Unite & Recover

Mackay Hospital and Health Service

ANNUAL REPORT 2021–2022

Queensland Government

Accessibility

Open Data

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

Public availability statement

An electronic copy of this report is available at http://www.mackay.health.qld.gov.au. Hard copies of the annual report are available by phoning the Media and Communications Manager on 07 4885 5984. Alternatively, you can request a copy by emailing mhhs-comms@health.qld.gov.au.

Interpreter Service statement

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on telephone 07 4885 5984 we will arrange an interpreter to effectively communicate the report to you.

Licence

Attribution

Content from this annual report should be attributed as: State of Queensland (Mackay Hospital and Health Service) Annual Report 2021-2022.

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Acknowledgment

Acknowledgement to Traditional Owners

Mackay Hospital and Health Service (HHS) respectfully acknowledges the Traditional Custodians of the land and sea on which we serve our communities, and pay our respect to Elders past, present and emerging. We also declare our commitment to reducing inequalities in health outcomes for Aboriginal and Torres Strait Islander peoples as we move to a place of equity, justice and partnership together.

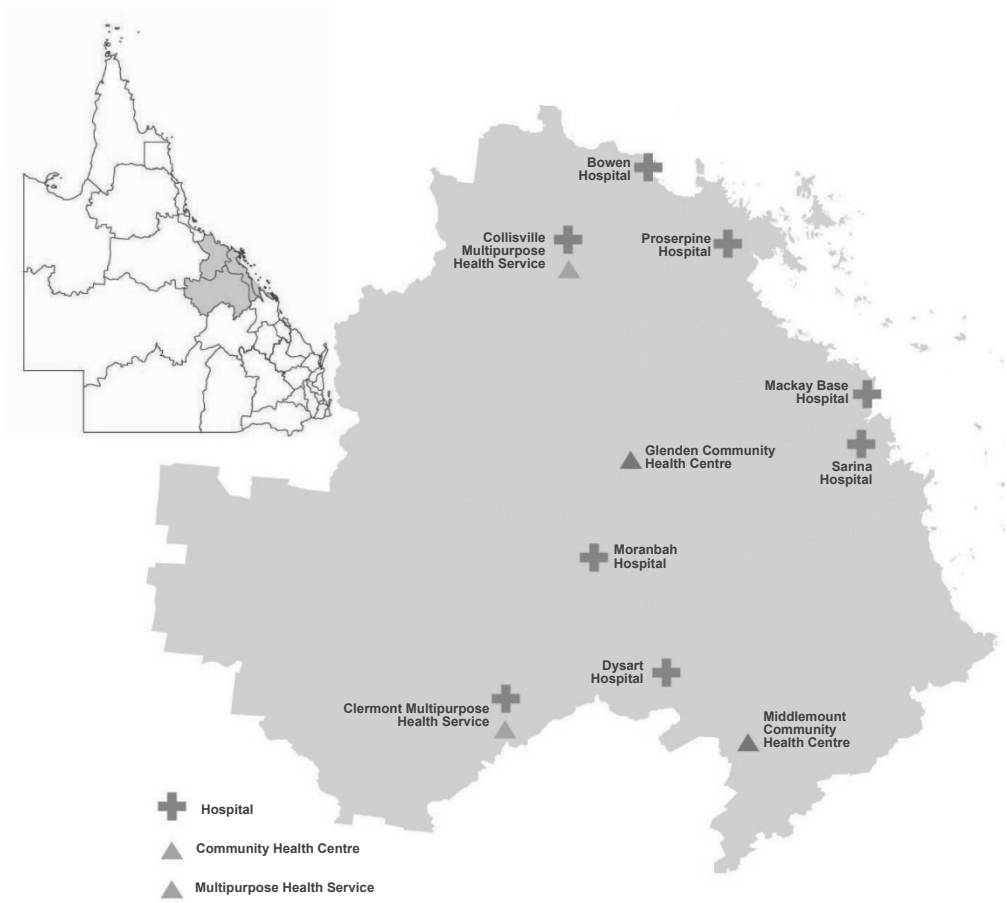
Mackay – Yuwi people
Sarina – Yuwi people
Moranbah – Barada Barna people
Dysart – Barada Barna people
Clermont – Wangan Jagalingou people
Glenden – Wiri people
Middlemount – Barada Barna people
Proserpine – Gia people
Cannonvale – Ngaro people
Bowen – Juru people
Collinsville – Birriah people

Aboriginal and Torres Strait Islander peoples terminology

Throughout the Annual Report, the terms ‘Aboriginal and Torres Strait Islander peoples’, ‘First Nations peoples’ and ‘Aboriginal peoples and Torres Strait Islander peoples’ are used interchangeably rather than ‘Indigenous’. Whilst ‘Indigenous’ is commonly used in many national and international contexts, Queensland Health’s preferred terminology is ‘Aboriginal and Torres Strait Islander peoples’, ‘Aboriginal peoples and Torres Strait Islander peoples’ or ‘First Nations peoples’.

Recognition of Australian South Sea Islanders

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



Letter of compliance

1 September 2022

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

Dear Minister

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

I certify that this Annual Report complies with:

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

A checklist outlining the annual reporting requirements is provided at 73 of this annual report.

Yours sincerely

Darryl Camilleri
Chair
Mackay Hospital and Health Board

Contents

Statement on Queensland Government objectives for the community

The Queensland Government's *Unite and Recover – Queensland Economic Recovery Plan* is a plan to advance Queensland - both now and into the future. Mackay HHS contributes to the priorities of Safeguarding our health; Supporting jobs; Building Queensland; Growing our regions; Investing in skills; and Backing our frontline services through delivery of the strategic objectives and strategies under Mackay HHS's strategic plan.

Mackay HHS's *Strategic Plan 2020-2024* contributes to the Queensland Government's *Unite and Recover – Queensland Economic Recovery Plan* by supporting six of its nine key community government objectives through the strategic objectives below*:*

Strategic Objectives & Outcomes	Alignment with Queensland Government's objectives
Inspired People • Valued, empowered and accountable staff • Diverse, capable and agile workforce • Safe, caring and supportive culture • Healthy staff who inspire others • Engaged staff embracing opportunities for change and improvement	• Supporting jobs: Support increased jobs in more industries to diversify the Queensland economy and build on existing strengths in agriculture, resources and tourism. • Growing our regions: Help Queensland's regions grow by attracting people, talent and investment, and driving sustainable economic prosperity. • Investing in skills: Ensure Queenslanders have the skills they need to find meaningful jobs and set up pathways for the future.
Exceptional Patient Experience • Informed and empowered people • Better access to services • Treat our patients as individuals • Care is co-designed with our patients, families, carers and communities • Safe and excellent care – continually improving	• Safeguarding our health: Safeguard people's health and jobs by keeping Queensland pandemic-ready. • Backing our frontline services: Deliver world-class frontline services in key areas such as health, education and community safety.
Excellence in Integrated Care • Seamless health and social care system • Navigable health system • Smart and responsible use of technology • Innovative, collaborative and productive partnerships	• Safeguarding our health: Safeguard people's health and jobs by keeping Queensland pandemic-ready. • Backing our frontline services: Deliver world-class frontline services in key areas such as health, education and community safety.
Sustainable Service Delivery • Services matched to community health needs • The right service in the right place by the right people at the right time – delivered as close to home as possible • Recognised teaching hospital • Research outcomes translated into action • Smart use of resources to deliverables	• Supporting jobs: Support increased jobs in more industries to diversify the Queensland economy and build on existing strengths in agriculture, resources and tourism. • Building Queensland: Drive investment in the infrastructure that supports our recovery, resilience and future prosperity. • Growing our regions: Help Queensland's regions grow by attracting people, talent and investment, and driving sustainable economic prosperity.

From the Chair and Chief Executive

It is with great pleasure we present the 2021-2022 Mackay HHS annual report.

This year we reflect on a busy 12 months with a growing demand for public healthcare and record presentations in our emergency departments. Our frontline clinicians have worked tirelessly to meet not only an increase in the number of emergency presentations, but an increase in the most urgent patients. In 2021-2022, Mackay HHS saw a 13.3 per cent increase in emergency presentations with a 19.2 per cent increase in the most urgent Categories 1 and 2 patients. Despite the increase, waiting times improved with more patients admitted or discharged within four hours compared to the same time last year.

The relentless demands of the COVID-19 pandemic continued to disrupt some planned care as we diverted our resources into treating those with COVID-19 in the hospital while we also worked to vaccinate the community. We are proud of our partnership with others to lift our health service vaccination rates from one of the lowest in Queensland to one of the highest with 93.6 per cent of the eligible population having two or more doses. This impressive response was due to the health service collaborating with General Practitioners, pharmacies and private providers such as Vanguard Health and Medical Rescue to deliver the vaccine to all corners of the health service. We also worked closely with Mayors and the District Disaster Management Group to support the logistics of the vaccine delivery roll out. It was a team effort we can all be very proud of.

The demand for testing and vaccination was at its peak in summer and we offer special thanks to staff working in uncomfortable conditions in full Personal Protective Equipment. Whether this was at the Mackay Showgrounds or outside the Proserpine Hospital emergency department, our staff have continued to front up every day and care for their community.

The pandemic has had an enormous impact on our community with more than 16,000 cases reported and sadly some deaths. The arrival of community transmission in December 2021 required us to open a dedicated COVID-19 ward for patients and to re-establish our Virtual Ward to care for stable patients in the comfort of their own home. Infrastructure upgrades were completed to support the treatment of COVID-19 (or suspect COVID-19) patients, including creating four isolation rooms in the Intensive Care Unit. We built a separate waiting room in the Mackay Base Hospital Emergency Department for respiratory patients and created single bed spaces in Bowen and Proserpine emergency departments. We would also like to thank our partners in the private sector who have helped us support patient care by providing additional beds.

The pandemic has resulted in some changes to our work practices that we can sustain moving forward and that provide benefit to patients. We have increased the use of telehealth, decreasing the need for patients to travel. The experience of caring for COVID-19 patients at home has further cemented our belief in the benefits of our Hospital in the Home model of care while being supported by a registered nurse and medical officer.

The growing need for acute care has meant our attention has also been focused on the necessary expansions to our infrastructure that is needed to continue to deliver care. In Bowen the community is now benefitting from an expanded $7 million Renal Dialysis Unit and Medical Imaging Department. Bowen Hospital now has a CT scanner which is saving patients travel time to Proserpine and Mackay and allow faster diagnosis of some conditions and injuries. The new renal unit has six chairs operating six days a week, again removing the burden of travel from unwell patients. The value of having care close to home cannot be underestimated.

Work on the new $31.5 million Sarina Hospital commenced in early 2022. This new facility is located on a new site in Sarina with the capacity for 19 beds, new staff accommodation and will allow for future expansion of the facility if required.

In October 2022 the health service commissioned an independent investigation into obstetrics and gynaecology services under Part 9 of the *Hospital and Health Boards Act 2011* (HHBA). The health service will receive this report in 2022-23 and has committed to sharing the outcomes and actions of the investigation.

This year we completed the preliminary business case to build a new Moranbah Hospital. Progression of our capital projects will be a strong focus for the health service in 2022-2023 with Whitsunday residents to benefit from the opening of a renal dialysis service at Proserpine Hospital. In Mackay we will embark on the detailed design stage of expanding Mackay Base Hospital to deliver additional wards and beds. Our capital programs will increase our capacity to admit patients to hospital and this will in turn support the flow of patients through emergency departments.

In 2022-2023 the health service will continue to respond to rising demand for care, with additional funding received to reduce waiting lists for elective surgery, gastrointestinal endoscopy and for appointments in the specialist outpatients department.

We also look forward to launching our first Health Equity Strategy in 2022-2023 with Mackay HHS's first Executive Director Aboriginal and Torres Strait Islander Health. This strategy has been created in collaboration with First Nations communities and partners and it will detail the activities to support a renewed and shared agenda to improve Aboriginal and Torres Strait Islander peoples' health outcomes, lived experiences and access to care across the system. Mackay HHS has developed the Our Mob Together Strong Health Alliance and Health Equity Advisory Group in order to partner with Aboriginal and Torres Strait Islander Community Controlled Health Organisations, North Queensland Primary Health Network, Traditional Custodians and First Nations Health consumers to create the strategy.

Our strong partnership with our consumer groups continued with much effort invested in community engagement in preparing for co-designing maternity services. The work of the Maternity Consumer Reference Group to co-design maternity care will continue into the new year and we look forward to the outcomes of this partnership with the community. Thank you to our communities for your contribution to the co-design of our services and to those who give up their time to participate in our consumer reference groups to provide advice about local healthcare services from a consumer and community perspective.

Our thanks also go to the Mackay Hospital Foundation and its valued volunteers for their time and fundraising to help improve the comfort of our patients and visitors. Significant work has gone into fundraising for construction of the Ronald McDonald Family Room at Mackay Base Hospital and we are indebted to the community events, organisations and individuals who have made this dream a reality. We look forward to welcoming the first families later this year and know they will appreciate a place to rest and recuperate away from the Child and Adolescent Unit.

To our dedicated volunteers from the Mackay Hospital Foundation and hospital auxiliaries in Mackay, Proserpine, Bowen and Clermont, your contribution cannot be underestimated. Your work plays a vital role in improving the journey of our patients.

Thank you to our staff for the professional and compassionate care you deliver and thank you to all of those who work to enable this care to be delivered. You are our greatest asset and we would not be where we are today without you.

Darryl Camilleri
Chair
Mackay Hospital and Health Board

Lisa Davies Jones
Chief Executive
Mackay Hospital and Health Service

About us

Mackay HHS is an independent statutory body overseen by an appointed Hospital and Health Board, established on 1 July 2012. Our responsibilities are set out in the HHBA and the *Financial Accountability Act 2009* and subordinate legislation. We operate according to the service agreement with the Department of Health which outlines the services to be provided, the funding arrangements and our performance indicators and targets.

Mackay HHS is responsible for the delivery of public hospital and health services including medical, surgical, emergency, obstetrics, paediatrics, specialist outpatient clinics, mental health, critical care and clinical support services to a population of approximately 174,816 people. The geographical catchment of Mackay HHS spans 90,364 square kilometres, extending from Bowen in the north to St Lawrence in the south, west to Clermont and northwest to Collinsville and includes Proserpine and the Whitsundays. Mackay HHS's Aboriginal and Torres Strait Islander population is 6.2 per cent, higher than the 4.7 per cent Queensland average. There is also a significant Australian South Sea Islander community in the region.

Strategic direction

Mackay HHS is committed to providing services that are efficient, diverse and flexible to changing community and government needs. The health service has focused on the following key areas specific to the health context – building our health workforce capacity and capability; delivering excellence in care for all patients; working collaboratively with our partners to support streamlined care, particularly for vulnerable people; and working in smart and efficient ways to grow and expand our services for the future.

The Mackay Hospital and Health Board (MHHB) sets the organisation's strategic agenda and monitors outcomes achieved against the Mackay HHS Strategic Plan and its performance against the service delivery statement. Mackay HHS's *Strategic Plan 2020-2024* sets out four inter-related objectives of Inspired People; Exceptional Patient Experiences; Excellence in Integrated Care and Sustainable Service Delivery each with their own strategies, to achieve Mackay HHS's vision.

Vision, Purpose, Values

Our Vision

Delivering Queensland's Best Rural and Regional Health Care

Our Purpose

To deliver outstanding health care services to our communities through our people and partners

Our Values

Collaboration | Trust | Respect | Teamwork

Priorities

In alignment with the Service Delivery Statement and our Strategic Plan 2020-2024, we continued to focus on achieving outcomes and progress towards realising the strategic objectives in 2021-2022 which were:

Inspired People

Creating a diverse and highly skilled workforce

Exceptional Patient Experiences

Improving patient flow and striving for patients to have better access to surgical and outpatient services

Excellence in Integrated Care

Continuing to respond to community health priorities, such as care of the elderly and chronic disease

Sustainable Service Delivery

Further developing contemporary models of care to help patients to spend less time in hospital

Aboriginal and Torres Strait Islander Health

Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 is the commitment and work of all staff and volunteers of Mackay HHS.

The burden of disease and injury in Queensland's Aboriginal and Torres Strait Islander people 2017 HHS profiles report states that within Mackay HHS boundaries, Aboriginal and Torres Strait Islander peoples experience 2.1 times the burden of disease and injury compared to non-Indigenous Queenslanders. Additionally, the gap of Health Adjusted Life Expectancy for Mackay HHS's Aboriginal and Torres Strait Islander peoples is 61.7 years compared to 73.7 years for the rest of Queensland.

The Mackay HHS Aboriginal and Torres Strait Islander Health Team established First Nation Information Exchange Meeting with local First Nations stakeholder groups to share information and promote vaccinations as the best way to protect the community and slow transmission. First Nations staff were trained and worked alongside the many dedicated staff working at the Mackay COVID-19 testing clinic during the pandemic period. The Aboriginal and Torres Strait Islander Health Team rallied together to plan and implement vaccinations at various locations throughout Mackay, Whitsunday and Isaac region, including a pop-up clinic at the Indigenous Football Carnival.

There are seven *Making Tracks towards Closing the Gap* Queensland Government funded programs, amounting to approximately $1.9 million. These are the health service's key drivers for improving access to outpatient appointments and acute hospital services, chronic disease management coordination, cultural support to patients, development and delivery of cultural practice education and resources to our workforce.

Mackay HHS has developed and implemented a pilot Education to Employment Program for Aboriginal and Torres Strait Islander grade 11 and 12 High School Students called 'Budyubari Bidyiri Kebi Stapal' (Big Dream, Small Steps). The initiative is designed for young Aboriginal and Torres Strait Islander people and seeks to inspire, educate, engage and motivate through structured health employment pathways. There are 15 School Based Traineeship positions available in this program and these positions are spread across all participating high schools in Mackay, Sarina, Mirani and Calen.

The Mackay HHS is committed to improving health equity for First Nations people. Mackay HHS participated in the Mackay Health Equity consultation forum facilitated by Queensland Aboriginal and Islander Health Council. The consultation report from this forum will be used by Mackay HHS to guide the planning and co-design of a Mackay Regional Health Equity Strategy in partnership with Aboriginal and Torres Strait Islander Community Controlled Health Organisations and other health stakeholder groups.

Our community based and hospital based services

Mackay HHS provides an integrated approach to service delivery across acute, primary health and other community based services including aged care assessment and Aboriginal and Torres Strait Islander programs. Primary health services include Mental Health, Oral Health, Home and Community Care, Mobile Women's Health, Alcohol and Other Drugs Service, Sexual Health, Aged Care Assessment Team and BreastScreen.

Mackay HHS facilities include:

- Mackay Base Hospital and Mackay Community Health Centre
- Proserpine Hospital | Cannonvale Community Health Centre
- Bowen Hospital
- Sarina Hospital
- Dysart Hospital | Middlemount Community Health Centre
- Moranbah Hospital | Glenden Community Health Centre
- Clermont Multipurpose Health Service (acute and aged care beds)
- Collinsville Multipurpose Health Service (acute and aged care beds)

Mackay HHS can treat most people locally. Those who require more specialist care or treatment are transferred to the Townsville University Hospital or Brisbane hospitals.

Mackay HHS provides free car parking for patients, families, visitors and staff. Consequently, there was no requirement to issue car parking concessions throughout 2021-2022.

Targets and challenges

There are many challenges facing Mackay HHS as we deliver and plan future health services in a complex and dynamic environment, further impacted by the COVID-19 pandemic. These include continued high growth in demand for public services, economic and population demographic changes, the burden of complex and chronic disease, sustainability of private partners, workforce recruitment and retention challenges and community expectations of service access and delivery. In addition, Mackay HHS residents demonstrate high rates of unhealthy behaviours including smoking, obesity and alcohol consumption. The population also continues to age, with older people having the greatest projected increase over the coming years.

These challenges represent an important opportunity for our communities to share in the responsibility of shaping future health and wellness outcomes. New technology and new ways of doing things are being embraced as part of our service optimisation and transformation agenda. Mackay HHS continues to build on our partnerships to ensure safe and sustainable services for our community. Empowering patients to own and manage their individual health remains a high priority and there is significant potential to achieve successes in reducing health risk factors in the Mackay HHS by adopting a whole-of-community approach.

Collaboration and partnerships, such as the strong one forged with North Queensland Primary Health Network (NQPHN), are crucial if we are to respond to the community's health priorities, such as mental health and chronic disease. By working across government and non-government sectors, business and industry, we can make significant gains in improving the health of our community and supporting initiatives that provide better integrated health care, support patient flow and enabling the right workforce to deliver services in the right place.

Looking ahead, we expect to see a continued increase in demand for public health services and continuing challenges in skilled workforce attraction and retention. Recruiting and retaining highly qualified staff in rural and regional areas is an ongoing challenge that Mackay HHS continues to manage through a variety of strategies including a 'Grow Our Own' approach by working collaboratively with local secondary and tertiary education providers.

Moving forward, our priorities are to deliver on key strategies through collaborative and productive partnerships with our private, public and non-government organisation partners and to plan for growth to improve access to health services as close to home as possible and deliver financially viable service models, including virtual care. This will, in part be addressed by continuing to progress works under the $31.5 million Sarina Hospital Redevelopment as well as progressing Mackay Base Hospital, Bowen Hospital and Moranbah Hospital redevelopment business cases, key to enabling access to care closer to home, growth of a range of services and providing expanded inpatient bed capacity, particularly at Mackay Base Hospital.

Mackay HHS strategies shape the future of health care in our region to achieve positive outcomes for its communities, with emphasis on health equity and improving health outcomes for our Aboriginal and Torres Strait Islander and Australian South Sea Islander population. Aboriginal and Torres Strait Islander peoples represent a higher proportion of the population in Mackay HHS, compared to the State of Queensland and we continue our commitment to close the gap for Aboriginal and Torres Strait Islander peoples through implementation of *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033*. Overall, we seek to provide better access to services; safe and excellent care; smart use of technology; and sustainable services matched to community health needs.

