Queensland Audit Office

Results of audit: Hospital and Health Service entities 2013-14

Report 5: 2014–15

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Queensland Audit Office

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The Honourable F Simpson MP
Speaker of the Legislative Assembly
Parliament House
BRISBANE QLD 4000

Dear Madam Speaker

Report to Parliament

This report is prepared under Part 3 Division 3 of the *Auditor-General Act 2009*, and is titled *Results of audit: Hospital and Health Service entities 2013–14* (Report 5: 2014–15).

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
Auditor-General

Contents

Summary

There were 17 Hospital and Health Services (HHSs) as principal providers of public health services across the metropolitan, regional and rural areas of Queensland during 2013–14.

HHSs were established on 1 July 2012 and are statutory bodies. Except for Torres Strait—Northern Peninsula HHS where the Director-General, Department of Health acted as the administrator, each HHS is governed independently and locally by a Hospital and Health Board. The Board is accountable to the Minister for Health for the performance of the HHS.

The functions and powers of HHSs and their relationships with the Department of Health (DoH) are set out in the *Hospital and Health Boards Act 2011*. DoH is responsible for the overall management of the public health system through a binding service agreement with each HHS.

The annual report of each HHS is the primary accountability document, reporting on HHS activities to its stakeholders and users of its services. It sets out the operational and financial performance and financial position of HHSs and includes audited financial statements. The audit opinion accompanying the financial statements provides readers with added assurance that the financial statements are reliable.

This report summarises the results of our 2013–14 financial audits of the 17 HHSs.

Conclusions

All 17 HHSs received an unmodified audit opinion for 2013–14; the same good result as last year, confirming the reliability of HHS financial statements in reporting the results of financial operations and assets and liabilities as at 30 June 2014.

The unmodified audit opinions for Cape York HHS and Torres Strait—Northern Peninsula HHS each included an emphasis of matter paragraph to highlight to the reader these two HHSs were abolished on 30 June 2014. The assets and liabilities of these HHS were transferred to the new Torres and Cape HHS which was established on 1 July 2014.

Also consistent with last year was the timely finalisation of their financial statements with all HHSs meeting the two-month legislative time frame for the preparation and audit of their financial statements by the end of August.

We noted an improvement in financial administration and practices at most HHSs, which can be broadly attributed to the management and finance staff of HHSs having a better understanding, in this second year of HHS operations, of financial management and reporting requirements and responsibilities.

All HHSs are in a sound financial position, with adequate liquidity to meet their short term liabilities. Solid net asset positions and no long term debt means all HHSs are financially sustainable in the medium to longer term.

Results of audit

We benchmarked the preparation processes used by HHSs to prepare financial statements against accepted better practice; processes at 11 HHSs (13 HHSs in 2012–13) were mostly satisfactory while the remaining six HHSs (four HHSs in 2012–13) require improvement.

Three of the four HHSs that required improvement in 2012–13 achieved a satisfactory level in 2013–14. This was a good result.

HHSs in rural and remote parts of the state face ongoing challenges of recruiting and retaining experienced finance staff. This was evident at five of the six HHSs requiring improvement in 2013–14 where the loss of experienced finance staff contributed to a deterioration in the quality of their financial statements preparation processes, compared to 2012–13.

Most HHSs have demonstrated good progress in adopting strategies for timely preparation of financial statements.

There were 16 HHSs that prepared a set of pro forma or 'shell' financial statements before 30 June 2014. This allowed management and audit to review early and provide more timely feedback on the statements which reduced subsequent time required to finalise a complete set of statements.

Across the HHS sector, the overall quality of these pro forma statements was better than in 2012–13, with 11 HHSs preparing good quality statements.

Improvements in financial statements preparation planning and quality assurance processes are required. Only four HHSs met their time table for providing their final draft financial statements to audit while only eight HHSs prepared consistent, good quality work papers to support the financial statements.

Most HHSs achieved good quality draft financial statements or improved from 2012–13.

Internal controls

We found internal control weaknesses at all 17 HHSs. No weaknesses were serious enough to require qualification of the audit opinion.

We identified a total of 153 significant issues, compared with 159 issues in 2012–13. All control weaknesses have been reported directly to the relevant HHS for management action. All HHSs have instituted or progressed corrective action to address these deficiencies.

Across the HHS sector, we noted a general improvement in financial administration and practices. The volume of control weaknesses indicated improving systems of internal controls needs to continue to become fully effective.

There were 125 issues (81.7 per cent) raised relating to deficiencies in control activities at HHSs. These controls are meant to reduce the risks of fraud and error, to detect these should they occur and to ensure necessary corrective action is taken.

DoH provides financial processing services to each HHS but there is no formal agreement to clarify the arrangements. This can lead to significant risk for each HHS.

All HHSs use the same DoH information technology systems for pharmacy and general purchasing but configuration deficiencies in these systems weaken the financial controls at HHSs.

Financial sustainability

HHSs rely significantly on state and federal funding, with $9.14 billion (89.2 per cent) of revenue from government to provide health-related services.

The financial performance of HHSs is measured primarily by their operating results because, under the service agreement and funding arrangements, the target operating result for each HHS is break-even or a surplus because DoH does not necessarily fund deficits. Twelve HHSs achieved this result.

We also used other financial ratios to measure short term financial sustainability. All HHSs are in a favourable position under the current funding arrangements, with adequate liquidity to meet their liabilities as they fall due.

No HHS has long term debt because DoH constructs and funds major infrastructure assets which, when completed, transfer to HHSs at no cost.

Operational efficiency and funding

The National Health Reform Agreement (NHRA) committed the Australian, state and territory governments to work in partnership to implement new arrangements for the health system, including the use of activity based funding (ABF). This means that funding is provided to most hospitals on the basis of activity provided at a fixed efficient price.

The introduction of the national ABF model from 1 July 2014 presents both opportunities and challenges for HHSs.

If HHSs can improve their efficiency in providing health-related services at the lowest possible cost then additional services can be provided because Commonwealth funding does not reduce in the short term for efficiency gains. Seven of 13 HHSs funded by activity in 2013–14 delivered services at an average cost below the Queensland benchmark.

The challenge for HHSs is to maintain and improve their efficiency to take advantage of available Commonwealth funds without compromising the quality of health care outcomes.

'ABF readiness' assessments performed by HHSs identified improvements are required in governance; recruitment and retention of clinical coders; clinical documentation; and costing systems.

Recommendations

It is recommended that the Hospital and Health Services in conjunction with the Department of Health:

1. **formalise shared service provider arrangements through a written service level agreement**
2. **implement controls at Hospital and Health Services to monitor the financial transactions processed on their behalf by Department of Health**
3. **implement controls to allow for the effective exercise of financial delegation for Hospital and Health Services approving:**
    - **purchases of inventory from central pharmacy**
    - **other purchase orders greater than $50 000.**

Reference to comments

In accordance with section 64 of the *Auditor-General Act 2009*, a copy of this report was provided to the Minister for Health; the Director-General, Department of Health; and the Board Chairs and Chief Executives of Hospital and Health Services. They were afforded the opportunity to provide comments for inclusion in this report. Their views have been considered in reaching our audit conclusions and are represented to the extent relevant and warranted in preparing this report.

The Department of Health provided a response and these comments are included in Appendix A of this report.

1 Context

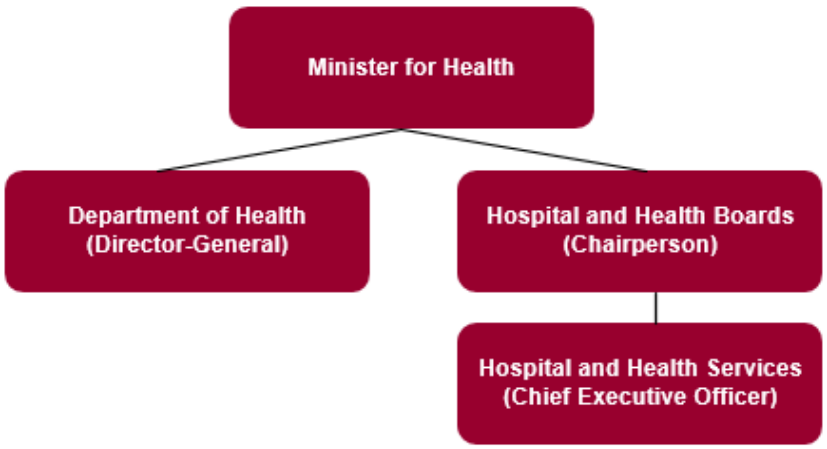
On 1 July 2012, 17 Hospital and Health Services (HHSs) were established across the state as the principal providers of public health services. These services are delivered by 182 public hospitals and health care facilities which the HHSs administer.

The Department of Health (DoH) is the manager of the health system and, through the Director-General, reports to the Minister for Health. The role of the system manager is to:

- purchase health care services from the HHSs
- manage statewide planning and industrial relations
- set policies, regulations and health service directives
- monitor performance of HHSs and the system as a whole
- collate and validate performance data and provide data to the Commonwealth.

This legal relationship is depicted in Figure 1A.

Figure 1A
Legal relationship between Minister, Department of Health and the HHSs
1 July 2012 to present



Source: Queensland Audit Office

The DoH Director-General has acted as the administrator of the Torres Strait—Northern Peninsula HHS from inception, holding the full powers of a board. This structure was put in place, rather than oversight by a Hospital and Health Board, due to the challenges of finding suitable board members for a remote location.

The *Hospital and Health Boards Amendment Regulation (No. 1) 2014*, made by Governor in Council on 24 April 2014, amended the *Hospital and Health Boards Regulation 2012* to establish a new Torres and Cape HHS, commencing on 1 July 2014.

The Cape York HHS and the Torres Strait—Northern Peninsula HHS were amalgamated to form this new Torres and Cape HHS as a single health service for the far north of the state under one Hospital and Health Board. The Cape York HHS and the Torres Strait—Northern Peninsula HHS were abolished on 30 June 2014.

DoH retains responsibility for overall management of the public health system performance. As required by the *Hospital and Health Boards Act 2011*, a binding service agreement between DoH and each HHS establishes the hospital and health-related services. The agreement also establishes teaching, research and other services the HHS provides, funding for these services and the performance outcomes for which the HHS is accountable.

Current service agreements cover the period from 1 July 2013 to 30 June 2016. The service agreement is underpinned by the HHS performance framework which describes how DoH monitors and manages the performance of HHSs in delivering public health services.

1.1 Financial reporting requirements

HHSs are statutory bodies under the *Hospital and Health Boards Act 2011* and, except for the Torres Strait—Northern Peninsula HHS, each is independently and locally controlled by a Hospital and Health Board. As statutory bodies, HHSs are subject to the requirements of the *Financial Accountability Act 2009*. Each Board is accountable to the Minister for Health.

Each HHS prepares general purpose financial statements in accordance with Australian accounting standards. As statutory bodies, HHSs are required, when preparing their annual financial statements, to have regard to the minimum reporting requirements contained in the financial reporting requirements for Queensland government agencies issued by Queensland Treasury and Trade.

The Financial and Performance Management Standard 2009 requires each HHS to provide draft financial statements for audit by an agreed date. This allows sufficient time to conduct the audit and to issue the audit opinion, required no later than two months after the end of the financial year to which the statements relate, that is, by 31 August.

The chairperson and the executive responsible for financial administration at each HHS must certify compliance with legislative requirements around establishing and keeping the accounts; that the financial statements present fairly the transactions for the financial year and the financial position; and that these financial reporting assertions are based on an appropriate system of internal control and risk management processes.

The *Financial Accountability Act 2009* requires that audited financial statements are included in the annual report of each HHS. It also requires that the annual report is given to the Minister by a date which allows the report to be tabled in Parliament by the Minister within three months after the end of the financial year to which the report relates.

The annual report of two HHSs were tabled in Parliament by 30 September 2014. The Minister has extended the tabling period for the remaining 15 HHSs, as authorised by the Financial and Performance Management Standard 2009. All annual reports were tabled in Parliament by 31 October 2014.

1.2 Audit responsibilities

Section 40 of the *Auditor-General Act 2009* requires the Auditor-General to audit the annual financial statements of all public sector entities, including those of statutory bodies and to prepare an auditor's report about the financial statements.

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, one or more of the following audit opinion types may be issued:

- 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.

Emphases of matter may be included with the audit opinion to highlight issues of which the auditor believes the users of the financial statements need to be aware. The inclusion of emphases of matter do not modify the audit opinion.

The *Auditor-General Act 2009* requires that, after the audit opinion has been issued, a copy of the certified statements and the auditor's report must be provided to the chief executive of the HHS and the Minister for Health.

As an integral part of the financial audit, the main components of each HHS's internal control framework are assessed to determine if the financial reporting controls in place are operating effectively, as well as the extent of compliance with legislative requirements.

If, in our professional judgement, we determine that controls are not well designed; that any of the controls that we tested did not operate as intended; or that controls should be in place but are missing, we are required by the auditing standards to communicate such controls deficiencies to management. We assign a risk rating to any financial controls deficiencies we raise so management can gauge their relative importance.

Significant controls deficiencies are communicated in writing to the board chair and the chief executive of the HHS and we assign these either a high or moderate risk rating;

- A high risk rating is applied where we have identified a serious control weakness or breakdown in the operation of a key control or combination of key controls, indicating the risk of material error or fraud in the financial statements is unacceptably high. These require prompt management action with a detailed action plan implemented quickly, generally within three months.
- A moderate risk rating is applied where we have identified a significant control weakness or breakdown in the operation of a control that it is not likely to prevent or detect the errors for which it was designed. These require management action with a detailed plan to be implemented within six months.

The *Auditor-General Act 2009* also requires that the Auditor-General reports to Parliament on each financial audit conducted. The report must state whether the audit has been completed and the financial statements audited. It must also include details of significant deficiencies where financial management functions were not performed adequately or properly.

This report satisfies these requirements.

1.3 Cost and structure of the report

The cost of preparing this report, including collation and confirmation of data that underpin matters reported was $150 000.

The report provides an overview of the financial administration and reporting issues of the 17 HHSs and is structured as follows:

- Chapter 2 provides the audit results of HHSs, including significant financial reporting issues and timeliness and quality of their financial statements
- Chapter 3 assesses the key internal controls over the reliability of financial reporting
- Chapter 4 presents the financial performance and position and examines the financial sustainability of HHSs
- Chapter 5 assesses the operational efficiency of HHSs and describes their funding arrangements
- Appendix A contains comments from entities subject to this audit
- Appendix B contains the status of the 2013–14 HHS financial statements
- Appendix C outlines better practice for preparation of financial statements
- Appendix D describes financial sustainability measures
- Appendix E contains a map of the areas covered by HHSs
- Appendix F contains a glossary of terms.

2 Results of audit

In brief

Background

There were 17 Hospital and Health Services (HHSs) located throughout Queensland in rural and urban areas required to prepare financial statements for 2013–14 and to include these statements in their annual reports.

Conclusions

We issued unmodified audit opinions for all 17 HHSs and they all met their two-month legislative time frame to finalise their financial statements. An emphasis of matter was included with the audit opinions for two HHSs to highlight that they were abolished on 30 June 2014.

Most HHSs have improved their processes to prepare financial statements and the quality of their draft statements, compared to their first year of operations in 2012–13. More improvement is needed if all HHSs are to achieve good practice consistently when measured against benchmarks for financial statement preparation.

Key findings

- Management and audit certified the financial statements for 17 HHSs by 31 August 2014 and all were issued with unmodified audit opinions.
- We included an emphasis of matter with our audit opinion for Cape York HHS and for Torres—Northern Peninsula HHS, identifying that they were abolished on 30 June 2014 and their assets and liabilities transferred to the new Torres and Cape HHS established on 1 July 2014.
- The financial statements preparation processes of 11 HHSs (13 HHSs in 2012–13) is satisfactory, while continued improvement is needed by six HHSs (four HHSs in 2012–13).

2.1 Background

There were 17 Hospital and Health Services (HHSs) which prepared financial statements for 2013–14.

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

2.2 Conclusions

All HHSs met the two-month legislative time frame to finalise their financial statements, consistent with the results in 2012–13 and all obtained clear audit opinions.

The aim for each HHS to have a robust process to prepare financial statements which produces both timely and reliable draft statements for auditing has yet to be realised fully.

Most HHSs have improved their processes to prepare financial statements and the quality of their statements when compared to their first year of operations in 2012–13. Staff turnover in the finance teams of five remote and regional HHSs contributed to a deterioration in the quality of their financial statement preparation processes this year, compared to 2012–13.

In 2012–13, 10 HHSs met the agreed date to provide their draft financial statements for audit, but these statements were not always complete. This resulted in a large volume of adjustments before they could be certified.

In 2013–14, only four HHSs met the agreed date to provide their draft financial statements for audit, but fewer adjustments were required to those statements.

2.3 Audit opinions

We issued unmodified audit opinions for all 17 HHSs, as was the case in 2012–13. An unmodified audit opinion confirms that the financial statements have been prepared in compliance with relevant accounting standards and prescribed requirements.

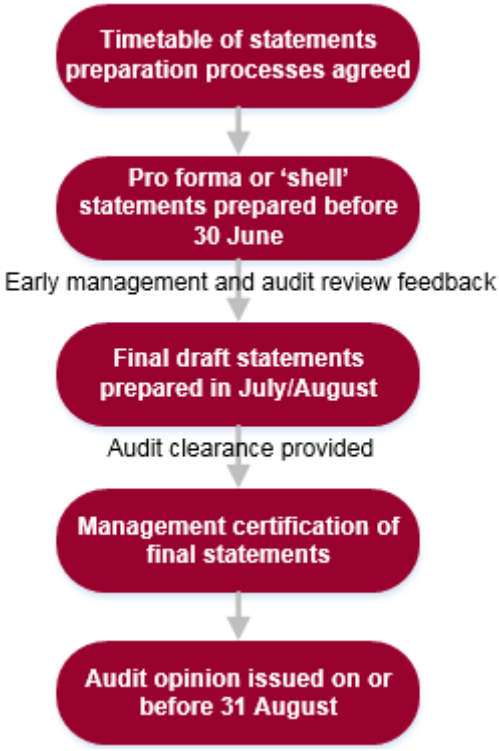
The unmodified audit opinions for Cape York HHS and Torres Strait—Northern Peninsula HHS each included an emphasis of matter to highlight to the reader that these two HHSs were abolished on 30 June 2014 and their assets and liabilities transferred to the new Torres and Cape HHS.

