
DRG E65B lung conditions affecting flow of air through the airways without complications^^ ● ≤ 5.4 days | ● > 5.4 days < 6.0 days | ● ≥ 6.0 days	12.7	2.4	3.9	2.9	3.9	3.5	4.8	3.1
DRG H08B gall bladder removal without complications ● ≤ 1.8 days | ● > 1.8 days < 2.0 days | ● ≥ 2.0 days		1.3	1.9	1.7	1.8	2.0	2.1	1.6
DRG I03B hip replacement without catastrophic complications^^ ● ≤ 6.4 days | ● > 6.4 days < 7.0 days | ● ≥ 7.0 days		4.2	5.6	5.0	7.1	5.7	5.9	5.2
DRG M02B prostate gland removal without complications^^ ● ≤ 2.7 days | ● > 2.7 days < 3.0 days | ● ≥ 3.0 days			2.5	2.4	3.1	3.0	2.2	2.0
Cost per QWAU for ABF facilities ● ≤ QEP of $4 676 | ● > QEP of $4 676	$5 524	$4 600	$4 398	$4 570	$4 414	$4 139	$4 651	$4 483
*Funding initiatives^^^*								
For each initiative category: Funding earned / (reduced) ($'000) Proportion of available funding earned (%) Number of relevant initiatives where full funding earned								
Payment for outcomes	2 006 73% 1 / 2	4 597 56% 0 / 2	7 670 42% 0 / 2	3 614 23% 0 / 2	995 18% 0 / 2	2 426 47% 0 / 2	3 191 56% 0 / 2	3 269 50% 0 / 2
Quality improvement payments	179 74% 0 / 2	1 159 65% 1 / 5	1 360 38% 1 / 5	3 027 84% 3 / 5	693 49% 1 / 5	749 61% 0 / 5	1 068 81% 2 / 5	1 236 86% 2 / 5
Other initiatives	336 N/A	189 N/A	3 487 N/A	2 167 N/A	1 015 N/A	1 091 N/A	428 N/A	964 N/A
Adverse events	-210 N/A	-223 N/A	-3 633 N/A	-2 890 N/A	-280 N/A	-401 N/A	-605 N/A	-883 N/A
'Never' events	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil

		Other regional			Rural and remote			
	CQHHS	MHHS	WBHHS	WMHHS	CWHHS	NWHHS	SWHHS	TCHHS
Financial performance								
Total revenue ($'000)	491 754	346 180	500 161	452 451	62 910	148 611	126 738	181 824
Total expenditure ($'000)	493 974	333 507	500 097	454 197	63 069	150 559	122 897	179 672
Operating result ($'000)	-2 220	12 673	65	-1 746	-159	-1 948	3 841	2 152
Total assets ($'000)	553 194	523 164	208 260	347 426	51 796	110 725	115 187	216 487
Total liabilities ($'000)	31 162	20 275	21 537	40 563	3 784	12 499	11 270	14 155
Ratios								
Current ratio ● > 1.00 | ● < 1.00	1.82	4.31	1.07	1.67	0.96	1.04	1.71	2.0
Number of days cash available ● > 14 days | ● < 14 days	27.78	83.27	4.32	36.48	9.77	19.22	46.84	42.75
Audit matters								
Number of audit issues	10	4	9	8	13	11	9	17
Operational performance								
Safety measures								
Healthcare associated Staphylococcus (Including MRSA) Bacteraemia cases per 10 000 bed days ● ≤ 2 cases | ● > 2 cases	0.15	0.31	0.75	0.79	0.00	0.00	0.0	0.00
Access measures								
National emergency access target (NEAT)—full year ● ≥ 90.0% | ● ≥ 85.0% < 90.0% | ● < 85.0%	86.9%	79.0%	83.1%	82.6%		89.1%		
Queensland emergency access target (QEAT)—full year ● ≥ 90.0% | ● ≥ 85.0% < 90.0% | ● < 85.0%	88.5%	81.2%	83.1%	82.6%	97.8%	89.1%	97.1%	91.9%
Elective surgery patients treated within the clinically recommended time								