From a whole of health system perspective, we will deliver local responses to the Department of Health and whole of Government priorities and initiatives. These include supporting the Queensland Government's *Unite and Recover – Queensland Economic Recovery Plan* objectives; the delivery of a health equity strategy and the realisation of Queensland Health's *My health, Queensland's future: Advancing health 2026*; working with the National Disability Insurance Agency; supporting staff and community members who are affected by family and domestic violence; and the impacts of the COVID-19 pandemic.

Governance

Our people

Providing high quality health care in rural and regional Queensland is a unique and privileged challenge. Mackay HHS is one organisation across eight hospitals and five community health centres. Mackay HHS's capacity to deliver excellent regional health care is supported by an exceptional workforce. Enabling our workforce to provide the highest level of care to the community we serve requires a proactive approach to workforce planning, development and engagement to create the right capability mix to meet current and future demands.

Board membership

The Governor in Council appoints Board Members based upon the recommendation of the Minister and approves the remuneration arrangements (consistent with the *Remuneration Procedures for Part-Time Chairs and Members of Queensland Government Bodies;* reported on page 64). The MHHB derives its authority from the HHBA and the *Hospital and Health Boards Regulation 2012*. Board Members act in accordance with their duties and abide by the Code of Conduct and Values for the Queensland Public Service in accordance with the *Public Sector Ethics Act 1994*.

The following committees support the functions of the MHHB. Each operates with terms of reference describing the purpose, duties and responsibilities, composition and membership. MHHB committees also undertake deep dives into service areas as required.

Executive Committee

The Executive Committee provides support to the MHHB in its role of controlling Mackay HHS by:

- Working with the Chief Executive to progress strategic issues identified by the MHHB
- Monitoring strategic human resources and work health and safety matters.
- Strengthening the relationship between the MHHB and the Chief Executive to ensure accountability in the delivery of services by Mackay HHS.

Meetings are held quarterly or as directed by the Chair.

Safety and Quality Committee

The Safety and Quality Committee provides strategic advice and recommendations to the MHHB regarding patient safety and quality assurance. Meetings are held quarterly or as directed by the Chair.

Audit and Risk Committee

The Audit and Risk Committee provides support to the MHHB in its responsibility for audit and risk oversight and management and operates in accordance with Queensland Treasury's Audit Committee Guidelines. Meetings are six times per year or as directed by the Chair.

Finance Committee

The Finance Committee provides advice to the MHHB on matters relating to the financial and operational performance of Mackay HHS. Meetings are six times per year or as directed by the Chair.

Table 1: Government bodies reporting

Name of Government body	*Mackay Hospital and Health Board*
Act or instrument	The MHHB derives its authority from the HHBA and the *Hospital and Health Boards Regulation 2012.*
Functions	The MHHB's functions include: • Develop strategic direction and priorities for the Mackay HHS. The MHHB uses local decision-making to develop plans, strategies and budgets to ensure accountable provision of health services to meet the needs of the community. • Monitor compliance and performance of the Mackay HHS. It oversees the operation of systems for compliance and risk management, and audit reporting to meet legislative requirements and national standards. • Focus on patient experience and quality outcomes. Meeting the challenges of distance and diversity is essential to providing patient care across the Mackay HHS. • Ensure evidence-based practice education and research. The MHHB encourages partnering with universities and training providers to boost clinical capability.
Achievements	Some of the key achievements of the MHHB in 2021-2022: • Commenced building the new Sarina Hospital • Completed construction of the new Bowen Hospital Medical Imaging and Renal Unit building • Approved the Strategic Asset Management Plan • Approved the Risk Management Framework
Financial reporting	MHHS is not exempted from audit by the Auditor-General and transactions of the entity are accounted for in the financial statements.
Remuneration	As reported on page 64, G1 Key Management Personnel Disclosures.
No. scheduled meetings / sessions	See table below
Total out of pocket expenses	$1,882.38

Board Members	MHHB	Committees			
		Executive	*Audit & Risk*	*Finance*	*Safety & Quality*
Darryl Camilleri	12 out of 12	3 out of 4	5 out of 5	7 out of 7	
David Aprile [1]	11 out of 12	3 out of 3		7 out of 7	
Richard Murray [1]	10 out of 12	3 out of 3			3 out of 3
Suzanne Brown	12 out of 12	3 out of 3	5 out of 5		
Adrienne Barnett	12 out of 12	2 out of 3			3 out of 3
Elissa Hatherly [1]	12 out of 12		5 out of 5		3 out of 3
Helen Caruso	12 out of 12		4 out of 5	7 out of 7	
Annabel Dolphin	10 out of 12			7 out of 7	
Tom McMillan [1]	12 out of 12				3 out of 3

[1] *Board Members who satisfy the Clinical Expertise requirement under section 23(4) of the HHBA.*

Mr Darryl Camilleri
Board Chair | Originally appointed on 29 June 2012, current term is 18 May 2021 to 31 March 2024

Mr Camilleri is the former Deputy Mayor of the Mackay Regional Council and has served as Chair for a number of community organisations. He is also a Chartered Accountant who has previously been in practice in Mackay specialising in small business and audit. He is also a graduate of the Australian Institute of Company Directors.

Mr David Aprile
Board Member | Originally appointed on 29 June 2012, current term is 1 April 2022 to 31 March 2024

Mr Aprile is a practicing pharmacist and a FCPA and is a former founding partner of a local pharmacy group and a current founding director of a Mackay property development group. He has previously served on community and government-based boards and advisory groups in Mackay including the Central Queensland University Advisory Board and Mackay Chamber of Commerce and shaping Mackay.

Professor Richard Murray
Board Member | Originally appointed on 29 June 2012, current term is 18 May 2021 to 31 March 2024

Professor Murray has over 30 years' experience in medicine, specialising in general practice and with a career focus on Aboriginal health, rural and remote medicine, public health, tropical medicine, health professional education and the needs of underserved populations. He is the Dean of the College of Medicine and Dentistry at James Cook University (JCU), the President of Medical Deans Australia and New Zealand, a member of the Council of the National Health and Medical Research Council and a past President of the Australian College of Rural and Remote Medicine. He is also a member of the Australian Institute of Company Directors.

Ms Suzanne Brown
Board Member | Originally appointed on 18 May 2016, current term is 10 June 2021 to 31 March 2024

Ms Brown is a Director and leading commercial solicitor at McKays Solicitors (Mackay). She is a director of the Resources Centre of Excellence Ltd. She is a Queensland Law Society Business Law Accredited Specialist and has served as a former director of North Queensland Bulk Ports Corporation Limited (and its subsidiaries).

Ms Adrienne Barnett
Board Member | Originally appointed on 18 May 2019, current term is 1 April 2022 to 31 March 2026

Ms Barnett's Aboriginal cultural heritage and identity has led her to many different roles during her 26 years of living in Mackay. She currently manages the Mackay and Region Aboriginal and Islander Development Association. Ms Barnett has been employed with Department of Aboriginal and Torres Strait Islander Partnerships and holds governance roles with Mackay Aboriginal and Islander Media Association and Kutta Mulla Gorinna Special Assistance School.

Dr Elissa Hatherly
Board Member | Originally appointed on 18 May 2019, current term is 1 April 2022 to 31 March 2026

Dr Hatherly has 20 years' experience as a doctor in the Mackay region, with particular interest in specialist Women's Health services in both the hospital's Family Planning clinic and general practice. As Head of the JCU Clinical School in Mackay, she oversees both undergraduate and general practice medical education and continues to build tertiary education options in the region. Dr Hatherly is also an advocate for preventative health care, improving health literacy and training healthcare professionals to deliver quality care close to home.

Mrs Helen Caruso
Board Member | Originally appointed on 18 May 2020, current term is 1 April 2022 to 31 March 2026

Mrs Caruso is a Mackay local and a Chartered Accountant with over 25 years' experience in her field. She has previously held roles as Chief Financial Officer and Practice Manger, specialising in the areas of strategy and growth, succession planning, human resources management, and evaluating and implementing new and innovative Information and Communication Technologies. She is also Graduate of the Australian Institute of Company Directors.

Ms Annabel Dolphin
Board Member | Originally appointed on 18 May 2021, current term is 18 May 2021 to 31 March 2024.

Ms Dolphin is an experienced non-executive director with over 20 years' experience specialising in strategic human resources, business advisory and corporate governance across a diverse range of sectors. She is currently President of Saints Netball Club Mackay and non-executive director for RACQ Ltd, Tourism Australia and local business owner of Helloworld Travel Mackay, Mt Pleasant and Townsville. In addition, she has served on several government and non-for-profit boards including within the energy, ports, education and health sector. She is also Graduate of the Australian Institute of Company Directors.

Mr Thomas (Tom) McMillan
Board Member | Originally appointed on 10 June 2021, current term is 10 June 2021 to 31 March 2024.

Mr McMillan is a Specialist Musculoskeletal Physiotherapist and experienced board member with governance and management roles across the healthcare spectrum. He is the Executive Director of the Physio Plus Group which provides multidisciplinary allied health services in private practices, private hospitals, disability, aged care, industry and elite sport in two Australian states. He is also the Vice-President Australian College of Physiotherapists, Clinical Lead for Australian Digital Health Agency, Member WorkCover Queensland Medical Allied Health Panel, and is an Adjunct Lecturer at JCU's College of Healthcare Sciences. He also sits on the Clinical Council of the NQPHN and the Council of the National Rural Health Alliance.

Executive management

Ms Lisa Davies Jones
Health Service Chief Executive
Ms Davies Jones has had a broad ranging healthcare career within nursing, service improvement, healthcare management and clinical governance. She has worked in several executive leadership roles within healthcare organisations in the United Kingdom and Queensland. Her strong commitments to improving health outcomes has led to a determination to see integrated health services codesigned with communities, for the seamless delivery of health care.

Ms Sharon Walsh
Chief Operating Officer
Ms Walsh started her career in healthcare nursing in South Africa. She has broad ranging experience that includes operational management, project management, and clinical governance. Her passion lies in ensuring the delivery of safe and high-quality care to every patient. While her career has predominantly been in quaternary healthcare, Ms Walsh also has experience with regional healthcare, having sat on the board of a regional health service in Victoria.

Ms Terry Johnson
Executive Director Mental Health, Public Health and Rural Services
Ms Johnson has extensive executive management and leadership experience within Queensland Health across a diverse range of service settings including large tertiary facilities, community services, mental health, aged care and rural health services. Her health career began in Brisbane where she spent many years within the former Prince Charles and Royal Brisbane Hospital Districts. She accepted a secondment to Central Queensland in early 2000 where she developed a passion for rural health and has been working in rural settings ever since.

Ms Karen Wade
Executive Director Nursing and Midwifery (acting)
Ms Wade is an experienced Healthcare Professional who has worked in Leadership and Executive roles for more than 35 years. During this time providing strong leadership and management in an environment of change, roles include: Acting Executive Officer, Executive Director of Nursing and Executive Director of Service Development for the Mercy Health and Aged Care Central Qld Group and District Director of Nursing and Executive Director of Quality and Safety Queensland Health CQHHS, Northern Regional Services Manager for Bolton Clarke, Executive General Manger Encore Care (Aged Care).

Ms Tanya Feekings
Executive Director Corporate Services | Chief Financial Officer
Ms Feekings has over 20 years' experience in both the public and private sectors providing strategic leadership for the delivery of Finance and other Corporate Services functions including Human Resources, Work Health and Safety, Infrastructure, Procurement, ICT and Fleet. She is a Fellow Certified Practising Accountant and the 2022 CPA Queensland Divisional President.

Associate Professor David Farlow
Executive Director Research and Innovation | Chief Medical Officer (acting)
Associate Professor Farlow first arrived in the Mackay HHS in 1984. Prior to his current role, he provided a broad range clinical services (rural generalist) and executive leadership roles within the Whitsunday Health Service and Mackay HHS. His expertise and experience include undertaking a range of investigations, service reviews and consultancies for Queensland Health. He is also the Clinical Dean of JCU's School of Medicine and Dentistry (Mackay campus).

Mr Darryl Turner
Executive Director People (acting)
Mr Turner has an extensive career in healthcare services and human resource management. He has worked in executive and senior leadership roles within Government and the private sector. He has vast experience in the Industrial Relations Commission, as well as being chief negotiator for many government and private sector certified agreements. Mr Turner has managed high-profile disputes with Trade Unions and employee advocates and has led large teams covering the portfolios of staff training, health and safety, recruitment and retention, talent management, workplace investigations, change management and restructures.

Ms Janet Geisler
Executive Director Strategy, Governance and Engagement
Ms Geisler has held senior and executive roles within public sector management, with extensive experience in leading strategy development and execution in complex environments with a proven record of adding value through the public health and community sectors. She is committed to driving strategies to enhance organisational performance, engagement and governance. She has extensive experience in partnering across government, industry, community with a strong commitment to improve the delivery of health and social care services for regional, rural and remote communities.

Mr Simon Costello
Executive Director Aboriginal and Torres Strait Islander Health
Mr Costello is a Goori (Aboriginal man) from Minjerribah (North Stradbroke Island) and is a Traditional Owner from the Quandamooka Nation, which takes in the Moreton Bay area of south-east Queensland. For the past 20 years he has worked in Queensland Health and State Government Aboriginal and Torres Strait Islander Housing across 16 Aboriginal and Torres Strait Local Government Areas throughout Queensland. He is leading the development and implementation of Mackay HHS's Health Equity Strategy in partnership with First Nations peoples and local Aboriginal and Torres Strait Islander community-controlled health organisations.

Organisational structure and workforce profile

Minister for Health and Ambulance Services

Department of Health
System Manager

Mackay Hospital and Health Board

Mr Darryl Camilleri
Mr David Aprile
Prof Richard Murray
Ms Suzanne Brown
Ms Adrienne Barnett
Dr Elissa Hatherly
Mrs Helen Caruso
Ms Annabel Dolphin
Mr Tom McMillan

Executive Committee

Finance Committee

Safety and Quality Committee

Audit & Risk Committee

Health Service Chief Executive
Ms Lisa Davies Jones

Chief Operating Officer
Ms Sharon Walsh

Executive Director
Mental Health, Public Health & Rural Services
Ms Terry Johnson

Executive Director
Nursing and Midwifery
Ms Karen Wade *(acting)*

Executive Director
Research and Innovation
Assoc. Prof David Farlow

Executive Director
Medical Services
Vacant
(Assoc. Prof David Farlow – acting Chief Medical Officer)

Executive Director
Corporate Services | Chief Financial Officer
Ms Tanya Feekings

Executive Director
People
Mr Darryl Turner *(acting)*

Executive Director
Strategy, Governance and Engagement
Ms Janet Geisler

Executive Director
Aboriginal and Torres Strait Islander Health
Mr Simon Costello

Strategic workforce planning and performance

Mackay HHS employs health professionals and support service staff. Medical, nursing, clinical and non-clinical support staff and volunteers work together to deliver quality care and service to the community. As at 30 June 2022, Mackay HHS had 2,676 full-time equivalent (FTE) staff.

*Table 2: More doctors, nurses and allied health practitioners**

Staff	*2017-18*	*2018-19*	*2019-20*	*2020-21*	*2021-22*
Medical	276	306	322	344	341
Nursing	917	962	1,033	1,060	1,105
Allied Health	278	288	304	368	394

*Table 3: Greater diversity in our workforce**

Staff	*2017-18*	*2018-19*	*2019-20*	*2020-21*	*2021-22*
Aboriginal and/or Torres Strait Islander	40	50	53	55	65

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

Attract, recruit and retain

During 2021-2022, Mackay HHS developed the following initiatives to attract, recruit and retain staff:

- Streamlining the general and nursing, and medical workforce recruitment teams to achieve efficiencies in staff recruitment.
- Participation by a senior officer with the Queensland Health UK and Ireland recruitment campaign in June 2022.
- Eleven Year 11 students commenced a Certificate III Health Support Services in September 2021 and will complete in October 2022 (part of Big Dream Small Steps program).
- The Mackay HHS Workforce Plan 2022-2024 was approved by the Executive Leadership Team.

Employee Health and Wellbeing Program

The Employee Health and Wellbeing Program supports staff to be healthy and active within the workplace and beyond. The program ensures that a holistic framework is adopted with the consideration of workforce health needs in mind. Providing a platform around healthy lifestyle ensures employees are provided with opportunities to engage in various programs that address their physical, emotional, financial and social health and wellbeing.

The Peer Support Program has 39 trained responders who regularly reach out to peers and engage in psychological first aid. In 2021-2022, there were 283 colleagues provided with psychological first aid and links to other supports.

Flexible Working Arrangements

Mackay HHS is committed to the provision of flexible work arrangements such as part time work. At 30 June 2022, 44 per cent of staff had part-time working arrangements. Mackay HHS regularly promotes flexible working arrangements and supports both line managers and employees to understand what options are available.

Diversity

The health service is committed to supporting people with a disability to have equal access to employment opportunities by aiming to have 2 per cent of our workforce consisting of people with a disability by 2022. The health service currently has 1.22 per cent of its workforce consisting of people with a disability.

Mackay HHS is dedicated to strengthening the number of employees who identify as Aboriginal and/or Torres Strait Islander. The health service has a target to increase workforce participation from 2 per cent to 5 per cent of staff who identify as Aboriginal and/or Torres Strait Islander. The health service currently has 2.35 per cent of its workforce that identify as Aboriginal and/or Torres Strait Islander.

Mackay HHS is also committed to gender diversity with:

- 60 per cent - Women employed in executive management roles; and
- 56 per cent - Women on the Board.

Performance Management and Development

The Professional Performance and Development plan process assists employees to have meaningful and productive career discussions. Mackay HHS continued working with Clinical Excellence Queensland to focus on general leadership training for clinical and non-clinical staff.

Industrial and Employee Relations Framework

Mackay HHS respects and values its relationships with local unions. A series of regular consultative forums are held to facilitate productive partnerships with industrial representatives. These include the Hospital and Health Service Consultative Forum, local consultative forums and Nursing and Midwifery Consultative Forum.

Early retirement, redundancy and retrenchment

No redundancy/early retirement/retrenchment packages were paid during the period.

Open Data

Mackay HHS has Open Data to report on Consultancies and Queensland Language Services Policy and the data can be found on the Queensland Government Open Data Portal (https://www.data.qld.gov.au/).

Mackay HHS has no Open Data to report on Overseas Travel.

Our risk management

Mackay HHS is committed to managing risk in a proactive, integrated and accountable manner. Mackay HHS's risk management practices recognise and manage risks and opportunities in a balanced manner. Risk is an inherent part of Mackay HHS's operating environment. Risk management activities are incorporated into strategic planning, governance reporting and operational processes.

Mackay HHS has a risk management policy, procedure and integrated Risk Management Framework based on the Australian/New Zealand ISO Standard 31000:2018 Risk Management - guidelines. The policy, procedure and framework outline Mackay HHS's intent, roles, responsibilities and implementation requirements. Mackay HHS's Risk Management Framework defines the processes for risk identification, recording, rating, key controls identification, determination of risk treatment required and regular monitoring and reporting of risks.

Risks are controlled within the financial and management accountabilities of each position. Significant risks are reported to the MHHB and the Audit and Risk Committee on a regular basis.

The HHBA requires annual reports to state each direction given by the Minister to Mackay HHS during the financial year and the action taken by Mackay HHS as a result of the direction. During the 2021-2022 period, no directions were given by the Minister to Mackay HHS.

Internal audit

Internal audit is an integrated component of corporate governance, promoting efficient management and assisting in risk management. Internal audit is an independent and objective assurance activity designed to improve the governance of Mackay HHS providing reports to the Audit and Risk Committee for the effective, efficient and economical operation of the health service. The Internal Audit Unit has a central role in improving operational processes and financial practices by:

- assessing the effectiveness and efficiency of Mackay HHS's financial and operating systems, reporting processes and activities
- identifying operational deficiencies and non-compliance with legislation or prescribed requirements
- assisting in risk management and identifying deficiencies in risk management
- bringing a broad range of issues to management's attention, including performance, efficiency and economy
- monitoring whether agreed remedial actions have been undertaken.

Audit reports include recommendations to address deficiencies in risk treatment and all audit reports are reviewed by the Audit and Risk Committee.

External scrutiny, Information systems and recordkeeping

External scrutiny

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

As a public sector entity, Mackay HHS is subject to an annual audit by the QAO. The QAO Final Management Report provided to Mackay HHS for 2020-2021 financial year contained no high risks.

Information systems and recordkeeping

Mackay HHS is committed to maintaining public trust in how we handle, protect and disclose personal and sensitive information.

Mackay Base Hospital utilises the integrated electronic Medical Record (ieMR) while the rural and remote facilities have paper-based records, with view-only access to ieMR. This enables simultaneous access to information by multiple users and assists in the coordinated care of patients. All system access is controlled and logged, and audit trails are regularly monitored.

Mackay HHS aims to protect the privacy and confidentiality of both patient and staff information. All access to and disclosure of clinical and corporate records is in accordance with the *Information Privacy Act 2009, Right to Information Act 2009* and HHBA. Regular privacy awareness communications and in-service training is available to all staff. They are also encouraged to undertake the online privacy training provided by the Office of the Information Commissioner

Mackay HHS is responsible for the management and safe custody of administrative records in accordance with the Records Governance Policy and *Public Records Act 2002*. Systems are in place to ensure all source documentation and paper records are appropriately stored, easily located and accessible when required and secured from unauthorised access.