2.4 Timeliness of financial statements

The timeliness of financial statements ensures they are useful and relevant in public sector accountability and government decision making. The later financial statements are produced and published after their balance date, the less useful they become.

Figure 2A illustrates the key phases involving active consultation between audit and management which help in finalising timely financial statements.

Figure 2A
Key financial statements phases



Source: Queensland Audit Office

All 17 HHSs met the legislative time frame of 31 August 2014 to prepare and audit HHS financial statements. The dates the financial statements were signed by management and the audit opinion issued are in Appendix B. Most HHSs have progressed and refined 2012-13 strategies to bring forward the planning and preparation process for financial statements before 30 June:

- 16 HHSs (the same as in 2012–13) prepared a set of pro forma financial statements before 30 June 2014 for early management and audit review; the remaining HHS provided its pro forma financial statements in early July 2014
- non-current asset revaluations were completed
- asset stocktakes were completed, including the investigation of any discrepancies and management endorsement of results
- accounting issues were resolved for one-off, complex or significant transactions and changes in accounting policies or estimations.

Figure 2B shows that only four HHSs (10 HHSs in 2012–13) met the agreed date to provide their final draft financial statements for audit, including their supporting working papers.

Figure 2B
Timeliness of key milestones of financial statements

Milestone	Who	Number of HHSs achieving milestone 2012–13	Number of HHSs achieving milestone 2013–14
Final draft of financial statements completed by agreed date	HHS	10	4
Financial statements certified by management by agreed date	HHS	5	16
Audit opinion issued by 31 August 2014	QAO	17	17

Source: Queensland Audit Office

In 2012–13, the first year for HHSs to prepare financial statements, we accepted draft financial statements that may not have been totally complete as meeting the agreed date for providing statements to us to progress audit of financial statements. The expectation was that the financial statements preparation process would improve in 2013–14.

As part of the 2013–14 agreement, we had advised HHSs that 'final draft financial statements' meant statements that were complete, of a quality that management would be prepared to sign and which required no or minimal adjustments. These criteria are consistent with those applied to all other public sector agencies.

Establishing agreed milestones helps HHSs finalise and provide timely financial statements for management and audit to complete within the statutory time frame.

Failing to provide complete, final draft financial statements by the agreed milestone date can result in additional audit costs for the HHS to meet the statutory time frame for providing an audit opinion. We may commence with an incomplete set of financial statements but this is not the most efficient way to complete the audit process and may result in us checking a number of draft versions before a complete final set of statements is finalised.

The reasons for not achieving the agreed date in 2013–14 included:

- delays in key management personnel data provided to 12 HHSs from the shared service provider
- turnover in finance staff, resulting in loss of experience in financial statements preparation at five HHSs
- understanding the new reporting requirements for disclosing the fair value of land and buildings.

2.5 Quality of draft financial statements

Most HHSs achieved good quality draft financial statements and supporting work papers or, if not, have shown improvement in preparing them.

2.5.1 Process quality

The processes of the 17 HHSs to prepare financial statements were benchmarked against recognised better practices presented in Appendix C.

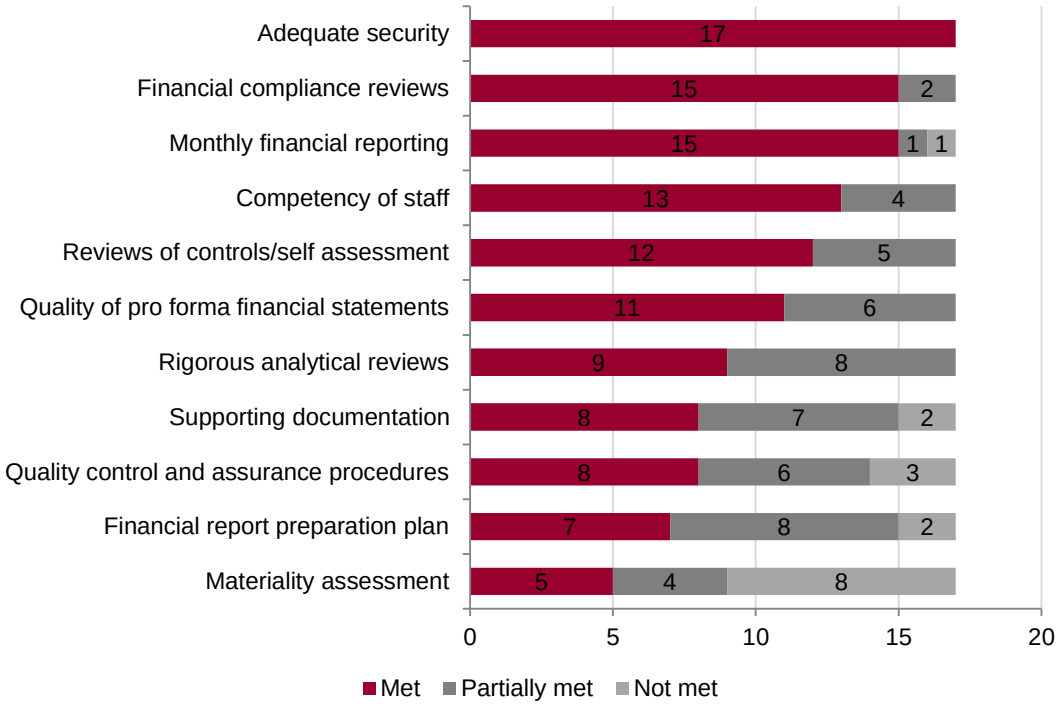
We assessed the processes of 11 HHSs (13 HHSs in 2012–13) to prepare financial statements as satisfactory overall; six HHSs (four HHSs in 2012–13) need continued improvement.

Five of the six HHSs that require improvement experienced turnover in finance staff during 2013–14 that resulted in loss of experience in preparation of financial statements. These five HHSs are located in regional and remote parts of the state where it can be difficult to recruit and retain suitably qualified finance staff. This represents an ongoing challenge for the HHSs to maintain or improve the quality of their financial management and reporting.

Three of the four HHSs assessed as needing improvement in 2012–13 achieved satisfactory processes to prepare financial statements for 2013–14.

Figure 2C shows our combined assessment of all HHSs' processes to prepare financial statements measured against better practice. The 'partially met' rating means elements within the better practice component were partially performed and further process improvement is required.

Figure 2C
Combined assessment of preparation processes for financial statements



Source: Queensland Audit Office

Nine HHSs that had 'not met' or 'partially met' ratings in 2012–13 have improved on these ratings for some components of better practice this year.

There is scope for improvement to strengthen the financial report preparation plan, given that only seven of 17 HHSs prepared a good quality detailed plan. A plan that provides sufficient details of the processes or tasks; shared service provider commitments; milestones; responsible officers and oversight; and that is rigorously monitored can help to achieve many of the better practice processes.

Improvement in the quality of the pro forma financial statements provided to audit is also required, given 11 of 17 HHSs prepared a set of good quality statements.

When good quality pro forma statements are prepared, this can streamline the financial statements process for both management and audit. We can undertake early verification of some elements of the statements and provide more timely and relevant feedback to management which reduces the time to finalise the complete set of draft statements.

Supporting work papers provide the essential connection between the financial accounting records and the financial statements. Poor preparation and review of work papers can directly affect the completeness and accuracy of financial statements balances and note disclosures. It also affects the efficiency of the financial statements audit, so the audit takes longer than it otherwise would or should have.

Work papers should include sufficient details of evidence to support each material account balance, referenced to supporting documentation such as reconciliations, results of stocktakes, confirmations from external parties and information about significant assumptions used in the calculation of balances.

Work papers should also be cross-referenced to the general ledger trial balance; and be subject to independent quality review that ensures the completeness and accuracy of the information.

Eight HHSs prepared consistent, good quality supporting documentation. Nine HHSs require further improvement with some work papers not prepared in a timely manner, lacking sufficient details, incomplete or incorrect. This indicates that the quality control over the preparation of work papers could be improved.

2.5.2 Adjustments

Before being given to audit, financial statements should be subject to appropriate internal quality assurance checks to confirm they are complete, materially accurate and compliant with reporting and disclosure requirements.

Ideally, only one set of financial statements should be prepared by management, with no adjustments required. The frequency and size of errors identified in the draft financial statements that required adjustment are direct measures of the draft statements' quality.

Any errors we detect in the draft financial statements are raised with management. Material errors require correction so an unqualified audit opinion can be issued. The entity itself may also change its draft financial statements, after submitting them to audit, if its quality assurance procedures subsequently identify that reported information is incorrect or incomplete.

Broadly, there are two types of adjustments:

- adjustments to financial statements—changes to the amounts being reported
- disclosure adjustments—changes to the commentary or financial note disclosure within the financial statements.

Figure 2D shows the combined adjustments made to financial statements by component.

Four of the 17 HHSs (10 HHSs in 2012–13) made adjustments initiated by management or arising from audit examinations to the final draft financial statements before audit opinions were issued.

The reduced number and value of adjustments, while positive, may represent a change in our method of reporting adjustments made rather than an improvement in the quality of preparation of financial statements.

In 2012–13, we determined the number and value of adjustments from the first reasonable set of draft statements. These statements were not always fully complete.

In 2013–14, we assessed timeliness of statements and adjustments made against the final complete set of draft financial statements provided to audit; however, in many cases, our audit of the financial statements commenced on an incomplete draft version.

We did note a general improvement had occurred for most HHSs in the quality of their draft financial statements, compared to 2012–13.

Figure 2D
Combined adjustments made to financial statements by component

Area of financial statements	2012–13 $ m	2013–14 $ m
Income	3.80	11.68
Expenses	16.34	1.84
Other comprehensive income	130.10	10.87
Net result	129.30	13.52
Assets	51.00	1.82
Liabilities	12.34	0.83
Equity	36.36	2.65
Total adjustments	**379.24**	**43.21**
Number of HHSs that processed a change	**10**	**4**

Source: Queensland Audit Office

For 2013–14, the significant adjustment illustrated in Figure 2D relates to an asset revaluation increase of $10.87 million at one HHS, which required adjustments to its income, other comprehensive income and net result.

Adjustments were also made to the notes to the financial statements to comply with disclosure requirements of HHS accounting policies, accounting standards and the Queensland Treasury and Trade financial reporting requirements.

These changes led to enhanced disclosures about:

- accounting policies adopted
- key executive remuneration
- land and buildings
- events occurring after balance date.

2.6 Significant financial reporting issues

Significant financial reporting issues were identified during 2013–14 to be resolved before forming an audit opinion on the financial statements.

2.6.1 Transfer of land and building ownership

Our report last year, *Results of audit: Hospital and Health Services entities 2012–13* (Report 8: 2013–14), reported the rationale for accepting the recognition and disclosure of land and buildings assets in the 2012–13 HHS financial statements.

While DoH retains legal ownership of the land and buildings of HHSs, recognition of these as assets of HHSs was based on effective control by HHSs through transfer to the HHSs of the full exposure to the risks and rewards of owning the assets—in particular, the assurance provided by the Minister for Heath that transfer of legal ownership was under consideration.

In June 2014, the Minister for Health authorised the transfer of the legal ownership of health-related land and buildings to HHSs over the next two financial years, commencing from 1 July 2014 and subject to DoH and each HHS having mutual confidence that the HHS has the capacity and capability to be an effective asset manager.

2.6.2 Valuation of Royal Children's Hospital buildings

On 29 May 2014, redevelopment was approved for the Herston health precinct which takes in the Royal Children's Hospital (RCH) buildings of Children's Health Queensland HHS.

At the time of signing of the audit opinion on the 2013–14 Children's Health Queensland HHS financial statements (on 29 August 2014), no decision had been made about the future development options for the RCH site.

Children's Health Queensland HHS plans to vacate the RCH buildings after commissioning the new Lady Cilento Children's Hospital, expected to occur before the end of 2014-15. When vacated, the RCH buildings will transfer to Metro North HHS, which obtained ownership title of the buildings on 1 July 2014.

The written down value of the RCH buildings was $59.82 million as at 30 June 2014, based on depreciated replacement cost methodology with estimated remaining useful lives ranging from 10 to16 years. Children's Health Queensland HHS had adopted this methodology because future use of the site was unknown at the time, so some continued use of the buildings as part of the redeveloped site was assumed.

We were satisfied that the valuation methodology by Children's Health Queensland HHS was reasonable and represented the fair value of the assets to Children's Health Queensland HHS as at 30 June 2014. The assets will likely transfer to Metro North HHS during 2014–15 at its fair value. Consistent with other transfers of assets between DoH and the HHSs, the RCH assets will transfer as a contribution by owners through the contributed equity account.

Decisions on the future use of the site may result in material adjustments to this asset value.

3 Internal controls

In brief

Background

Internal controls include the systems, policies and activities each Hospital and Health Service (HHS) establishes to ensure the effectiveness and efficiency of its operations, reliability of financial reporting and compliance with applicable legislation.

As part of the financial audit, we assess key internal controls over the reliability of financial reporting and raise any weaknesses identified with management for corrective action. An integrated system of internal controls reduces the risk an entity must overcome to achieve its objectives.

Conclusions

Financial administration improved at most HHSs, which we attribute to the management and finance staff of HHSs having a better understanding, in this second year of their operations, of their financial management and reporting requirements and responsibilities.

Systems of internal controls need to improve further to reduce the risks of fraud and error.

Key findings

- We reported 153 (159 in 2012–13) internal control weaknesses to HHSs. Fewer issues were identified at eight HHSs, compared to last year.
- Eleven HHSs require improvement to their financial management practice manuals.
- Fifteen HHSs can improve their risk management: risk management policies were not finalised; risk appetite and tolerance levels were not well documented; management of risks was not integrated effectively into strategic and operational planning; and risk registers were incomplete.
- Seven HHSs are not monitoring transactions processed by their shared service provider, and because of serious control weaknesses, there is a greater risk that fraudulent or erroneous transactions could occur and not be detected by these HHSs.
- There are no written agreements between each HHS and DoH on financial transaction processing functions performed by DoH.
- Financial delegations are effectively established and operate as intended. The assignment of delegated authority is well aligned to the business structure and staff responsibilities.
- Information technology system deficiencies allow expenditure approval authority to be exceeded for pharmacy purchases and provide unlimited expenditure approval authority for other general purchases exceeding $50 000. There is currently no effective monitoring to identify exceptions.
- Relevant HHSs have addressed issues we raised in 2012–13, pertaining to the lack of an internal audit function or the preparation of a chief financial officer statement of assurance.

Recommendations

It is recommended that the Hospital and Health Services in conjunction with the Department of Health:

1. **formalise shared service provider arrangements through a written service level agreement**
2. **implement controls at Hospital and Health Services to monitor the financial transactions processed on their behalf by Department of Health**
3. **implement controls to allow for the effective exercise of financial delegation for Hospital and Health Services approving:**
   - **purchases of inventory from central pharmacy**
   - **other purchase orders greater than $50 000.**

3.1 Background

The *Hospital and Health Boards Act 2011* recognises Hospital and Health Services (HHSs) as statutory bodies under the *Financial Accountability Act 2009*. The *Financial Accountability Act 2009* imposes significant responsibilities on statutory bodies, including the duty to manage the statutory body efficiently, effectively and economically and to establish and maintain appropriate systems of internal control and risk management.

Internal controls are processes (including policies, procedures and systems) that are established, operated and monitored by an entity's management to provide reasonable assurance to management and its governing body about the achievement of organisational objectives. There are five core elements of an integrated system of controls:

- **Control environment**, being management's actions, attitudes, policies and values that influence day to day operations. Control environment factors include management's integrity and operating style; organisational culture and values; organisation structure and the assignment and delegation of authority; and processes to obtain and develop qualified and skilled employees.
- **Risk assessment**, being management's processes to consider risks in achieving an organisation's objectives, forming a basis for how the risks should be managed.
- **Control activities**, being the policies and procedures implemented so management directives are carried out and necessary actions are taken to address identified risks. Control activities operate at all levels and in all functions. They include activities such as approvals, authorisations, verifications, reconciliations, reviews of operating performance, security of assets and segregation of incompatible duties.
- **Information and communication**, being the systems used to provide information in a form and time frame that allows employees to discharge their responsibilities; and the ways that control communication of responsibilities throughout the entity.
- **Monitoring of controls**, being the methods management employs to oversee and assess the operating effectiveness of control activities in practice. Oversight and assessment may be achieved through ongoing supervision, periodic self-assessments and separate evaluations.

When all of these components are present in an integrated system of internal control and they operate together effectively, they reduce the risks an entity must overcome to achieve its objectives to levels acceptable by management.

Internal controls cannot eliminate risk altogether. They operate to provide reasonable assurance to management about:

- the effectiveness and efficiency of organisational operations
- the reliability of accounting records and financial reports
- compliance with applicable laws, regulations and policies.

3.2 Conclusions

Across the HHSs sector, corporate governance particularly systems of financial management oversight has generally improved but this progress needs to continue with greater focus given to establishing strong financial controls, and processes to monitor that these operate as intended.

The effectiveness of financial controls at HHSs is weakened by configuration deficiencies in DoH information technology systems that provide financial transaction processing services and support to all HHSs.

The absence of a service level agreement clarifying the processing arrangements between each HHS and DoH caused significant misunderstandings and financial management risks for all HHSs.