	Other regional				Rural and remote			
	CQHHS	MHHS	WBHHS	WMHHS	CWHHS	NWHHS	SWHHS	TCHHS
Category 1—full year ● ≥ 98.0% | ● ≥ 95.0% < 98.0% | ● < 95.0%	97.3%	99.9%	100.0%	99.9%		91.1%		
Category 2—full year ● ≥ 95.0% | ● ≥ 92.0% < 95.0% | ● < 92.0%	99.7%	100.0%	99.9%	99.6%		92.4%		
Category — full year ● ≥ 95.0% | ● ≥ 92.0% < 95.0% | ● < 92.0%	100.0%	100.0%	100.0%	100.0%		94.6%		
Proportion of long waiting specialist outpatients								
Category 1—June 2015 (targets vary per HHS)	22.2%	26.4%	2.0%	2.5%		55.3%		
Category 2—June 2015 (targets vary per HHS)	17.4%	24.6%	14.8%	17.7%		39.7%		
Category 3—June 2015 (targets vary per HHS)	2.1%	12.5%	2.7%	7.2%		6.5%		
Increase in number of non-admitted patient telehealth service events ● ≥ 10.0% | ● ≥ 5.0% < 10.0% | ● < 5.0%					101.0%	48.5%	107.7%	161.8%
*Efficiency measures^*								
Total targets met for average length of stay per DRG applicable to the HHS	16 / 16	15 / 16	16 / 16	16 / 16		10 / 11		
Individual results for average length of stay (days) for DRGs where a HHS missed the target:								
DRG H08B gall bladder removal without complications ● ≤ 1.8 days | ● > 1.8 days < 2.0 days | ● ≥ 2.0 days	1.8	2.6	1.8	1.0		2.3		
Cost per QWAU for ABF facilities ● ≤ QEP of $4 676 | ● > QEP of $4 676	$4 685	$4 625	$4 635	$4 291		$5 910		
*Funding initiatives^^^*								
For each initiative category: Funding earned / (reduced) ($'000) Proportion of available funding earned (%) Number of relevant initiatives where full funding earned								

	Other regional				Rural and remote			
	CQHHS	MHHS	WBHHS	WMHHS	CWHHS	NWHHS	SWHHS	TCHHS
Payment for outcomes	2 343 59% 0 / 2	1 328 50% 0 / 2	3 362 83% 0 / 2	1 803 48% 0 / 5		748 62% 0 / 5		
Quality improvement payments	499 51% 1 / 5	591 72% 1 / 5	445 47% 1 / 5	680 59% 2 / 5	106 78% 1 / 4	36 13% 0 / 5	99 48% 0 / 4	156 57% 1 / 4
Other initiatives	152 N/A	351 N/A	175 N/A	563 N/A	373 N/A	186 N/A	916 N/A	789 N/A
Adverse events	-95 N/A	-160 N/A	-490 N/A	-283 N/A	0 N/A	-38 N/A	0 N/A	0 N/A
'Never' events	Nil	Nil	Nil	Nil		Nil		

^ We report on potentially preventable hospitalisations in Chapter 4
^^ National key performance indicators on average length of stay include these DRGs
^^^ Figure G1 provides further information on these funding initiatives

Source: Queensland Audit Office compiled from Department of Health and Hospital and Health Service data

Appendix D—Results of financial statements simplification

Figure D1
Results of financial statements simplification

HHS classification	HHS	2015 No. of note disclosures	2014 No. of note disclosures	Change in number of disclosure
South East Queensland	CHQHHS	28	35	-7
	GCHHS	26	34	-8
	MNHHS	25	35	-10
	MSHHS	31	36	-5
Large regional	CHHHS	30	36	-6
	DDHHS	26	30	-4
	SCHHS	34	40	-6
	THHS	24	38	-14
Other regional	CQHHS	26	28	-2
	MHHS	26	33	-7
	WBHHS	24	35	-11
	WMHHS	30	35	-5
Rural and remote	CWHHSS	24	29	-5
	NWHHS	33	34	-1
	SWHHS	25	30	-5
	TCHHS*	34		34
Sector average		28	34	-6

* First year of operation therefore no reduction in notes.