There are procedures and work instructions in place that ensure compliance with the *Health Sector (Clinical Records) Retention and Disposal Schedule*, *Health Sector (Corporate Records) Retention and Disposal Schedule* and *General Retention and Disposal Schedule.*

CEO Attestation of IS18:2018 information security risks

During the 2021-2022 financial year, the Mackay HHS have an informed opinion that information security risks were actively managed and assessed against the Mackay HHS's risk management policy, procedure and integrated Risk Management Framework with appropriate assurance activities undertaken in line with the requirements of the Queensland Government Enterprise Architecture (QGEA) Information security policy (IS18:2018).

Queensland Public Service ethics

The *Public Sector Ethics Act 1994* defines Mackay HHS as a public service agency. Therefore, the Code of Conduct for the Queensland Public Service is applicable to employees.

Mackay HHS is committed to upholding the values and standards of conduct outlined in the Code of Conduct for the Queensland Public Service, consisting of four core aspirational principles:

- integrity and impartiality
- promoting the public good
- commitment to the system of government
- accountability and transparency.

Each principle is strengthened by a set of values and standards of conduct describing the behaviour that will demonstrate that principle. All Mackay HHS employees are required to undertake training in the Code of Conduct for the Queensland Public Service during their induction and in orientation sessions. Staff are required to refresh their understanding of the Code of Conduct annually and following any changes (via on-line training).

Mackay HHS is committed to upholding the Queensland Public Service Values. Queensland's public sector has five organisational values to support this goal. The values are the building blocks for our workplace culture and our own HHS specific values and related behaviours.

Human Rights

In 2021-2022, Mackay HHS has assessed eight complaints where *Human Rights Act 2019* provisions were considered. These complaints were assessed, and there were no complaints considered to breach human rights.

Mackay HHS continues to work towards achieving human rights culture across the health service in the seven indicators identified by the Human Rights Commissioner:

- Staff awareness, education and development
- Community consultation and engagement about human rights
- Awareness raising and supporting for related entities
- Reviews and development of legislation or subordinate legislation
- Review of policies and procedures
- Internal complaint management for human rights complaints
- Future plans

Some of the initiatives undertaken by Mackay HHS include:

- Continue to review and improve communication, onboarding and training of staff.
- Take steps to include community consultation and engagement with stakeholders, clients, or consumers about human rights through the appropriate forums.
- Raise awareness of human rights with entities engaged by the health service.
- Review of the Consumer Feedback: Complaint, compliment and suggestion procedure to include steps on identifying, considering and responding to Human Rights complaints.

Confidential information

The HHBA requires annual reports to state the nature and purpose of any confidential information disclosed in the public interest during the financial year. During the 2021-2022 period, one disclosure was authorised in relation to specified patient information. The patient information was disclosed to the Queensland Maternal and Perinatal Quality Council for the purposes of collecting and analysing clinical information regarding maternal and perinatal mortality and morbidity to identify state-wide and facility-specific trends and making recommendations to improve safety and quality.

Performance

Non-financial Performance

Mackay HHS progressed a range of initiatives during 2021-2022 to support achievement of its strategic objectives, as outlined in the table below.

Strategic Objectives	Key Performance Indicators	Results/Achievements
Inspired People	• Progress on staff engagement survey results • Decreased time to recruit • Increased retention (reduced turnover) • Decreased lost time injury frequency rate • Reduced percentage of agency nurse and medical locum annual spend	• The Working for Queensland staff survey returned a result of 62% for agency engagement. Agency engagement results remain above Queensland Public Sector of 60%. • The average time to recruit staff has increased slightly for nursing (2.7%), medical (5.4%) and other staff (4.9%), with overall timings exacerbated by factors associated with COVID-19 including internal and international border closures and quarantine requirements. It is recognised that attraction and retention of staff is more challenging in regional and rural areas and the health service is actively working to grow a pipeline of clinical staff through a 'Grow Our Own' approach. • Lost time injury frequency rate decreased during 2021-2022 to 12.85 per million hours worked. This is primarily attributable to an increase in education and awareness for safe work practices which remains a focus to decrease the lost time injury frequency rate. • A decrease in medical locum spends of $861k or 9.5% was achieved in 2021-2022. An increase in agency nurse spend (43%) is largely attributable to factors associated with the COVID-19 pandemic and increased nursing workforce associated with response requirements including testing and vaccinating.
Exceptional Patient Experience	• Maintained and improved National Safety and Quality health service indicators • Improved patient experience survey satisfaction rates including cultural appropriateness • Reduced wait times for elective surgery, emergency admissions and specialist outpatient clinics • Increased uptake rates of alternatives to hospital care	• Mackay HHS has maintained accreditation against the National Safety and Quality Health Service Standards in Healthcare (second edition) and is scheduled for reaccreditation in 2022-2023. • 87% of patients surveyed across Mackay HHS reported their Overall Rating of Care as Very Good or Good in 2021-2022. 75% of patients reported that culturally appropriate resources were available to them and 85% of identified patients reported being offered support from an Aboriginal and Torres Strait Islander health worker. • Wait times for elective surgery attained 91.0% for category 1. The delivery of elective surgery was impacted by COVID-19 however this result is an improvement of 3.3% compared to 2021-2022. There were nine category 1 patients waiting longer than clinically recommended timeframes that were ready for surgery as at 30 June 2022. Overall, elective surgery saw a reduction of 25% in referrals treated compared to last year due to cancellation of non-urgent elective surgery in January 2022, and the ongoing impacts of COVID-19 on patient and staff illness and staff furlough, the latter resulting in theatres not operating at full capacity in quarter 3 and part of quarter 4. Compared to 2020-2021, 21% less referrals were received in 2021-2022. • Wait times for emergency length of stay attained 75% for emergency department attendances who depart within four hours of their arrival in the department. This result means an additional 269 patients were discharged within the timeframe notwithstanding a 4% increase of patients presenting to Mackay HHS emergency departments compared to the previous year. This has resulted in 16% more presentations (15,824 more presentations) with 12,315 patients discharged in time. • Wait times for patients attending emergency departments which were seen within recommended timeframes had a slight decrease to 99% for category 1; 92% for category 2; 80% for category 3; 91% for category 4 and 99% for category 5. Category 1 result was due to four identified data errors at two facilities. All other categories achieved target or above.

Strategic Objectives	Key Performance Indicators	Results/Achievements
		• Specialist Outpatient Clinic seen in time results declined for patients in 2021-2022 with 62.9% for category 1. Specialist Outpatients has been significantly impacted by COVID-19 in 2021-2022 with cancellation of non-urgent appointments unable to be conducted via telehealth and ongoing impact of patient and staff illness, staff furlough and other unplanned staff leave. Junior medical shortages and a reduction in Visiting Medical Officer services provided by Townsville University Hospital have contributed to an 8.8% reduction in patients receiving their first appointment compared to 2020-2021, and an 8.4% drop in referrals received. • Gastrointestinal Endoscopy treated in time results attained improved with 93.7% for Category 4 (seen in 30 days), an increase of 22.1% compared to 2020-2021. There were only five patients waiting longer than clinically recommended timeframes that were ready for surgery as at 30 June 2022. Overall, there was a 9% reduction in treated gastrointestinal endoscopy referrals compared to 2020-2021, with a 6% drop in referrals received. • Uptake rates of alternatives to hospital care increased largely through the expansion of the Hospital in the Home model of care with an increase of over 140 discharges (36% increase) from the service in 2021-2022.
Excellence in Integrated Care	• Improved results in our Aboriginal and Torres Strait Islander Closing the Gap targets • Reduced number of potentially preventable hospitalisations • Increased telehealth and other digital health solutions	• Improving Aboriginal and Torres Strait Islander health will be achieved through the development and implementation of the Health Equity Strategy. Significant works on the development of the Health Equity Strategy have been completed in 2021-2022 and plan to be finalised and published in 2022-2023. • Continued to improve results in our Closing the Gap targets with achieving 23.1% (against a target of 20.7%) for First Nations mothers who stopped smoking by the end of 20 weeks gestation; a decrease in low birthweight rates to 6.15%; a decrease in discharge against medical advice to 2.22%; an increase of 15.9% in Aboriginal and Torres Strait Islander people that have completed Oral Health courses; and a decrease in numbers of potentially preventable diabetes complications to 3.3% • The number of potentially preventable hospitalisations overall decreased to 8.1%. • Telehealth usage increased by 8.1% in 2021-2022, to 15,308 outpatient occasion of service events.
Sustainable Service Delivery	• Reduced health service average cost per weighted activity unit • Increased staff engagement in research and evaluation collaborations • Increased retention of junior clinical staff • Positive financial operating results achieved	• The estimated cost per weighted activity unit remained consistent with a slight decrease at $5,442. • A total of 208 staff members received academic support in 2012-2022 (increase of 104 staff from 2021-2022), with 7 staff members receiving grant funding support through Mackay Institute of Research and Innovation to progress their research in a diverse range of clinical areas. • Mackay HHS achieved a 56% retention rate of Intern medical officers, a decrease of 16% from 2020-2021. • Reportable operating position deficit of $4 million.

Service standards

The variance between the 2021-2022 target and the 2021-2022 actual results can be attributed to the impact of the COVID-19 response, with the temporary suspension of non-urgent elective surgery in January 2022. This flow on effect impacted on our specialist outpatient performance due to the health service's decision to prioritise essential services whilst ensuring appropriate COVID-19 response. Delivery of planned care services has been impacted due to increased cancellation from patient illness and staff furloughing, whilst unplanned care has been impacted with demand from both COVID-19 and regular patients.

Table 4: Service Statement – Performance 2021-2022

Mackay Hospital and Health	2021-22 Target	2021-22 Actual
Effectiveness measures		
Percentage of emergency department patients seen within recommended timeframes[1]:		
• Category 1 (within 2 minutes)	100%	99%
• Category 2 (within 10 minutes)	80%	92%
• Category 3 (within 30 minutes)	75%	80%
• Category 4 (within 60 minutes)	70%	91%
• Category 5 (within 120 minutes)	70%	99%
Percentage of emergency department attendances who depart within four hours of their arrival in the department[1]	>80%	75%
Percentage of elective surgery patients treated within the clinically recommended times[2]:		
• Category 1 (30 days)	>98%	91%
• Category 2 (90 days)[3]	..	73%
• Category 3 (365 days)[3]	..	73%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days[4]	<2	0.2
Rate of community mental health follow up within 1-7 days following discharge from an acute mental health inpatient unit[5]	>65%	54.9%
Proportion of re-admissions to acute psychiatric care within 28 days of discharge[6]	<12%	13.2%
Percentage of specialist outpatients waiting within clinically recommended times[7]:		
• Category 1 (30 days)	70%	68%
• Category 2 (90 days)[8]	..	38%
• Category 3 (365 days)[8]	..	64%
Percentage of specialist outpatients seen within clinically recommended times[7]:		
• Category 1 (30 days)	81%	62%
• Category 2 (90 days)[8]	..	48%
• Category 3 (365 days)[8]	..	92%
Median wait time for treatment in emergency departments (minutes)[1]	..	10
Median wait time for elective surgery treatment (days)[2]	..	41
Efficiency measures		
Average cost per weighted activity unit for Activity Based Funding facilities[9]	$4,977	$5,442
Other measures		
Number of elective surgery patients treated within clinically recommended times[2]:		
• Category 1 (30 days)	1,179	1,168
• Category 2 (90 days)[3]	..	851
• Category 3 (365 days)[3]	..	236
Number of Telehealth outpatients service events[10]	13,640	15,308
Total weighted activity units (WAU)[11]		
• Acute Inpatients	46,075	42,604
• Outpatients	10,015	9,770
• Sub-acute	3,158	4,164
• Emergency Department	12,227	12,613
• Mental Health	3,692	3,441
• Prevention and Primary Care	1,665	1,599
Ambulatory mental health service contact duration (hours)[12]	>27,854	30,977
Staffing[13]	2,621	2,676

1. During the COVID pandemic Emergency Departments across Queensland were presented with demand from both COVID and regular patients. In response many public Emergency Departments established fever clinics to assess and treat suspected COVID-19 cases in safe and effective manner. As fever clinic services represent an extension of regular operational services and as a result, the 2021-2022 Actual includes some fever clinic activity. Emergency Department performance (including POST) has been impacted by the increased patient treatment time and resources required to manage COVID-19 precautions.

2. In response to the COVID-19 pandemic the delivery of planned care services has been impacted. This has resulted from occasions of temporary suspension of routine planned care services to manage priority demand, increased cancellations resulting from patient illness and staff furloughing as a result illness or Health Service Directives.
3. As the system focuses to manage the backlog of deferred care patients, treated in time performance will continue to be impacted. As a result, the continuation of treat in time performance targets for category 2 and 3 patients applicable for 2021-2022 will be carried forward into 2022-2023.
4. Staphylococcus aureus (including MRSA) bloodstream (SAB) infections 2021-22 Estimated Actual rate is based on data reported between 1 July 2021 and 31 March 2022.
5. Mental Health rate of community follow up 2021-2022 Actuals are as of 16 August 2022.
6. Mental Health readmissions 2021-2022 Actuals are for the period 1 July 2021 to 31 May 2022, as of 16 August 2022.
7. In response to the COVID-19 pandemic the delivery of planned care services has been impacted. This has resulted from occasions of temporary suspension of routine planned care services to manage priority demand, increased cancellations resulting from patient illness and staff furloughing as a result illness or Health Service Directives.
8. As the system focuses to manage the backlog of deferred care patients, treated in time performance will continue to be impacted. As a result, the continuation of treat in time performance targets for category 2 and 3 patients applicable for 2021-2022 will be carried forward into 2022-2023.
9. The 2021-2022 Target varies from the published 2021-2022 Service Delivery Statement due to a change in the WAU phase. All measures are reported in QWAU Phase Q24. The variation in difference of Cost per WAU to target is a result of the additional costs of the COVID-19 pandemic. 2021-2022 Actuals are as of 22 August 2022.
10. Telehealth 2021-2022 Actual is as of 18 August 2022.
11. The 2021-2022 Actual is below target due to a decrease in routine care services resulting from occasions of temporary suspension of routine planned care services to manage priority demand, increased cancellations resulting from patient illness and staff furloughing as a result of illness or Health Service Directives. The 2021-2022 Target varies from the published 2021-2022 Service Delivery Statement due to a change in the WAU phase. All measures are reported in QWAU Phase Q24. The 2021-2022 Actual figures are as of 22 August 2022. As the Hospital and Health Services have operational discretion to respond to service demands and deliver activity across services streams to meet the needs of the community, variation to the Target can occur.
12. Ambulatory Mental Health service contact duration 2021-2022 Actual is as of 16 August 2022.
13. Corporate FTEs are allocated across the service to which they relate. The department participates in a partnership arrangement in the delivery of its services, whereby corporate FTEs are hosted by the department to work across multiple departments. 2021-2022 Actual is for pay period ending 26 June 2022.

Financial summary

Mackay HHS has recorded a financial deficit of $4 million for the year ending 30 June 2022. This is compared to the financial surplus in 2020-2021 of $3.3 million incurred by Mackay HHS.

Mackay HHS will continue to focus on robust financial stewardship to ensure the best value for the State's investment.

Income

Mackay HHS's income is sourced from three major areas:

- Public health services funding
- Own source revenue including user charges
- Australian Government funding.

Mackay HHS total income was $567 million which includes:

- Activity Based Funding for hospital services was 59 per cent or $332.3 million
- Non-Activity Based Funding was 12 per cent or $70.8 million
- User charges comprising patient and non-patient funding was 7 per cent or $37.7 million
- Australian Government grant funding was 18 per cent or $103.1 million
- Other revenue was 1 per cent or $5.5 million
- Other grant funding was 3 per cent or $17.6 million
- Land revaluation was $0.1 million

Expenses

The total expenses were $571 million, an average of $1.6 million a day for providing health services.

Labour costs within Mackay HHS make up approximately 65 per cent of expenditure with the remaining 35 per cent being non-labour costs such as supplies, services, and depreciation charges.

These services include clinical supplies, electricity, pathology services, prosthetics, repairs and maintenance, outsourced medical services, communications, patient travel costs and medication.

Table 5: Mackay HHS service allocations

Where the money goes	%
Admitted patient services in acute care institutions	49.5
Non-admitted patient services in acute care institutions	14.5
Mental health includes community services	7.7
Nursing homes for the aged	2.9
Patient transport	1.5
Public health services	2.2
Other community health services	15.8
Health administration	5.9

Anticipated maintenance

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

Anticipated maintenance is defined as maintenance that is necessary to prevent the deterioration of an asset or its function, but which has not been carried out. Some anticipated maintenance activities can be postponed without immediately having a noticeable effect on the functionality of the building. All anticipated maintenance items are risk assessed to identify any potential impact on users and services and are closely managed to ensure all facilities are safe.

As of 30 June 2022, the Mackay HHS had reported anticipated maintenance of $15.8 million.

Mackay HHS is continuing to undertake condition-based assessments to establish the backlog maintenance for the facilities, and the value of anticipated maintenance may vary as a result. Findings from the condition-based assessments is analysed to prioritise the most urgent backlog items and align with operational maintenance process.

Mackay HHS is seeking assistance from the Sustaining Capital branch. Priority Capital Works funding applications are currently being compiled for review and submission. Minor maintenance not eligible for Priority Capital Works funding will be sought from the HHS operational budget or Capital Maintenance and Annual Renewal.

Mackay Hospital and Health Service

ABN 87 427 896 923

Annual Financial Statements

For the year ended 30 June 2022

Mackay Hospital and Health Service
Statement of Comprehensive Income
For the year ended 30 June 2022

OPERATING RESULT	Notes	2022 $'000	2021 $'000
Income			
User charges and fees	B1-1	37,741	40,463
Funding public health services	B1-2	506,094	463,489
Grants and other contributions	B1-3	17,613	15,487
Other revenue	B1-4	5,452	6,194
Revaluation increment	B1-5	70	4,365
Total Income		**566,970**	**529,998**
Expenses			
Employee expenses	B2-1	57,974	54,012
Health service employee expenses	B2-2	314,514	294,511
Supplies and services	B2-3	149,109	134,194
Depreciation and amortisation	C5 & C9	31,080	30,247
Other expenses	B2-4	18,329	13,705
Total Expenses		**571,006**	**526,669**
Operating Surplus/(Deficit)		**(4,036)**	**3,329**
Other Comprehensive Income			
Items Not Reclassified to Operating Result			
Increase in Asset Revaluation Surplus	C5-2	25,325	2,133
Other Comprehensive Income		**25,325**	**2,133**
Total Comprehensive Income		**21,289**	**5,462**

The accompanying notes form part of these financial statements.

Mackay Hospital and Health Service
Statement of Financial Position
As at 30 June 2022

	Note	2022 $'000	2021 $'000
Current Assets			
Cash and cash equivalents	C1	20,194	25,235
Receivables	C2	4,131	4,829
Inventories	C3	3,935	3,677
Other assets	C4	11,292	10,820
Total Current Assets		**39,552**	**44,561**
Non-Current Assets			
Property, plant and equipment	C5	384,799	373,713
Right-of-use assets	C9	306	767
Total Non-Current Assets		**385,105**	**374,480**
Total Assets		**424,657**	**419,041**
Current Liabilities			
Payables	C6	34,105	28,121
Accrued employee benefits	C7	777	992
Lease liabilities	C9	274	570
Other liabilities	C8	5,216	3,246
Total Current Liabilities		**40,372**	**32,929**
Non-Current Liabilities			
Lease liabilities	C9	34	203
Total Non-Current Liabilities		**34**	**203**
Total Liabilities		**40,406**	**33,132**
Net Assets		**384,251**	**385,909**
Equity			
Contributed equity	C10-1	284,587	307,534
Accumulated surplus		20,754	24,790
Asset revaluation surplus	C10-2	78,910	53,585
Total Equity		**384,251**	**385,909**

The accompanying notes form part of these financial statements.

Mackay Hospital and Health Service
Statement of Changes in Equity
For the year ended 30 June 2022

	Note	Contributed equity Note C10-1 $'000	Accumulated surplus $'000	Asset revaluation surplus Note C10-2 $'000	Total equity $'000
Balance as at 1 July 2020		329,461	21,461	51,452	402,374
Operating Result		-	3,329	-	3,329
Other Comprehensive Income					
Increase in asset revaluation surplus		-	-	2,133	2,133
Total Comprehensive Income for the Year		-	3,329	2,133	5,462
Transactions with Owners as Owners:					
Net assets transferred in	C5-2	840	-	-	840
Equity injections	C5-2	7,480	-	-	7,480
Equity withdrawals - Depreciation Funding		(30,247)	-	-	(30,247)
Net Transactions with Owners as Owners		(21,927)	-	-	(21,927)
Balance at 30 June 2021		**307,534**	**24,790**	**53,585**	**385,909**
Balance as at 30 June 2021		307,534	24,790	53,585	385,909
Net effect of changes in accounting policies/prior year adjustments - refer Note G3		-	-	-	-
Balance as at 1 July 2021		307,534	24,790	53,585	385,909
Operating Result		-	(4,036)	-	(4,036)
Other Comprehensive Income					
Increase in asset revaluation surplus		-	-	25,325	25,325
Total Comprehensive Income for the Year		-	(4,036)	25,325	21,289
Transactions with Owners as Owners:					
Net assets transferred in	C5-2	781	-	-	781
Equity injections	C5-2	17,352	-	-	17,352
Equity withdrawals - Other	E4-1	(10,000)		-	(10,000)
Equity withdrawals - Depreciation Funding		(31,080)		-	(31,080)
Net Transactions with Owners as Owners		(22,947)	-	-	(22,947)
Balance at 30 June 2022		**284,587**	**20,754**	**78,910**	**384,251**

The accompanying notes form part of these financial statements.