Most HHSs are still developing the right culture for managing risks—one where risk management is considered both essential and valuable and is supported by a suitable framework and actively promoted. All HHSs have a risk management framework but not all the components that make up a dynamic framework are in place or operating as intended at 15 HHSs. Risk management is such an integral component of effective governance and management that these 15 HHSs face a greater threat of failure to deliver expected services or to achieve their objectives should identified risks eventuate.

Mostly financial delegations are suitably established and controls are in place to ensure they operate as designed.

3.3 Effectiveness of internal controls

As part of our financial audit, we assess key internal controls over the reliability of financial reporting. We raise any weaknesses we identify with HHS executive management to take corrective action.

We reported 153 (159 in 2012–13) significant control weaknesses to management across all HHSs during 2013–14. Figure 3A groups the weaknesses by the components of the internal control framework. It demonstrates that it is the detailed control activities which operate at the transaction level where most corrective action is required.

Figure 3A
Significant control weaknesses reported across HHSs

Component	Number of issues 2012–13	Number of issues 2013–14
Control environment	24	13
Risk assessment	4	15
Control activities	117	125
Information and communication	0	0
Monitoring of controls	14	0
Total significant control weaknesses	**159**	**153**

Source: Queensland Audit Office

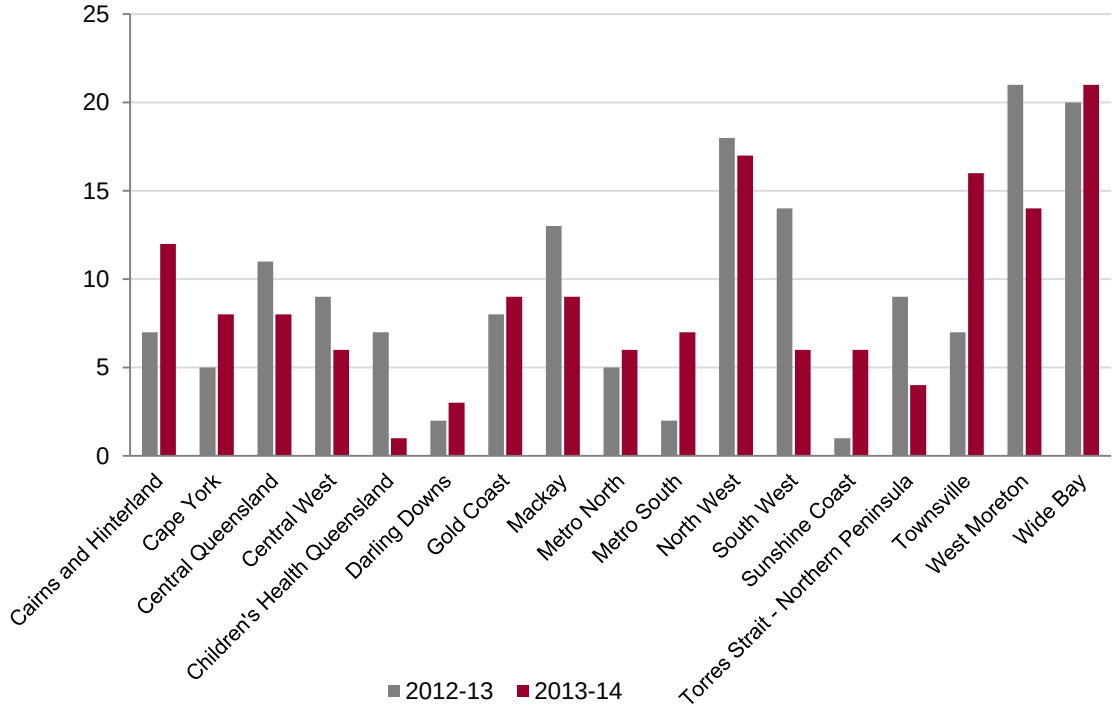
The decrease in the number of control environment and monitoring issues is consistent with our expectations that the corporate governance structures of HHSs would mature in this second year of their operations.

In 2013–14, we focused on risk assessment and the following aspects of control activities, which increased the number of audit issues we raised compared to 2012–13:

- compliance with financial delegations
- monitoring of shared service processing
- pharmacy controls.

Figure 3B illustrates the number of significant control weaknesses we identified by HHS. The number of issues has reduced at eight HHSs, compared to 2012–13. We noted that in most cases, for issues raised in 2012–13, HHS management implemented remedial action.

Figure 3B
Number of significant control weaknesses identified at each HHS in 2013–14



Source: Queensland Audit Office

3.3.1 Control environment

Planning and accountability documents outline the goals, strategies and policies for implementing an organisation's vision, managing finances, ensuring information system security and achieving sustainable management of infrastructure. Effective policies and plans allow management to reinforce relevant legislative requirements and organisational priorities and are a cornerstone in establishing a good control environment.

The Financial and Performance Management Standard 2009 requires HHSs to prepare and maintain a financial management practice manual as the paramount policy manual covering financial management and operations. The financial management practice manual is the initial point of reference for staff at HHSs for financial policy and guidelines.

In 2012–13, we reported all HHSs had adopted and put in use the DoH financial management practice manual; 13 of the 17 HHSs had not finalised updating their financial management practice manual to reflect the practices of their own operations.

Our follow up review in 2013–14 found nine HHSs are progressing the completion of a suitable financial management practice manual and two HHSs have made little or no progress.

All financial management practice manuals should be finalised without further delay to reflect the required board policies accurately and achieve effective financial management and reporting.

3.3.2 Risk management

The aim of risk management is not to eliminate risk. It is the process of identifying and assessing possible risks. From this understanding, an entity prepares an appropriate mitigation plan to reduce the consequences of unacceptable costs or losses.

HHSs face various types of risks. Some may be external in nature, such as natural disasters. Others are internal and within management's control, such as workforce issues or non-compliance in financial reporting. Once risks are identified, management needs to evaluate these for critical effects and the level of attention warranted.

Managing risks and threats through an effective system of risk management increases the confidence of HHSs that they can deliver the expected level of health services.

In our report *Results of audit: Hospital and Health Services entities 2012–13* (Report 8: 2013–14), we identified issues with 13 of the 17 HHSs in establishing risk management policies and risk registers.

In 2013–14, we further assessed whether:

- governance arrangements clearly define the accountabilities for strategic and operational risk management and designate the ownership for risk responsibilities and activities
- risk assessment is integrated with strategic and operational planning
- risk appetite has been established to articulate clearly the levels of acceptable risk
- communication to staff about responsibilities, duties and actions is supported by awareness education and training.

We identified that 15 HHSs have failings in these risk management assessment areas and in some cases in more than one area, caused by deficient policies or practices.

While HHSs have made progress to establish risk management policies and practices following their formation on 1 July 2012, most are still generally developing a positive, mature risk culture.

Ongoing monitoring and periodic reviews by management of their risk management frameworks can help to determine whether or not the risk management approach and process are achieving expected outcomes and opportunities for improvement.

Of 17 HHSs, 16 have incorporated a policy requirement to review the risk management framework periodically. The remaining HHS has not yet finalised its policy.

Governance arrangements

The *Financial Accountability Act 2009* places responsibility on the boards and chief executives of HHSs to establish and maintain appropriate systems of risk management.

The Financial and Performance Management Standard 2009 prescribes that the system for risk management must provide for:

- the mitigation of the risk to the statutory body and the state from unacceptable costs or losses associated with the operations of the statutory body
- the management of the risks that may affect the ability of the statutory body to continue to provide government services.

The risk management framework represents the risk management objectives, policies and guidelines, accountabilities, resources and processes for identifying and managing risks; the monitoring and reporting processes; and continuous risk management improvement.

Good risk management practices promote active participation across the entity. All staff members should clearly understand their roles in identifying, assessing, treating, monitoring and reviewing risks.

We found that all 17 HHSs have:

- established a framework to escalate new, emerging and changed risks appropriately
- outlined the responsibilities of officers, staff and governance committees in their risk management policies and procedures,
- established a 'champion' for risk management
- established appropriate governance arrangements by the board or its sub-committees and the audit and risk committee to oversee, monitor and review risk management activities.

We identified common issues with risk management policies and practices:

- five HHSs do not have tailored or finalised risk management policies approved and in place
- eight HHSs have not adequately identified and recorded, in their risk registers, the risk exposure of significant financial transactions to material fraud and loss or financial reporting error
- HHSs have a framework and process in place to identify and assess risks, but the recording of details in risk registers is incomplete for six HHSs.

These six HHSs have not consistently or clearly documented, in their risk register, the risk owners for risks, proposed risk treatment strategies, time frame for implementing strategies or officers responsible for risk treatment plans.

Although governance arrangements for monitoring risk activities are in place for all HHSs, the incomplete nature of the risk registers for the six HHSs suggests that more active monitoring is needed.

Leaving a risk register incomplete diminishes its use and ability to track the progress of risk treatment strategies.

Integration into planning processes

Division 2 of the Financial and Performance Management Standard 2009, which relates to planning processes, recommends that strategic and operational plans identify and analyse the potential effects of key risks and/or critical issues to achieving an entity's objectives and purpose.

Risk analysis should contribute to the planning process and help management identify new strategies, initiatives or actions that fundamentally affect an entity's ability to achieve its objectives.

Risk registers identify the major risk exposures and the control measures adopted to mitigate or manage those risks. Risks from strategic and operational plans included in the risk register are more likely to be reviewed and managed routinely.

Eleven HHSs have not integrated risk management effectively into planning activities, some demonstrating ineffective planning activities in multiple areas:

- three have no approved strategic plan or operational plan
- four do not include, or only partially include risks that threaten the achievement of goals in the strategic or operational plans
- seven HHSs that identified key risks in their strategic or operational plans do not include all identified risks in the risk register.

Risk appetite

Good risk management involves a process for ensuring, when risks are identified, that they are reliably treated and managed. An entity must establish its risk appetite and set risk tolerance levels that escalate risks exceeding tolerances to management.

Risk appetite is the amount of risk that an entity is prepared to accept at any point in time. Risk tolerance is the variation from the pre-determined risk appetite which an agency is prepared to accept. Together, they define an entity's unique attitude to risk. Their absence can lead to confusion over the levels of acceptable risk and to shortcomings in the response to risk.

An entity's risk appetite and tolerance levels are typically described in the risk management policy or through a specific risk appetite statement.

Figure 3C outlines the key attributes for an effective risk appetite statement.

Figure 3C
Risk appetite

Key attributes for an effective risk appetite statement
• Aligned—is linked to the entity's mid and long term strategies. • Complete—covers all fundamental risks in the agency risk profile. • Measurable—contains a small number of succinct quantitative and qualitative statements used to define the risk that will or will not be assumed. • Realistic—establishes a sufficient buffer between risk appetite and the entity's capacity to absorb risks/shocks and sets real boundaries that account for severe stress.

Source: Queensland Audit Office

Of the 17 HHSs, 11 have not adequately documented or approved their risk appetite and tolerance levels so proper and consistent risk communication, measurement and management can occur.

Communication

Training and awareness programs for key staff covering an employee's duty when risks are identified are critical to effective understanding of risk management practices and processes and their contribution to organisational objectives.

Risk management training and staff awareness programs can be improved in 12 HHSs, where there is no formal process to distribute information on risk management; absent or inadequate training programs; or immature training on risk management activities.

3.3.3 Control activities

Control activities are the specific procedures established to protect assets, ensure reliable accounting records, promote efficiency and encourage adherence to the organisation’s policies.

Effective controls provide early warning of weaknesses or susceptibility to error, support for timely reporting and early identification of irregularities.

Two common significant control weaknesses that occurred across HHSs relate to:

- ineffective or partially effective monitoring of shared service provider processing
- the purchasing of pharmaceuticals.

Monitoring of shared service provider

DoH as a shared service provider provides accounts payable and payroll transaction processing services as well as information system support to all HHSs.

While the shared service provider processes transactions on behalf of HHSs, under the *Financial Accountability Act 2009,* HHSs remain accountable for the accuracy and validity of transactions processed to their ledgers. All HHSs need to be assured of the completeness and accuracy of financial transactions and that there are no material weaknesses in the end to end processing.

External audit plays a role in this assurance process under Australian Auditing Standard ASAE 3402 *Assurance Reports on Controls at a Service Organisation.* This standard requires the auditor to report on the system descriptions and the design and operating effectiveness of the controls at the service organisation.

The shared service provider engaged us to provide an assurance report on the descriptions of controls and their operational effectiveness from 1 July 2013 to 28 February 2014. Our audit identified three control deficiencies at the shared service provider that increased the opportunity for fraudulent or erroneous payments. Additional audit testing did not identify any unauthorised transactions that would result in a material misstatement of the financial statements for any HHS.

Our audit of the shared service provider's systems of internal controls found significant risks to HHSs relying excessively on the shared service provider. HHSs should have appropriate monitoring controls in place to confirm the material accuracy and the validity of transactions posted to their ledgers by the shared service provider.

Seven HHSs were not effectively monitoring transactions processed by the shared service provider.

Shared service provider arrangements are not underpinned by a formal service level agreement signed by both parties (DoH and each HHS). A service level agreement defines and clarifies the accountabilities, roles and responsibilities of each party for all elements of transaction processing and the related internal controls. The agreement should also include the performance measures against which the quality and timeliness of services provided and the responsibilities of both parties can be assessed and improved.

The absence of a service level 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 and the implementation of non-standard processes which may increase the cost of the services. The lack of clear performance measures reduces the ability to identify process breakdowns, resolve issues and improve service delivery.

We identified significant misunderstandings at different HHSs, due to the absence of a service level agreement:

- reconciling items on a key accounts payable reconciliation are not being examined and cleared because both parties believe the other party is actioning these reconciling items
- the scope of responsibilities for each party to verify different data entry items in the payroll system is not clear
- there is a lack of understanding around the authority of the shared service provider to withdraw funds from the HHS bank account
- the responsibilities and approval for certain procurement and payment activities are not clear.

Purchasing of pharmaceuticals

All HHSs use the same information system to purchase pharmaceuticals from DoH's central pharmacy. There is a control deficiency in this information system: the system does not provide the HHS purchasing officer with the value of pharmaceuticals being purchased before approving the order. This risks purchasing officers inadvertently exceeding their financial delegation limits for approving purchases. We found evidence that this had occurred.

At six HHSs where a purchasing officer exceeded his or her delegated limit, because of the lack of a monitoring check, they were not aware at the time, or even later, that this breach had occurred.

To strengthen delegation controls, HHSs should consult with DoH about a program modification to its pharmacy system to provide the order value before purchase approval.

At another six HHSs, we found segregation of duties was ineffective, with the same staff member allowed to approve the order, receive the goods and update the records for pharmaceuticals.

Pharmaceutical items, particularly drugs, inherently have a higher risk of theft and misuse and usually require greater levels of security and management safeguards. All HHSs should introduce robust controls and checks to ensure the integrity of purchasing and inventory records, including estimating the pharmaceutical order value before purchase and overseeing situations where the same officer orders, receives and records pharmaceuticals.

Financial delegations

As part of our annual financial audit, we routinely examine whether transactions are approved by those who are authorised to do so. In 2013–14, we examined in greater depth:

- the framework used to establish delegated authority over financial transactions
- the effectiveness of delegated authority over the period
- the forms of monitoring and content of reviews over the exercise of authority.

At 11 HHSs, we identified deficiencies in either the delegation framework or delegations in practice but these are not systemic across the HHSs. Mostly financial delegations are suitably established and controls are in place to ensure they operate as designed.

Delegations framework

The board of each HHS is responsible for the efficient, effective and economical operation of the HHS. To achieve this practically, certain functions or responsibilities need to be delegated to other staff. The power to delegate is contained in the *Hospital and Health Boards Act 2011*, enabling the board to delegate functions to the health service chief executive and the chief executive to sub-delegate functions, with board approval, to appropriately qualified employees.

The financial delegations framework comprises an approved financial delegations policy and associated instrument of delegation. The policy describes the delegate's responsibilities; the process of administering financial delegations; and principles around the exercising of delegations. The instrument of delegation outlines the schedule of delegated authorities—delegation type, delegated positions and the level of financial delegation.

Except for one HHS which has no approved financial delegations policy, all HHSs have their policy and instrument of delegation approved by the correct authority.

It is important that the policy and the instrument of delegation are kept up to date and relevant to allow business activities to operate efficiently; and that they are readily accessible to inform delegates of their delegation.

The policy should include a requirement for the framework to be reviewed periodically—preferably at least annually and particularly when significant changes to business operations or the organisational structure occur.

Two HHSs do not contain a specific requirement for periodic review of their policy.

All HHSs provide some form of training or guidance to delegated officers covering policies, procedures, responsibilities and consequences of non-compliance.

Most HHSs operate a decentralised organisational structure because of their diverse hospital and health operations across various localities.

We found that 16 of the 17 HHSs have clear and direct lines of delegated financial authority that are consistent with their organisational structure and that the assignment of delegation authorities align with the business structure and staff responsibilities.

Delegations in operation

The two most common forms of purchasing and paying for goods and services across HHSs are by direct invoice and by order/invoice where a purchase order is raised and approved for every transaction. Ordinarily, there is stronger control in confirming the validity and accuracy of purchases when an invoice can be agreed with a purchase order.

Direct invoices require manual authorisation on a paper-based expenditure voucher by the expenditure approval officer and verification of the validity of the invoice by the voucher preparing officer.

If the payment exceeds $1 000, an authorised certifying officer is required to verify the financial delegation of the expenditure approval officer and validate his or her signature.

Our enquiries revealed that the certifying officer at two HHSs does not hold a register or listing of specimen signatures. This reduces the ability of the certifying officer to validate the authenticity of the approving officer's signature.

We tested a random sample of expenditure vouchers at each HHS to assess the operation of the financial delegations.