Source: Queensland Audit Office

Appendix E—Queensland HHS areas

Figure E1
Hospital and Health Service areas and facilities

Source: Department of Health

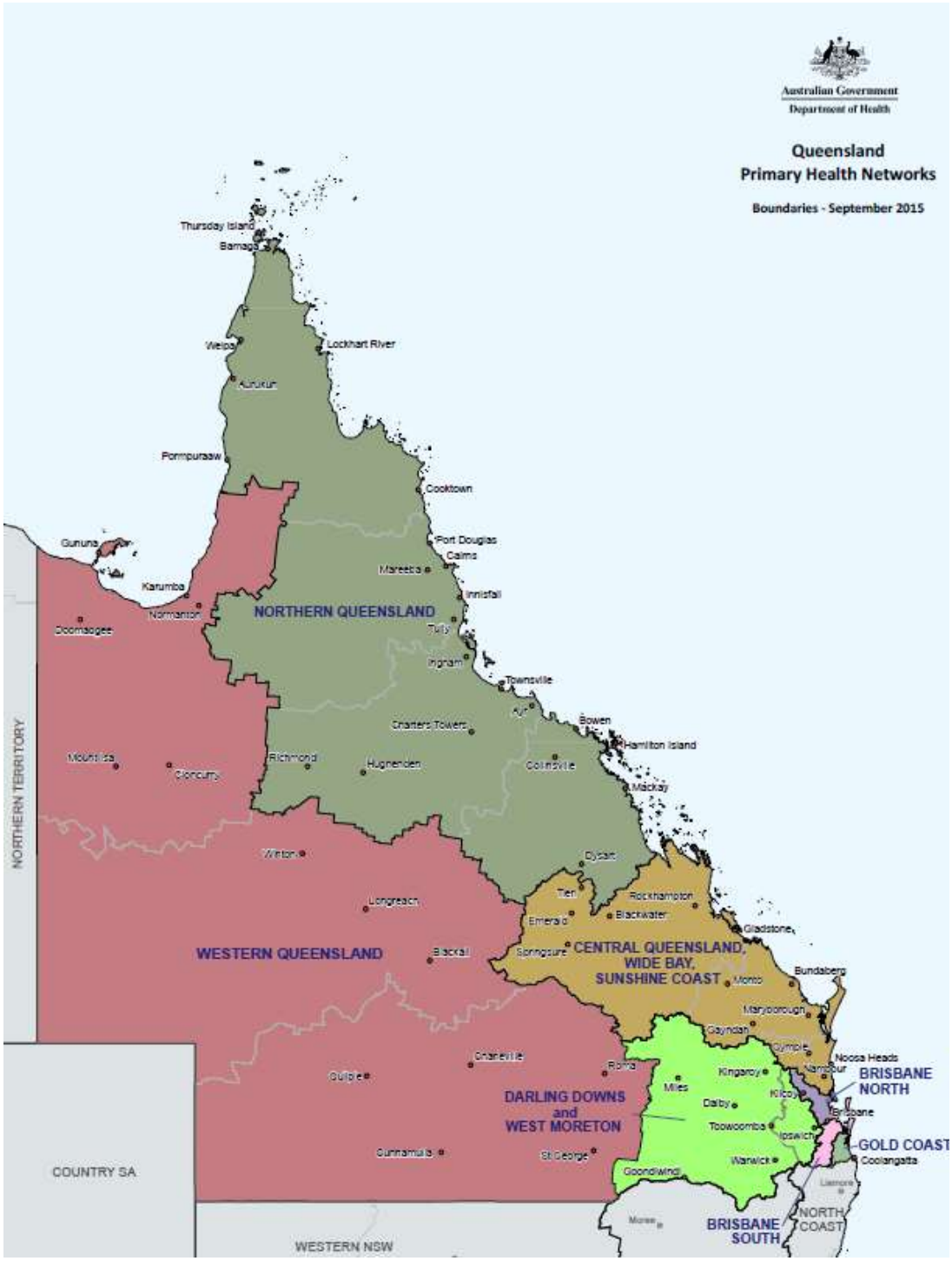
Appendix F—Queensland primary health networks

Figure F1
Listing of Queensland primary health networks

Primary health network	Operator
Brisbane North	Partners 4 Health Ltd
Brisbane South	Metro South Medicare Local Ltd
Gold Coast	Primary Care Gold Coast Limited
Darling Downs and West Moreton	Darling Downs and West Moreton Primary Health Network Limited
Western Queensland	Western Queensland Primary Care Collaborative Limited
Central Queensland, Wide Bay, Sunshine Coast	Sunshine Coast Health Network Ltd
Northern Queensland	North Queensland Primary Healthcare Network Limited

Source: Department of Health (Australian Government)

Figure F2
Queensland primary health networks boundaries



Note: this map overlays the HHS boundaries as disclosed in Figure D1.