Mackay Hospital and Health Service
Statement of Cash Flows
For the year ended 30 June 2022

	Note	2022 $'000	2021 $'000
Cash flows from operating activities			
Inflows			
User charges and fees		37,135	37,491
Funding public health services		474,801	433,983
Grants and other contributions		13,586	11,161
GST input tax credits from ATO		2,728	7,945
GST collected from customers		259	917
Other receipts		5,425	6,058
		533,934	**497,555**
Outflows			
Employee expenses		(58,189)	(55,086)
Health service employee expenses		(313,429)	(303,653)
Supplies and services		(144,111)	(123,666)
GST paid to suppliers		(2,719)	(8,139)
GST remitted to ATO		(193)	(974)
Other payments		(11,980)	(9,613)
		(530,621)	**(501,131)**
Net cash from/(used by) operating activities	CF-1	**3,313**	**(3,576)**
Cash flows from investing activities			
Inflows			
Sales of property, plant and equipment		608	113
Outflows			
Payments for property, plant and equipment		(15,746)	(9,854)
Net cash from/(used by) investing activities		**(15,138)**	**(9,741)**
Cash flows from financing activities			
Inflows			
Equity injections		17,352	7,480
Outflows			
Lease payments	CF-2	(568)	(566)
Equity Withdrawal - Other	E4-1	(10,000)	-
Net cash from/(used by) financing activities		**6,784**	**6,914**
Net increase/(decrease) in cash and cash equivalents		**(5,041)**	**(6,403)**
Cash and cash equivalents at the beginning of the financial year		25,235	31,638
Cash and cash equivalents at the end of the financial year	C1	**20,194**	**25,235**

The accompanying notes form part of these statements.

NOTES TO THE STATEMENT OF CASH FLOWS

CF-2 CHANGES IN LIABILITIES ARISING FROM FINANCING ACTIVITIES

	2022	*2021*
	$'000	*$'000*
Lease liabilities		
Balance at 1 July	773	289
Non-cash movements:		
New leases acquired during the year	304	1,091
Remeasurement	(202)	(41)
Cashflows:		
Lease repayments	(569)	(566)
Balance at 30 June	**306**	**773**

Assets received or liabilities donated/transferred by the Hospital and Health Service to agencies outside of the State Health portfolio agencies are recognised as revenues (refer Note B1-3) or expenses as applicable.

Assets received or liabilities transferred by the Hospital and Health Service because of Machinery-of-Government, or administrative arrangements are set out in the Statement of Changes in Equity and Note C10-1.

PREPARATION INFORMATION

GENERAL INFORMATION

The Mackay Hospital and Health Service (referred to as MHHS or Hospital and Health Service or HHS) was established on 1st July 2012 as a statutory body under the *Hospital and Health Boards Act 2011* and is controlled by the State of Queensland which is the ultimate parent.

The head office and principal place of business of MHHS is Mackay Base Hospital, 475 Bridge Road, MACKAY QLD 4740.

For information in relation to the MHHS' financial statements, please visit the website www.health.qld.gov.au/mackay.

COMPLIANCE WITH PRESCRIBED REQUIREMENTS

The Hospital and Health Service has prepared these financial statements in compliance with section 62 (1) of the *Financial Accountability Act 2009* and section 39 of the *Financial and Performance Management Standard 2019.* The financial statements comply with Queensland Treasury's Minimum Reporting Requirements for reporting periods beginning on or after 1 July 2021.

The Hospital and Health Service is a not-for-profit statutory body, and these general-purpose financial statements are prepared on an accrual basis (except for the Statement of Cash Flow which is prepared on a cash basis) in accordance with Australian Accounting Standards and Interpretations applicable to not-for-profit entities.

New accounting standards early adopted and/or applied for the first time in these financial statements are outlined in Note G3.

PRESENTATION

Currency and Rounding

Amounts included in the financial statements are in Australian dollars and rounded to the nearest $1,000 or, where that amount is $500 or less, to zero, unless disclosure of the full amount is specifically required.

Comparatives

Comparative information reflects the audited 2020-21 financial statements.

Current/Non-Current Classification

Assets and liabilities are classified as either 'current' or 'non-current' in the Statement of Financial Position and associated notes.

Assets are classified as 'current' where their carrying amount is expected to be realised within 12 months after the reporting date. Liabilities are classified as 'current' when they are due to be settled within 12 months after the reporting date, or MHHS does not have an unconditional right to defer settlement to beyond 12 months after the reporting date.

All other assets and liabilities are classified as non-current.

AUTHORISATION OF FINANCIAL STATEMENTS FOR ISSUE

The financial statements are authorised for issue by the Chair of the Hospital and Health Service, the Chief Executive and the Executive Director, Corporate Services at the date of signing the Management Certificate.

BASIS OF MEASUREMENT

Historical cost is used as the measurement basis in this financial report except for the following:

- Land and buildings which are measured at fair value.
- Inventories which are measured at cost, adjusted when applicable for any loss in service potential; and
- Lease liabilities which are measured at net present value.

Historical Cost

Under historical cost, assets are recorded at the amount of cash or cash equivalents paid or the fair value of the consideration given to acquire assets at the time of their acquisition. Liabilities are recorded at the amount of proceeds received in exchange for the obligation or at the amounts of cash or cash equivalents expected to be paid to satisfy the liability in the normal course of business.

Fair Value

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date under current market conditions (i.e., an exit price) regardless of whether that price is directly derived from observable inputs or estimated using another valuation technique. Fair value is determined using one of the following two approaches in MHHS:

- The market approach uses prices and other relevant information generated by market transactions involving identical or comparable (i.e., similar) assets, liabilities or a group of assets and liabilities, or
- The cost approach reflects the amount that would be required currently to replace the service capacity of an asset. This method includes the current replacement cost methodology.

Where fair value is used, the fair value approach is disclosed.

BASIS OF MEASUREMENT (continued)

Present Value

Present value represents the present discounted value of the future net cash inflows that the item is expected to generate (in respect of assets), or the present discounted value of the future net cash outflows expected to settle (in respect of liabilities) in the normal course of business.

Net realisable value

Net realisable value represents the amount of cash or cash equivalents that could currently be obtained by selling an asset in an orderly disposal.

THE REPORTING ENTITY

The financial statements include the value of all revenues, expenses, assets, liabilities and equity of Mackay Hospital and Health Service.

SECTION A

HOW WE OPERATE – OUR OBJECTIVES AND ACTIVITIES

A1 OBJECTIVES OF MHHS

The HHS is responsible for providing primary health, community and public health services in the area assigned under the *Hospital and Health Boards Regulation 2012*. This includes responsibility for the direct management of hospitals in Mackay, Proserpine, Bowen, Moranbah, Dysart, Collinsville, Clermont, and Sarina including outpatient and primary care clinics.

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

A2 CONTROLLED ENTITIES

The Hospital and Health Service has no wholly owned controlled entities nor indirectly controlled entities.

A2-1 DISCLOSURES ABOUT OTHER RELATED ENTITIES

North Queensland Primary Healthcare Network Limited

North Queensland Primary Healthcare Network Limited (NQPHNL) was established as a public company limited by guarantee on 21 May 2015. Mackay Hospital and Health Service is one of eleven members along with Cairns and Hinterland Hospital and Health Service, Townsville Hospital and Health Service, Torres and Cape Hospital and Health Service, the Pharmacy Guild of Australia (Queensland Branch), the Australian College of Rural and Remote Medicine, Northern Aboriginal and Torres Strait Islander Health Alliance, Queensland Alliance for Mental Health, CheckUP, Australian Primary Healthcare Nurses Association and the Council on the Ageing, with each member holding one voting right in the company.

The principal place of business of NQPHNL is Cairns, Queensland. The Company's principal purpose is to work with general practitioners, other Primary Health Care providers, community health services, pharmacists, and hospitals in North Queensland to improve and coordinate Primary Health Care across the local health system for patients requiring care from multiple providers.

As each member has the same voting entitlement (9%), it is considered that none of the individual members has power or significant influence over NQPHNL (as defined by AASB 10 *Consolidated Financial Statements and AASB 128 Investments in Associates and Joint Ventures*). Each member's liability to NQPHNL is limited to $10. NQPHNL is legally prevented from paying dividends to its members and its constitution also prevents any income or property of the Company being transferred directly or indirectly to or amongst the Members.

As NQPHNL is not controlled by Mackay HHS and is not considered a joint operation or an associate of Mackay HHS, financial results of NQPHNL are not required to be disclosed in these statements.

Tropical Australia Academic Health Centre Limited

Tropical Australia Academic Health Centre Limited (TAAHCL) was established as a public company limited by guarantee on 3 June 2019. Mackay Hospital and Health Service is one of eight members along with Cairns and Hinterland Hospital and Health Service, James Cook University including Australian Institute of Tropical Health and Medicine, North Queensland Primary Healthcare Network Limited, North West Hospital and Health Service, Torres and Cape Hospital and Health Service, Townsville Hospital and Health Service and Queensland Aboriginal and Islander Health Council, with each member holding two voting rights in the company.

The principal place of business of TAAHCL is James Cook University, Queensland. The Company's principal purpose is the advancement of health through the promotion of the study and research of health topics of special importance to people living in the tropics.

As each member has the same voting entitlement (12.5%), it is considered that none of the individual members has power or significant influence over TAAHCL (as defined by AASB 10 *Consolidated Financial Statements and AASB 128 Investments in Associates and Joint Ventures*). Each member's liability to TAAHCL is limited to $10. TAAHCL is legally prevented from paying dividends to its members and its constitution also prevents any income or property of the Company being transferred directly or indirectly to or amongst the Members.

As TAAHCL is not controlled by Mackay HHS and is not considered a joint operation or an associate of Mackay HHS, financial results of TAAHCL are not required to be disclosed in these statements.

SECTION B

NOTES ABOUT OUR FINANCIAL PERFORMANCE

B1 REVENUE

B1-1 USER CHARGES AND FEES

	2022	2021
	$'000	$'000
Revenue from contracts with customers		
Pharmaceutical Benefit Scheme	16,107	13,907
Sales of goods and services	1,417	2,033
Capital and research projects	1,207	3,211
Hospital fees	19,010	21,312
	37,741	**40,463**

Accounting Policy – Revenue from contracts with customers (User Charges)

Revenue from contracts with customers is recognised when MHHS transfers control over a good or service to the customer, when performance obligations are satisfied and measured at the amount of the transaction price allocated to the performance obligation. Where consideration is received for performance obligations to be satisfied in the following year, revenue is deferred with a contract liability being recognised.

The table below provides information about the nature and timing of the satisfaction of performance obligations, significant payment terms and revenue recognition for MHHS's user charges revenue from contracts with customers.

Type of good or service	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policies
Pharmaceutical Benefits Scheme		
Pharmaceutical benefits scheme (PBS) - public hospital patients can access medicines listed on the PBS if they are being discharged or attending outpatient day clinics and admitted receiving chemotherapy treatment. Medicare Australia reimburses the cost of the pharmaceutical items at the agreed wholesale price. Patients generally pay a co-payment which is deducted from the Commonwealth reimbursement price.	MHHS's obligation under the arrangement is the distribution of medication to patients at the reduced PBS rate. Reimbursements are claimed electronically via PBS Online (either fortnightly or monthly) and submitted to Medicare Australia. Payments from Medicare go directly to MHHS.	Revenue is recognised at a point in time when service obligations are met. Where MHHS has satisfied the performance obligations for drugs provided but not yet claimed through the PBS arrangement a contract asset is raised.
Sales of goods and services		
Multi-purpose nursing home fees - long term nursing home and psychogeriatric patients are required to contribute towards their daily care, community care, medical services, and pharmacy services. Specific fees are determined by the Department of Health and are legislated under the *Aged Care Act 1997*.	MHHS's obligation under the contract is the provision of daily care to eligible Commonwealth aged care clients in MHHS's multipurpose facilities. Invoices are raised monthly to residents based on the number of bed days service provided.	Revenue is recognised over time as the patient care is provided.
Home community aged care packages - services to eligible Commonwealth clients for home support such as home maintenance, domestic assistance, nursing care etc. Eligible clients are required to make a co-contribution for services provided. The Commonwealth's contribution to these services is outlined in Note B1-3 Grants and other contributions.	MHHS's obligation under the arrangement is the provision of personal services to eligible clients. Invoices against individual customers are raised monthly based on the service type, frequency, and rate (set by the DOH).	Revenue is recognised over time as the personal services are provided.
Capital and Research Projects		
Revenue management of capital projects – the Department of Health purchases services for approved capital projects as part of Queensland Health's capital delivery program.	MHHS's obligation is to manage the procurement and payment of invoices approved by the Department of Health for capital works. Approval from the Department on costs incurred must be received before the invoices and revenue can be raised. Invoices raised against the Department of Health are generally settled within 30 days.	Revenue is recognised as the services are provided each month and a contract asset representing MHHS's right to consideration for services delivered but not yet billed raised where applicable.
Provision of other goods and services - MHHS provides a range of clinical research and other services to private companies and individuals.	MHHS's obligation is to provide agreed research/other services usually over a 12-month period. Invoices are raised as services are provided. Clinical trials are invoiced in accordance with milestones included in contractual agreements.	Revenue is recognised over time with customers simultaneously receiving and consuming benefits provided. A contract asset representing MHHS's right to consideration for services delivered but not yet billed is raised where applicable.

B1 REVENUE (continued)

B1-1 USER CHARGES AND FEES (continued)

Accounting Policy (continued)

Hospital fees		
Private patients - public hospital patients have the option to elect to be treated as a private patient when admitted with rates for each service set annually by the Department of Health.	MHHS's obligation is the delivery of patient care. Health funds are invoiced once a patient is discharged, and services are clinically coded. This can take 4-6 weeks. The amount paid by health funds may be adjusted when a private health funds accepts a claim. Payment by health funds is typically made within 60 days.	Revenue is recognised over time as patient care is simultaneously received and consumed by our customers. Where health fund payment rates for services rendered are lower than that established by the Department, discounts are recognised.
Private practice arrangements - senior and visiting medical officers employed by MHHS can elect to treat private patients in MHHS facilities under current employment contracts. Doctors can either assign 100% of private patient billings to MHHS (compensated by additional wage allowances) or alternatively retain professional service revenue after deduction of a service fee to MHHS based on a set % of total medical billings deposited into the private practice trust account during the month.	Assigned revenue - MHHS's obligation is provision of medical services to private patients. Retained revenue – MHHS's obligation is to provide administrative services. Medical treatment provided to private patients is bulk billed to Medicare Australia, with same day electronic lodgement of claims. Cash payments are received approximately 2 days after lodgement of claim.	Assignment revenue is recognised at a point in time as services are provided to private patients. Service fee revenue from retention doctors is recognised at the end of the month, once all administrative duties associated with the operation of the trust account are completed.
Compensable patients - public hospital patients who have received hospital services for an injury, illness or disease and have an entitlement to receive a compensation payment (e.g., workers' compensation, motor vehicle accidents) are charged for services with claims raised directly against the insurer.	MHHS obligation is the delivery of patient care to approved WorkCover recipients. Rates for each service is set annually by the Department of Health in consultation with relevant insurers. Patients must meet relevant claim criteria established under the respective schemes and be approved by the insurers for treatment. Workcover claims are submitted online daily along with required supporting documents. Cash payments are received approximately 2 days after lodgement of claim.	Revenue is recognised once a patient has been approved for treatment, and services are provided.

B1-2 FUNDING PUBLIC HEALTH SERVICES

	2022	*2021*
	$'000	*$'000*
Revenue from contracts with customers		
Activity based funding	332,272	306,445
Other grants and contributions		
Block funding	70,772	61,844
Teacher training funding	14,406	13,021
Depreciation funding	31,080	30,247
General purpose funding	57,564	51,932
	506,094	**463,489**

Disclosure about funding received to deliver public health services

Funding is provided predominantly from the Department of Health for specific public health services purchased by the Department in accordance with a Service Agreement (SA). The Australian Government pays its share of National Health funding directly to the Department of Health, for on forwarding to the Hospital and Health Service.

The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by MHHS. Cash funding from the Department of Health is received fortnightly for State payments and monthly and quarterly for Commonwealth payments and is recognised as revenue as the performance obligations under the service agreement are discharged. Commonwealth funding in 2021-22 $175.268 mil (2021: $152.819 mil).

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

Additional funding has been provided under the *National Partnership Agreement on COVID-19 Response* to meet costs directly attributed to the treatment of COVID-19 patients (diagnosed or suspected), and additional costs of activities directed at preventing the spread of COVID-19. In 2021-22 $19,642 mil funding (2021: $7.592 mil) was received for COVID-19.

Smaller hospitals are supported through block funding where the technical requirements of applying ABF are not able to be satisfied, and there is an absence of economies of scale, that means some services would not be financially viable. Teacher training grants are provided to support the MHHS and are calculated based on the numbers of doctors, clinical graduates, and research positions.

Other general-purpose funding supports the provision of a wide range of services for primary and community healthcare and includes other services that fall outside the scope of the National funding model. These are state-funded and have specific conditions attached.

Depreciation funding is provided to offset depreciation charges incurred by MHHS. This is a non-cash revenue and is offset with an equity withdrawal for the same amount refer Statement of Changes in Equity refer Note C10-1.

Accounting Policy – Public health services

Activity Based Funding

Activity based funding (ABF) is provided according to the type and number of services purchased by the Department of Health, multiplied by the Queensland Efficiency Price (QEP) or other prices in the SA.

ABF funding is received for inpatients, critical care, sub and non-acute, emergency department, mental health, and outpatients.

There is no funding guarantee for the National Health Reform Agreement beyond 30 June 2021 and the Department of Health will perform reconciliation process against the service agreement and the purchased activity for the financial year.

This will reflect the agreed position between the parties following the conclusion of the end of year technical adjustment process. The purchase of any additionally activity will push the system above its Commonwealth capped target.

The Department is exploring the possibility of entering a bilateral agreement with the Commonwealth around additional activity to non-recurrently complete "restoring planned care" initiative and managing the bed impact of COVID.

Other public health service revenue

Non-ABF funding is received for other services MHHS has agreed to provide under the Service Agreement. This includes block, teacher, depreciation, and most of the other general-purpose funding.

This funding has specific conditions attached that are not related to activity covered by ABF. The funding is received in cash fortnightly in advance.

Block and teacher training funding, although under an enforceable agreement, do not contain sufficiently specific performance obligations and are recognised as revenue when received**.**

Recognition of revenue for other "general purpose" funding is dependent on the specific performance obligations attached to each funding sub-type.

Where the obligations are not sufficiently specific, revenue is recognised as it is received. Funding with sufficiently specific obligations, are recognised over time as the services/goods are provided and obligations met with the price implicit in the SA.

B1-3 GRANTS AND OTHER CONTRIBUTIONS

	2022	*2021*
	$'000	*$'000*
Revenue from contracts with customers		
Home and community care grants	4,065	4,059
Specific purpose payments	7,289	5,708
Other grants and contributions		
Other grants	1,886	1,554
Services received below fair value	4,373	4,166
	17,613	**15,487**

Accounting Policy – Services received below fair value

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

MHHS receives corporate services support from the Department of Health at no cost. Corporate services received include payroll services, financial transactions services (including accounts payable and banking services), administrative services and information technology services.

Accounting Policy – Grants, contributions, donations, and gifts

Grants, contributions, donations arise from non-exchange transactions where MHHS does not directly give approximately equal value to the grantor.

Where the grant agreement is enforceable and contains sufficiently specific performance obligations for MHHS to transfer goods or services to a third-party on the grantor's behalf, the transaction is accounted for under AASB 15 *Revenue from Contracts with Customers*. In this case, revenue is initially deferred (as a contract liability) and recognised, as or when, the performance obligations are satisfied.

Otherwise, the grant is accounted for under AASB 1058 *Income of Not-for-Profit Entities*, whereby revenue is recognised upon receipt of the grant funding, except for special purpose capital grants received to construct non-financial assets controlled by MHHS.

Special purpose capital grants are recognised as unearned revenue when received, and recognised progressively as revenue, as MHHS satisfies its performance obligations under the grant through construction of the asset.

Contributed assets are recognised at their fair value.

Disclosure – Grants and contributions

MHHS has several grant arrangements that relate to funding of activity-based services, primarily related to aged care clients and the provisions of specialist medical training. The arrangements outlined below have been identified as having sufficiently specific performance obligations under enforceable grant agreements. The remaining grants, although under enforceable agreements, do not contain sufficiently specific performance obligations, and are recognised upon receipt.

Grants – recognised as performance obligations are satisfied

The following table provides information about the nature and timing of the satisfaction of performance obligations, significant payment terms, and revenue recognition for MHHS's grants and other contributions that are contracts with customers.

Type of good or service	Nature and timing of satisfaction of performance obligations, including significant payment terms.	Revenue recognition policies
Commonwealth Home and Community Care - MHHS provides services to eligible Commonwealth clients for home support services under a two-year agreement between the State and Commonwealth. Services include a range of activities performed at client's homes including personal and wellness care, patient care and home maintenance. The number of hours/trips per annum and applicable rates are included in agreed work activity plan.	MHHS's obligation is to provide agreed personal services and patient care to approved recipients. Payments from the Commonwealth government are made quarterly in advance.	Amounts received are recognised as contract liabilities until performance obligations are satisfied. Revenue is recognised as services are performed. Where activity levels contracted are not fully delivered at year end, and exceed the level allowed for carryover into the next year, an unearned revenue or contract liability is raised.
Improving Access to Primary Care in Rural and Remote Areas - COAG s19(2) Exemptions Initiative - under a Memorandum of Understanding between the State and Commonwealth governments, MHHS receives payment through Medicare Australia for medical services provided to public patients presenting to the emergency department of approved rural and remote health facilities.	MHHS's obligation is the provision of medical services to eligible public patients. Claims for services performed are lodged electronically, with amounts received based on Medicare item numbers and rates set by the Commonwealth.	Revenue is recognised as services are provided to patients. The use of funds generated under this arrangement are restricted and must be used for community maintenance programs.
Specialist Training Program - training to eligible medical specialists under contract agreements with multiple medical colleges. The trainee must be a member of the medical college and is the recipient of the service. Approved training placement must be within the specified area of interest, in a specified regional location; and exceed a minimum service period (3 months).	MHHS's obligation is to provide eligible trainees appropriate training placement within the specific area of speciality. Payments from the colleges are made in arrears on a bi-annual basis upon receipt and acceptance of performance reports, financial acquittals, and trainee details.	Once the minimum training period specified in the contract has been satisfied, revenue is recognised over time as services are simultaneously received and consumed by the trainee. A contract asset representing MHHS's right to consideration for services delivered but not yet billed is raised where applicable.