Across six HHSs, we detected six instances of non-compliance with financial delegations:

- four instances of direct invoices (three exceeding $1 000) where the expenditure approval officer exceeded the delegated authority and this was not detected by the certifying officer
- one instance of a purchase order authorised by an officer without delegation
- one instance where the certifying officer was not delegated to undertake this check.

We undertook further audit examination of these delegation breaches to confirm that the payment was valid and not a fraudulent transaction.

Manual authorisation is limited by its reliance on the user's knowledge of the correct and appropriate use of financial delegations. Processing transactions through an information technology system can significantly reduce the risk of financial delegation errors and opportunities for fraud.

Order/invoice transactions are usually processed through an information technology system which automates the confirmation of delegated officers by restricting approval access for expenditure transactions to the financial delegates recorded in the system.

The benefits of an information technology system depends on strong access security, records maintenance and a reliable system configuration.

All HHSs use the same DoH information technology system to purchase and pay for goods and services. The highest level of expenditure approval in this system is set at $50 000. The system then allows unlimited authority for any delegated officer on this $50 000 level. This unlimited delegation is not the intent of the board and chief executive.

To strengthen delegation controls, HHSs should consult with DoH about a program modification to provide better scope for HHSs to restrict expenditure approval authorities.

In the meantime, to reduce the risks of fraud or error, all HHSs should implement a monitoring check for proper expenditure approval for transactions exceeding $50 000.

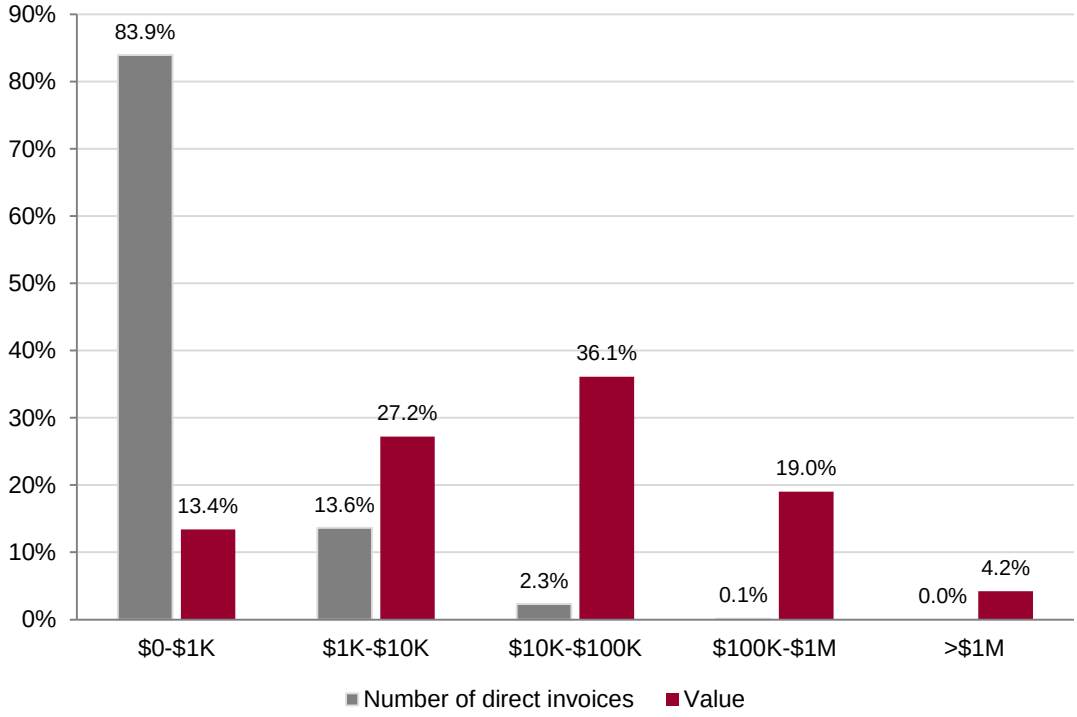
There is no effective control in place at four HHSs to align delegation details in the current approved instrument of delegation and the information technology system.

Monitoring the exercise of authority

Expenditure vouchers such as direct invoices require manual authorisation and processing, and as such are most susceptible to override of financial delegations.

Figure 3D illustrates the volume and dollar range of direct invoices processed by all HHSs (excluding transactions between HHSs and DoH such as payroll and pharmacy related costs) for the period 1July 2013 to 30 April 2014.

Figure 3D
Volume and dollar range of direct invoices processed over ten months



Source: Queensland Audit Office

Over the 10 month period, 584 294 direct invoices with a total value of $859.36 million were processed for HHSs. Almost 85 per cent of direct invoices by volume were below the $1 000 threshold meaning the approver's signature on these invoices was not independently validated. The remaining 94 000 invoices representing 87 per cent of the direct invoices by dollar value ($744.21 million) were subject to the certifying officer check.

HHSs adopted the $1 000 threshold from DoH practices when they were established. HHSs have not since reassessed the appropriateness of the $1 000 threshold in light of their own risk appetite and risk mitigation strategies.

There are potential cost savings and efficiencies in adopting a different threshold. If for example a threshold of $10 000 is used then the number of transactions requiring the certifying officer check would fall by roughly 80 000 transactions (85 per cent), but still cover almost 60 per cent of total value ($510.46 million). But such savings need to be balanced against the risk of error and fraud.

Over the last four years, DoH has used an automated accounts payable system at the Ipswich service centre for processing 85 per cent of West Moreton HHS invoices, including direct invoices. This accounts payable system removes paper-based expenditure vouchers and manual authorisations, reduces processing delays and provides a complete electronic payments audit trail. Given these substantial benefits, DoH should assess further roll-out of this system for other HHSs.

3.3.4 Monitoring internal controls

Monitoring activities evaluate whether internal controls are in place and operating effectively, detecting and remediating any control deficiencies.

In our report to Parliament *Results of audit: Hospital and Health Services entities 2012–13* (Report 8: 2013–14), we reviewed three key monitoring controls—internal audit, audit committees and chief financial officer statement of assurance about the effective operation of key financial controls. While all HHSs have established audit committees, some HHSs were still strengthening other aspects of these monitoring controls.

Internal audit function

In Report 8: 2013–14, we had reported that only 11 of the 17 HHSs had established an internal audit function. During 2013–14, all HHSs established an internal audit function. One HHS has not prepared an internal audit charter outlining its nature of operations, status and authority and responsibilities.

Chief financial officer statement of assurance

Although it is not a legislative requirement for a HHS chief financial officer to prepare a statement of assurance for the health service chief executive and the board about the operation of financial internal controls, 12 of the 17 HHSs adopted this as better practice for 2012–13.

For 2013–14, all 17 HHSs prepared a statement of assurance and we noted better processes to support the chief financial officer statements.

4 Financial performance, position and sustainability

In brief

Background

The annual financial statements of Hospital and Health Services (HHSs) provide a measure of their financial performance and financial position. To remain sustainable, HHSs must manage their financial risks and, at the same time, maintain the expected level of health services.

This chapter provides an assessment of the financial sustainability of HHSs through an analysis of key performance indicators, based on 2013–14 results.

Conclusions

All HHSs are in a sound financial position, with adequate liquidity to meet their short term liabilities.

A strong net asset position and lack of any long term debt means all HHSs are financially sustainable in the longer term.

Key findings

- The sector achieved operating surpluses of $184.38 million, with 12 HHSs reporting operating surpluses and five HHSs reporting operating deficits for the first time. The financial position of these five HHSs is sound to adequately cover these deficits.
- Total combined revenue is $10.25 billion, an increase in 2013–14 of $405.55 million. Total expenditure is $10.06 billion, an increase in 2013–14 of $382.98 million. These increases were due to additional funding for backlog maintenance and waitlist reduction initiatives.
- Revenue from private practice increased by $19.96 million, with more public patients electing to be treated as private patients, more senior medical officers billing and improved timeliness of billings.
- Land and buildings represent the significant component of HHSs financial position. Total assets of $8.87 billion included land and buildings with a net value of $6.96 billion. Land and buildings include $1.96 billion of major infrastructure assets transferred from the Department of Health.
- All HHSs have the ability to maintain their short term financial liquidity, with positive operating cash flows and adequate cash holdings.

4.1 Background

The financial performance of Hospital and Health Services (HHSs) is reported annually in their statements of comprehensive income. The financial position of HHSs is measured annually in their statements of financial position by reference to their net assets, being the difference between total assets and total liabilities.

A service agreement between the Department of Health (DoH) and each HHS establishes the health-related services to be provided by each HHS, the funding to provide these services and the key performance indicators to measure the delivery of these services.

4.2 Conclusions

All HHSs have the present capacity to meet their current and future expenditure obligations as they fall due and to absorb foreseeable changes and emerging financial risks without significantly changing current revenue and expenditure policies.

Short term financial ratios for all HHSs are favourable, with all achieving positive operating cash flows.

The longer term financial position of all HHSs is also favourable with all HHSs having significant asset holdings and no long term debt, mainly due to major infrastructure assets being funded and constructed by DoH and transferred to the HHSs at no cost.

4.3 Financial performance

Financial performance is measured primarily by the operating result—the difference between operating revenue inflows and expenditure outflows. The target specified in each HHS's service agreement is that the operating result should be break-even or in surplus—requiring HHSs to manage their costs actively to deliver health-related services as deficits are not necessarily funded by DoH.

4.3.1 Operating results

The HHS sector achieved, in aggregate, a combined operating surplus of $184.38 million ($159.56 million in 2012–13).

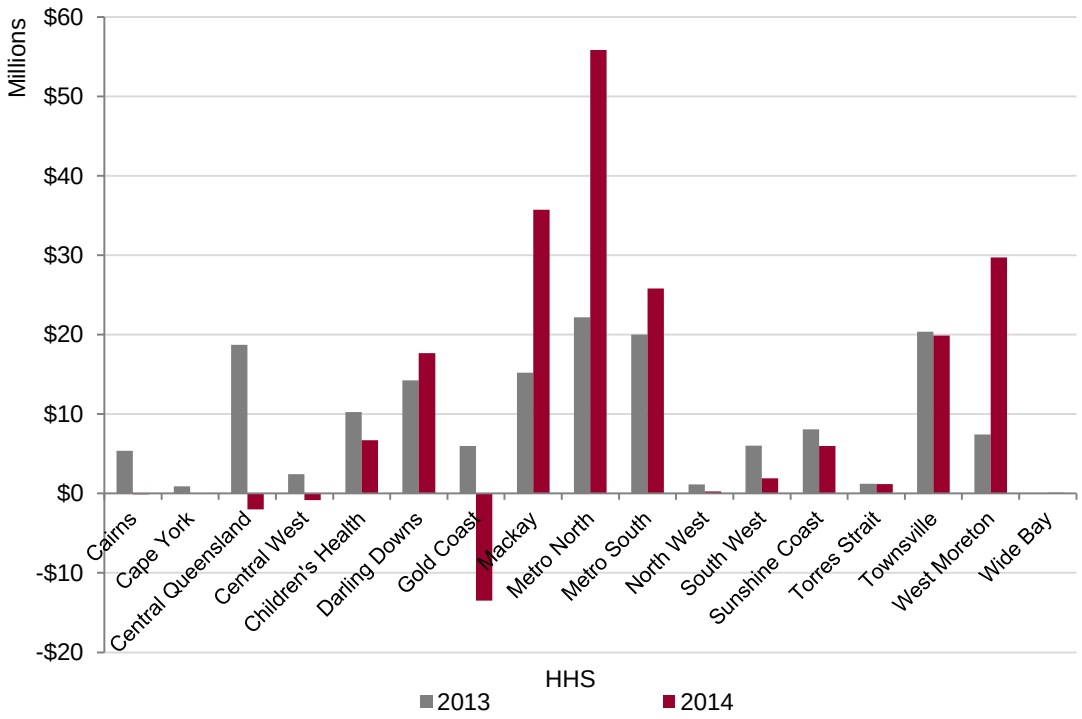
Total revenues were $10.25 billion ($9.84 billion in 2012–13) and expenses of $10.06 billion ($9.68 billion in 2012–13). Total revenue increased by 4.1 per cent, faster than expenses, which increased by 3.9 per cent compared to 2012–13.

The increase in revenue primarily arose from:

- additional funding for health-related services of $182.77 million to reduce waiting times for outpatient clinics, elective surgery and emergency care and for new services at the Gold Coast University Hospital
- funding of $61.46 million for the first year of the four year backlog maintenance program commenced during 2013-14 to address high priority and critical operational maintenance, life cycle replacements and infrastructure upgrades
- uplift in user charges of $142.24 million due to better identification and collection of patient fees and private practice revenue; and increased activity and changes in funding arrangements for the pharmaceutical benefits scheme.

Figure 4A shows that 12 HHSs achieved an operating surplus for 2013–14.

Figure 4A
Operating result by HHS



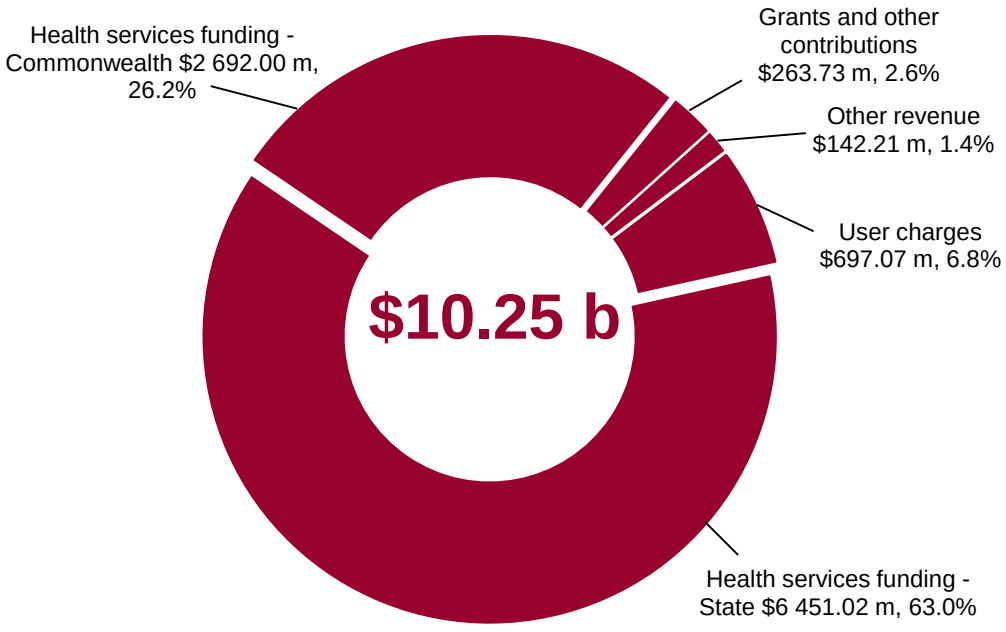
Source: Queensland Audit Office

Five HHSs reported operating deficits, with three–Cairns and Hinterland, Cape York and Central West HHSs–each reporting deficits of less than $1 million. The deficits of all five HHSs did not impact on their services–all five generated positive operating cash flows.

4.3.2 Operating revenues

Figure 4B shows the composition of the $10.25 billion in total revenue for 2013–14.

Figure 4B
Operating revenue composition



Source: Queensland Audit Office

The revenue for HHSs to provide health-related services is derived primarily from the Commonwealth and the state. These funds totalled $9.14 billion in 2013–14 ($8.90 billion in 2012–13) representing 89.2 per cent of total revenue (90.4 per cent in 2012–13).

User charges

In 2013–14, HHSs earned an aggregate of $697.07 million in user charges, which includes revenue from hospital fees, sale of goods and services, reimbursements from the pharmaceutical benefits scheme and rental income.

Hospital fees include private practice fees of $140.73 million in 2013–14 ($120.77 million in 2012–13) arising from the right of practice scheme.

The right of practice scheme allows senior medical officers (SMOs) who are employed in the public health system to also treat and bill patients of the public health system who elect private treatment. The fees charged for these services flow to the public health system.

In our report to Parliament *Right of private practice in Queensland public hospitals* (Report 1: 2013–14), it was reported that, in 2011–12:

- almost 50 per cent of SMOs who received a private practice allowance as part of their remuneration generated no revenue from billing patients
- an estimated $22.76 million in revenue was forgone across a variety of billable services.

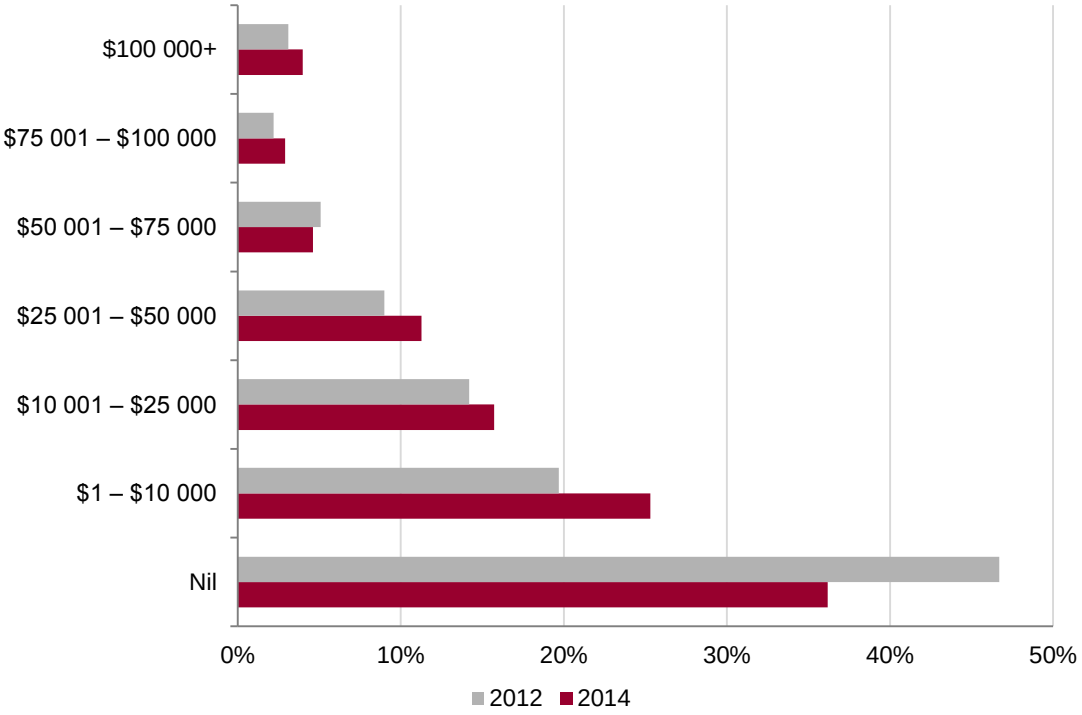
In response to our recommendation that DoH and HHSs *'make immediate attempts to recover forgone revenue if cost effective, and investigate further revenue uplift opportunities'*, DoH established the Revenue Recovery Taskforce in July 2013. The Taskforce specifically identified a range of clinical services that had been provided to private patients but not billed across financial years 2011–12 and 2012–13 and, in collaboration with relevant HHSs, billed more than $11 million in 2013–14.