Source: Department of Health (Australian Government)

Appendix G—Funding initiatives 2014–15

Figure G1
Funding initiatives for HHS in 2014–15

Category	Initiative	Description
Payment for outcomes	Specialist outpatient access	The percentage of people who were, at a monthly census date, waiting within the clinically recommended time for their urgency category for an initial specialist outpatient appointment.
	Chronic disease readmissions	The percentage of patients readmitted as an emergency with a chronic condition to any Queensland hospital within 28 days of any in-scope index admission.
Quality improvement payments	Childhood immunisation	The percentage of children fully immunised for their age cohort.
	Smoking cessation	The proportion of inpatients clinically supported onto the smoking cessation clinical pathway.
	Stroke	The proportion of acute stroke presentations receiving stroke unit care (for HHSs with stroke units), and targets in the proportion of stroke patients receiving specialist stroke support and multidisciplinary care (for HHSs without stroke units).
	Non-admitted data	The quality of non-admitted patient level data for national reporting requirements.
	Palliative care	The proportion of patients who were given the opportunity to contemplate an advance care plan (ACP).
Other initiatives	Telehealth	Paying for additional outpatient telehealth activity or provision of telehealth consultancy for inpatients.
	Rural care activity volume	Additional payment to block funded F and G facilities at a marginal rate ($2 220 per QWAU) for additional activity up to cap (capped to 10% above the 2014–15 purchased QWAUs for each F/G facility).
	High cost / low volume	Additional payments for unforeseen variations in high cost, low volume activity.
Adverse events	Pressure injury	Disincentives to minimise hospital acquired stage 3 and 4 pressure injuries.
	Blood stream infections	Disincentives to minimise hospital acquired blood stream infections.
	Psychotropic medication	Disincentives to minimise hospital acquired injury associated with administration of psychotropic medication for mental health inpatients.
	Mental health frequent re-admissions	No payment for more than ten admissions to acute mental health inpatient units within 12 months.
'Never' events	'Never' events	Zero payment for six ‘never’ events. A 'never event' is defined as serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.

Source: HHS Service Agreements

Appendix H—Glossary

Figure H1
Glossary

Terms	Definition
Accountability	Responsibility on public sector entities to achieve their objectives about the reliability of financial reporting, effectiveness and efficiency of operations, compliance with applicable laws, and reporting to interested parties.
Australian accounting standards	Technical pronouncements that set out the required accounting for particular types of transactions and events. The Australian Accounting Standards Board (AASB) sets these standards.
Australian Refined Diagnosis-Related Group (DRG)	Australian admitted patient classification system that provides a clinically meaningful way of relating the number and type of patients treated in a hospital to the resources required by the hospital. Each DRG represents a class of patients with similar clinical conditions requiring similar hospital services.
Asset	A resource controlled by an entity as a result of past events and from which future economic benefits are expected to flow to the entity.
Asset valuation	The process of determining the fair market value of an asset.
Auditor-General Act 2009	An Act of the State of Queensland that establishes the responsibilities of the Auditor-General, the operation of the Queensland Audit Office, the nature and scope of audits to be conducted and the relationship of the Auditor-General with parliament.
Audit opinion	Positive written expression within a specified framework indicating the auditor's overall conclusion on the financial report based on audit evidence obtained.
Average length of stay	The total number of days spent in a hospital divided by the number of stays
Casemix	The range and types of patients (the mix of cases) treated by a hospital or other health service. Casemix classifications (such as DRGs) provide a way of describing and comparing hospitals and other services for management purposes.
Depreciation	The systematic allocation of a fixed asset's capital value as an expense over its expected useful life to take account of normal use, obsolescence or the passage of time.
Efficiency	The use of resources so output is optimised for any given set of resource inputs or input is minimised for any given quantity and quality of output.
Episode of care	A period of health care with a defined start and end.
Expense	Outflow of cash or other assets from an entity to another person, company or entity.