B1 REVENUE (continued)

B1-3 GRANTS AND OTHER CONTRIBUTIONS (continued)

Type of good or service	Nature and timing of satisfaction of performance obligations, including significant payment terms.	Revenue recognition policies
Commonwealth transition care supports eligible Commonwealth aged care clients for care after a hospital stay. Care packages provided are in accordance with an approved plan, with a defined schedule of daily rates for services stipulated under the agreement with the Commonwealth.	MHHS's obligation is to provide eligible patients with care packages in accordance with approved care plans. Payments from the Commonwealth are advanced at the beginning of the month. At the end of the month, claims are lodged with the department including details on persons visited and duration of visit. A subsequent adjustment either up or down is made by the department	Amounts received are recognised as contract liabilities until performance obligations are satisfied. Revenue is recognised over time as patient care is provided in accordance with scheduled daily rates. A contract asset representing MHHS's right to consideration for services delivered but not yet billed raised where applicable.
Aged care packages – provides personal care services and other personal assistance to person over 65 years in the home under an agreement between the State and Commonwealth. Rates for services are dependent on the approved level of the home care package assessed by Commonwealth to approved recipients.	MHHS's obligations under the arrangement is to provide personal care services to approved Commonwealth recipients based on agreed level of care. Payments from the Commonwealth are advanced at the beginning of the month. At the end of the month, claims are lodged with the department including details by care recipient id, level of care and number of days provided. A subsequent adjustment to revenue either up or down is made by the Department of Human Services.	Amounts received are recognised as contract liabilities until performance obligations are satisfied. Revenue is recognised as services are provided to aged care customers. A contract asset representing MHHS's right to consideration for services delivered but not yet billed raised where applicable.

B1-4 OTHER REVENUE

	2022	*2021*
	$'000	*$'000*
Recoveries	5,387	6,109
Other	65	85
	5,452	**6,194**

Accounting Policy – Other revenue

Other revenue primarily reflects recoveries of payments for contracted staff from third parties such as universities and other government agencies. Other revenue is recognised based on either invoicing for related goods, services and/or the recognition of accrued revenue based on estimated volumes of goods or services delivered.

B1-5 REVALUATION INCREMENT

	2022	*2021*
	$'000	*$'000*
Revaluation increments - land	70	4,365
	70	**4,365**

Accounting Policy - Revaluations

Land is measured at fair value using independent revaluations, desktop market revaluations or indexation by the State Valuation Service (SVS) within the Department of Resources.

Any revaluation increment arising on the revaluation of an asset is credited to the asset revaluation surplus of the appropriate class, except to the extent it reverses a revaluation decrement for the class previously recognised as an expense. A decrease in the carrying amount on revaluation is charged as an expense, to the extent it exceeds the balance, if any, in the revaluation surplus relating to that asset class.

Decrements in land values in prior years were reflected as an expense in the operating statement, resulting in accumulated losses carried forward of $1.313 mil at 30 June 2022 (2021: $1.383 mil).

B2 EXPENSES

B2-1 EMPLOYEE EXPENSES

	2022 $'000	2021 $'000
Employee benefits		
Wages and salaries	49,307	46,390
Annual leave levy	3,379	2,924
Employer superannuation contributions	3,777	3,421
Long service leave levy	1,190	1,087
Employee related expenses		
Workers' compensation premium	104	58
Other employee related expenses	217	132
	57,974	**54,012**

	No.	No.
B2-1 NUMBER OF EMPLOYEES (Full-Time Equivalent)		
Number of employees	**108**	**112**

*Reflecting Minimum Obligatory Human Resource Information (MOHRI)

Accounting Policy – Superannuation

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

Defined Contributions Plans – Contributions are made to eligible complying superannuation funds based on the rates specified in the relevant EBA or other conditions of employment. Contributions are expensed when they are paid or become payable following completion of the employee's service each pay period.

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

Key management personnel and remuneration disclosures are detailed in Note G1.

Accounting Policy – Wages and salaries

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

Accounting Policy – Workers' compensation premiums

MHHS pays premiums to Workcover Queensland in respect of its obligations for employee compensation. Workers' compensation insurance is a consequence of employing employees, but it is not counted in an employee's total remuneration package. It is not an employee benefit and is recognised separately as employee related expense.

Accounting Policy – Sick leave

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

Accounting Policy – Annual leave and long service leave

Under the Queensland Government's Central Schemes for Annual Leave (ALCS) and Long Service Leave (LSLS), levies are paid by MHHS to cover the cost of employee's accruing annual leave and long service leave entitlements (including leave loading and on-costs).

The levies are expensed in the period in which they are payable.

Amounts paid to employees for annual leave and long service leave are claimed from the scheme quarterly in arrears.

Accounting Policy – COVID response leave

Queensland Government announced in November 2020 that an additional two-day leave was granted to all non-executive employees of the Department of Health and Hospital and Health Services based on set eligibility criteria for recognition of the efforts of health workers, and those supporting health workers, in response to COVID-19. The leave must be taken by 31st March 2023 or eligibility is lost.

The entire value of the leave was paid by MHHS to Department of Health in 2021 for $1.972 mil. The leave is expensed in the period in which it is rostered in, and the remaining balance treated as a prepayment from the Department of Health (for DOH contracted employees) and a liability on our balance sheet for MHHS staff.

Accounting Policy – Recoveries of Employee Expenses

Payments received for MHHS employees working for other agencies or on secondment are offset against wages and salaries expenses to ensure the reported expenses reflect the actual wages and salaries incurred for employees working for the agency in that financial year.

B2 EXPENSES (continued)

B2-2 HEALTH SERVICE EMPLOYEE EXPENSES

	2022 *$'000*	*2021* *$'000*
Department of Health	314,514	294,511
	314,514	**294,511**

B2-2 NUMBER OF EMPLOYEES (Full-Time Equivalent)	No.	No.
Number of health service employees	**2,568**	**2,467**

The Hospital and Health Service through service arrangements with the Department of Health has engaged 2,568 (2021: 2,467) full time equivalent persons at 30 June 2022. As well as direct payments to the department, premium payments made to Workcover Queensland representing compensation obligations are included in this category 2022: $2.306 mil (2021: $1.499 mil).

Accounting Policy – Health service employee expense

In accordance with the *Hospital and Health Boards Act 2011*, the employees of the Department of Health are referred to as Health service employees. Under this arrangement:

- The Department of Health provides employees to perform work for MHHS, acknowledges and accepts its obligations as the employer of these employees.
- MHHS is responsible for the day-to-day management of these departmental employees.
- MHHS reimburses the Department of Health for the salaries and on-costs of these employees. This is disclosed as Health service employee expense.

Accounting Policy – Recoveries of Health Service Employee Expenses

Payments received for health services employees working for other agencies or on secondment are recorded as part of other revenue (See Note B1-4).

Accounting Policy – Consultants and contractors

Temporary staff employed through employment agencies and consultants engaged for professional services are expensed as services are provided. Payments are categorised as either medical or non-medical based on services provided.

B2-3 SUPPLIES AND SERVICES

	2022 *$'000*	*2021* *$'000*
Inventories consumed		
Clinical supplies and services	24,389	22,654
Drugs	21,669	20,754
Contractors and consultants		
Medical	18,464	16,850
Other	1,243	1,235
Outsourced medical services	17,513	12,726
Pathology, blood and parts	15,606	13,310
Repairs and maintenance	10,124	10,905
Patient travel	10,081	9,996
Communications	6,352	6,047
Electricity and other energy	4,313	4,186
Computer services	3,645	3,370
Building services	2,659	2,102
Catering and domestic supplies	1,595	1,381
Other travel	1,489	920
Lease expenses	895	422
Other	9,072	7,336
	149,109	**134,194**

Accounting Policy – Distinction between grants and procurement

For a transaction to be classified as supplies and services, the value of goods or services received by the department must be of approximately equal value to the value of the consideration exchanged for those goods or services. Where this is not the substance of the arrangement, the transaction is classified as a grant.

Accounting Policy – Outsourced medical services

Outsourced medical services are health related services provided by third parties to complement or extend HHS capability or capacity and are expensed as services are consumed. This includes services which HHS does not have inhouse expertise for and emergent services for specific community needs such as COVID-19 vaccination clinics.

Accounting Policy – Inventories consumed

All inventories held for distribution in hospital and health facilities are expensed at the time of issue. Stock held and available for use in the wards and other facilities, at 30 June is recorded as inventory in the Statement of Financial Position where material.

Accounting Policy - Lease expenses

Lease expenses include lease rentals for short-term leases, leases of low-value assets and variable lease payments. Refer to Note C9-1 for other lease disclosures.

B2-4 OTHER EXPENSES

	2022	2021
	$'000	$'000
Insurance premiums - QGIF	5,296	5,083
Services received free of charge	4,373	4,166
Other legal costs	3,452	676
Funding expense	3,415	1,678
Insurance premiums - Other	145	52
Impairment trade receivables	131	382
Ex-gratia payments	9	17
Other	1,508	1,651
	18,329	**13,705**

Accounting Policy – Insurance

The Department of Health insures property and general losses above a $10,000 threshold through the Queensland Government Insurance Fund (QGIF). Health litigation payments above a $20,000 threshold and associated legal fees are also insured through QGIF. QGIF collects from insured agencies an annual premium intended to cover the cost of claims occurring in the premium year.

Legal costs include $2.667 mil relating to formal obstetrics and gynaecology review.

The Insurance Arrangements for Public Health Entities Health Service enables Hospital and Health Services to be named insured parties under the department's policy. For the 2021-22 policy year, the premium was allocated to each HHS according to the underlying risk of an individual insured party.

Disclosure – Special payments and services received free of charge

Special payments represent ex gratia expenditure and other expenditure that MHHS is not contractually or legally obligated to make to other parties. MHHS maintains a register of all special payments greater than $5,000. In FY22 an ex-gratia payment exceeding $5,000 was paid for compassionate reasons to the family of an employee who passed away tragically in the course of duty.

MHHS receives corporate services support from the Department of Health at no cost. Further information on services provided and their treatment is available at Note B1-3.

B2-5 AUDITOR REMUNERATION

	2022	2021
	$'000	$'000
Audit services - Queensland Audit Office		
Audit of financial statements	**172**	**164**

There are no non-audit services included in this amount.

SECTION C
NOTES ABOUT OUR FINANCIAL POSITION

C1 CASH AND CASH EQUIVALENTS

	2022 $'000	2021 $'000
Imprest accounts	5	5
Cash at bank*	18,733	23,780
QTC cash funds*	1,456	1,450
	20,194	**25,235**

Cash deposited with Queensland Treasury Corporation earns interest, calculated daily reflecting market movements in cash funds. The annual effective interest rate was 0.76% (2021: 0.51%).

Accounting Policy – Cash and cash equivalents

For the purposes of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques receipted but not banked at 30 June as well as deposits at call with financial institutions and cash debit facility. MHHS operational bank accounts form part of the Whole-of-Government (WOG) banking arrangement with the Commonwealth Bank of Australia and does not earn interest on surplus funds nor is it charged interest or fees for accessing its approved cash debit facility. Any interest earned on the WoG fund accrues to the Consolidated Fund.

General trust bank and term deposits do not form part of the WoG banking arrangement and incur fees as well as earn interest.

*MHHS receives cash contributions primarily from private practice clinicians and external entities to provide for education, study, and research in clinical areas. Contributions are also received from benefactors in the form of gifts, donations, and bequests for stipulated purposes. At 30 June 2022, amounts of $2.784 mil (2021: $2.580 mil) in General Trust, including $1.884 mil (2021: $1.701 mil) for excess earnings under Granted Private Practice, set aside for the specified purposes underlying the contribution.

C2 RECEIVABLES

	2022 $'000	2021 $'000
Trade debtors	4,160	4,890
Less: Loss allowance	(959)	(1,066)
	3,201	3,824
GST receivable	1,055	1,064
GST payable	(125)	(59)
	930	1,005
	4,131	**4,829**

Accounting Policy – Receivables

Receivables are measured at amortised cost which approximates their fair value at reporting date. Trade debtors are recognised at the amounts due at the time of sale or service delivery i.e., the agreed purchase/contract price. The recoverability of trade debtors is reviewed on an ongoing basis at an operating unit level. Trade receivables are generally settled within 120 days. No interest is charged, and no security is obtained.

Disclosure – Receivables

The closing balance of receivables arising from contracts with customers as at 30 June 2022 is $4.160 mil (1 July 2021: $4.89 mil)

C2-1 IMPAIRMENT OF RECEIVABLES

Accounting Policy – Impairment of receivables

The loss allowance for trade debtors reflect lifetime expected credit losses, incorporating reasonable and supportable forward-looking information. This includes economic changes that impact MHHS's debtors and relevant industry data, to form part of the impairment assessment.

Other categories of receivables represent monies owing by Queensland or federal government agencies. No loss allowance is recorded for these receivables due to low credit risk exposure i.e., high credit rating.

Where there is no reasonable expectation of recovery of monies owing by a debtor, the debt is written-off by directly reducing the receivable against the loss allowance. This occurs when a third default notice has been issued (normally after 120 days) and debt enforcement activity has ceased. If the amount of debt written off exceeds the loss allowance, the excess is recognised as an impairment loss. The amount of impairment losses recognised for trade debtors is disclosed below.

C2 RECEIVABLES (continued)

C2-1 IMPAIRMENT OF RECEIVABLES (continued)

Disclosure – Credit risk exposure of receivables

The maximum exposure to credit risk for receivables at balance date is the gross carrying amount of those assets. No collateral is held as security and no credit enhancements relate to receivables held by MHHS.

The HHS uses a provision matrix to measure expected credit losses based on observed historical default rates over the past five years, adjusted for changes in macroeconomic indicators (used to assess the impact on the future collectability of receivables). Loss rates are calculated for customer profiles with similar loss patterns with the following two major groups identified:

- Private patient's ineligible for health assistance under Medicare arrangements with the federal government; and
- Other trade receivables.

MHHS's patient activity is heavily influenced by movements in regional population. Depending on the status of the tourism, agricultural and mining sectors the region experiences significant fluctuations in population, with a large proportion of the workforce transient in nature and includes overseas/interstate visitors requiring treatment. Economic growth has been determined as the most relevant forward-looking indicator for both groups of receivables. Where economic growth is strong, historical default rates are adjusted upwards to reflect the change in the population base i.e., higher proportion of visitors/transient workforce. Set out below is the credit risk exposure on MHHS's trade debtors broken down by aging band.

The higher loss rate in FY22 below represents specific provisions taken against ineligible patient receivables primarily due to recent low rates of successful collection.

Impairment group - Trade debtors:

	2022			2021		
	Gross receivables	*Loss rate*	*Expected credit losses*	*Gross receivables*	*Loss rate*	*Expected credit losses*
Ageing	*$'000*	*%*	*$'000*	*$'000*	*%*	*$'000*
Current	2,109	7.5%	158	2,308	0.6%	15
31 to 60 days	870	12.2%	106	1,009	4.2%	42
61 to 90 days	367	22.9%	84	444	12.8%	57
> 90 days	814	75.1%	611	1,128	84.4%	952
Total	**4,160**		**959**	**4,889**		**1,066**

Disclosure - Movement in loss allowance for trade debtors

	2022	*2021*
	$'000	*$'000*
Balance at beginning of the year	1,066	800
Amounts written off during the year	(231)	(116)
Increase in allowance recognised in operating result	124	382
Balance at the end of the year	**959**	**1,066**

C3 INVENTORIES

	2022	*2021*
	$'000	*$'000*
Inventories held for distribution - at cost		
Pharmaceutical drugs	1,491	1,248
Clinical supplies	2,431	2,418
Catering and domestic	13	11
	3,935	**3,677**

Accounting Policy – Inventories

Inventories consist mainly of clinical supplies and pharmaceuticals held for use and distribution in MHHS facilities and are provided to public admitted patients free of charge except for pharmaceuticals which are provided at a subsidised rate. Inventories are valued at the cost, adjusted where applicable, for any loss of service potential. Cost is assigned on a weighted average cost.

C4 OTHER ASSETS

	2022 $'000	2021 $'000
Prepayments	1,723	2,284
Contract assets	6,603	6,269
Other	2,966	2,267
	11,292	**10,820**

Accounting Policy – Other assets

Prepayments include $0.515 mil (2021: $0.975 mil) for COVID Response Leave.

MHHS recognises it's right to consideration for services provided or goods delivered to customers under a contract but not yet billed, as a contract asset.

Where a right to consideration exists under an agreement (not arising from contracts with customers), and funds have not been receipted or invoiced, accrued revenue is recognised, and disclosed as part of Other.

Disclosure – Contract assets

Contract assets arise from contracts with customers and are transferred to receivables when MHHS's right to payment becomes unconditional, This usually occurs when the invoice is issued to the customer. All contract assets are assessed for indicators of impairment on a monthly basis. If an indicator of impairment exists, the HHS determines the asset's recoverable amount. Any amount by which the asset's carrying amount exceeds the recoverable amount is recognised as an impairment loss from an entity's contracts with customers. Contract assets are assessed for impairment by reference to events such as a breach of contract, performance failure or a past due event that is assessed to have a detrimental impact on the recoverability of that asset.

The Department of Health owed $7.317 mil (2021: $5.732 mil) at 30 June to MHHS including $4.35 mil in contract assets (2021: $3.464mil) for project management and purchases of additional health service activity, and $2.966 mil (2021: $2.267 mil) for other funding to support the provision of health services (other assets). For further details on the nature of these transactions refer to Note B1-2.

C5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION

C5-1 ACCOUNTING POLICIES

Property, Plant and Equipment

Items of property, plant, and equipment with a cost or other value equal to or more than the following thresholds and with a useful life of more than one year are recognised at acquisition.

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

Items below these values are expensed. Land improvements undertaken by MHHS are included in the building class.

MHHS has an annual maintenance program for its buildings. Expenditure is only added to an asset's carrying amount if it increases the service potential or useful life of the existing asset. Maintenance expenditure that merely restores the original service potential (lost through ordinary wear and tear) is expensed.

Componentisation of Complex Assets

Complex assets comprise separately identifiable components (or groups of components) of significant value, that require replacement at regular intervals and at different times to other components comprising the complex asset. On initial recognition, the asset recognition thresholds outlined above apply to the complex asset as a single item. Specialised health service buildings with a gross replacement value of $3 mil or more are complex in nature and componentised. Components are separately recorded and valued on the same basis as the asset class to which they relate.

Acquisition of Assets

Historical cost is used for the initial recording of all property, plant, and equipment acquisitions. Historical cost is determined as the value given as consideration plus costs incidental to the acquisition (such as architects' fees and engineering design fees), plus all other costs incurred in getting the assets ready for use.

Where assets are received free of charge from another Queensland government entity (whether as a result of a machinery-of-Government change or other involuntary transfer), the acquisition cost is recognised as the carrying amount in the books of the other agency immediately prior to the transfer. Assets acquired at no cost or for nominal consideration, other than from another Queensland Government entity, are recognised at their fair value at the date of acquisition.

Measurement using historical cost

Plant and equipment are measured at historical cost net of accumulated depreciation and accumulated impairment losses in accordance with Queensland Treasury's *Non-Current Asset Policies for the Queensland Public Sector* (NCAP). The carrying amounts for plant and equipment at cost are not materially different from their fair value.

Measurement using fair value

Land and buildings are measured at fair value in accordance with AASB 116 Property*, Plant and Equipment*, AASB 13 *Fair Value Measurement* and Queensland Treasury's *Non-Current Asset Policies for the Queensland Public Sector* (NCAP).

These assets are reported at their revalued amounts, being the fair value at the date of valuation, less any subsequent accumulated depreciation and accumulated impairment losses where applicable. Separately identified components of assets are measured on the same basis as the assets to which they relate. In respect of the abovementioned asset classes, the cost of items acquired during the financial year has been judged by management to materially represent their fair value at the end of the reporting period.

Revaluation of property measured at fair value

Land and building classes measured at fair value, are assessed on an annual basis either by comprehensive valuations or using appropriate and relevant indices undertaken by independent professional valuers/quantity surveyors. For financial reporting purposes, the revaluation process for MHHS is managed by the finance unit with input from the infrastructure branch and Executive Director of Corporate Services. The appointment of the independent valuer was undertaken through MHHS procurement process.

Comprehensive revaluations are undertaken as part of a rolling valuation spanning a maximum of five years. However, if a particular asset class experiences significant and volatile changes in fair value, that class is subject to specific appraisal in the reporting period, where practical, regardless of the timing of the last specific appraisal. Where assets have not been specifically appraised in the reporting period, their previous valuations are materially maintained via the application of relevant indices. MHHS uses indices to provide a valid estimation of the assets' fair values at reporting date.

Materiality is considered in determining whether the differences between the carrying amount and the fair value of an asset warrant revaluation.

