ANNUAL REPORT
2015–2016

Mackay Hospital and Health Service

Queensland Government

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Mackay Hospital and Health Service Annual Report 2015–2016

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Letter of compliance

9 September 2016

The Honourable Cameron Dick MP
Minister for Health and Minister for Ambulance Services
Member for Woodridge
Level 19, 147–163 Charlotte Street
Brisbane Qld 4000

Dear Minister,

I am pleased to present the Annual Report 2015–2016 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 2009*, and
- the detailed requirements set out in the *Annual report requirements for Queensland Government agencies*.

A checklist outlining the annual reporting requirements can be found on pages 34–35 of this annual report.

Yours sincerely

The Honourable Timothy Mulherin
Board Chair
Mackay Hospital and Health Board


RACQ CQ RESCUE

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Board Chair and Chief Executive message

Our valued staff met the challenge of providing excellent care in the face of increased demand. We have an extremely capable workforce which delivered some outstanding results for the community. Mackay Base Hospital's capacity expanded to include opening a two-bed High Dependency Unit within the Intensive Care Unit supported by three new consultant Intensivists. This supports patients who require more specialised care and monitoring than can be provided on the wards.

Delivering outstanding healthcare to our communities has been the focus of our activities throughout the Mackay Hospital and Health Service (Mackay HHS) in 2015–16. There are many highlights from the year, all of which position Mackay HHS as one of the best performing regional hospitals in Queensland. A record level of activity was undertaken in the health service with an increase of 7.1% above the target for 2015–2016.

We have invested time in creating strategies and plans to take us into the future. Ground work was also laid for a workforce strategy which will be completed in 2016. A strong focus on recruitment and retention will be the cornerstone of this, underpinned by our culture and values. The values moving forward are Collaboration, Trust, Respect and Teamwork. Staff contributed to the creation of these values which were launched at a staff celebration event where we also acknowledged length of service award recipients and service excellence awards for individuals and teamwork which reflected the values.

Our connections with health service and academic partners were strengthened to reinforce that we are one health service. Collaboration with the North Queensland Primary Health Network (NQPHN), James Cook University (JCU), Central Queensland University (CQU) and Tropical Australian Academic Health Centre (TAAHC) is helping provide integrated care to the region. The development of Health Pathways has also grown exponentially during the year to link GPs and primary health care with the health service. Connections with the community were formalised with the creation of the Consumer Advisory Partners (CAP) group and the Community of Interest. These community members help shape the service, treatment and care we provide. We also continued to enjoy support from the Mackay Hospital Foundation and its many volunteers.

Mackay HHS invested its retained earnings in several areas, including reducing wait times for outpatients and surgery. Surgical and outpatients waiting times continued to improve and performed strongly during the year, with a record low number of only 193 people waiting longer than the recommended times for an outpatient appointment at 30 June 2016. For the past 12 months nearly every patient at Mackay Base Hospital had their elective surgery on time. In addition we met patient safety performance indicators set by the Department of Health.

Investments were also made to prepare for the Digital Hospital upgrade in July 2016 and to improve child health community services. Retained earnings were used to finance the refurbishment of the new Carlyle Community Health Centre which houses community Child Youth and Family Health Services in one purpose-built area.

Mackay HHS is building its future with investments in infrastructure and our people. Record numbers of graduate nurses and intern doctors started their career with us and we are working hard to encourage them to continue to develop their careers with us. It has been a significant year for capital works at rural facilities with more than $16 million allocated for upgrades to Bowen, Sarina, Proserpine, Clermont, Dysart and Moranbah hospitals. We have boosted education and training and acted on feedback from the Working for Queensland Survey. Staff engagement has improved with an increase in survey responses and satisfaction with working in the health service.

Overall this has been an outstanding year of which our staff, partners, communities and the health service leadership should be very proud.

A note from the Board Chair

During the year, the Mackay HHS benefited from the leadership of former Board Chair Colin Meng, and Board Members Tom McMillan and Laura Veal. Chief Executive Clare Douglas has capably lead the health service and is currently on secondment at the Cairns and Hinterland HHS as their Interim Chief Executive. I thank them for their considerable service to the Mackay HHS. We are also pleased to welcome Helen Chalmers as Acting Chief Executive.