The increase in private practice revenue of $19.96 million (16.5 per cent) reflects the work of the Taskforce, in addition to other ongoing HHS initiatives such as:

- increasing the number of public patients electing to be treated as a private patient
- improving the timeliness of billing processes.

As can be seen in Figures 4C, the proportion of SMOs receiving private practice allowance that are now billing for private patient services has risen by more than 10 per cent to 63.8 per cent in 2013–14, compared to 53.3 per cent in 2011–12.

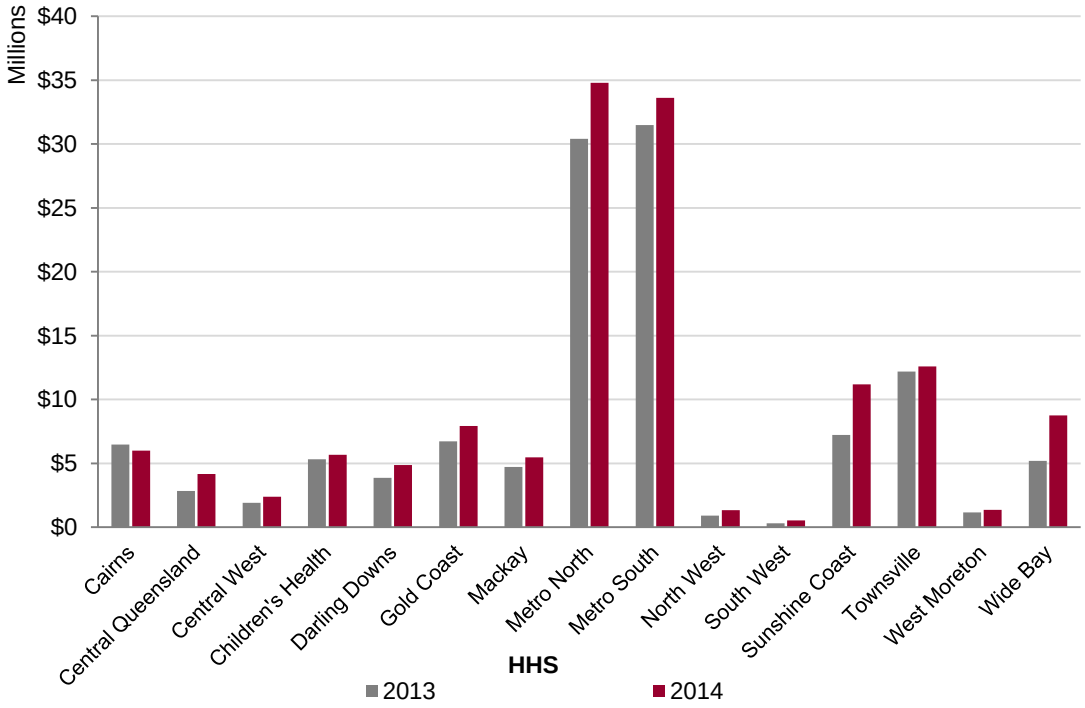
Figure 4C
Billing levels of SMOs receiving private practice allowance



Source: Queensland Audit Office

Figure 4D shows private practice revenue generated by relevant HHSs.

Figure 4D
HHS private practice revenue

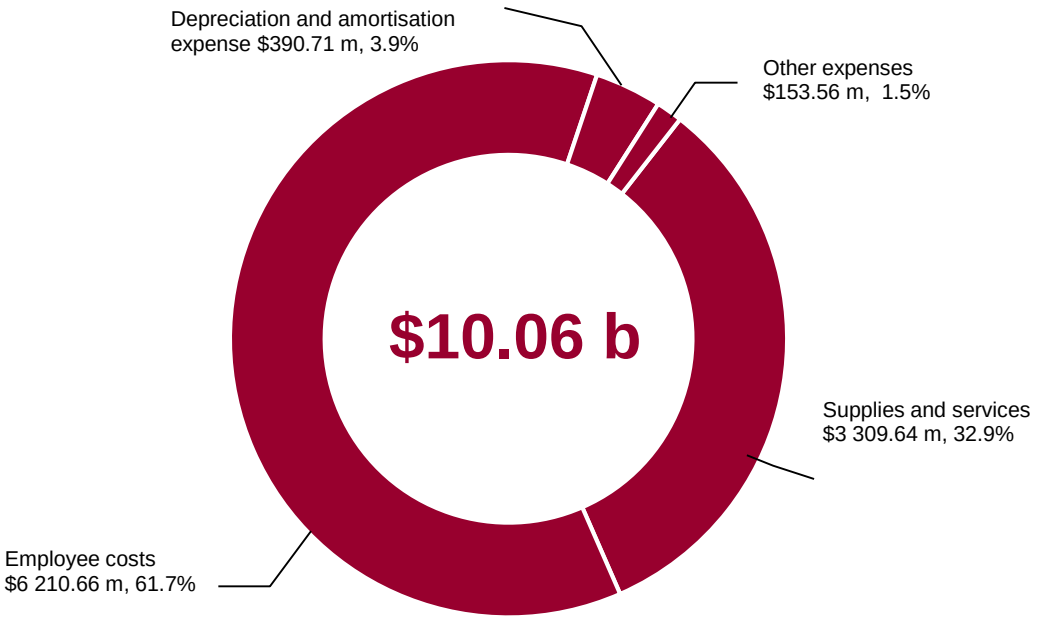


Source: Queensland Audit Office

4.3.3 Operating expense

Figure 4E shows the composition of total operating expenses of $10.06 billion for 2013–14.

Figure 4E
Composition of operating expenses



Source: Queensland Audit Office

Employee costs continue to be the largest expenditure, with a total of $6.21 billion ($6.72 billion in 2012–13) incurred across HHSs. The number of full time equivalent (FTE) employees for all HHSs approximated 59 980 as at 30 June 2014 (57 905 at 30 June 2013). Gold Coast HHS accounted for 33 per cent of the increase, mainly due to new services and additional activity associated with the opening of the Gold Coast University Hospital.

The increase in the number of FTE employees this year has not been matched by an increase in total employee costs. This is due to the effect of the voluntary redundancy program which resulted in higher employee costs in 2012–13.

4.4 Financial position

The financial position of HHSs is measured by reference to their net assets—the difference between total assets and total liabilities. Over time the financial position can indicate whether financial health is improving or deteriorating. A growing positive net assets position indicates that a HHS will have greater capacity to meet an increase in future service demands.

As at 30 June 2014, the combined net assets position of HHSs totalled $8.11 billion ($6.03 billion at 30 June 2013) comprising total assets of $8.87 billion ($6.66 billion at 30 June 2013) and liabilities of $0.75 billion ($0.64 billion at 30 June 2013).

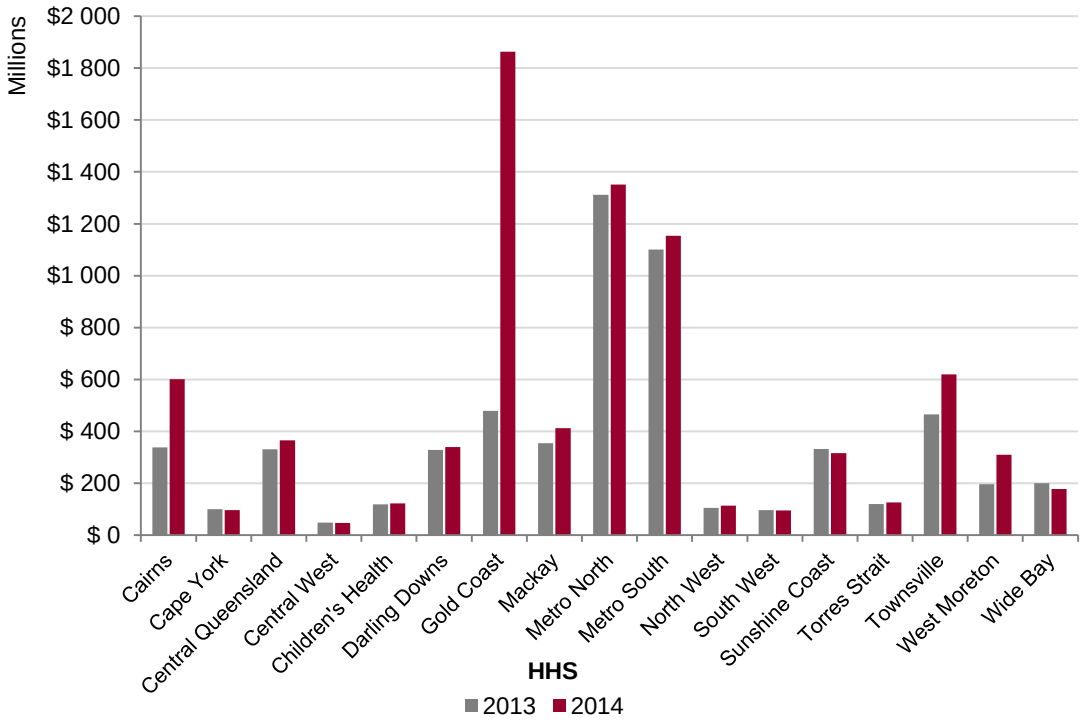
The main net assets component comprises land and buildings of $6.96 billion (78.5 per cent of total assets), reflecting the high level of infrastructure held by the sector to deliver health-related services.

The state significantly contributes to this growth in infrastructure assets rather than it being a financial burden for HHSs. DoH is responsible for funding and constructing all major infrastructure projects. Once completed, the asset is transferred at no cost to the HHS, through a transfer notice approved by the Minister of Health. HHSs are also specifically funded by DoH for the ongoing maintenance and depreciation costs of these assets.

Figure 4F shows the net assets position of each HHS as at 30 June 2014, with all HHS showing positive net assets.

The increase in net assets of $2.08 billion primarily resulted from the transfer of completed land and buildings assets from DoH of $1.96 billion, and significantly this included the transfer of the Gold Coast University Hospital of $1.42 billion.

Figure 4F
HHS net assets



Source: Queensland Audit Office

4.4.1 Assets

Land and buildings

The most significant asset component held by HHSs are land and buildings, representing $6.96 billion of the total assets held by the sector as at 30 June 2014 ($5.11 billion as at 30 June 2013).

The net increase in land and buildings of $1.85 billion includes the transfer from DoH of completed buildings assets, revaluation adjustments and assets transferred out.

Figure 4G presents the significant projects completed and transferred to HHSs during 2013-14.

Figure 4G
Significant projects completed and transferred in 2013–14

HHS	Project	$ billion
Gold Coast	Gold Coast University Hospital	1.42
Cairns and Hinterlands	Cairns Base Hospital Redevelopment	0.24
West Moreton	Ipswich Hospital Expansion	0.08

Source: Department of Health

The new infrastructure increases the capacity and capability of the health sector to meet the current and future demands for health-related services.

The Gold Coast University Hospital (GCUH) in Southport opened in September 2013. The GCUH has a capacity of 750 overnight beds and was operating 561 overnight beds by June 2014—substantially increasing the 456 bed capacity of the former Gold Coast Hospital that it replaced. As well as becoming one of Queensland's largest clinical teaching and research facilities, the hospital is equipped to offer new and extended specialised services to treat more patients on the Gold Coast.

Once decommissioned, the former Gold Coast Hospital was transferred from Gold Coast HHS to DoH. The property is being prepared for sale as a cleared development site, with work underway to demolish buildings on the site, scheduled for completion in 2014–15.

The redevelopment of the Cairns Base Hospital increased the number of overnight and same day hospital beds to 531 beds—an increase of 168 beds, and expanded capacity to deliver additional health-related services, including radiation oncology, cardiac care, birthing, aged care and rehabilitation services.

The Ipswich Hospital expansion added 84 beds (24.6 per cent) and associated facilities and services.

As at 30 June 2014, DoH had capital works in progress of $1.84 billion which primarily included infrastructure assets that will be transferred to HHSs when the projects are completed. Significant projects that are currently in progress include:

- Lady Cilento Children's Hospital to replace the Royal Children's Hospital—scheduled to be commissioned before the end of 2014
- Sunshine Coast Public University Hospital
- Mackay Base Hospital redevelopment
- Rockhampton Hospital redevelopment stage 2.

4.5 Financial sustainability

Financial sustainability examines the capacity of HHSs to meet current and future expenditure as it falls due and to absorb foreseeable changes and emerging risks without significantly changing their revenue and expenditure policies.

Short term indicators assess the ability of HHSs to maintain a positive operating cash flow and adequate cash holdings and to generate an operating surplus.

Long term indicators assess whether there is adequate funding available to cover long term debt and to replace assets. We have not assessed long term financial sustainability in terms of these aspects—no HHS has long term borrowings as major infrastructure assets are constructed and funded by DoH and transferred to HHSs at no cost to HHSs.

Although HHSs are responsible for the maintenance of infrastructure assets, they are provided funding for this and for the depreciation charges.

A significant component of revenue is derived from the Commonwealth and the state—$9.14 billion in 2013–14 ($8.90 billion in 2012–13), representing 89.2 per cent of total revenue for 2013–14 (90.4 per cent in 2012–13). Consequently, any material changes to this funding can affect financial sustainability.

The 2014–15 service agreements confirm funding variations from 2013-14 for HHSs ranging from a minor reduction in funds of 1.3 per cent to an increase of 45.2 per cent for the operations of the new Lady Cilento Children's Hospital. Due to the continued and assured funding from the Commonwealth and the state and the ratio assessments, short term financial sustainability for all HHSs is sound.

4.5.1 Short term financial sustainability indicators

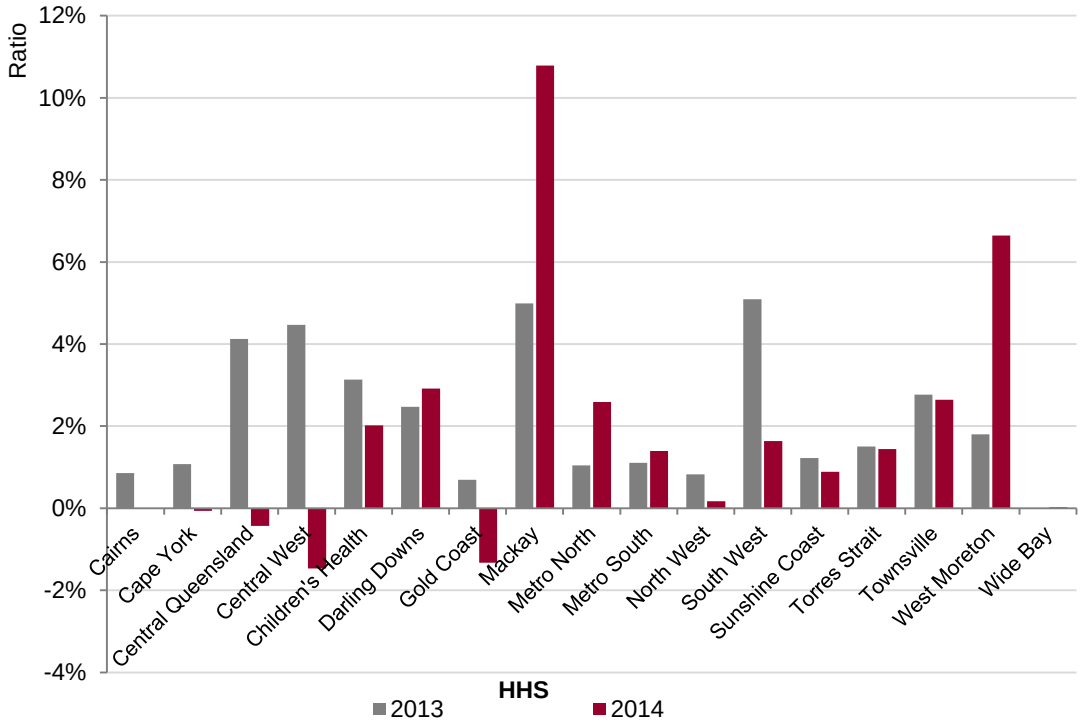
Appendix D describes in more detail the financial sustainability ratios we used to assess HHSs' short term sustainability.

Operating ratio

The operating ratio indicates the extent to which operating revenue covers operating expenses. A higher ratio indicates a better growth capacity to meet current and future operating and capital expenditure obligations.

Figure 4H shows the operating ratio as at 30 June achieved by each HHS.

Figure 4H
Operating ratio



Source: Queensland Audit Office

The target for each HHS as specified in the service agreement is a break-even or surplus operating result. The five HHSs identified with operating deficits in Figure 4A of this report also have negative operating ratios in 2013–14.