The fair values reported by MHHS are based on appropriate valuation techniques that maximises the use of available and relevant observable inputs and minimise the use of unobservable inputs (refer to Note D1-1).

Reflecting the specialised nature of health service buildings for which there is not an active market, fair value is determined using current replacement cost. Current replacement cost is determined as the replacement cost of a modern equivalent asset adjusted for functional and economic obsolescence. Buildings are measured at fair value by applying either, a revised estimate of individual asset's current replacement cost, or an interim index which approximates movement in market prices for labour and other key resource inputs, as well as changes in design standards as at reporting date. These estimates are developed by independent quantity surveyors.

Indices used are also tested for reasonableness by applying the indices to a sample of assets, comparing the results to similar assets that have been valued by an independent professional valuer or quantity surveyor, and analysing the trend of changes in values over time. Through this process, which is undertaken annually, management assesses and confirms the relevance and suitability of indices provided based on MHHS's own circumstances.

On revaluation, buildings are revalued using a cost valuation method (e.g., current replacement cost). Accumulated depreciation is adjusted to equal the difference between the gross amount and the carrying amount, after considering accumulated impairment losses and changes in remaining useful life. This is generally referred to as the 'gross method'.

Depreciation

Property, plant, and equipment are depreciated on a straight-line basis. Annual depreciation is based on fair values and MHHS's assessments of the useful remaining life of individual assets. Land is not depreciated as it has an unlimited useful life.

Key judgement: Straight line depreciation is used reflecting the progressive, and even, consumption of service potential of these assets over their useful life to MHHS.

Assets under construction (work-in-progress) are not depreciated until they reach service delivery capacity. Service delivery capacity relates to when construction is complete, and the asset is first used or is installed ready for use in accordance with its intended application. These assets are then reclassified to the relevant classes within property plant and equipment.

Where assets have separately identifiable components, subject to regular replacement, components are assigned useful lives distinct from the asset to which they relate and depreciated accordingly, as doing so results in a material impact on the depreciation expense reported.

Any expenditure that increases the originally assessed capacity or service potential of an asset is capitalised and the new depreciable amount is depreciated over the remaining useful life of the asset.

The depreciable amount of improvements to or on leasehold land is allocated progressively over the shorter of the estimated useful lives of the improvements or the unexpired period of the lease. The unexpired period of leases includes any option period where exercise of the option is probable.

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

Class	Depreciation rates
Buildings and Improvements	
- Structural fabric of building	0.93 to 11.11%
- External fabric	0.93 to 11.11%
- Internal fabric	0.93 to 10.0%
- Internal finishes	1.39 to 12.5%
- Fittings	1.39 to 9.09%
- Building services	1.39 to 11.11%
- Land improvements	1.22 to 3.33%
- Other buildings including residential	0.91 to 7.14%
- Plant and equipment including artworks	1.00 to 25.00%

C5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

C5-1 ACCOUNTING POLICIES (continued)

Indicators of impairment and determining recoverable amount

Key judgement and estimate: All property, plant and equipment are assessed for indicators of impairment on an annual basis or, where the asset is measured at fair value, for indicators of a change in fair value/service potential since the last valuation was completed. Where indicators of a material change in fair value or service potential since the last valuation arise, the asset is revalued at the reporting date under AASB 13 *Fair Value Measurement*. If an indicator of possible impairment exists, management determines the asset's recoverable amount under *Impairment of Assets (*AASB 136). Recoverable amount is equal to the higher of the fair value less costs of disposal and the asset's value in use subject to the following:

- As a not-for profit entity, certain property, plant, and equipment of MHHS is held for the continuing use of its service capacity and not for the generation of cashflows. Such assets are typically specialised in nature. In accordance with AASB 136, where such assets measured at fair value under AASB 13, that fair value (with no adjustment for disposal costs) is effectively deemed to be the recoverable amount. Consequently, AASB136 does not apply to such assets unless they are measured at cost.

- For other non-specialised property, plant and equipment measured at fair value, where indicators of impairment exist, the only difference between the asset's fair value and its fair value less costs of disposal, is the incremental costs attributable to the disposal of the asset. Consequently, the fair value of the asset determined under AASB 13 will materially approximate its recoverable amount where the disposal costs attributable to the asset are negligible. After the revaluation requirements of AASB 13 are first applied to these assets, applicable disposal costs are assessed and, in the circumstances where such costs are not negligible, further adjustments to the recoverable amount are made in accordance with AASB 136.

Any amount by which the asset's carrying amount exceeds the recoverable amount is considered an impairment loss. An impairment loss is recognised immediately in the Statement of Comprehensive Income, unless the asset is carried at a revalued amount, in which case the impairment loss is offset against the asset revaluation surplus of the relevant class to the extent available. Where no asset revaluation surplus is available in respect of the class of asset, the loss is expensed in the Statement of Comprehensive Income as a revaluation decrement.

Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of its recoverable amount, but so that the increased carrying amount does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset in prior years.

For assets measured at cost, impairment losses are reversed through income. For assets measured at fair value, to the extent the original decrease was expensed through the Statement of Comprehensive Income, the reversal is recognised as income; otherwise, the reversal is treated as a revaluation increase for the class of asset through asset revaluation surplus. When an asset is revalued using a market valuation approach, any accumulated impairment losses at that date are eliminated against the gross amount of the asset prior to restating for the revaluation.

C5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

C5-2 PROPERTY, PLANT AND EQUIPMENT - BALANCES AND RECONCILIATIONS OF CARRYING AMOUNT

2022	Land (Level 2) $'000	Buildings (Level 3) $'000	Plant and equipment (at cost) $'000	Capital works in progress (at cost) $'000	Total $'000
Gross	18,170	633,603	61,558	7,358	720,689
Less: Accumulated depreciation	-	(303,220)	(32,670)	-	(335,890)
Carrying amount at 30 June 2022	**18,170**	**330,383**	**28,888**	**7,358**	**384,799**
Represented by movements in carrying amount:					
Carrying amount at 1 July 2021	18,100	327,712	25,885	2,016	373,713
Transfers in -from other Queensland Government entities	-	-	781	-	781
Acquisitions	-	659	8,256	6,832	15,747
Donated assets	-	-	98	-	98
Disposals	-	(336)	(81)	(1)	(418)
Transfers between classes	-	891	598	(1,489)	-
Net revaluation increments/(decrements)	70	25,325	-	-	25,395
Depreciation expense	-	(23,868)	(6,649)	-	(30,517)
Carrying amount at 30 June 2022	**18,170**	**330,383**	**28,888**	**7,358**	**384,799**

C5-2 PROPERTY, PLANT AND EQUIPMENT - BALANCES AND RECONCILIATIONS OF CARRYING AMOUNT (continued)

2021	Land (Level 2) $'000	Buildings (Level 3) $'000	Plant and equipment (at cost) $'000	Capital works in progress (at cost) $'000	Total $'000
Gross	18,100	585,474	58,887	2,016	664,477
Less: Accumulated depreciation	-	(257,762)	(33,002)	-	(290,764)
Carrying amount at 30 June 2021	**18,100**	**327,712**	**25,885**	**2,016**	**373,713**
Represented by movements in carrying amount:					
Carrying amount at 1 July 2020	13,735	341,409	23,321	7,810	386,275
Transfers in - practical completion projects from the Department of Health	-	740	160	-	900
Transfers in - from other Queensland Government entities	-	-	-	-	-
Acquisitions	-	578	7,513	1,763	9,854
Donated assets	-	-	267	-	267
Disposals	-	(220)	(146)	-	(366)
Transfers out to other Queensland Government entities	-	-	(60)	-	(60)
Transfers between classes		6,863	694	(7,557)	-
Net revaluation increments/(decrements)	4,365	2,133	-	-	6,498
Depreciation expense	-	(23,791)	(5,864)	-	(29,655)
Carrying amount at 30 June 2021	**18,100**	**327,712**	**25,885**	**2,016**	**373,713**

C5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

C5-2 VALUATION OF PROPERTY, PLANT AND EQUIPMENT INCLUDING KEY ESTIMATES AND JUDGEMENTS

Land

Land is measured at fair value using independent revaluations, desktop market revaluations or indexation by the State Valuation Service (SVS) within the Department of Natural Resources, Mines and Energy.

MHHS commenced its rolling comprehensive revaluation program for land holdings in 2022, with State Valuation Service engaged in the current year to comprehensively revalue six parcels of land. Desktop valuations were applied to two parcels of land and indexation was applied to the remaining ten parcels.

The fair value of land was based on publicly available data on sales of similar land in nearby localities in the twelve months prior to the date of the valuation. In determining the values, adjustments were made to the sales data to consider the location of MHHS's land, its size, street/road frontage and access, and any significant restrictions. The extent of the adjustments made varies in significance for each parcel of land. Subjective adjustments are made to observable data for land classified as reserve (by the Minister for a community purpose). Reserve land parcels are not sold and therefore there are no directly observable inputs. This land can only be sold when un-gazetted and converted to freehold by the State.

The revaluation program resulted in an increment to the carrying amount of land of $0.070 mil (2021: $4.365 mil).

Buildings

MHHS engaged independent quantity surveyors, AECOM Pty Ltd to comprehensively revalue all buildings with a replacement cost exceeding $500,000 under a rolling valuation program spanning a maximum of five years. In FY22 13 buildings were comprehensively valued, while the remainder of buildings materially maintained their previous valuations via the application of relevant indices to provide a valid estimation of the assets' fair values at reporting date.

and calculate an annual index for all other assets. Refer to Note D1-2 for further details on the revaluation methodology applied.

The revaluation program resulted in an increment of $25.325 mil or 32% increase (2021: increment $2.133 mil) to the carrying amount of buildings.

C6 PAYABLES

	2022 *$'000*	*2021* *$'000*
Trade creditors	30,515	25,616
Accrued labour - Department of Health	3,590	2,505
	34,105	**28,121**

Trade creditors include $24.091 mil (2021: $18.512 mil) owing to the Department of Health at 30 June plus other trade creditors of $10.014 mil (2021: $7.104 mil).

Accounting Policy – Payables

Payables are recognised for amounts to be paid in the future for goods and services received. Trade creditors are measured at the agreed purchase/contract price, net of applicable trade and other discounts. The amounts are unsecured and normally settled within 30 - 60 days.

C7 ACCRUED EMPLOYEE BENEFITS

	2022 *$'000*	*2021* *$'000*
Wages outstanding	732	960
Superannuation accrued	45	32
	777	**992**

Accounting Policy – Accrued employee benefits

No provision for annual leave or long service leave is recognised in MHHS's financial statements as the liability is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*.

Under the Queensland Government's Central Schemes for Annual Leave (ALCS) and Long Service Leave (LSLS), levies are made throughout the year by MHHS to cover the cost of employee's accruing annual leave and long service leave entitlements (including leave loading and on-costs).

The levies are expensed in the period in which they are payable.

Amounts paid to employees for annual leave and long service leave are claimed from the scheme quarterly in arrears.

C8 OTHER LIABILITIES

	2022	*2021*
	$'000	*$'000*
Contract liabilities	965	1,243
Sundry Payables	3,338	1,532
Other	913	471
	5,216	**3,246**

Accounting policy – Other liabilities

Funding for health services from the DoH is recognised as a contract liability on receipt. Revenue is recognised when the service agreement performance obligations are met.

Disclosure – Contract liabilities

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

Most contract liabilities represent unearned revenue for patient fees and goods and services from Commonwealth 2022: $0.490 mil (2021: $1.243 mil).

Sundry payables reflect public health funding received by the HHS to be returned to DoH (or deferred to next year) as per the Service Level Agreement. For further details on the nature of these transactions refer to Note B1-2.

C9 RIGHT OF USE ASSETS AND LEASE LIABILITIES

C9-1 LEASES AS LESSEE

	2022 $'000	2021 $'000
Right-of-use assets		
Gross value	1,140	1,289
Less Accumulated depreciation	(834)	(522)
Carrying amount at 30 June	**306**	**767**
Represented by movements in carrying amount:		
Balance at 1 July	767	309
Additions	304	1,091
Remeasurement	(202)	(41)
Depreciation	(563)	(592)
Balance at 30 June	**306**	**767**
Lease liabilities		
Current	274	570
Non-Current	34	203
Total	**308**	**773**

Disclosures - Leases as lessee

Details of leasing arrangements as lessee

MHHS enters residential property leases to provide short-term employee housing. Some of these leases are short-term leases, however residential property leases are typically for 12 months and may include an option to renew a further 1 year. MHHS assesses at lease commencement whether it is reasonably certain to exercise the renewal options. Historically MHHS exercises renewal options, with lease terms recognised inclusive of extension options. This is reassessed if there is a significant event or significant change in circumstances within its control.

Residential property lease payments are fixed. MHHS has no option to purchase the leased premises at the conclusion of the lease, although the lease provides for a right of renewal at which time lease terms are renegotiated based on market review or CPI. As the future rent increases are variable, they are not captured in the right-of-use asset or lease liability until the increases take effect.

Motor vehicles

The Department of Energy and Public Works (DEPW) provides MHHS with access to motor vehicles under government-wide frameworks. These arrangements are categorised as procurement of services rather than as leases because DHPW has substantive substitution rights of the assets. The related service expense is included in Note B2-3.

Accounting policy – Measurement of ROU Assets

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

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

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

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

MHHS measures right-of-use assets from concessionary leases at cost on initial recognition, and after initial recognition.

MHHS has elected to not recognise right-of-use assets and lease liabilities arising for short-term leases and leases of low value assets. The lease payments are recognised as expenses on a straight-line basis over the lease term. An asset is considered low value where it is expected to cost less than $10,000 when new.

When a contract contains both a lease and non-lease component such as asset maintenance services, MHHS allocates the contractual payments to each component based on their stand-alone prices. However, for leases of plant and equipment, MHHS has elected to not separate lease and non-lease components and instead accounts for them as a single lease component.

Lease liabilities are initially recognised at the present value of lease payments over the lease term that are not yet paid. The lease term includes any extension or renewal options that MHHS is reasonably certain to exercise. The future lease payments included in the calculation of the lease liability comprise the following:

- fixed payments (including in-substance fixed payments), less any lease incentives receivable.
- variable lease payments that depend on an index or a rate, initially measured using the index or rate as at the commencement date.
- amounts expected to be payable under residual value guarantees.
- the exercise price of a purchase option and/or lease payments in an optional renewal period that MHHS is reasonably certain to exercise; and
- payments for termination penalties if the lease term reflects the early termination.

When measuring the lease liability, MHHS uses its incremental borrowing rate as the discount rate where the interest rate implicit in the lease cannot be readily determined, which is the case for all MHHS's leases. To determine the incremental borrowing rate. MHHS uses loan rates provided by Queensland Treasury Corporation that correspond to the commencement date and term of the lease.

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

C10 EQUITY

C10-1 CONTRIBUTED EQUITY

Interpretation *1038 Contributions by Owners Made to Wholly Owned Public Sector Entities* specifies the principles for recognising contributed equity by MHHS. The following items are recognised as contributed equity by MHHS during the reporting and comparative years:

- Cash equity contributions fund purchases of equipment, furniture and fittings associated with capital work projects managed by MHHS. In 2022 MHHS received $17.4 mil (2021 $7.5 mil) funding from the State as equity injections throughout the year. These outlays are paid by the Department of Health on behalf of the State.

- Non-reciprocal transfers of assets between Hospital and Health Services. In 2014, the Minister for Health signed an enduring designation of transfer for property, plant, and equipment between Hospital & Health Services (HHS) and the Department of Health. This transfer is recognised through equity when the Chief Finance Officers of both entities agree in writing to the transfer.

- Equity withdrawal of funds by the Department of Health on behalf of the State, MHHS received $40.1mil funding in 2022 (2021 $30.2 mil) from the Department of Health to account for the cost of depreciation. However, as depreciation is a non-cash expenditure item, the Health Minister has approved a withdrawal of equity by the State for the same amount, resulting in a non-cash revenue and non-cash equity withdrawal.

During this year a number of assets have been transferred under this arrangement.	*2022* *$'000*	*2021* *$'000*
Transfer in - practical completion of projects from the Department of Health*	-	740
Net transfer of property, plant and equipment from the Department of Health	781	160
Net transfers equipment between HHS	-	(60)
	781	**840**

*Construction of major health infrastructure is managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department of Health to MHHS.

C10-2 ASSET REVALUATION SURPLUS BY ASSET CLASS

	2022 *$'000*	*2021* *$'000*
Buildings		
Balance at the beginning of the financial year	53,585	51,452
Revaluation increments	25,325	2,133
Total	**78,910**	**53,585**

Accounting Policy - Asset revaluation surplus

The asset revaluation surplus represents the net effect of upward and downward revaluations of assets to fair value.

See Note B1-5 for Land Revaluation.

SECTION D

NOTES ABOUT RISKS AND OTHER ACCOUNTING UNCERTAINTIES

D1 FAIR VALUE MEASUREMENT

D1-1 ACCOUNTING POLICIES AND BASIS FOR FAIR VALUE MEASUREMENT

What is fair value?

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

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

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

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

Fair value measurement hierarchy

MHHS does not recognise any financial assets or financial liabilities at fair value (except at initial recognition).

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

Level 1 represents fair value measurements that reflect unadjusted quoted market prices in active markets for identical assets and liabilities;

Level 2 represents fair value measurements that are substantially derived from inputs (other than quoted prices included within level 1) that are observable, either directly or indirectly; and

Level 3 represents fair value measurements that are substantially derived from unobservable inputs.

None of MHHS's valuations of assets or liabilities are eligible for categorisation into level 1 of the fair value hierarchy. There were no transfers of assets between fair value hierarchy levels during the period.

Refer to Note C5-2 for disclosure of categories for assets measured at fair value.

The fair value of health service buildings is computed by quantity surveyors, AECOM. The methodology is known as the Current Replacement Cost (CRC) valuation technique. CRC is the price that would be received for the asset, based on the estimated cost to a market participant buyer to acquire or construct a substitute asset of comparable utility, adjusted for obsolescence.

AECOM determines the replacement cost of an asset by utilising a cost model which has been developed, providing a twenty-two-element cost plan (cost estimate) of the asset through the determination of key cost drivers such as.

- Asset type (clinical building, administration, clinic etc.)
- Gross floor area (GFA) or building footprint
- Number and height of staircases
- Girth of the building
- Height of the building
- Number of lifts and number of ‘stops’
- Location

The estimate has been compiled by measuring quantities using drawings obtained from Mackay Hospital and Health Service and verified on site or by completing a site measurement. This is done using CAD measurement software (CostX) and compared against previous valuations.

In determining the replacement cost of each building, the estimated replacement cost of the asset, or the likely cost of construction including fees and on costs if tendered on the valuation date is assessed. This is based on internal records of the original cost, adjusted for more contemporary design/construction approaches and current construction contracts. Assets are priced using Brisbane rates with published industry benchmark location indices applied. Revaluations are then compared and assessed against current construction contracts for reasonableness.

AECOM adjusts the replacement cost for both functional and economic obsolescence. This is assessed through determining whether the asset contains the same functionality or utility of a modern equivalent asset in terms of its components (e.g., does the current building have air conditioning expected in a modern equivalent asset); and does the asset contain materially significant components required under the National Construction Code (NCC).

D1 FAIR VALUE MEASUREMENT (continued)

D1-2 LEVEL 3 FAIR VALUE MEASUREMENT - SIGNIFICANT VALUATION INPUTS AND IMPACT ON FAIR VALUE (continued)

Significant judgement was used to assess the remaining service potential of a facility, given local climatic and environmental conditions. Physical site inspections by AECOM, combined with refurbishment history, local knowledge of asset performance and future planned asset replacement programs were used to inform these assumptions.

There are no other direct or significant relationships between the unobservable inputs which materially impact fair value.

Valuations assume a nil residual value. Significant capital works, such as a refurbishment across multiple floors of a building, will result in an improved condition assessment, however the cost of refurbishing a building includes a premium, especially in functioning facilities. For example, it can include costs related to demolition and dismantling of the old building, asbestos removal, additional Health and Safety costs, impacts from continuing to provide services during construction and slower construction timeframes. The valuation removes these "premium" costs and calculates values based on efficient construction practices. The removal of 'premium costs' will typically result in a decline in building values.

D2 FINANCIAL RISK DISCLOSURES

D2-1 FINANCIAL INSTRUMENT CATEGORIES

Financial assets and financial liabilities are recognised in the Statement of Financial Position when MHHS becomes party to the contractual provisions of the financial instrument. The MHHS has the following categories of financial assets and financial liabilities:

Category	Note	2022 $'000	2021 $'000
Financial assets at amortised cost			
Cash and cash equivalents	C1	20,194	25,235
Receivables	C2	4,131	4,829
Total		**24,325**	**30,064**
Financial liabilities at amortised cost			
Payables	C6	34,105	28,121
Lease liabilities	C9	308	773
Total		**34,413**	**28,894**

No financial assets and financial liabilities have been offset and presented net in the Statement of Financial Position.

D2-2 FINANCIAL RISK MANAGEMENT

MHHS's activities expose it to a variety of financial risks - credit risk, liquidity risk and interest rate risk. Financial risk management is implemented pursuant to Government and MHHS's policy. These policies focus on the unpredictability of financial markets and seek to minimise potential adverse effects on the financial performance of MHHS.

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

Risk exposure	*Measurement method*
Credit risk	Ageing analysis, cash inflows at risk
Liquidity risk	Monitoring of cash flows by employee and supplier obligations as they fall due
Interest risk	Interest rate sensitivity analysis

Credit risk is further discussed in Note C2 Receivables.