On behalf of the Mackay Hospital and Health Board (MHHB), I wish to express my gratitude to all staff for their pride and commitment in their work – day in, day out – that supports Mackay HHS in being one of the strongest performing health services in Queensland. The Mackay HHS recognises the wonderful work of the Mackay Hospital Foundation and its volunteers who do so much to improve the comfort of our patients. From fundraising to purchasing medical equipment to a friendly welcome when you walk in the door to reading stories to our smallest patients; their impact is felt and appreciated every day.

In the two month period I have been Board Chair, I have been impressed with the thoroughness, diligence, experience and commitment of the Mackay Hospital and Health Board members and their passion for developing safe and sustainable services across the region and supporting our outstanding workforce. The Mackay HHS benefits from their governance and advocacy at a local level daily.

The Honourable Timothy Mulherin
Board Chair
Mackay Hospital and Health Board

Helen Chalmers
Acting Chief Executive
Mackay Hospital and Health Service

2015 Snapshot and Highlights 2016

9,219
*Operations performed**

209,963
Outpatient appointments provided

78,812
People presented to emergency departments

4,844
Telehealth consultations

1,718
Babies born

41,511
Dental treatments

1,296
Number of staff recognised for 5 to 50 years' service

244
Number of school students who completed "Deadly Choices" 8-week school program

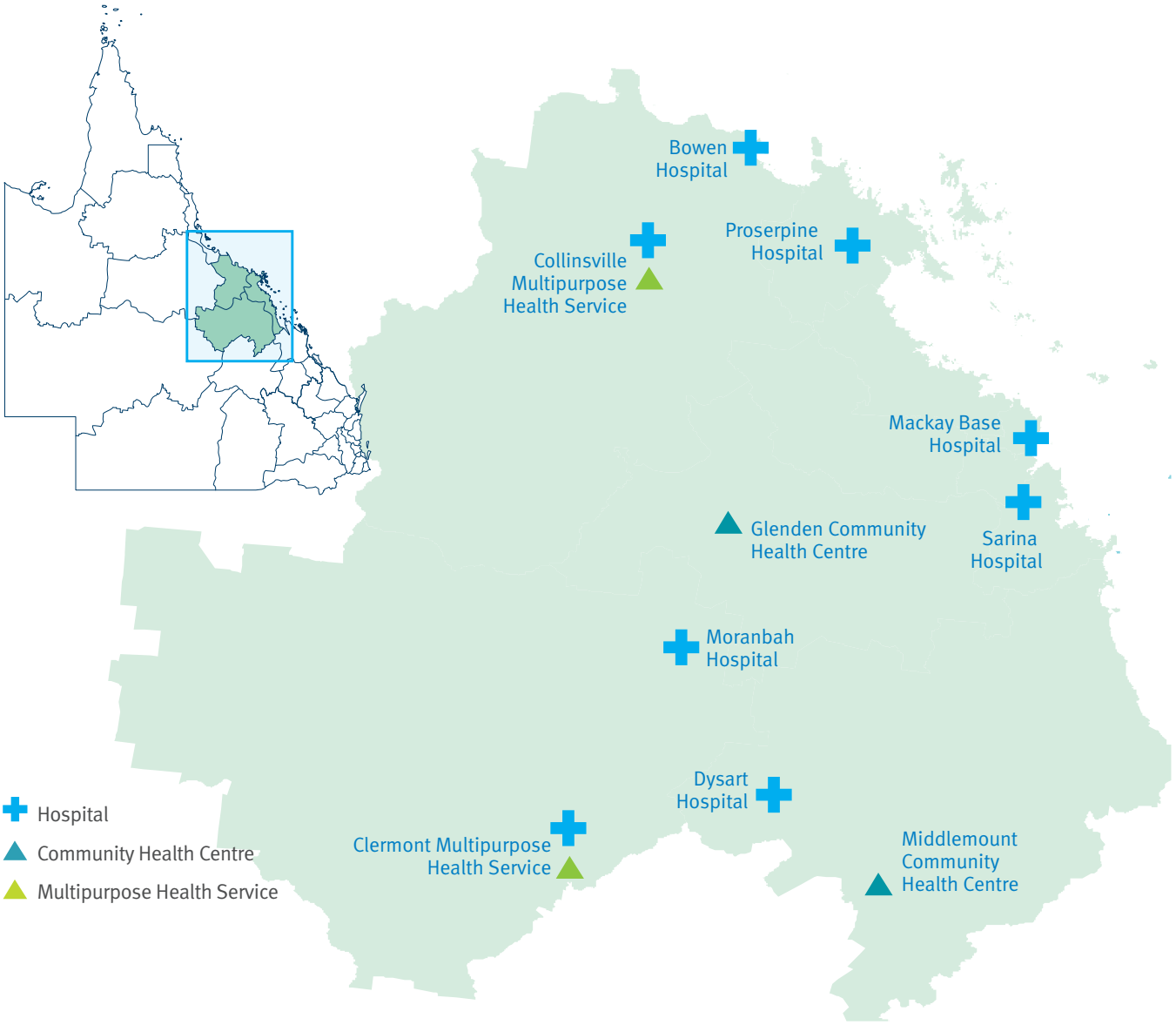
47,338
*Patients cared for on our wards***