Three HHSs reported deficits of less than $1 million—Cairns and Hinterland ($0.114 million), Cape York ($0.053 million) and Central West ($0.845 million) HHSs. Each had sufficient cash reserves to cover these deficits.

Central Queensland and Gold Coast HHSs reported operating deficits of $1.99 million and $13.47 million respectively. Both HHSs recognised land and buildings revaluation decrements of $11.18 million and $14.18 million in their operating expenses respectively but these transactions did not diminish their cash reserves.

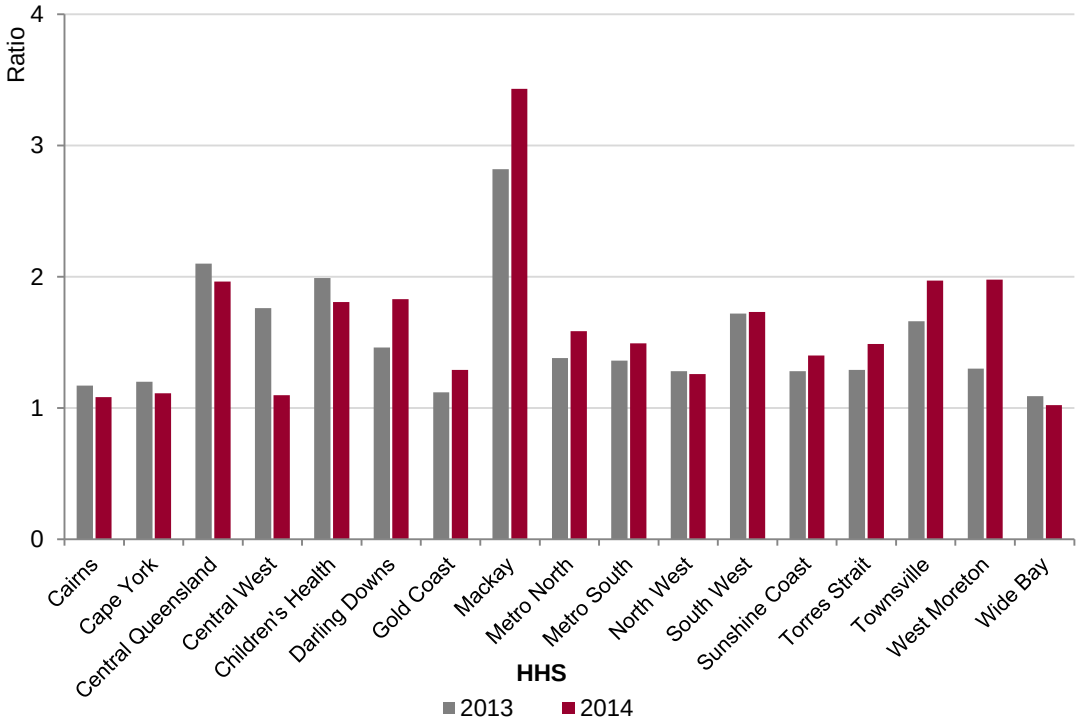
The highest operating ratio for the sector of 10.79 per cent ratio for Mackay HHS resulted from the recognition of $10.87 million in revenue from a reversal of a 2012–13 buildings revaluation decrement.

Current ratio

The current ratio measures the ability to pay existing short term liabilities with current liquid assets (cash, inventories, receivables). A higher current ratio indicates more liquid assets than short term liabilities, demonstrating the HHS has more capacity to pay its obligations. A ratio of one or more is a good indication that obligations can be met.

Figure 4I shows some variability in the current ratio when compared to last year, but all HHSs have a ratio of one or better indicating sufficient liquid assets are available to meet their short term liabilities as they fall due, which is a good result.

Figure 4I
Current ratio



Source: Queensland Audit Office

The high current ratio for Mackay HHS primarily arose from an increase in cash holdings of $28.17 million at 30 June 2014 due to savings in the cost to deliver health-related services.

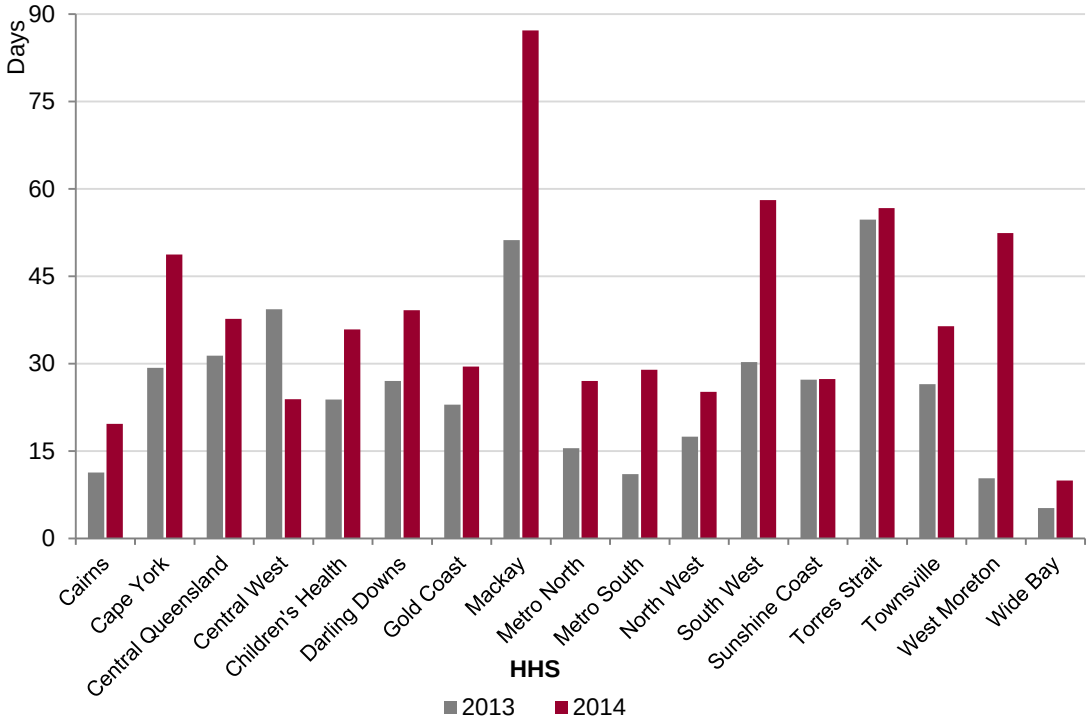
Number of days cash available indicator

Each HHS is responsible for its own cash management. Its ability to manage cash prudently is significantly affected by its dependency on the fortnightly funding payments from DoH because a HHS does not generate sufficient own-source revenue to fund health-related activities adequately.

For prudent financial management, HHSs should have unrestricted cash holdings equivalent to at least 14 days to cover the usual operating cash outflows during the funding period.

Figure 4J shows the number of days HHSs could continue to meet operating expenses after year end, using available unrestricted cash held at 30 June.

Figure 4J
Number of days that cash is available



Source: Queensland Audit Office

As at 30 June 2014, except for Wide Bay HHS (with ten days' coverage), all other HHSs had sufficient cash available to cover 14 days or more of operating expenses—having only ten days' coverage does not represent fiscal stress rather is an indicator for Wide Bay HHS to diligently monitor and manage its cash flow activities.

All HHSs generated positive cash flows in their operating activities during 2013–14—indicating that each HHS generated more cash than it spent, providing better opportunity to maintain and grow operations. All HHSs except Central West HHS increased their cash holdings at 30 June 2014, compared to last year.

5 Operational efficiency and funding

In brief

Background

The National Health Reform Agreement (NHRA) introduced the use of activity based funding (ABF). ABF aims to improve public hospital efficiency by funding public hospitals based on the nature of services provided to individual patients at a fixed price. The introduction of ABF has required Hospital and Health Services (HHSs) to review operational processes and systems so the cost of providing services is equal to or less than the funding received.

The operational efficiency of HHSs is measured by how well they have used their financial resources to deliver health care services to the community. The nature and level of services to be delivered are agreed between each HHS and the Department of Health (DoH) in a service agreement. Each service agreement includes specific benchmarks against which services delivered are monitored. DoH publishes information about the performance of HHSs on its website. HHSs publish information about their performance in their annual reports.

Conclusions

The introduction of the national funding model from 1 July 2014 presents both opportunities and challenges for HHSs. If HHSs can improve their efficiency in providing health-related services at the lowest possible cost then additional services can be provided because Commonwealth funding does not reduce in the short term for efficiency gains. Improvements in HHS systems and processes are required to take full advantage of this opportunity.

The challenge for HHSs is to maintain and improve efficiency to take advantage of these available funds without compromising the quality of health care outcomes.

Key findings

- Seven of 17 HHSs met their activity targets in 2013–14; seven exceeded their activity target; and the remaining three were below their target.
- Seven of 13 HHSs funded by activity in 2013–14 delivered services at an average cost below the Queensland benchmark.
- Queensland hospitals have amongst the shortest length of stay outcomes in Australia.
- We issued an unmodified audit opinion with an emphasis of matter for the Queensland state pool account in 2013–14, drawing attention to the special purpose basis of accounting.
- Changes announced by the Australian Government in their 2014–15 budget may impact on Commonwealth funding levels from 1 July 2017.
- HHSs have undertaken assessments to gauge their readiness for ABF and areas for improvement were identified.
- HHSs are working to improve the quality of coded clinical data that underpin the calculation of ABF.

5.1 Background

The National Health Reform Agreement (NHRA) partnered the Commonwealth with state and territory governments to implement new arrangements for the health system, including the use of activity based funding (ABF). ABF aims to improve public hospital efficiency by funding public hospitals based on the nature of services provided to individual patients at a fixed price. The introduction of ABF into Hospital and Health Services (HHSs) requires HHSs to review operational processes and systems so the cost of providing services is equal to or less than the funding received.

Some public hospital services and hospitals in regional, rural and remote communities will be funded through block funding rather than ABF, primarily because patient volumes will not generate sufficient funding under ABF to cover the fixed costs of maintaining services at those hospitals. Unlike ABF, block funding is not based on levels of public health care activity.

The operational efficiency of HHSs is measured by how well they have used their financial resources to deliver health care services to the community. The services to be delivered are agreed between each HHS and the Department of Health (DoH) and are included in a service agreement. Each service agreement includes specific benchmarks against which services delivered are monitored to improve the timeliness, quality, safety, cost efficiency and volume of services provided to the community. DoH publishes information about the performance of HHSs on its website. HHSs publish information about their performance in their annual reports.

Operational efficiency can be divided into two parts:

- technical efficiency—services are being provided at the lowest possible cost
- allocative efficiency—services the community values most are provided within the available resources.

This chapter examines the technical efficiency of HHSs; allocative efficiency is beyond the scope of this report.

5.2 Conclusions

The introduction of the national funding model from 1 July 2014 presents both opportunities and challenges for HHSs. If HHSs can improve their efficiency in providing health-related services at the lowest possible cost then additional services can be provided because Commonwealth funding does not reduce in the short term for efficiency gains.

'ABF readiness' reviews at HHSs indicate that improvements in HHS systems and processes are required to take full advantage of this opportunity.

The challenge for HHSs is to maintain and improve efficiency to take advantage of these available funds without compromising the quality of health care outcomes.

5.3 Performance against efficiency measures

HHS efficiency is measured at local, state and national levels. Operational efficiency is usually determined and benchmarked through key performance indicators (KPIs). Varying government bodies report different KPI, informed by the performance frameworks in place. Under the *Hospital and Health Boards Act 2011*, Hospital and Health Boards are each accountable for the performance of their individual HHS.

5.3.1 Service agreement performance measures

DoH and HHSs agree performance expectations each year, recorded in a service agreement between the DoH Director-General and the Board Chair of each HHS. DoH has established a Hospital and Health Service performance management framework to monitor and report on the performance of HHSs.

Each service agreement contains KPIs across three domains of equity, effectiveness and efficiency that the HHS must meet. These KPIs were defined in 2013–14 as either Tier 1 or Tier 2:

- Tier 1 KPIs are critical system markers which operate as intervention triggers. Underperformance in a Tier 1 KPI triggers immediate attention, analysis of the cause of the deviation and consideration of the need for intervention.
- Tier 2 KPIs are used as supporting indicators to assist in providing context to Tier 1 KPIs when triggered within a specific domain.

Figure 5A outlines the Tier 1 and selected Tier 2 efficiency and financial performance KPIs for HHSs included in the 2013–14 service agreements.

Figure 5A
Service agreement efficiency and financial performance KPIs for HHSs

Level	Indicator	Target for HHS
Tier 1	Full year forecast operating position	Balanced or surplus
	Purchased activity – variance between purchased activity and actual activity	Metro North and Metro South: + / - 1% All other HHSs: + / - 2%
Tier 2	Year to date operating position	Balanced or surplus
	Average Queensland weighted activity unit cost	At or below the Queensland ABF price

Source: Department of Health and Hospital and Health Services' service agreements

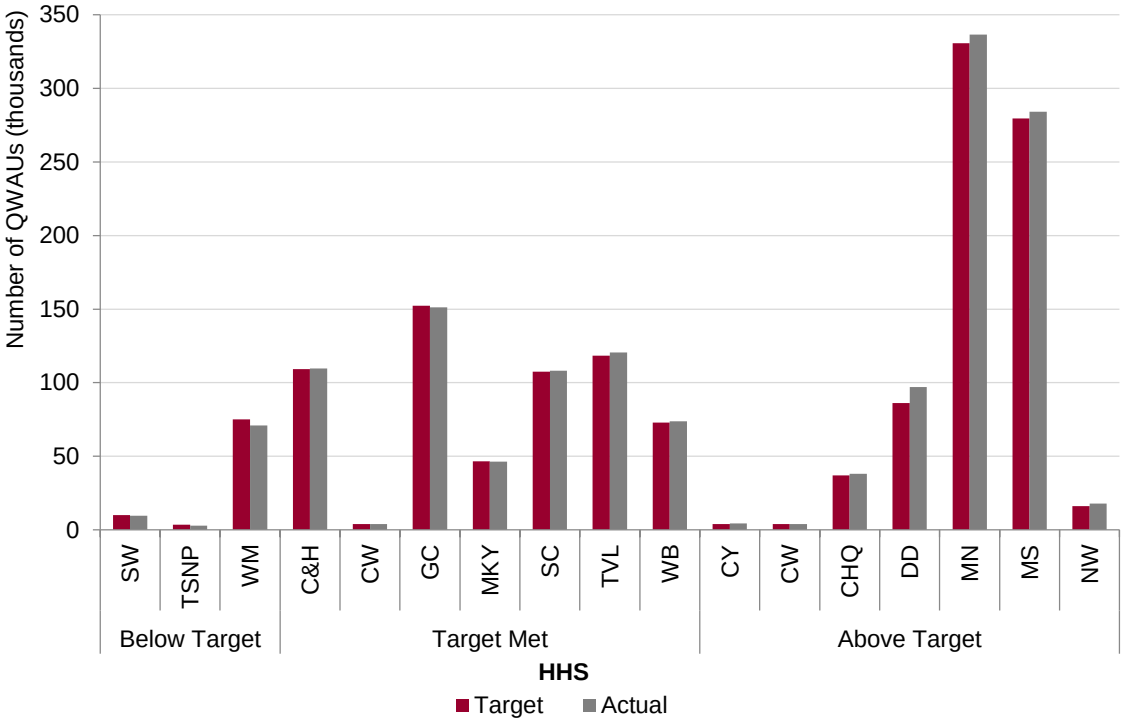
The operating position for each HHS is examined in Chapter 4 of this report.

Purchased activity vs actual activity

Weighted activity units (WAUs) are used to measure hospital activity. Each public hospital service can be compared and valued by weighting it for its clinical complexity. The average hospital service is worth one WAU. More intensive and expensive activities are worth multiple WAUs, the simpler and less expensive are worth fractions of a WAU. Queensland adapted the national model, and measures activity by Queensland WAUs (QWAUs).

Each HHS is given an activity 'target' within its service agreement which equates to the number of services purchased by DoH, expressed in QWAUs. The performance of each HHS for 2013–14 measuring actual services delivered against the purchased target is shown in Figure 5B.

Figure 5B
Purchased vs actual QWAUs per HHS



Source: Department of Health

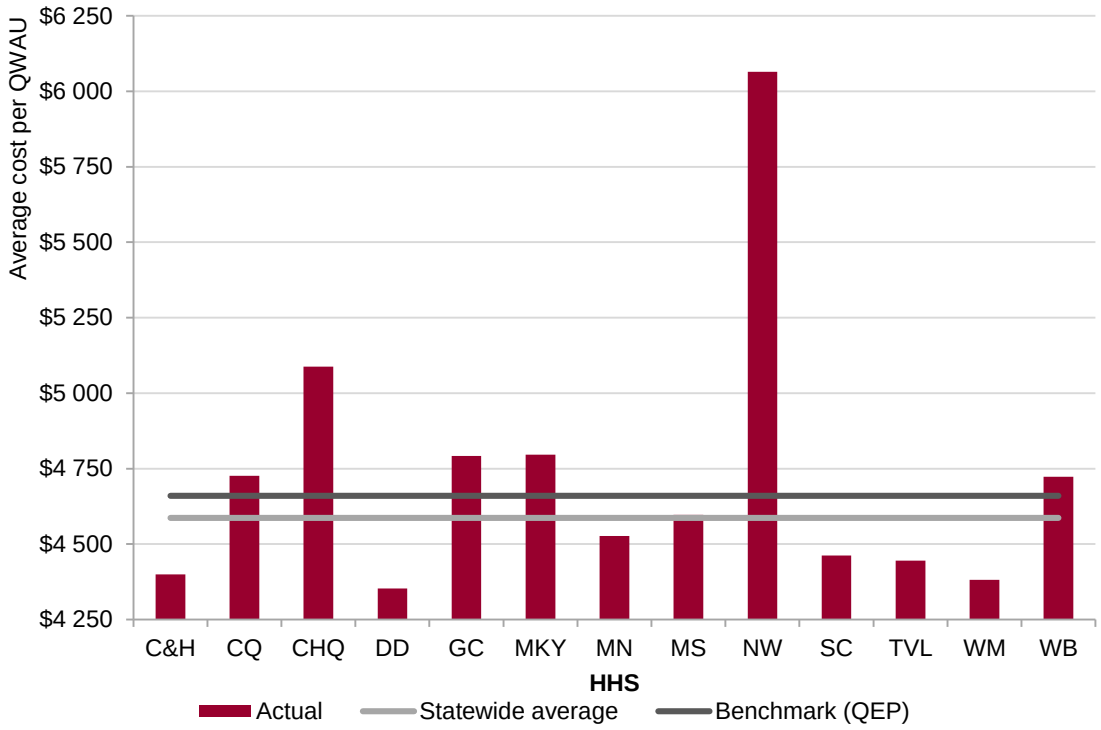
Seven of 17 HHSs (2012–13: eight) met their activity targets in 2013–1; seven (2012–13: four) exceeded their activity target of +/- 1 or 2 per cent; and the remaining three (2012–13: five) were below their target.