Terms	Definition
Financial Accountability Act 2009	An Act of the State of Queensland that establishes the accountability for the administration of the state's finances and for financial administration of departments and statutory bodies, as well as annual reporting to parliament by departments and statutory bodies.
Financial report	Structured representation of the financial information, which usually includes accompanying notes, derived from accounting records and used to communicate an entity's economic resources or obligations at a point in time or the changes for a period in accordance with a financial reporting framework.
Financial and Performance Management Standard 2009	Subordinate legislation of the State of Queensland that provides a framework for an accountable officer of a department or a statutory body to develop and implement systems, practices and controls for the efficient, effective and economic financial and performance management of the department or statutory body.
Financial reporting requirements	Queensland reporting requirements for annual financial statements used to assist departments and statutory bodies in the preparation of their financial statements. They include additional guidance and advice on new and revised accounting policies and standards.
Financial sustainability	An entity's ability to manage financial resources so it can meet its spending commitments both at present and into the future.
Financial year	The period of 12 months for which a financial report is prepared.
Fraud	An intentional act by one or more individuals among management, those charged with governance, employees or third parties involving the use of deception to obtain an unjust or illegal advantage.
Governance	The control arrangements in place at an entity that govern and monitor its activities to achieve its strategic and operational goals.
Hospital and Health Services (HHSs)	Entities established as statutory bodies under the *Hospital and Health Boards Act 2011*. An independent Hospital and Health Board controls each HHS.
Hospital and Health Boards Act 2011	An Act of the State of Queensland that sets out financial reporting and annual reporting requirements for Hospital and Health Boards.
Internal control	The process designed, implemented and maintained by those charged with governance, management and other personnel to provide reasonable assurance about achieving reliability of financial reporting, effectiveness and efficiency of operations and compliance with applicable laws and regulations. Internal controls play an important role in preventing and detecting error and fraud and protecting the entity's resources.
Legislative timeframe	The date prescribed by legislation for a public sector entity to finalise its financial statements or annual report.
Liability / liabilities	A present obligation of the entity arising from past events, the settlement of which is expected to result in an outflow of resources from the entity.

Terms	Definition
Materiality	Depends on the size or nature of the item or error judged in the particular circumstances of its omission or misstatement; information is material if its omission or misstatement could influence the economic decisions of users taken, based on the financial statements.
Misstatement	A difference between the amount, classification, presentation or disclosure of a reported financial report item and the amount, classification, presentation or disclosure that is required for the item to be in accordance with the applicable financial reporting framework; misstatements can arise from error or fraud.
National Emergency Access Target (NEAT) and Queensland Emergency Access Target (QEAT)	The percentage of patients who attended an emergency department (ED) whose length of stay in the ED was within four hours. NEAT results report on 26 hospitals each year. QEAT results include an additional 32 hospitals on top of the 26 NEAT hospitals.
Net assets	Total assets less total liabilities.
Operating result	An entity's total revenue less their total expenses to show what the entity has earned or lost in a given period.
Prescribed requirements	Requirements prescribed by an Act or a financial management standard. Prescribed requirements do not include the requirements of a financial management practice manual.
Relative stay index	The actual number of patient days for acute care separations in selected Australian Refined Diagnosis-Related Groups (DRGs) divided by the expected number of patient days adjusted for casemix. Includes acute care separations only. Excludes patients who died or were transferred within two days of admission, or separations with length of stay greater than 120 days, DRGs for 'rehabilitation', DRGs which are predominantly same day (such as R63Z chemotherapy and L61Z admit for renal dialysis), DRGs which have a length of stay component in the definition, and error DRGs.
Revenue	Income received from normal business activities.
Risk	The effect of uncertainty on objectives. An effect is a deviation from the expected—positive and/or negative. Objectives can be strategic, operational or functional (such as financial, fraud or clinical) and can apply at different levels (such as system-wide, HHS, team or project).
Weighted activity unit (WAU)	A unit of measure used to compare different health services based on the level of resource utilisation. The Independent Hospital Pricing Authority (an Australian Government Body) determines the value of a national weighted activity unit (NWAU). The Queensland Department of Health determines the value of a Queensland weighted activity unit (QWAU).

Source: Queensland Audit Office

Auditor-General Reports to Parliament

Reports tabled in 2015–16

Number	Title	Date tabled in Legislative Assembly
1.	Results of audit: Internal control systems 2014–15	July 2015
2.	Road safety – traffic cameras	October 2015
3.	Agricultural science research, development and extension programs and projects	November 2015
4.	Royalties for the regions	December 2015
5.	Hospital and Health Service entities 2014–15	December 2015

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