9,228
Number of breast screens

* Total numbers for Mackay Base Hospital and Proserpine Hospital

** Excluding boarders

Our organisation



Our role and function

The Mackay HHS is an independent statutory body governed by the MHHB, established on 1 July 2012. Our responsibilities are set out in the legislation contained in the *Hospital and Health Boards Act 2011* (Qld) (HHBA) and the *Financial Accountability Act 2009* and subordinate legislation.
Our purpose is to deliver safe, efficient and sustainable hospital and health services. 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.

About the Mackay Hospital and Health Service

The Mackay HHS provides 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 around 182,049. Our population lives in a 90,362sq km area from Bowen in the north to St Lawrence in the south, west to Clermont and north-west to Collinsville. Proserpine and the Whitsundays are also included in this region.

The Aboriginal and Torres Strait Islander population in the Mackay region is 4.1% of the overall population (2011 census), higher than the 3.6% Queensland average. There is also a significant South Sea Islander community in the region.

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.

The health service has 334 approved beds and bed alternatives plus 31 aged care beds.

Facilities include:

- Mackay Base Hospital and Mackay Community Health
- Whitsunday Health Service comprising Proserpine Hospital and Primary Health Centre and Cannonvale Primary Health Centre
- Bowen Hospital and Primary Health Centre
- Sarina Health Service comprising Sarina Hospital and Primary Health Centre
- Dysart Health Service comprising Dysart Hospital, Primary Health Centre and Middlemount Primary Health Centre
- Moranbah Health Service comprising Moranbah Hospital, Primary Health Centre and Glenden Primary Health Centre
- Clermont Multi-Purpose Health Service (MPHS) comprising Montcler Nursing Home, Monash Lodge and the Clermont Hospital
- Collinsville Multipurpose Health Service.

Mackay HHS is able to treat most people locally. Those who require more specialist care or treatment are transferred to The Townsville Hospital or Brisbane hospitals.

Strategic risks, challenges and opportunities

There are many challenges facing the Mackay HHS as we deliver and plan future health services in a complex and dynamic environment. These include the changing population; burden of complex and chronic disease; workforce challenges; financial sustainability, especially in our rural communities; and community and service expectations regarding access to and performance of the health service. These challenges bring us many opportunities to implement alternative models of care; to form the right partnerships; improve our capacity and productivity; and progress our learning, research and innovation agenda.

More broadly, these challenges represent an important opportunity for our communities to have shared responsibility in shaping their future health and wellness outcomes. There is significant potential to achieve successes in the areas of health literacy and reducing our health risk factors, through empowering individuals and families. Our future outlook sees the health service continue to work across government; with the non-government sector; business and industry to make significant gains in improving the health of our community. This includes working with local governments and the Northern Queensland Primary Health Network at a foundational level to realise improvements in the health system as a whole.

Looking ahead, we expect to see a continued increase in demand for public health services, within a constrained fiscal environment. This means we will focus on responding to the community's health priorities, such as mental health and continue our commitment to Closing the Gap for Aboriginal and Torres Strait Islander people. We will remain resolute in improving our patient flow, including theatre efficiency; working to achieve shorter stays in emergency departments and ensuring our patients are treated within the clinically recommended time. To respond to the demand, recruiting and retaining a skilled workforce will continue to be a strong focus for the health service.

From a whole of health system perspective, we will deliver local responses to Department of Health and whole of Government priorities and initiatives. These include supporting the realisation of Queensland's health vision to 2026; responding to occupational violence; and supporting staff and community members who are affected by family and domestic violence.

Public Service Values

Mackay HHS is committed to upholding the Queensland Public Service Values. In alignment with these values our ambition is to be a high performing, impartial and productive workforce that puts our health consumers first.