Average Queensland weighted activity unit cost

ABF is provided by DoH to HHSs based on the average cost of hospital services across the state, called the Queensland Efficient Price (QEP). HHSs need to deliver the agreed number of services at or below the QEP in order to be measured as efficient. HHSs are measured by the average cost of delivering one QWAU in their HHS.

The actual average QWAU cost for each HHS that received ABF in 2013–14 is shown in Figure 5C. Comparison is made to the actual statewide average QWAU cost and the QEP.

Figure 5C
Average QWAU cost per HHS funded by ABF



Source: Department of Health

Seven of the 13 HHSs funded by ABF in 2013–14 had an average QWAU cost below the QEP (2012–13: six). Two HHSs improved their performance from 2012–13 to now be under the QEP whilst one HHS that met the QEP in 2012–13 did not meet the QEP in 2013–14.

The 2013–14 service delivery statement (SDS) for Queensland Health provided an estimate of $4 568 as the statewide average cost per QWAU; two per cent below the QEP of $4 660.

The actual statewide average QWAU cost achieved was $4 587; 0.4 per cent higher than estimated in the SDS, but $73 (1.6 per cent) below the QEP benchmark. This is an improvement from 2012–13 where the statewide average was $111 (2.5 per cent) above the QEP for that year.

5.3.2 National performance measures

Various Commonwealth bodies monitor the performance of HHSs (and Queensland as a whole) nationally. The Council of Australian Governments endorsed a national performance and accountability framework in 2012. This framework identifies a number of KPIs across three domains of equity, effectiveness and efficiency. The efficiency domain has four KPIs and these are shown in Figure 5D.

Figure 5D
National efficiency key performance indicators

Indicator	Included in this report	Comments
Relative stay index for multi-day stay patients	Yes	Reported below
Day of surgery admission rates for non-emergency multi-day stay patients	No	Queensland's performance has not been publically reported
Cost per weighted separation and total case weighted separations	No	Currently under review by Australian Government bodies and Queensland's performance has not been publically reported
Financial performance against activity funded budget (annual operating result)	Yes	Reported in chapter 4

Source: Queensland Audit Office based on National Performance and Accountability Framework and Australian Institute of Health and Welfare, Australian hospital statistics 2012–13

Relative stay index

Information about the average length of stay by all 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.

Relative stay indices 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 (for example in home care).

The latest available national data published by the Australian Institute of Health and Welfare (AIHW) are from 2012–13. Queensland had the lowest reported relative stay index for public hospitals of all Australian states and territories, as shown in Figure 5E. Over the same period Queensland's reported performance against the 'safety' KPIs in the effectiveness domain were in line with the national average according to the AIHW, meaning the shorter hospital stays has not resulted in poorer health outcomes.

Figure 5E
Relative stay index for public hospitals by state or territory

Data presented are the directly standardised relative stay index

Source: Australian Institute of Health and Welfare, Australian hospital statistics 2012–13

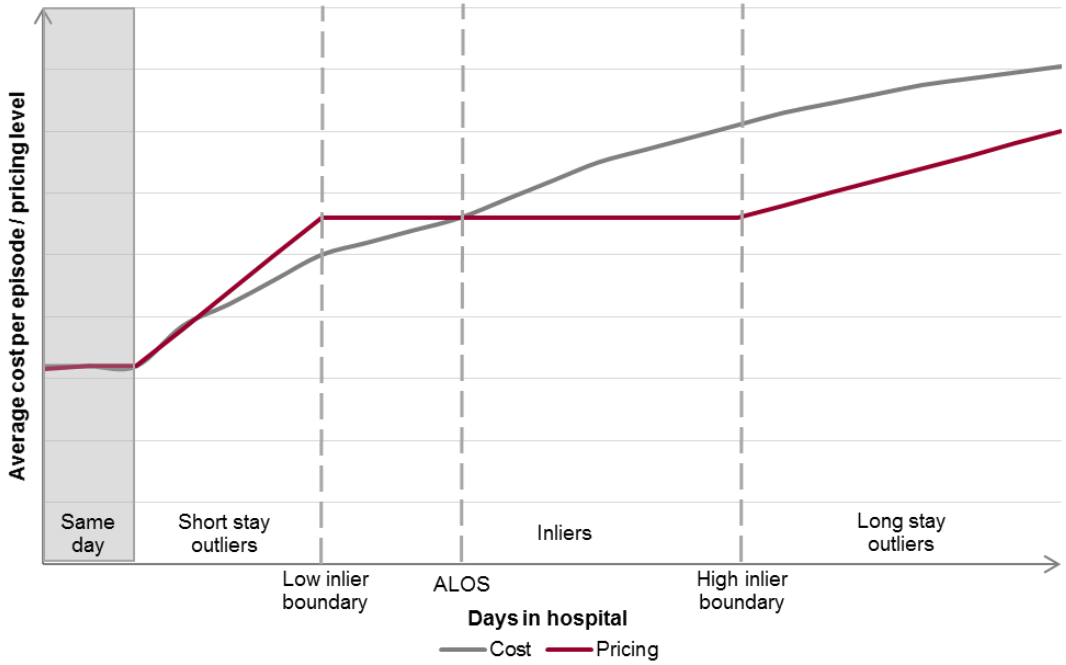
Average lengths of stay for selected groups

Length of stay outcomes are important for HHSs funded via ABF as the price paid for each inpatient episode of care varies depending on the length of stay.

Each inpatient episode of care is classified under an Australian Refined Diagnosis-Related Group (AR-DRG). This system groups patients with similar clinical conditions requiring similar hospital services. Each AR-DRG has an allocated average length of stay with minimum and maximum 'trim points'.

As a patient's length of stay continues, the cost of care may outweigh the level of funding received. If the length of stay is lower than the average, then funding paid to a HHS will result in a 'surplus' position. Conversely, if the length of stay is much higher than the average (an outlier), then a HHS will be in a 'shortfall' position. This is demonstrated in Figure 5F.

Figure 5F
Cost versus pricing for inpatient episodes of care



Source: QAO adapted from IHPA's National Pricing Model Technical Specifications 2014–15

Overall, each HHS needs to be at or below the average length of stay for each AR-DRG to provide cost efficient services. The AIHW selects particular AR-DRGs to measure the average length of stay outcomes for patients. The AIHW selects AR-DRGs on the basis of:

- homogeneity, where variation in the length of stay is more likely to be attributable to the hospital's performance rather than variations in the patients themselves
- representation across clinical groups and surgical and medical AR-DRGs
- differences between jurisdictions and/or sectors
- policy interest, by including similar groups in other Australian hospital statistics (such as procedures for elective surgery waiting times), high volume and/or cost and changes in volume over years.

The latest available national data published by AIHW are from 2012–13. Queensland had the shortest (or equal shortest) average length of stay for 14 of 20 AR-DRGs reported. Queensland had the second shortest average length of stay for a further three groups and the third shortest average length of stay for the remaining three groups. This means, for these AR-DRGs, Queensland hospitals are more likely to be providing cost-efficient services.

DoH has revised the KPIs in the 2014–15 service agreements and included a new KPI for length of stay in public hospitals. HHSs will be measured on the average length of stay for selected AR-DRGs for patients who stay one more nights in hospital. Specific targets will be set for each HHS to meet under their service agreement with DoH.

5.4 Health service funding in Queensland

The Commonwealth and state funding to HHSs for most public hospital services over the two financial years from 2012 to 2014 has been provided on the basis of hospital activity, but the amount paid was derived from a historical funding framework.

From 1 July 2014, ABF for most public hospital services will be based on an agreed number of patient health care services paid at a fixed price determined by the Independent Hospital Pricing Authority (an Australian Government body).

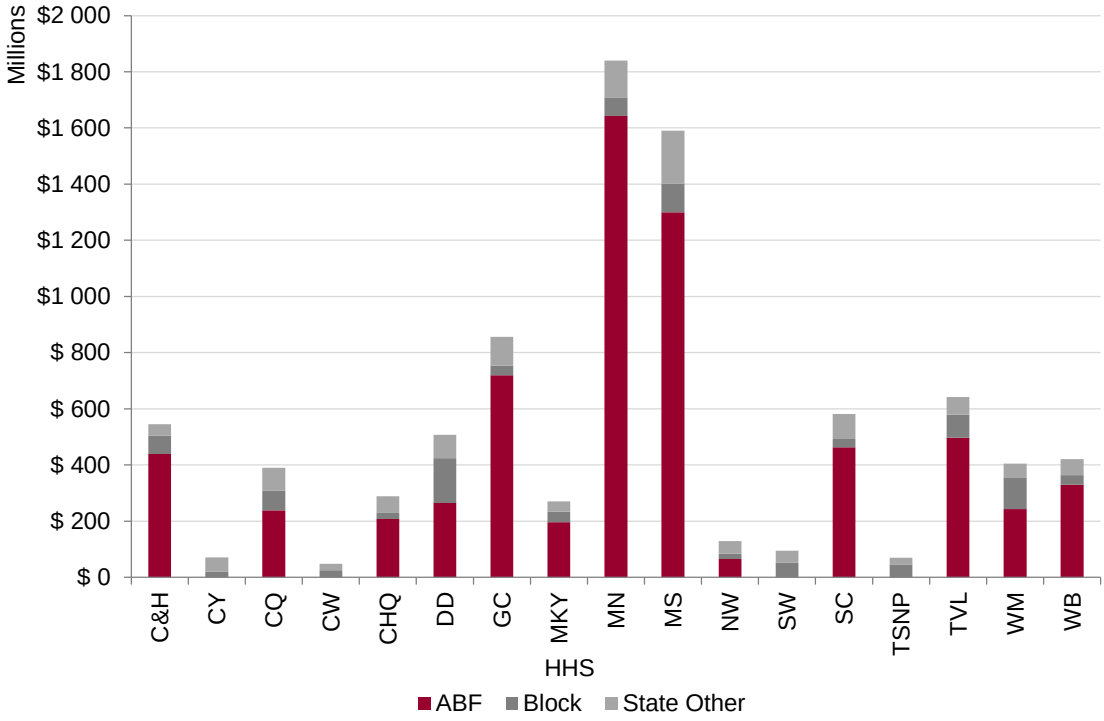
Public hospital services not funded via ABF are delivered through block funding. Block funding provides a set amount to deliver public hospital services, regardless of the number of activities delivered. Commonwealth funding for block funded services from 1 July 2014 will be based on a set dollar amount that represents the average cost of block funded hospitals across Australia. Block funded hospitals will be grouped based on their size and location (remoteness) and this will determine the final amount of funding provided.

Public hospital services within all HHSs are funded through block funding, or a combination of block funding and ABF to ensure HHSs have the appropriate capacity to deliver the expected services.

The state also provides other funding for items not covered by the NHRA including primary health care and prevention, promotion and protection activities.

Figure 5G shows the combination of ABF, block and other state funding provided to each HHS in 2013–14. Four HHSs do not receive ABF—Cape York, Central West, South West and Torres Strait–Northern Peninsula HHS.

Figure 5G
Health service funding per HHS



Source: Department of Health

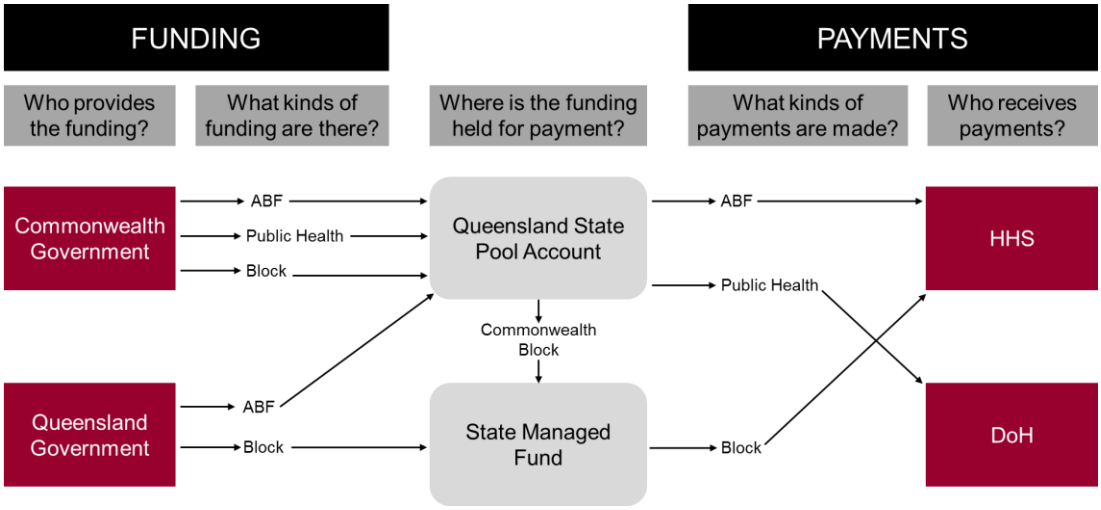
5.4.1 The National Health Funding pool

The activities of HHSs are primarily funded by the Commonwealth and state. Funding is pooled and allocated through a state pool bank account which is part of the National Health Funding Pool. The state also maintains a separate state managed fund to manage Commonwealth and state contributions and payments for block funding.

The Commonwealth also contributes funding for various public health programs such as for essential vaccines, child health and youth services.

Figure 5H illustrates these funding flows.

Figure 5H
Funding flows of the National Health Funding Pool



Source: Queensland Audit Office adapted from the Administrator of the National Health Funding Pool Public Hospital Funding website—www.publichospitalfunding.gov.au

Each financial year, the Administrator of the National Health Funding Pool prepares special purpose financial statements for each state pool account for audit by the respective state and territory Auditor-General. This statement details the receipts into and payments from the state pool account. The pool account received $2.81 billion from the Commonwealth and $4.77 billion from the Queensland Government during 2013–14.

We issued an unqualified audit opinion on the 2013–14 statements with an emphasis of matter drawing attention to the special purpose basis of accounting.

5.4.2 Future funding changes

From 1 July 2014 to 30 June 2017, the Commonwealth is funding 45 per cent of growth in health service activity with the state funding the remaining 55 per cent.

Then from 1 July 2017, the Commonwealth had agreed to fund 50 per cent of growth in activity, but this has changed. The Australian Government announced in its 2014–15 budget that funding for public hospitals will be indexed through a combination of growth in the Consumer Price Index (CPI) and population from 1 July 2017. This means that increases in Commonwealth funding will not be tied directly to increases in activity as measured by WAUs.

The state may be left to fund any Commonwealth funding shortfall if growth in public hospital expenditure exceeds growth in the CPI and population. DoH is assessing the impact from the Australian Government measures on the purchasing and funding model for HHSs. This assessment includes considerations of whether to continue state funding to HHSs after 1 July 2017 based on activity performed; a combination of the CPI and population growth; or on another basis.

The Australian Government also announced that it will not proceed with the funding guarantee provided under the NHRA. The guarantee provided additional funding of $16.4 billion above previous funding levels across all state and territory governments over six years from 1 July 2014. Reward funding of a potential $42 million to Queensland over two years from 1 July 2014 for achieving elective surgery and emergency department performance benchmarks under the National Partnership Agreement on Improving Public Hospital Services will also cease.

The Australian Government is expecting to make $1.98 billion in savings from these measures over four years from 2014–15 across the state and territory governments. At the time of preparation of this report, DoH is unable to provide information on the financial impact on Queensland.

Under other Australian Government proposed measures, state and territory governments may be permitted to introduce patient fees for GP equivalent visits to public hospital emergency departments. This is to deter unnecessary use of emergency departments which may result from patients attempting to avoid the patient contribution proposed by the Australian Government for bulk-billed standard GP consultations and out-of-hospital pathology and imaging services from 1 July 2015.

5.4.3 HHS readiness for activity based funding

Of the 13 HHSs that receive ABF, five undertook a formal preparedness assessment during 2013–14 in preparation for the new accountability and funding model from 1 July 2014. The other eight HHSs have also undertaken some activities to gauge readiness.

Areas examined include planning and budgeting; reporting and monitoring; governance arrangements; coding practices (including peer audit activity); and education and training.

These reviews reported positively that clinical coders used information sharing mechanisms on policies and practices (including complex coding) to improve coding accuracy; clinical staff provided legible and comprehensive documentation; and budgets were realigned to reflect ABF principles.

Areas identified for improvement included:

- lack of coordination within the HHS on ABF matters or ineffective follow up on previous ABF action plans
- lack of an ABF governance body
- inability to recruit and retain clinical coders, affecting coding timeliness, accuracy and peer audit activity
- lack of timely and available clinical documentation for coding purposes (for example, electronic discharge summaries)
- immature or absent systems to improve costing practices
- inadequate education and training of clinicians and key stakeholders on the effects of ABF.