Liquidity risk

Liquidity risk is the risk that MHHS will not have the resources required at a particular time to meet its obligations to settle its financial liabilities. MHHS is exposed to liquidity risk through its trading in the normal course of business and aims to reduce the exposure to liquidity risk by ensuring that enough funds are always available to meet employee and supplier obligations. An approved debt facility of $6.00 mil (2021: $6.00 mil) under WOG banking arrangements to manage any short-term cash shortfalls has been established. Nil funds have been withdrawn against this debt facility as at 30 June 2022 (2021: Nil).

All financial liabilities (except lease liabilities) at amortised cost are current in nature and will be due and payable within twelve months. As such no discounting has been applied. Lease liabilities are both current and non-current and have been discounted accordingly.

Interest risk

MHHS is exposed to interest rate risk on its 24-hour call deposits, however there is no significant interest risk on its cash deposits. The HHS does not undertake any hedging in relation to interest rate risk. Changes in interest rate have a minimal effect on the operating result of MHHS.

D2 FINANCIAL RISK DISCLOSURES (continued)

D2-3 LIQUIDITY RISK – CONTRACTUAL MATURITY OF FINANCIAL LIABILITIES

The following tables sets out the liquidity risk of financial liabilities held by MHHS. They represent the contractual maturity of financial liabilities, calculated based on undiscounted cash flows relating to the liabilities at reporting date. The undiscounted cash flows in these tables differ from

the amounts included in the Statement of Financial Position that are based on discounted cash flows.

	2022		Contractual maturity		2021	Contractual maturity	
	Total		***< 1 Yr***	***1-5 Yrs***	**Total**	***< 1 Yr***	***1-5 Yrs***
	$'000		*$'000*	*$'000*	**$'000**	*$'000*	*$'000*
Payables	**34,105**	-	34,105	-	**28,121**	28,121	-
Leased liabilities	**309**	-	277	32	**776**	573	203
	34,414		**34,382**	**32**	**28,897**	**28,694**	**203**

D3 CONTINGENCIES

(a) Litigation in progress

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

	2022 Number of cases	2021 Number of cases
Supreme Court	3	4
Federal Court	1	-
District Court	3	1
	7	**5**

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). MHHS's liability in this area is limited to an excess per insurance event of $20,000 per claim - refer Note B2-4. As at 30 June 2022, MHHS has 8 claims currently managed by QGIF, some of which may never be litigated or result in payments to claims (excluding initial notices under Personal Injuries Proceedings Act).

Supreme, Federal and District Court figures represent the matters that have been referred to QGIF for management. MHHS's legal advisers and management believe that the final amounts payable (if any) and timing of outcome in respect of the litigation before the courts is not quantifiable at this time.

D4 COMMITMENTS

(a) Capital expenditure commitments

	2022 $'000	2021 $'000
Commitments for capital expenditure at reporting date (inclusive of non-recoverable GST input tax credits) are payable:		
Building		
No later than 1 year	3,489	51
Total	**3,489**	**51**
Plant and Equipment		
No later than 1 year	5,689	2,394
Total	**5,689**	**2,394**

D5 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE

All Australian accounting standards and interpretations with future effective dates are either not applicable to MHHS's activities or have no material impact.

D6 EVENTS AFTER BALANCE SHEET DATE

There are no matters or circumstances that have arisen since 30 June 2022 that have significantly affected or may significantly affect MHHS' operations, the results of those operations, or the HHS's state of affairs in future financial years.

D7 SIGNIFICANT FINANCIAL IMPACTS

D7-1 SIGNIFICANT FINANCIAL IMPACTS – COVID 19 PANDEMIC

The following significant transactions were recognised by Mackay HHS during the 2021-22 financial year in response to the COVID-19 pandemic.

	2022	*2021*
	$'000	*$'000*
STATEMENT OF COMPREHENSIVE INCOME		
Significant revenue transactions arising from COVID-19		
Additional funds for COVID-19 related expenses	17,106	7,592
Additional funds for COVAX related expenses	8,793	1,051
Additional funds for COVID Response Leave - front line staff backfill	1,041	624
Additional funds for COVAX mandate backfill expenses	370	-
Waived collection of café licence revenues	-	(26)
Own Source Revenue lost	(692)	-
Total Revenues	**26,618**	**9,241**
Significant expense transactions arising from COVID-19		
Costs incurred in response to COVID-19 epidemic	17,106	7,592
Costs incurred in response to COVAX	8,793	1,051
Annual Leave not taken	-	-
COVID Response Leave taken	352	700
Costs incurred COVAX Mandate backfill	370	-
Impairment of receivables	-	(14)
Total Expenses	**26,621**	**9,329**
Net Impact	**(3)**	**(88)**

STATEMENT OF COMPREHENSIVE INCOME		
	2022	*2021*
	$'000	*$'000*
Significant changes in assets and liabilities from COVID-19		
Provision for impairment of receivables	-	(153)
COVID Response Leave Prepayment	515	975
Net Impact Assets	**515**	**822**
COVID Response Leave Liability	80	118
Net Impact Liabilities	**80**	**118**

D7-2 SIGNIFICANT FINANCIAL IMPACTS – Obstetrics & Gynaecology Services Review

A Health Service Investigation under Part 9 of the Hospital and Health Boards Act 2011 was commissioned in relation to the delivery of public sector health services related to obstetrics and gynaecology services. The cost of the investigation year to date was $4.15 million. At the time of reporting, the investigation was ongoing, with further costs expected in 2022-23 to finalise and implement the response to the findings and/ or recommendations.

SECTION E

NOTES ON OUR PERFORMANCE COMPARED TO BUDGET

E1 BUDGETARY REPORTING DISCLOSURES

This section discloses MHHS's original published budgeted figures for 2021-22 compared to actual results, with explanations of major variances, in respect of MHHS's Statement of Comprehensive Income. Note original published budget from the Service Delivery Statement (SDS) has been reclassified to improve transparency and analysis by remapping budgeted transactions on the same basis as reported in actual financial statements.

E2 BUDGET TO ACTUAL COMPARISON – STATEMENT OF COMPREHENSIVE INCOME

E2-1 BUDGET TO ACTUAL COMPARISON - STATEMENT OF COMPREHENSIVE INCOME

	Variance Notes	Actual 2022 $'000	Original SDS Budget 2022 $'000	SDS Budget V Actual Variance $'000
OPERATING RESULT				
Income				
User charges and fees	V1.	37,741	33,541	4,200
Funding public health services	V2.	506,094	460,877	45,217
Grants and other contributions	V3.	17,613	14,892	2,721
Other revenue		5,452	5,270	182
Revaluation increment		70	1	69
Total Income		**566,970**	**514,581**	**52,389**
Expenses				
Employee expenses*	V4.	57,974	53,585	4,389
Health service employee expenses**	V5.	314,514	301,583	12,931
Supplies and services	V6.	149,109	121,643	27,466
Depreciation and amortisation	V7.	31,080	26,949	4,131
Other expenses	V8.	18,329	10,821	7,508
Total Expenses		**571,006**	**514,581**	**56,425**
Operating Results		**(4,036)**	**-**	**(4,036)**
Other Comprehensive Income				
Items Not Reclassified to Operating Result				
Increase/(decrease) in Asset Revaluation Surplus	V9.	25,325	-	25,325
Total Comprehensive Income		**21,289**	**-**	**21,289**

* Persons directly employed by Mackay Hospital and Health Service. ** Persons employed directly by the Department of Health working in MHHS facilities see Note B2-2 for further details.

E2-1 EXPLANATION OF MAJOR VARIANCES - STATEMENT OF COMPREHENSIVE INCOME

V1. User charges and fees

User charges exceeded budget by $4.20 mil for the year ended 30 June 2022 primarily reflecting higher Pharmaceutical Benefit Scheme Reimbursements (PBS) $2.71 mil and revenue from managing capital projects on behalf of the Department of Health $1.12 mil. Variations to PBS income reflected a combination of increased patient activity and changes to drugs prescribed with different treatments applied to allow better outcomes for patients and additional drugs included in the rebate list. These costs and associated revenue reimbursements are not captured at the time of budget.

Cash inflows for user charges and fees exceeded the SDS budget by $3.86 mil. The key contributors to this are consistent with the reasons set out above.

V2. Funding public health services

Services exceeded budget by $45.22 mil for the year ended 30 June 2022 primarily reflecting COVID reimbursement through the National Partnership Agreement along with additional funding received throughout the year to increase health services for the community and region.

Cash inflows for health services and fees exceeded the SDS budget by $40.87 mil due to reasons set out above.

V3. Grants and other contributions

Grants and other contributions exceeded SDS original budget by $2.72 mil at 30 June 2022. During 2022, there was an increase in patient activity in home support programs and aged care services which has resulted in increased federal grant funding of $1.89mil above budget and a donation of $1.01M received from the Mackay Hospital Foundation (MHF).

E2 BUDGET TO ACTUAL COMPARISON – STATEMENT OF COMPREHENSIVE INCOME (continued)

E2-1 EXPLANATION OF MAJOR VARIANCES - STATEMENT OF COMPREHENSIVE INCOME (continued)

V4. Employee expenses

Employee expenses were $4.39 mil over budget due to higher costs for senior medical officer's wages including increased sick, other leave during the year, predominantly related to COVID resulting in increased overtime ($1.64 mil over budget). Additional funding was approved by the Department of Health post the budget to address ongoing COVID impacts and to address other service initiatives required Senior Medical staff.

V5. Health service employee expenses

These expenses were $12.93 mil over budget due to higher costs for additional positions to deliver COVID response and community vaccination roll out plus additional services funded throughout the year to increase health services for the community and region.

Cash inflows for health service employees and fees exceeded the SDS budget by $12.93 mil due to reasons set out above.

V6. Supplies and services

This increase relates primarily to higher cost drug expenditure ($3.68 mil) due to a combination of increased patient activity and changes to drugs prescribed with different treatments applied to allow better outcomes for patients, partially offset by the increase in PBS revenue in note 1 above. Other items include capital projects expenditure (partially offset by capital projects revenue in note 1 above). Pathology (over budget by $3.91 mil) and clinical supplies ($3.25 mil), primarily associated with response to COVID, additional costs associated with projects and unplanned internal reviews, and expenditure related to additional funding from amendment windows provided to address ongoing demand within the region.

V7. Depreciation and amortisation

The variance to budget relates to the timeframes or commissioning of completed capital work in progress, valuation increments, new asset acquisitions and depreciation charges for right of use assets.

V8. Other expenses

This variance relates primarily to an increase in legal fees of $3.40 mil largely due to the formal review of maternal health services, and a further $3.34 mil relating to return and/or deferral of departmental funds as outlined in the Service Level Agreement (SLA).

Cash inflows for other exceeded the SDS budget by $5.522 mil largely due to the reasons set out above.

V9. Asset revaluation surplus

This variance of $25.33 mil relates to the results of the annual valuation program which involved 13 building being comprehensively revalued this financial year and indices applied to remaining building portfolio

Statement of Financial Position exceeded the SDS budget by $16.27 mil primarily due to the reason set out above, along with additional capital and clinical equipment purchases.

E3 BUDGET TO ACTUAL COMPARISON – STATEMENT OF FINANCIAL POSITION

E3-1 BUDGET TO ACTUAL COMPARISON - STATEMENT OF FINANCIAL POSITION

	Variance Notes	Actual 2022 $'000	Original SDS Budget 2022 $'000	SDS Budget V Actual Variance $'000
Current Assets				
Cash and cash equivalents	V10.	20,194	34,642	(14,448)
Receivables	V11.	4,131	10,529	(6,398)
Inventories	V12.	3,935	4,442	(507)
Other assets	V13.	11,292	1,724	9,568
Total Current Assets		**39,552**	**51,337**	**(11,785)**
Non-Current Assets				
Property, plant and equipment	V9.	384,799	368,532	16,267
Right of use assets		306	26	280
Total Non-Current Assets		**385,105**	**368,558**	**16,547**
Total Assets		**424,657**	**419,895**	**4,762**
Current Liabilities				
Payables	V14.	34,105	30,046	4,059
Accrued employee benefits		777	2,355	(1,578)
Lease liabilities		274	690	(416)
Other liabilities	V15.	5,216	3,274	1,942
Total Current Liabilities		**40,372**	**36,365**	**4,007**
Non-Current Liabilities				
Lease liabilities		34	44	(10)
Total Non-Current Liabilities		**34**	**44**	**(10)**
Total Liabilities		**40,406**	**36,409**	**3,997**
Net Assets		**384,251**	**383,486**	**765**
Equity		**384,251**	**383,486**	**765**

E3-1 EXPLANATION OF MAJOR VARIANCES - STATEMENT OF FINANCIAL POSITION

V10. Cash and cash equivalents

This variance is driven primarily by the MHHS allocation of $10.00 mil as a contribution toward Sarina Hospital redevelopment which was transferred to the Department (Capital Branch) in mid-FY22.

Cash inflows for Equity Withdrawals exceeded SDS budget for the reasons set out above.

V11. Receivables

Receivables were $6.40 mil lower than budget due to accrued revenue of $6.50 mil reclassed to Other assets while the budget remained in Receivables (refer also note V10).

V12. Inventories

Variance is largely due to stock consumption outpacing supply chain replenishments impacted by COVID and natural disasters.

V13. Other assets

Other assets were $9.57 mil over budget primarily due to accrued revenue being reclassed from Receivables to Other assets as per note V8 above.

V14. Payables

Payables were $4.06 mil over budget due to different times between receipt and payment of invoices related to new projects and reviews.

V15. Other liabilities

Other liabilities were $1.94 mil over budget primarily due to lower-than-expected delivery of funded programs due to various factors including COVID related delays, resulting in higher than budgeted returns and/or deferrals of Departmental funds.

BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOWS

E4-1 BUDGET TO ACTUAL COMPARISON - STATEMENT OF CASH FLOWS

	Variance Notes	Actual 2022 $'000	Original SDS Budget 2022 $'000	SDS Budget V Actual Variance $'000
Cash flows from operating activities				
Inflows				
User charges and fees	V1.	37,135	33,274	3,861
Funding public health services	V2.	474,801	433,928	40,873
Grants and other contributions	V3.	13,586	10,843	2,743
GST input tax credits from ATO		2,728	8,398	(5,670)
GST collected from customers		259	622	(363)
Other receipts		5,425	5,270	155
		533,934	**492,335**	**41,599**
Outflows				
Employee expenses	V4.	(58,189)	(53,444)	(4,745)
Health service employee expenses	V5.	(313,429)	(300,496)	(12,933)
Supplies and services	V6.	(144,111)	(122,238)	(21,873)
GST paid to suppliers		(2,719)	(9,367)	6,648
GST remitted to ATO		(193)	(580)	387
Other payments	V8.	(11,980)	(6,458)	(5,522)
		(530,621)	**(492,583)**	**(38,038)**
Net cash from/(used by) operating activities		**3,313**	**(248)**	**3,561**
Cash flows from investing activities				
Inflows				
Sales of property, plant and equipment		608	309	299
Outflows				
Payments for property, plant and equipment	V16.	(15,746)	-	(15,746)
Net cash from/(used by) investing activities		**(15,138)**	**309**	**(15,447)**
Cash flows from financing activities				
Inflows				
Equity injections	V17.	17,352	-	17,352
Outflows				
Payment of lease liabilities		(568)	-	(568)
Equity Withdrawal - Other	V10.	(10,000)		(10,000)
Net cash from/(used by) financing activities		**6,784**	**-**	**6,784**
Net increase/(decrease) in cash and cash equivalents		**(5,041)**	**61**	**(5,102)**
Cash and cash equivalents at the beginning of the financial year		25,235	34,581	(9,346)
Cash and cash equivalents at the end of the financial year		**20,194**	**34,642**	**(14,448)**

E4-1 EXPLANATION OF MAJOR VARIANCES - STATEMENT OF CASH FLOWS

V16. Cash flows - Payments for property, plant, and equipment

Payments for property, plant, and equipment in 2022 were higher by $15.75 mil than budgeted primarily due to increased spend on clinical and capital projects partially due to COVID response and increases in capacity to meet growing service delivery requirements.

V17. Cash flows – Equity injections

Cash flows from equity injections relates to capital project costs paid for by the HHS and reimbursed by the Department which were not included in the original budget (included in the Department of Health's consolidated budget) consisting of $1.46 mil capital maintenance and asset renewal, $7.50 mil Health Technology Equipment Replacement, $2.38 mil COVID and $5.43 mil for capital projects.

SECTION F

WHAT WE LOOK AFTER ON BEHALF OF THIRD PARTIES

F1 TRUST TRANSACTIONS AND BALANCES

The Hospital and Health Service acts in a fiduciary trust capacity in relation to patient trust accounts. Consequently, these transactions are not recognised in the financial statements. Trust activities are included in the audit performed annually by the Auditor-General of Queensland. The cumulative value of transactions and balances in patient fiduciary trust accounts were equal to or less than $1,000 in 2022 and 2021.

F2 GRANTED PRIVATE PRACTICE

Granted Private Practice permits Senior Medical Officers (SMOs) employed in the public health system to treat individuals who elect to be treated as private patients. SMOs receive a private practice allowance and assign practice revenue generated to the Hospital (Assignment arrangement). Alternatively, SMOs pay a facility charge and administration fee to the Hospital and retain an agreed proportion of the private practice revenue (Retention arrangement) with the balance of revenue deposited into a trust account to fund research and education of medical staff. In addition, all SMOs engaged in private practice receive an incentive on top of their regular remuneration. The private practice fund activities are included in the annual audit performed by the Auditor-General of Queensland. Receipts and payments relating to both the granted private practice arrangements and right of private practice system during the financial year are as follows:

	2022 $'000	2021 $'000
Receipts		
Billings - (Doctors and Visiting Medical Officers)	8,286	8,993
Interest	18	13
Total receipts	**8,304**	**9,006**
Payments		
Payments	6,852	9,064
Hospital and Health Service recoverable administrative costs	1,472	1,576
Hospital and Health Service - Education/travel/research fund	35	130
Total payments	**8,359**	**10,770**
Closing balance of bank account under a trust fund arrangement not yet disbursed and not restricted cash	**736**	**793**

SECTION G

OTHER INFORMATION

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES

Details of Key Management Personnel

In accordance with *AASB 124 Related Party Disclosures,* MHHS's responsible Minister (Minister of Health and Minister for Ambulance Services) and persons in positions with authority and responsibility for planning, directing, and controlling the activities of MHHS during the year are identified as MHHS's Key Management Personnel (KMP). This includes Board members of MHHS. Details on non-ministerial KMP positions, responsibilities and KMP remuneration policies are detailed below. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management and the Board.

Position	Responsibilities
Health Service Chief Executive	Responsible for the overall leadership and management of the Mackay Hospital and Health Service to ensure that MHHS meets its strategic and operational objectives. This position is the single point of accountability for ensuring patient safety through the effective executive leadership and management of all hospital and health services. This position is accountable to the Hospital and Health Board for ensuring that the HHS achieves a balance between efficient service delivery and high-quality health outcomes
Executive Director, Operations Mackay	Responsible to the Chief Executive for the strategic and operational management of the service divisions within Mackay
Executive Officer, Corporate Services	Responsible to the Chief Executive to ensure the financial and fiscal responsibilities of the HHS are met. Provides governance arrangements to meet financial performance targets and imperatives. Provides strategic and financial advice in all aspects of finance management and activity performance.
Executive Director, Mental Health, Public Health & Rural Services	Responsible to the Chief Executive for delivering effective and efficient services of all clinical and non-clinical services and resources within the portfolio of Mental Health, Public Health and Rural Services within the Mackay Hospital and Health Service.
Executive Director, People	Responsible to the Chief Executive for the management of people and cultural issues within the MHHS. Provides strategic development and strategies to achieve maximum employee engagement, safety, and productivity and to ensure the HHS's capacity to attract and retain the skilled resources required.
Executive Director, Medical Services & CMO	Responsible to the Chief Executive for clinical governance and leadership and direction of clinical services across the HHS. Provides executive leadership, strategic focus, authoritative counsel, and expert advice on a wide range of professional and policy issues that meet safe clinical practice standards.
Executive Director, Research & Innovation & Clinical Dean	Responsible to the Chief Executive for the delivery of a sustainable medical workforce for Mackay Hospital and Health Service by developing the organisation as a preferred training location and employer of choice. There are two parts to the role: The Clinical Dean role is to support the development of MHHS (together with Townsville and Cairns HHSs) as a provider of postgraduate medical specialty training and research and the Northern Clinical Training Network (NCTN) with James Cook University as the hub. The position holder is the specialist advisor to the Executive Director, Medical Services, Chief Executive and Board on medical workforce matters, particularly in relation to the innovation and research elements of clinical practices at Mackay Hospital and Health Service.
Executive Director, COVID (temporary)	Responsible to the Chief Executive to ensure Mackay Hospital and Health Service is prepared for the response required for COVID in the community, including COVID-19 testing, vaccination and planning for outbreaks and positive COVID patients in the community. The role works closely with the Emergency Management Team and acts as Health Incident Controller for the COVID Response for the Mackay Hospital and Health Service.
Executive Director, Nursing & Midwifery	Responsible to the Chief Executive for strategic and professional leadership of nursing workforce across MHHS.
Executive Director, Strategy, Governance and Engagement	Responsible to the Chief Executive for leadership and development of frameworks and systems for integrated planning, strategy management, governance, risk, audit and performance monitoring within the Mackay Hospital and Health Service.
Executive Director, Aboriginal & Torres Strait Islander Health	Responsible to the Chief Executive for leadership and direction of Aboriginal and Torres Strait Islander hospital and health services across the HHS. Provides executive leadership, strategic focus, authoritative counsel, and expert advice on a wide range of professional and policy issues in all aspects of ATSI health related matters.