Queensland's public sector has five organisational values to support this goal. The values are the building blocks for our workplace culture.

Customers first

- Know your customers
- Deliver what matters
- Make decisions with empathy

Ideas into action

- Challenge the norm and suggest solutions
- Encourage and embrace new ideas
- Work across boundaries

Unleash potential

- Expect greatness
- Lead and set clear expectations
- Seek, provide and act on feedback

Be courageous

- Own your actions, successes and mistakes
- Take calculated risks
- Act with transparency

Empower people

- Lead, empower and trust
- Play to everyone's strengths
- Develop yourself and those around you

The Mackay HHS Strategic Plan demonstrates the Queensland Public Service Values in action.

Our performance

The Queensland Government's Objectives for the Community

Our strategic direction

Mackay HHS is committed to providing services that are efficient, diverse and flexible to changing community and government needs. Our strategic plan reflects the Queensland Government's priorities regarding frontline services; jobs and communities. More specifically, we have focussed on the following key areas specific to the health context – strengthening our public health system; supporting disadvantaged people; ensuring safe, productive and fair workplaces and achieving better health-related education and training outcomes.

The MHHB sets the organisation's strategic agenda and monitors performance against its delivery. The Mackay HHS Strategic Plan 2014–18 (2015 update) set out five inter-related objectives each with their own strategies, to achieve the Mackay HHS vision. These strategic objectives were – Patient Safety and Quality; Planning and Performance; People and Process; Partnerships and Engagement; and Progressing Excellence. In 2015–16 a range of services, programs and initiatives were implemented to deliver on our strategic objectives, including those highlighted below:

Patient Safety and Quality

Our strategies:

- ensure that positive patient experience is at the core of everything we do
- meet national patient safety and quality standards
- empower patients and carers to be active in their own care
- provide effective health response to community emergencies
- drive local initiatives that respond to local needs and enhance services.

Clinical governance from ward to MHHB

Mackay HHS's commitment to patient safety was recognised when the Patient Safety First Initiative won the 2015 Queensland Health Awards for Excellence in the Integrity and Accountability category and was highly commended in the 2015 Premier's Award for Courage and Integrity. This work was focused on ensuring clear accountability for patient safety. It resulted in improved clinical engagement and morale and an increase in the number of clinical incidents reported as staff are encouraged to report and see a rapid response in incident investigations and actions. It also worked to improve medical recruitment by reducing staff fatigue and risk of burnout.

Reducing long wait patients in Specialist Outpatients Department

The number of people waiting longer than clinically recommended for Specialist Outpatients Department appointments at Mackay and Proserpine has decreased significantly. At the end of the financial year Proserpine had zero long waits and Mackay 193. This has improved patient satisfaction and outcomes as a result of being treated within clinically recommended time. This result reflects $3.6 million provided by Queensland Health (QH) as well as investment from Mackay HHS Retained Earnings to decrease the waiting lists especially in vascular, cardiology, rheumatology, haematology, neurology and neurosurgery.

Nurses at the heart of new endoscopy model

Nurse Led Endoscopy Clinics at Mackay Base Hospital and Proserpine Hospital are helping to manage increased demand for endoscopy procedures. Nurse led clinics are a model of care indicated where there are service gaps due to high demand and or workforce shortages. These clinics are expanding and are a pioneering use of the nursing workforce. They provide more continuity of care and improved access to care. Additional funds were allocated to improve waiting times for Specialist Outpatients Department assessment for endoscopy procedures and to ensure follow-up procedures were completed within recommended clinical timeframes.

BreastScreen celebrates milestone and achieves KPIs

BreastScreen Mackay achieved its target of 9000 screens in 2015–16, with 9228 screens performed. The service has a screening and assessment centre in Mackay and a mobile service that visits Tieri, Middlemount, Dysart, Clermont, Moranbah, Glenden, Walkerston, Mirani, Seaforth, Calen, Proserpine, Cannonvale, Sarina and other community locations. The Mackay service celebrated 20 years of life saving checks for women with a special anniversary morning tea attended by 40 guests in June 2016.

Dental

Mackay HHS's Oral Health continues to meet its KPIs with no patients waiting longer than the recommended time on any wait list. All schools in the Mackay HHS area had a visit in 2015–16, with Glenden and Middlemount schools now part of the annual visits. Patient surveys show a high level of satisfaction with the service. Mackay and Proserpine hospital and school dental clinics continue to play a valuable role in training university students. From July to December 2016 there were nine JCU students training and 10 from January to June 2016. In 2015–16 six dental assistants completed training. Electronic clinical records and digital x-rays were introduced into all adult clinics in November 2015.