Coding improvement initiatives

The quality of information used to calculate funding for public health services depends on accurately classified and coded activity data. The ability of coders to classify accurately the services provided depends on the completeness and quality of clinical documentation which is often manually written in patient records.

If all information required for coding is not accurately captured and processed then errors in the classification of activities can materially affect HHS funding. Figure 5I shows how the incorrect identification and coding of activity can result in loss of funding via ABF.

Figure 5I
Example of funding difference from coding variation

Item	Classification DRG E62C	Classification DRG E62A
Definition	Respiratory infections/ inflammations without complications	Respiratory infections/ inflammations with catastrophic complications
Length of stay (days)	6	6
WAUs in 2014–15	0.7649	2.2742
Australian government funding in 2014–15	$3 830	$11 387

Source: Queensland Audit Office using information from the Independent Hospital Pricing Authority

HHSs have published fact sheets on their local intranet and provided information and awareness sessions to clinicians on the importance of clinical coding. One HHS has also produced checklist sheets that are specific to a clinical specialty with points for clinicians to consider that would improve the completeness and accuracy of clinical coding.

Ongoing dialogue is required between the coders and clinicians to improve the quality of coded data. Case study 1 provides a simple example of how engagement between clinicians and coders can improve coding accuracy.

Case study 1

Engagement between clinicians and coders

Members of the Redcliffe Hospital coding team have expanded their clinical experience by visiting operating theatres to view procedures. With the assistance of senior coding staff and theatre nurse educators, coders were encouraged to attend and ask questions as the procedures were being performed.

Following the procedure viewing, the charts were coded and double checked by all members of the coding team. The coding team and some of the theatre nurses involved in these cases then made a joint presentation at a 'Theatre In-Service Meeting'.

Each case was displayed on a slideshow and the coding for the admission was explained. Poor quality documentation was highlighted as the greatest barrier to good quality coding and the clinical staff members were advised on how they can help the coding team.

The Redcliffe Hospital coding team can now visit theatre regularly to view specific procedures. Coding staff understand procedures better, theatre staff understand the coding process better and discussion between coders and clinicians is enhanced.

Source: Statewide Health Information Management Clinical Coding Network

HHSs have experienced difficulty recruiting and retaining clinical coders. It can take 12 to 18 months on the job to train a coder to work independently. One HHS provided additional funding in 2013–14 to resource its coding audit and coder-clinician liaison functions better.

Representatives from those 13 HHSs that receive ABF have established a Statewide Health Information Management Clinical Coding Network (the Network). The Network aims to improve health information management and clinical coding services through education and development and sharing coding related tools and resources. DoH provides some funding to assist the Network.

The Network has developed a statewide clinical coding audit framework which includes a program of audit activity. The objective is to *'assess the validity of data underpinning the Activity Based Funding model'*. The audit program includes:

- measuring coding accuracy against national standards and rules
- examining the effects of coding errors
- supporting data quality improvement in admitted patient data reporting.

A Queensland coding audit committee comprised of representatives from ABF HHSs has been established to plan, manage and implement the audit program over a three-year period commencing in 2014.

A pilot audit found improvements are required in completing required clinical documentation, diagnosis information capture and coder–clinician liaison. The Network is currently considering findings from an external consultant review of the pilot audit prior to rolling out the audit program in full.

Appendices

Appendix A—Comments

In accordance with section 64 of the *Auditor-General Act 2009*, a copy of this report was provided to the Minister for Health; the Director-General, Department of Health; and the Board Chairs and Chief Executives of Hospital and Health Services, and they were afforded the opportunity to provide comments for inclusion in this report, should they wish to.

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

Comments received from Director-General, Department of Health

Queensland Government

Enquiries to: Mr Narinder Singh
Senior Director
Statutory and Advisory Services
Finance Branch
Telephone: 3234 0116
File Ref: DG075312

21 NOV 2014

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

Dear Mr Greaves Andrew

Thank you for your letter dated 24 October 2014, regarding the results of the audit of Hospital and Health Services' (HHSs) financial statements for 2013-2014.

I acknowledge receipt of the report sections proposed to be included in the Queensland Audit Office's report to Parliament. The Department of Health is not responding on behalf of the HHSs, however, acknowledges the recommendations related to the Department and has engaged with the relevant stakeholders within the Department to implement the audit recommendations. The Department's responses to the audit recommendations will be provided directly to Mr Damon Olive, Audit Director, Queensland Audit Office.

It is pleasing to note in the audit report that all 17 HHSs received an unmodified audit opinion. It is noted that the former Cape York HHS and Torres Strait – Northern Peninsula HHS audit opinions included an emphasis of matter paragraph to highlight to the reader that they were abolished on 30 June 2014.

The Department will continue to work with the Queensland Audit Office to implement strategies to improve processes in the preparation of annual financial statements for the Department and where applicable for the HHSs to achieve better practices in financial reporting.

Should you require further information in relation to this matter, I have arranged for Mr Narinder Singh, Senior Director, Statutory and Advisory Services, Finance Branch, on telephone 3234 0116, to be available to assist you.

Yours sincerely

Ian Maynard
Director-General
Queensland Health

Office	Postal	Phone	Fax
19th Floor Queensland Health Building 147 - 163 Charlotte Street BRISBANE QLD 4000	GPO Box 48 BRISBANE QLD 4001	3234 1553	3234 1482

Response to recommendations

Attachment 2

Response to QAO report to the Minister - Audit of the HHSs
With the HHSs being separate legal entities the Department does not respond on behalf of the HHSs. The Department has reviewed the report and has provided responses where there is Departmental involvement.

Specific areas of the report responded to by the Department

Summary
Recommendations

It is recommended that the Hospital and Health Services in conjunction with the Department of Health:

- **Formalise shared service provider arrangements through a written service level agreement**

  Management response
  Accounts Payable
  A consultation process with HHSs and business areas on responsibilities, timeframes and content is underway. The objective is to have a draft SLA for Accounts Payable in place by 31 March 2015.

  Information system support
  HSIA has a Support Services Agreement with each of the HHSs. The agreements are reviewed and signed annually. HSIA is meeting each of the HHS Chief Executives during the month of November to present the 14/15 agreement for signature.

  Payroll Portfolio
  Payroll Portfolio established a Service Catalogue during quarter one 2014 and has commenced work on developing a Schedule to the Service Level Agreements that Health Support Queensland is developing with Hospital and Health Services. This activity will be ongoing throughout quarter one and two of 2015 with an aim to have agreed SLAs in place for the 2015/16 financial year.

- **Implement controls at Hospital and Health Services to monitor the financial transactions processed on their behalf**

  Management response
  A HHS finance work group, which includes the Department, has been discussing the monitoring of financial transactions processed on behalf of the HHSs. The actions being implemented are:
  - *A FAMMIS report has been developed to enable local users to see who has posted into their HHS ledger accounts. It is currently anticipated that this report will be rolled out to key users in the month of November 2014*
  - *The Department and the HHSs are working closely on improving the transparency on systems generated postings into the HHSs general ledgers*

- **Implement controls to allow for the effective exercise of financial delegation for Hospital and Health Services approving:**
  - **Purchases of inventory from central pharmacy**

    Management response
  - *Health Service Queensland (HSQ) has confirmed that a modification to the iPharmacy system was made in June 2014, which will allow the purchasing officer to see the value of the Store Transfer Request (STR) before transferring to Central Pharmacy for processing*
  - *Further to the above HSQ has instructed the users of the iPharmacy system to obtain appropriate delegation for iPharmacy purchases*

Response to recommendations

- **Other purchase orders greater than $50,000**

  Management response
  A number of enhancements to systems and processes have been undertaken in conjunction with the implementation of the new Expenditure Delegations Framework (incorporating financial and procurement delegations), that was implemented on 10 November 2014. These enhancements have enabled data analytics to be undertaken, including the monitoring and reporting of cases of exceeding delegations.

2.4 Timeliness of financial statements
Delays in key management personnel data provided to 12 HHSs from the shared service provider

Management response
The delay in the provision of key management data to the HHS was a result of the following:

- *The data requests from the HHSs were incomplete in a number of cases*
- *Some of the data extracts provided by payroll needed to be rerun*
- *QAO needed to perform a review of the data before it was released to the HHSs, as a result a number of queries needed to be resolved before the data was released*

To prevent delays occurring in the 2014-15 financial year the Department has been in discussions with QAO with regard to an alternative approach for the HHSs to source the data. The use of the DSS system to source the data is being considered.

3.3.3 Control activities

Monitoring the exercise of authority
Over the last four years, DoH has used an automated accounts payable system at the Ipswich service centre for processing 85 per cent of West Moreton HHS invoices, including direct invoices. This accounts payable system removes paper-based expenditure vouchers and manual authorisations, reduces processing delays and provides a complete electronic payments audit trail. Given these substantial benefits, DoH should assess further roll-out of this system to other HHSs.

Management response
Finance Transactional Services are assessing suitable products in the current WoG banking tender for automated accounts payable solution. Liaison with procurement and contestability as part of this process is underway. Consultation to date with the HHS group has supported the use of automation tools in the AP function. This has also identified the large change management effort required on their part for the implementation of any such process.

Appendix B—Status of HHS financial statements

Figure B1
2013–14 audit opinions

Audit	Financial statements signed	Opinion issued	Opinion	Certified by 31 August legislated timeframe
Cairns and Hinterland Hospital and Health Service	20.08.2014	26.08.2014	U	✓
Cape York Hospital and Health Service	28.08.2014	29.08.2014	E	✓
Central Queensland Hospital and Health Service	22.08.2014	31.08.2014	U	✓
Central West Hospital and Health Service	21.08.2014	26.08.2014	U	✓
Children's Health Queensland Hospital and Health Service	28.08.2014	29.08.2014	U	✓
Darling Downs Hospital and Health Service	26.08.2014	28.08.2014	U	✓
Gold Coast Hospital and Health Service	21.08.2014	25.08.2014	U	✓
Mackay Hospital and Health Service	28.08.2014	31.08.2014	U	✓
Metro North Hospital and Health Service	27.08.2014	28.08.2014	U	✓
Metro South Hospital and Health Service	18.08.2014	22.08.2014	U	✓
North West Hospital and Health Service	22.08.2014	28.08.2014	U	✓
South West Hospital and Health Service	25.08.2014	31.08.2014	U	✓
Sunshine Coast Hospital and Health Service	19.08.2014	20.08.2014	U	✓
Torres Strait–Northern Peninsula Hospital and Health Service	28.08.2014	29.08.2014	E	✓
Townsville Hospital and Health Service	25.08.2014	28.08.2014	U	✓
West Moreton Hospital and Health Service	29.08.2014	29.08.2014	U	✓
Wide Bay Hospital and Health Service	26.08.2014	31.08.2014	U	✓

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

Source: Queensland Audit Office

Appendix C—Better practice for preparation of financial statements

Figure C1
Selected better practice-preparation of financial statements

Key area	Better practice
Financial report preparation plan	Establish a plan that outlines the processes, resources, milestones, oversight and quality assurance practices required in preparing the financial report
Preparation of pro forma financial statements	Prepare pro forma financial statements before 30 April and provide to the auditors to enable early identification of amendments, minimising the need for significant disclosure changes at year end
Materiality assessment	Assess materiality, including quantitative and qualitative thresholds, at the planning phase in consultation with the audit committee; the assessment assists preparers to identify potential errors in the financial report
Monthly financial reporting	Adopt full accrual monthly reporting to assist in preparing the annual financial report; this allows for the year end process to be an extension of the month end process
Rigorous quality control and assurance procedures	Require a review of the supporting documentation, data and the financial report itself by an appropriately experienced and independent officer prior to providing to the auditors
Supporting documentation	Prepare documentation of a high standard to support and validate the financial report and provide a management trail
Rigorous analytical reviews	Undertake rigorous and objective analytical review during the financial report preparation process to help to improve the accuracy of the report
Reviews of controls/self-assessment	Establish sufficiently robust quality control and assurance processes to provide assurance to the audit committee on the accuracy and completeness of the financial report
Competency of staff	Require that staff members preparing the financial report have a good understanding and experience in applying relevant accounting standards and legislation; require that they also have project management and interpersonal skills
Adequate security	Protect and safeguard sensitive information throughout the process to prevent inappropriate public disclosure

Source: Queensland Audit Office

Appendix D—Financial sustainability measures

Figure D1
Short term sustainability measures

Measure	Formula	Description	Target
Current ratio	Current assets/current liabilities	Measures the ability to pay existing liabilities in the next 12 months	A ratio of 1 or more (more current assets than short term liabilities)
Operating ratio	Operating result/total operating revenue	The higher the ratio, the greater the capacity to meet current and future operating and capital expenditure obligations, as operating revenues more than cover operating expenses	A positive ratio (surplus operating result)
Average number of days cash available	Unrestricted cash/ (total annual operating cash outflows/365 days)	Measures the number of days of operating expenses that an entity could meet with its cash on hand at 30 June; unrestricted cash includes cash equivalents, but excludes cash held where the use has been restricted such as special purpose funds or patient money	14 days' cash supply for operating expenses

Source: Queensland Audit Office

Appendix E—Queensland HHS areas

Figure E1
Hospital and Health Service areas and facilities

Source: Department of Health

Appendix F—Glossary

Figure F1
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 (AAS)	Australian accounting standards, including interpretations, are set by the Australian Accounting Standards Board (AASB) to be applied by: • entities required by the *Corporations Act 2001* to prepare financial reports • governments in preparing financial statements for the whole of government and the General Government Sector • entities in the private or public, for profit or not for profit sectors that are reporting entities or that prepare general purpose financial statements.
Australian Accounting Standards Board (AASB)	An Australian Government agency that develops and maintains financial reporting standards applicable to entities in the private and public sectors of the Australian economy.
Australian Refined Diagnosis-Related Group (AR-DRG)	Australian admitted patient classification system which 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 AR-DRG represents a class of patients with similar clinical conditions requiring similar hospital services.
Appropriate	Measures or indicators that provide users with sufficient information to assess the extent to which an entity has achieved a predetermined target, goal or outcome.
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.
Auditor's 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 AR-DRGs) provide a way of describing and comparing hospitals and other services for management purposes.

Terms	Definition
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.
Effectiveness	The achievement of the objectives or other intended effects of activities at a program or entity level.
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.
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 is intended 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 provided to assist departments and statutory bodies in the preparation of their financial statements: the requirements provide updates on new and revised accounting policies and standards and additional guidance and advice on the application of such 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 are used to 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* which are independently and locally controlled by a Hospital and Health Board.
Hospital and Health Boards Act 2011	An Act of the State of Queensland which sets out financial reporting and annual reporting requirements for Hospital and Health Boards.

Terms	Definition
Information system	A component of internal control that includes the financial reporting system and consists of the procedures and records established to initiate, record, process and report entity transactions (as well as events and conditions) and to maintain accountability for the related assets, liabilities and equity.
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.
Internal audit	An appraisal activity established or provided as a service to the entity, internal audit functions include examining, evaluating and monitoring the adequacy and effectiveness of internal control and reporting deficiencies to management.
Legislative time frame	The date prescribed by legislation for a public sector entity to finalise its financial statements or annual report.
Liability	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.
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 on the basis of 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.
Net assets	Total assets less total liabilities.
Net result	Calculated by subtracting an entity’s total expenses from its total revenue to show what the entity has earned or lost in a given period of time.
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.
Qualified audit opinion	Opinion issued when the financial statements as a whole comply with relevant accounting standards and legislative requirements, with the exceptions noted in the opinion; exceptions could be the effect of a disagreement with those charged with governance, a conflict between applicable financial reporting frameworks or a limitation on scope that is considered material to an element of the financial report.

Terms	Definition
Relative stay index	The actual number of patient days for acute care separations in selected Australian Refined Diagnosis-Related Groups (AR-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, AR-DRGs for 'rehabilitation', AR-DRGs which are predominantly same day (such as R63Z chemotherapy and L61Z admit for renal dialysis), AR-DRGs which have a length of stay component in the definition, and error AR-DRGs *Directly standardised versus indirectly standardised* The directly standardised method applies the average length of stay of each AR-DRG for the group of interest and is multiplied by the national population (total number of separations in each AR-DRG) to derive the expected number of patient days. Direct standardisation methods are generally used where the populations and their characteristics are stable and reasonably similar. Groups can be compared using the directly standardised rates as the activity of each group is weighted using the same set of weights, namely the national casemix. The indirectly standardised method applies the national average length of stay for each AR-DRG to the relevant population of interest (number of separations for each AR-DRG in the hospital group) to derive the expected number of patient days. This method is generally used when rate information (average length of stay for each AR-DRG in this analysis) for the population of interest is unknown or subject to fluctuation because of small population sizes. An indirectly standardised rate compares a group with a 'standard population rate' so, using this method, rates for different groups are not strictly comparable because each group has a different casemix to which the national average length of stay data have been applied.
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).
Risk management	The systematic identification, analysis, treatment and allocation of risks; the extent of risk management required will vary depending on the potential effect of the risks.
Unqualified audit opinion	Opinion issued when the financial statements comply with relevant accounting standards and prescribed requirements.
Written down value	The value of an asset after accounting for depreciation or amortisation, written down value is calculated by subtracting accumulated depreciation or amortisation from the asset's original value and reflects the asset's present worth from an accounting perspective.

Source: Queensland Audit Office

Auditor-General Reports to Parliament

Reports tabled in 2014–15

Number	Title	Date tabled in Legislative Assembly
1.	Results of audit: Internal control systems 2013–14	July 2014
2.	Hospital infrastructure projects	October 2014
3.	Emergency department performance reporting	October 2014
4.	Results of audit: State public sector entities for 2013–14	November 2014
5.	Results of audit: Hospital and Health Service entities 2013–14	November 2014

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