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration Policies

Ministerial remuneration entitlements are outlined in the Legislative Assembly of Queensland's Members' Remuneration Handbook. MHHS does not bear any cost of remuneration of Ministers. Most Ministerial entitlements are paid by the Legislative Assembly, with the remaining entitlements being provided by Ministerial Services Branch within the Department of the Premier and Cabinet. As all Ministers are reported as KMP of the Queensland Government, aggregate remuneration expenses for all Ministers are disclosed in the Queensland General Government and Whole of Government Consolidated Financial Statements, which are published as part of Queensland Treasury's Report on State Finances.

Section 74 of the *Hospital and Health Board Act 2011* provides the contract of employment for health executive staff must state the term of employment, the person's functions, and any performance criteria as well as the person's classification level and remuneration package. Section 74 of the Act also provides the Chief Executive authority to fix the remuneration packages for health executives, classification levels and terms and conditions having regard to remuneration packages for public sector employees in Queensland or other States and remuneration arrangements for employees employed privately in Queensland.

Remuneration policy for the Service's key executive management personnel is set by direct engagement common law employment contracts. The remuneration and other terms of employment for the key executive management personnel are also addressed by these common law employment contracts. The contracts provide for other benefits including motor vehicles and expense payments such as rental or loan repayments.

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

Short-term employee expenses which include:

- salary, allowances and leave entitlements earned and expensed for the entire year or for that part of the year during which the employee was a key management person.
- non-monetary benefits – consisting of provision of vehicle and expense payments together with fringe benefits tax applicable to the benefit.

Long term employee expenses include amounts expensed in respect of long service leave entitlements earned.

Post-employment expenses include amounts expensed in respect of employer superannuation obligations.

Termination benefits include payments in lieu of notice on termination and other lump sum separation entitlements (excluding annual and long service leave entitlements) payable of termination of employment or acceptance of an offer of termination of employment.

Performance bonuses are not paid under the contracts in place.

Board remuneration

The Mackay Hospital and Health Service is independently and locally controlled by the Hospital and Health Board (Board). The Board appoints the health service chief executive and exercises significant responsibilities at a local level, including controlling (a) the financial management of the Service and the management of the Service's land and buildings (section 7 *Hospital and Health Board Act 2011*).

In accordance with the *Hospital and Health Boards Act 2011*, the Governor in Council appoints Board members, on the recommendation of the Minister, for a period not exceeding 4 years. Board members are paid an annual salary based on their position as well as fees for membership on sub-committees. Remuneration is calculated in accordance with the guidance statement issued by the Department of The Premier and Cabinet, titled *"Remuneration procedures for part-time chairs and member of Queensland Government bodies*". Under the procedure, Hospital and Health Services are assessed as 'Governance' entities and grouped into different levels of a remuneration matrix based on a range of indicators including revenue/budget, net and total assets, independence, risk, and complexity.

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

KMP Remuneration Expense

The following disclosures focus on the expenses incurred by MHHS attributable to non-Ministerial KMP during the respective reporting periods. Therefore, the amounts disclosed reflect expenses recognised in the Statement of Comprehensive Income.

2022

Position (date resigned if applicable)	*Name*	*Short Term Employee Expenses*		*Long term Employee Expenses*	*Post-Employment Expenses*	*Total Expenses*
		Monetary Expenses	*Non-monetary Benefits*			
		$'000	*$'000*	*$'000*	*$'000*	*$'000*
Health Service Chief Executive	Ms Lisa Davies Jones	320	-	7	29	356
Executive Director, Corporate Services (acting) to 27 May 2022	Mr Ben Wearmouth	154	-	3	14	171
Executive Director, Corporate Services (appointed 28 March 2022)	Ms Tanya Feekings	50	-	1	4	55
Executive Director, Operations (acting) to 26 September 2021	Mr Ivan Franettovich	42	-	1	3	46
Executive Director, Operations (acting) from 26 September 2021*	Ms Belinda Berg	170	-	4	16	190
Executive Director, Mental Health, Public Health & Rural Services (acting) 14 June to 1 August 2021, 10 January to 6 March 2022 and 11 April to 25 April 2022	Ms Julie Minogue	64	-	1	5	70
Executive Director, Mental Health, Public Health & Rural Services	Ms Terry Johnson	187	-	4	17	208
Executive Director, People to 1 March 2022	Mr Terence Seymour	126	22	3	11	162
Executive Director, People (acting) from 28 February 2022	Mr Darryl Turner	89	-	2	8	99
Executive Director, Medical Services & Chief Medical Officer (resigned 6th May 2022)	Professor Philip Reasbeck	944	-	12	31	987
Executive Director, Research & Innovation and Chief Medical Officer (acting) from 10 December 2021	Associate Professor David Farlow	531	2	12	43	588
Executive Director, Nursing & Midwifery to 1 November 2021	Ms Julie Rampton	177	-	4	18	199
Executive Director, Nursing & Midwifery (acting) from 1 November 2021	Ms Karen Wade	224	-	5	17	246
Executive Director, Strategy, Governance and Engagement	Ms Janet Geisler	178	-	4	21	203
Executive Director, Aboriginal & Torres Strait Islander Health	Mr Simon Costello	163	-	4	18	185
Executive Director, COVID (temporary) from 1 November 2021 to 19 June 2022	Ms Julie Rampton	76	-	2	9	87

* Ms Sharon Walsh was appointed Chief Operations Officer on 27 June 2022.

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

KMP Remuneration Expense (continued)

2021

Position (date resigned if applicable)	*Name*	*Short Term Employee Expenses*		*Long term Employee Expenses*	*Post-Employment Expenses*	*Total Expenses*
		Monetary Expenses	*Non-monetary Benefits*			
		$'000	*$'000*	*$'000*	*$'000*	*$'000*
Health Service Chief Executive (resigned 30 November 2020)	Ms Jo Whitehead	123	10	3	11	147
Health Service Chief Executive (appointed 20 November 2020)	Ms Lisa Davies Jones	213	-	5	19	237
Executive Director, Corporate Services (resigned 15 October 2020)	Mr Marc Warner	52	-	1	5	58
Executive Director, Corporate Services (acting) from 28 September 2020	Mr Ben Wearmouth	146	-	3	13	162
Executive Director Operations (acting)	Mr Ivan Franettovich	190	0	4	18	212
Executive Director, Mental Health, Public Health & Rural Services	Ms Terry Johnson	192	0	4	19	215
Executive Director, People (resigned 12 October 2020)	Mr Rod Francesco	26	-	0	2	28
Executive Director, People (appointed 7 December 2020)	Mr Terence Seymour	103	-	2	11	116
Executive Director, Medical Services & Chief Medical Officer	Professor Philip Reasbeck	481	-	11	37	529
Executive Director, Research & Innovation	Associate Professor David Farlow	512	3	11	40	566
Executive Director, Nursing & Midwifery	Ms Julie Rampton	256	-	5	25	286
Executive Director, Strategy, Governance and Engagement	Ms Janet Geisler	166	-	4	19	189

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration paid or owing to board members during 2021-22 was as follows:

Board Member	*Name*	*Short Term Employee Expenses*		*Post-Employment Expenses*	*Total Expenses*
		Monetary Expenses	*Non-monetary Benefits*		
		$'000	*$'000*	*$'000*	*$'000*
Chairperson	Mr Darryl Camilleri	85	-	8	93
Board Member	Mr David Aprile	47	-	5	52
Board Member	Professor Richard Murray	47	-	5	52
Board Member	Ms Helen Caruso	46	-	5	51
Board Member	Ms Suzanne Brown	47	-	5	52
Board Member	Ms Adrienne Barnett	46	-	5	51
Board Member	Dr Elissa Hatherly	46	-	5	51
Board Member	Ms Annabel Dolphin	43	-	4	47
Board Member	Mr Tom McMillan	43	-	4	47

Remuneration paid or owing to board members during 2020-21 was as follows:

Board Member	*Name*	*Short Term Employee Expenses*		*Post-Employment Expenses*	*Total Expenses*
		Monetary Expenses	*Non-monetary Benefits*		
		$'000	*$'000*	*$'000*	*$'000*
Chairperson (passed away 7 September 2020)	Hon Timothy Mulherin	17	-	2	19
Chairperson (appointed 18 May 2021)	Mr Darryl Camilleri	78	-	7	85
Board Member	Mr David Aprile	47	-	4	51
Board Member	Professor Richard Murray	47	-	4	51
Board Member	Ms Helen Caruso	46	-	4	50
Board Member (re-appointed 10 June 2021)	Ms Suzanne Brown	44	-	4	48
Board Member (resigned 17 May 2021)	Dr Leeanne Heaton	39	-	4	43
Board Member	Ms Adrienne Barnett	43	-	4	47
Board Member	Dr Elissa Hatherly	48	-	5	53
Board Member (appointed 18 May 2021)	Ms Annabel Dolphin	5	-	0	5
Board Member (appointed 10 June 2021)	Mr Tom McMillan	2	-	0	2

G2 RELATED PARTY TRANSACTIONS

Transactions with other Queensland Government-controlled entities

Mackay Hospital and Health Service is controlled by its ultimate parent entity, the State of Queensland. All State of Queensland controlled entities meet the definition of a related party in AASB 124 *Related Party Disclosures*.

The following table summarises significant transactions with Queensland Government controlled entities.

Entity – Department of Health	**2022 $'000**	**2021 $'000**
Revenue	511,811	471,317
Expenditure	362,769	336,115
Asset	7,317	5,732
Liability	28,095	21,017

Department of Health

MHHS's primary source of funding is provided by the Department of Health, with payments made in accordance with a service agreement. The signed service agreements are published on the Queensland Government website and are publicly available. Revenue under the service arrangement was $506.1 mil for the year ended 30 June 2022 (2021: $463.5 mil). For further details on the purchase of health services by the Department of Health refer to Note B1-2.

MHHS, through service arrangements with the Department of Health, has engaged 2,568 (2021: 2,467) full time equivalent persons. In accordance with the Hospital and Health Boards Act 2011, the employees of the Department of Health are referred to as health service employees. In 2022, $312.5 mil (2021: $292.7 mil) was paid to the Department for Health service employees. The terms of this arrangement are fully explained in Note B2-2.

The Department of Health centrally manages, on behalf of Hospital and Health Services, a range of services including pathology testing, pharmaceutical drugs, clinical supplies, patient transport, telecommunications, and technology services. These services are provided on a cost recovery basis. In 2022, these services totalled $45.9 mil (2021: $39.3 mil). In addition, MHHS receives corporate services support from the Department at no cost refer to Note B1-3. Corporate services received include payroll services, financial transactions services (including accounts payable and banking services), administrative services and information technology services. In 2022, the fair value of these services was $4.4 mil (2021: $4.2 mil).

Any associated receivables or payables owing to the Department of Health at 30 June 2022 are separately disclosed in Note C2 and Note C6. No impairment has been applied to these balances.

The Department of Health also provides funding from the State as equity contributions to purchase property, plant, and equipment. All construction of major health infrastructure is managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department of Health to MHHS. Where costs are borne by MHHS on departmental funded projects, the Department of Health reimburses MHHS for those costs. In 2022, $1.1 mil (2021: $3.2 mil) in recoveries was recognised.

Throughout the year, funding recognised to cover the cost of depreciation is offset by a withdrawal of equity by the State for the same amount. For further details on equity transactions with the Department of Health refer to Note C10-1.

There are no other material transactions with other Queensland Government controlled entities.

Transactions with people/entities related to Key Management Personnel

All transactions in the year ended 30 June 2022 between Mackay Hospital and Health Service and key management personnel, including their related parties were on normal commercial terms and conditions and were immaterial in nature and dollar.

G3 FIRST YEAR APPLICATION OF NEW ACCOUNTING STANDARDS OR CHANGES IN POLICY

Accounting standards applied for the first time

No accounting standards or interpretations that apply to MHHS for the first time in 2021-22 have any material impact on the financial statements.

Accounting standards early adopted

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

G4 TAXATION

MHHS is a State body as defined under the Income *Tax Assessment Act 1936* and is exempt from federal government taxation except for Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). The Australian Taxation Office has recognised the Department of Health and the sixteen Hospital and Health Services as a single taxation entity for reporting purposes.

All FBT and GST reporting to the federal government is managed centrally by the Department of Health, with payments/ receipts made on behalf of the MHHS reimbursed monthly. GST credits receivable from, and GST payable to the ATO, are recognised on this basis. Refer to Note C2.

G5 CLIMATE RISK DISCLOSURE

Climate Risk Assessment

MHHS addresses the financial impacts of climate related risks by identifying and monitoring the accounting judgements and estimates that will potentially be affected, including asset useful lives, fair value of assets, provisions or contingent liabilities and changes to future expenses and revenue.

MHHS has not identified any material climate related risks relevant to the financial report at the reporting date, however, constantly monitors the emergence of such risks under the Queensland Climate Action Plan 2030, Queensland Government's Climate Transition Strategy and Queensland Adaption Strategy publications.

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

Mackay Hospital and Health Service

Management Certificate

For the year ended 30 June 2022

These general-purpose financial statements have been prepared pursuant to section 62(1) of the *Financial Accountability Act 2009* (the Act), section 39 of the *Financial and Performance Management Standard 2019* and other prescribed requirements. In accordance with section 62(1)(b) of the Act we certify that in our opinion:

a) the prescribed requirements for establishing and keeping the accounts have been complied with in all material respects; and

b) the financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Mackay Hospital and Health Service for the financial year ended 30 June 2022 and of the financial position of Mackay Hospital and Health Service at the end of that year, and

We acknowledge responsibility under sections 7 and 11 of the *Financial and Performance Management Standard 2019* for the establishment and maintenance, in all material respects, of an appropriate and effective system of internal controls and risk management processes with respect to financial reporting through-out the reporting period.

Darryl Camilleri
Chair, Mackay Hospital and Health Board
26 August 2022

Lisa Davies Jones
Chief Executive Officer
26 August 2022

Tanya Feekings
Chief Financial Officer
26 August 2022

Queensland Audit Office
Better public services

INDEPENDENT AUDITOR'S REPORT

To the Board of Mackay Hospital and Health Service

Report on the audit of the financial report

Opinion

I have audited the accompanying financial report of Mackay Hospital and Health Service.

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2022, and its financial performance and cash flows for the year then ended

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

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

Basis for opinion

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

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

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

Key audit matters

Key audit matters are those matters that, in my professional judgement, were of most significance in my audit of the financial report of the current period. I addressed these matters in the context of my audit of the financial report as a whole, and in forming my opinion thereon, and I do not provide a separate opinion on these matters.

Specialised buildings valuation ($330.4 million)

Refer to Note C-5 in the financial report.

Key audit matter	How my audit addressed the key audit matter
Buildings were material to Mackay Hospital and Health Service at balance date and were measured at fair value using the current replacement cost method. In 2022 Mackay Hospital and Health Service performed a comprehensive revaluation of 13 material buildings / site improvements with the remainder subject to indexation. The current replacement cost method comprises: • gross replacement cost, less • accumulated depreciation. Mackay Hospital and Health Service derived the gross replacement cost of its buildings at the balance date using unit prices that required significant judgements for: • identifying the components of buildings with separately identifiable replacement costs • developing a unit rate for each of these components, including: o estimating the current cost for a modern substitute (including locality factors and oncosts o identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference. The measurement of accumulated depreciation involved significant judgements for forecasting the remaining useful lives of building components. The significant judgements required for gross replacement cost and useful lives are also significant judgements for calculating annual depreciation expense. Using indexation required: • significant judgement in determining changes in cost and design factors for each asset type since the previous revaluation • reviewing previous assumptions and judgements used in the last comprehensive valuation to ensure ongoing validity of assumptions and judgements used.	My procedures included, but were not limited to: • assessing the adequacy of management's review of the valuation process and results • reviewing the scope and instructions provided to the valuer • assessing the appropriateness of the valuation methodology and the underlying assumptions with reference to common industry practices • assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices • assessing the competence, capabilities and objectivity of the experts used to develop the models • for unit rates, on a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the: o modern substitute (including locality factors and oncosts) o adjustment for excess quality or obsolescence • evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices • evaluating useful life estimates for reasonableness by: o reviewing management's annual assessment of useful lives o at an aggregated level, reviewing asset management plans for consistency between renewal budgets and the gross replacement cost of assets o testing that no building asset still in use has reached or exceeded its useful life o enquiring of management about their plans for assets that are nearing the end of their useful life o reviewing assets with an inconsistent relationship between condition and remaining useful life • Where changes in useful lives were identified, evaluating whether the effective dates of the changes applied for depreciation expense were supported by appropriate evidence.

Responsibilities of the entity for the financial report

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

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

Auditor's responsibilities for the audit of the financial report

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

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

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

- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

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

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

Statement

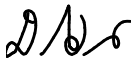
In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2022:

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

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

Prescribed requirements scope

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



29 August 2022

David Adams
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

Glossary

Terms

Activity based funding A management tool with the potential to enhance public accountability and drive technical efficiency in the delivery of health services by:
- capturing consistent and detailed information on hospital sector activity and accurately measuring the costs of delivery
- creating an explicit relationship between funds allocated and services provided
- strengthening management's focus on outputs, outcomes and quality
- encouraging clinicians and managers to identify variations in costs and practices so they can be managed at a local level in the context of improving efficiency and effectiveness
- providing mechanisms to reward good practice and support quality initiatives.

Acute care Care in which the clinical intent or treatment goal is to:
- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of an illness or injury
- protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function.

Chronic A long-term or persistent condition.

Full-Time Equivalent Refers to full-time equivalent staff currently working in a position.

Health outcome Change in the health of an individual, group of people or population attributable to an intervention or series of interventions.

Hospital Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.

Hospital and Health Boards The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to managing a complex health care organisation.

Hospital and Health Service HHS is a separate legal entity established by Queensland Government to deliver public hospital services.

Non-admitted patient services An examination, consultation, treatment or other service provided to a non-admitted patient (does not undergo a hospital's formal admission process) in a functional unit of a health service facility.

Outpatient Non-admitted health service provided or accessed by an individual at a hospital or health service facility.

Patient flow Optimal patient flow means the patient's journey through the hospital system, be it planned or unplanned, happens in the safest, most streamlined and timely way to deliver good patient care.

Performance indicator A measure that provides an 'indication' of progress towards achieving the organisation's objectives usually has targets that define the level of performance expected against the performance indicator.

Private hospital A private hospital or free standing day hospital and either a hospital owned by a for-profit company or a non-profit organisation and privately funded through payment for medical services by patients or insurers patients admitted to private hospitals are treated by a doctor of their choice.

Public hospital Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.

Registered nurse An individual registered under national law to practice in the nursing profession as a nurse, other than as a student.

Statutory bodies A non-department government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.

Sustainable A health system that provides infrastructure, such as workforce, facilities and equipment and is innovative and responsive to emerging needs, for example, research and monitoring within available resources.

Sub-Acute Somewhat acute; between acute and chronic.

Telehealth Delivery of health-related services and information via telecommunication technologies, including:
- Live, audio and/or video interactive links for clinical consultations and educational purposes
- Store and forward Telehealth, including digital images, video, audio and clinical (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists
- Teleradiology for remote reporting and clinical advice for diagnostic images
- Telehealth services and equipment to monitor people's health in their home.

Acronyms

FTE Full-Time Equivalent
HHS Hospital and Health Service
HHBA *Hospital and Health Boards Act 2011*
iEMR integrated electronic Medical Record
JCU James Cook University
MHHB Mackay Hospital and Health Board
NQPHN Northern Queensland Primary Health Network
QAO Queensland Audit Office
QGEA Queensland Government Enterprise Architecture
WAU Weighted Activity Unit

Compliance Checklist

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister/s	ARRs – section 7	3
Accessibility	Table of contents Glossary	ARRs – section 9.1	4 72
	Public availability	ARRs – section 9.2	1
	Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 9.3	1
	Copyright notice	*Copyright Act 1968* ARRs – section 9.4	1
	Information Licensing	*QGEA – Information Licensing* ARRs – section 9.5	1
General information	Introductory Information	ARRs – section 10	6-7
Non-financial performance	Government's objectives for the community and whole-of-government plans/specific initiatives	ARRs – section 11.1	5
	Agency objectives and performance indicators	ARRs – section 11.2	8-10, 18-19
	Agency service areas and service standards	ARRs – section 11.3	20-21
Financial performance	Summary of financial performance	ARRs – section 12.1	22
Governance – management and structure	Organisational structure	ARRs – section 13.1	14
	Executive management	ARRs – section 13.2	13
	Government bodies (statutory bodies and other entities)	ARRs – section 13.3	11
	Public Sector Ethics	*Public Sector Ethics Act 1994* ARRs – section 13.4	17
	Human Rights	*Human Rights Act 2019* ARRs – section 13.5	17
	Queensland public service values	ARRs – section 13.6	17
Governance – risk management and accountability	Risk management	ARRs – section 14.1	16
	Audit committee	ARRs – section 14.2	11
	Internal audit	ARRs – section 14.3	16
	External scrutiny	ARRs – section 14.4	16
	Information systems and recordkeeping	ARRs – section 14.5	16
	Information Security attestation	ARRs – section 14.6	17
Governance – human resources	Strategic workforce planning and performance	ARRs – section 15.1	15
	Early retirement, redundancy and retrenchment	Directive No.04/18 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	15
Open Data	Statement advising publication of information	ARRs – section 16	1
	Consultancies	ARRs – section 31.1	https://data.qld.gov.au
	Overseas travel	ARRs – section 31.2	https://data.qld.gov.au
	Queensland Language Services Policy	ARRs – section 31.3	https://data.qld.gov.au
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	67
	Independent Auditor's Report	FAA – section 62 FPMS – section 46 ARRs – section 17.2	68-71

FAA: *Financial Accountability Act 2009*
FPMS: *Financial and Performance Management Standard 2019*
ARRs: *Annual report requirements for Queensland Government agencies*

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Mackay Hospital and Health Service
www.mackay.health.qld.gov.au