Planning and Performance

Our strategies:

- develop services in accordance with the Mackay HHS Clinical Services Plan
- ensure that health infrastructure has the flexibility and capacity to meet future service requirements
- ensure purchasing decisions achieve value for money, are innovative and respond to community needs
- ensure investment decisions consider quality, efficiency and opportunity cost
- leverage system-wide procurement arrangements
- manage the lifecycle of assets.

High Dependency Unit opens

Higher acuity and deteriorating patients in Mackay Base Hospital are now being cared for in a two-bed High Dependency Unit within the Intensive Care Unit. These patients require more specialised care than can be provided on the ward but less than the Intensive Care Unit admission criteria. The new unit has improved the flow of patients from theatre recovery and reduced inter-hospital transfers due to increased bed availability. The new beds ensure sicker patients receive care in an appropriate location.

Whitsunday Allied Health Assistants

The introduction of an Allied Health assistant model has improved access to outpatient chronic disease services and programs. A dietician has been employed to provide an inpatient and outpatient service to the Whitsunday region, including Bowen and Collinsville. Implementation of an Eat Walk Engage program is aimed at preventing deconditioning of inpatients with a long hospital stays. This initiative was made possible through Rural and Revitalisation Funding 2015–16 and has increased services available to the community through:

- increased availability of the falls prevention program
- introduction of a dementia support group
- increased pharmacist input in the cardiac rehabilitation program
- decreased waiting times for physiotherapy, occupational therapy and speech therapy outpatient appointments.

Telehealth expansion

The expansion of Telehealth in Mackay HHS is providing increased access to specialist services. Additional telehealth clinics were established with the Princess Alexandra Hospital and Royal Brisbane and Women's Hospital for surgical weight management, renal transplant, rheumatology and thoracic surgery. Clinics to provide more support to rural renal and cardiac patients also started. Telehealth provides safe care for patients in their community and brings the specialist to the patient to avoid travel to Mackay, Townsville or Brisbane.

Infrastructure

Mackay Child, Youth and Family Health services relocated to new accommodation in Carlyle Street, Mackay in June 2016. This has provided the community with easier access to child health services with more clinic space and carparks available. The building was purchased with Department of Health funding of $2.6 million and the $2.2 million refurbishment funded by the MHHB using retained earnings. Clinics offered at Carlyle Community Health Centre include drop-in and appointment clinics, hearing and pre-prep health checks and immunisation.

Collinsville's health services are being brought together in a single health precinct with the co-location of Queensland Ambulance Service with the Collinsville MPHS. This will provide the community with a modern ambulance station that is located close to acute hospital services, general practice and aged care.

People and Process

Our strategies:

- embed a culture of safety in our workplace
- ensure our staff are appropriately skilled for the services they provide
- provide effective clinical and corporate governance systems
- invest in leadership, management, capability and foster emerging talent
- enhance quality through ongoing teaching and continuous learning
- support and inspire staff to maximise their personal wellbeing
- implement requirements of Government legislation for the nursing workforce.

Staff reward and recognition

Long serving staff and high performing teams and individuals were recognised at the Let's Celebrate staff event in 2016. Service Excellence Awards were presented to entries that reflected the new Mackay HHS values of Respect, Collaboration, Trust and Teamwork. The CE Values Champion award is presented to a team or individual who has excelled in celebrating all of the values in practice and is devoted to living our values every day. A total of 1,296 staff were recognised for continuous service to QH for periods ranging from five to 50 years.

Developing the capability of our workforce

Mackay HHS's first Education and Research Strategy has been developed and endorsed by the MHHB following an extensive consultation process. The four-year strategy provides direction for developing staff in order to achieve our strategic objectives.

A leadership program for middle managers and staff aspiring towards a management role has been implemented. The six-month Middle Managers Program equips managers with skills to effectively lead their teams and manage staff. The first cohort of the Middle Managers Program was launched in July 2015 with 77 managers completing the program as at 30 June 2016.

Skills Centre – simulation training

Clinicians have increased their use of simulation training as part of embedding a culture of education in the Mackay HHS. The use of simulation training has doubled in the past year and diversified to include more programs specific to work areas. Faculty from all areas has been trained with 24 clinicians now trained in Simulation, Debriefing and Developing Simulation Events. Simulation use has diversified to include job interviews and more educators are developing programs specific to their area.

Partnerships and Engagement

Our strategies:

- simplify access to primary care services for our community
- communicate relevant information to our community about our services
- ensure the consumer perspective is considered at all levels of planning and delivery
- engage with our community regarding their health needs
- optimise the use of local health partners in the delivery of services.

Increasing consumer and community engagement

Our partnerships with consumers and community reached a new level this year when our first CAP group was formed. The CAP has eight members which represent our diverse geographical catchment area. Members of the CAP are both consumers and community members and all have well-established networks with different areas of the Mackay region. Members offer various skill sets and networks with different community health networks and associations. The first CAP meeting was held in March 2016 and members now meet monthly.

Developing meaningful relationships with our consumers, their families and carers, the community and stakeholders is essential to meeting the healthcare needs of our communities. Mackay HHS is dedicated to involving consumers in the delivery, design and implementation of healthcare services for the Mackay region. This helps deliver outstanding healthcare services to our communities through our people and partners.

Closing the Gap

Mackay HHS continues to implement Close the Gap initiatives to improve health outcomes of Aboriginal and Torres Strait Islander people. The health service has made a concerted effort to increase Aboriginal and Torres Strait Islander patients accessing their outpatient appointments as well as decreasing the number of Aboriginal and Torres Strait Islander patients failing to attend outpatient appointments. Efforts are focused on reducing the number of potentially preventable hospitalisations and the number of patients who discharge themselves from hospital against medical advice.

The Deadly Choices Program was expanded to rural schools with 244 students successfully completing the eight-week program. Students from Mackay, Bowen, Proserpine, Moranbah, Dysart and Sarina have participated. Community Deadly Choices events in Mackay, Clermont, Sarina and Bowen were also attended by 800 registered participants. The Mackay HHS team also held a Breast screening day for Aboriginal and Torres Strait Islander women with 38 women screened.

HealthPathways program

HealthPathways is changing the way patients enter the hospital system and helps avoid unnecessary referrals to specialist doctors. The project is working with General Practitioners (GPs) and the NQPHN to write referral pathways for all treatment options and services. Mackay HealthPathways went live in June 2015, giving all GPs, health service and other primary care staff access to the website. In 2015–16 there were 225 pathways completed and 120 in draft form.

Mackay HealthPathways was introduced as a strategy to reduce long waits, reduce patient suffering delays in receiving care, improve health system integration and efficiency and to provide clear guidelines for referrals and prompt return to primary care. It involves hospital specialists, nursing, allied health and a GP Clinical editor who agree on best practice guidelines to be used by all health professionals private, public or primary care. The HealthPathway site is a “one stop site” for best practice advice, local directory, education, alerts, reference resources and patient information for all health services.

Partnerships and collaboration

The Mackay Hospital Foundation coordinates a volunteer program at Mackay Base Hospital providing a range of services to support patients, their families, visitors and hospital staff. Approximately 90 volunteers provide support through a range of services and areas including: information desk, trolley services, fundraising support, administration support, play group in the Child and Adolescent Unit, gift shop, library service and vending machine program. The Foundation distributed $204,922 from donations and fundraising activities across the Mackay HHS in 2015–16. This has funded medical equipment, services, research and other extras that provide comfort and care for patients and support staff to have the best working environment. The Foundation has also been successful in a number of grant applications for medical equipment from the Humpty Dumpty Foundation and Variety.

Mackay HHS partners with tertiary institutions to support career development and work placement for students. In particular there are close connections with JCU, CQU and Queensland University for professions including dental, medical, nursing, allied health and medical imaging.

Our connections with primary healthcare providers have strengthened through our partnership with the NQPHN. Mackay HHS along with Torres and Cape HHS, Cairns and Hinterland HHS and Townsville HHS was instrumental in establishment of the NQPHN. Through this partnership we aim to improve the health outcomes for communities and individuals.

A landmark collaboration agreement was signed in April 2016 between north Queensland health services, NQPHN, JCU and the Australian Institute of Tropical Health and Medicine to establish the TAAHC. The Centre will focus on tropical health, Aboriginal and Torres Strait Islander health and the provision of services in regional, rural and remote settings. By embedding research into health service delivery, TAAHC aims to improve quality and efficiency of care, enhance recruitment and retention of professionals in the region and encourage greater investment in the north. The Centre is housed at the JCU/Mackay Base Hospital Education and Research Centre.

Progressing Excellence

Our strategies:

- invest in innovations that promote and protect health, and support self-responsibility for health
- enable access to safe and sustainable care through the clever use of technology
- embed the application of evidence and research into the organisation
- encourage participation in research activities by leveraging partnerships with the tertiary and private sector
- promote a culture of turning ideas into action.

Emergency training

Proserpine Hospital's Emergency Training Program provides education and training for doctors who work in the emergency department but are not Fellows of the Australasian College of Emergency Medicine (ACEM). ACEM is funding Mackay HHS for three years to run the training. This provides non-FACEM doctors with professional development in a recognised qualification and increases the number of doctors with emergency medicine qualifications in rural hospitals, leading to improved outcomes for people needing urgent care.

Allied Health expanded scope practice

A team headed by Associate Professor Alison Pighills published a journal article in the November 2015 in the International Journal of Therapy and Rehabilitation. Their research investigated whether training Occupational Therapists and Physiotherapists to carry out clinical tasks which were usually the domain of the other profession was as clinically effective, in terms of patient outcome, as uni-professional care delivered by individual specialists. The research showed there was no difference in the clinical outcomes measured for patients who received care provided by clinicians using expanded scope practice or traditional uni-professional care.

This research was driven by the need for rural clinicians to expand their scope and become more generalist in their practice to prevent clients from having to travel long distances to access care. Rural health facilities service small, disbursed patient population and cannot justify full-time posts for each of the core allied health professions. Historically, Mackay HHS has allocated part time posts for each profession in rural facilities which were difficult to fill. Expanded scope practice enables full-time appointments of rural generalist clinicians.

Telehealth Emergency Medicine Support Unit

Hamilton Island residents and visitors who require non-critical specialised emergency advice may no longer be forced to travel thanks to a new telehealth service. Mackay Base Hospital is the first hospital to offer an island community around the clock access to specialised health services. The Telehealth Emergency Management Support Unit was launched in November 2015 and also supports rural hospitals. It offers 24/7 non-critical emergency support to the island and rural hospitals via video conferencing.

This model provides a digital alternative to face-to-face access to medical support from larger hospitals when a second opinion is needed. Benefits of this advice and support include:

- early and appropriate clinical intervention
- improved capability to manage patients locally in their community
- avoids unnecessary retrievals and transfers of patients
- assists in the early identification and management of the deteriorating patient
- increases local clinical capacity and clinician satisfaction
- improves patient satisfaction and outcomes.

Service Delivery Statements: 2015–16 Performance Statement

Our performance against the Service Delivery Statement as set out in the State Budget 2015–16 is outlined below:

Mackay HHS – Service Standards	Notes*	2015–16 Target/Est.	2015–16 Actual
Effectiveness Measures			
Percentage of patients attending emergency departments seen within recommended timeframes:			
• Category 1 (within 2 minutes)		100%	99.6%
• Category 2 (within 10 minutes)		80%	78%
• Category 3 (within 30 minutes)		75%	66.6%
• Category 4 (within 60 minutes)	1	70%	74.1%
• Category 5 (within 120 minutes)	1	70%	94.8%
• All categories		..	72%
Percentage of emergency department attendances who depart within four hours of their arrival in the departments	2	90%	76.8%
Percentage of elective surgery patients treated within clinically recommended times:			
• Category 1 (30 days)		›98%	99.8%
• Category 2 (90 days)		›95%	99.9%
• Category 3 (365 days)		›95%	100%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days		‹2.0	0.7
Rate of community follow-up within 1–7days following discharge from an acute mental health inpatient days		›65%	72.6%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge		‹12%	10.1%
Percentage of specialist outpatients waiting within clinically recommended times:			
• Category 1 (30 days)		..	85%
• Category 2 (90 days)		..	92%
• Category 3 (365 days)		..	98.7%
Median wait time for treatment in emergency departments (minutes)		20	19
Median wait time for elective surgery (days)		25	46

Mackay HHS – Service Standards	Notes*	2015–16 Target/Est.	2015–16 Actual
Efficiency measure			
Average cost per weighted activity unit for Activity Based Funding facilities		$5,288	$5,219
Other measures			
Total weighted activity units:			
• Acute Inpatient	3	25,115	28,178
• Outpatients		8,038	8,947
• Sub-acute		1,724	1,748
• Emergency Department		8,539	9,182
• Mental Health		3,289	3,246
• Interventions and Procedures		4,283	4,481
Ambulatory mental health service contact duration (hours)		›27,000	27,579

Notes:

1. Over the past 12 months there were 57,392 emergency department presentations at Mackay Base Hospital, which is a decrease of 3.7% over the same period last year. The majority of the reduction was experienced in urgency categories 4 and 5, representing a 15.4% reduction rate from 2014–15. The improved FastTrack process also attributed to the above target efficiency in category 5 patients.
2. The increase in category 2 and 3 presentations contributed to the decrease in emergency department attendance departures within recommended timeframes. The Queensland Emergency Access Target has been set at 80% for 2016–17.
3. The Mackay HHS recorded an increase of 7.1% in activity for 2015–2016 which is reflected in an increase in Acute Inpatient weight activity units for the reporting period.

Financial performance

The Mackay HHS has incurred a planned financial deficit of $7.05 million for the year ending 30 June 2016.

Strong financial stewardship in previous years has led to funds being built up by the HHS in Retained Earnings.

The MHHB resolved in the 2015–2016 financial year that it would invest a significant amount of the retained earnings in initiatives to improve health services delivery to its community. These included the following initiatives:

- Digital Hospital Project
- Innovation
- Surgery and Outpatients wait list improvements.

If the reported deficit is adjusted for the MHHB-approved spend from retained earnings the Mackay HHS has achieved a breakeven position as committed to in its Service Delivery Statement.

There will be continuing focus on robust financial stewardship as we seek to ensure the best value for the taxpayer's dollar.

Income

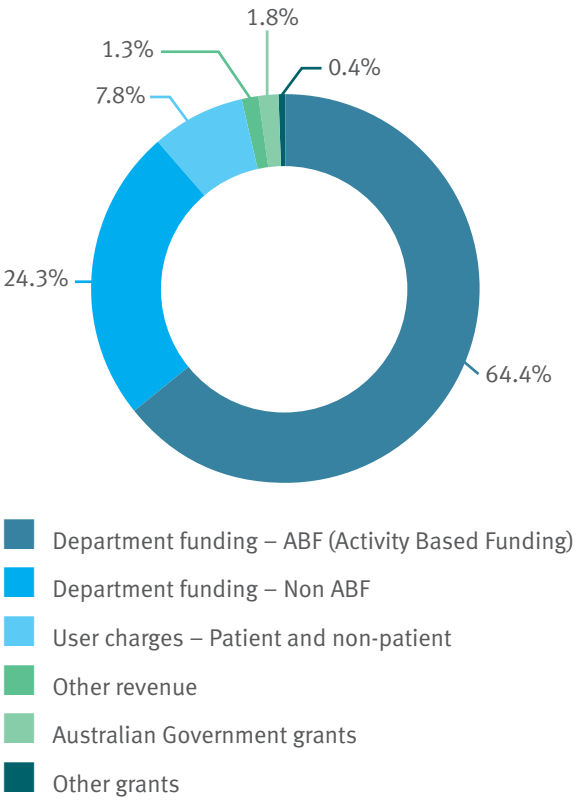
Mackay HHS's income is sourced from three major areas:

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

Figure 1 details the extent of these funding sources for 2015–2016. Mackay HHS total income was $366.9 million which includes:

- The **Activity Based Funding (ABF)** for hospital services was 64.4 percent or $236.3 million
- **Non ABF funding** was 24.3% or $89.2 million
- **User charges** comprising patient and non-patient funding was 7.8% or $28.5 million
- **Australian Government grant** funding was 1.8% or $6.5 million
- **Other revenue** was 1.4% or $5.0 million
- **Other grants** were 0.4% or $1.3 million.

Figure 1. Revenue by funding type



Expenses

The total expenses were $374 million, an average of approximately $1 million a day for providing health services.

Labour costs within Mackay HHS make up almost 67% of expenditure with the remaining 33% being non-labour costs such as supplies, services, and depreciation charges.

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

Figure 2 shows the allocations to services within the Mackay HHS.

Figure 2. 2015–16 Expenses

Where the money goes	%
Mackay Hospital – Patient Services	57%
Rural Health Services	18%
Mental Health	6%
HHS Support Functions	6%
HHS Corporate Services	13%
Other Support Services	0.2%

Our people

Providing high quality health care in rural and regional Queensland is a unique and privileged challenge. Mackay HHS is one organisation across many facilities. The 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.

Workforce

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.

Full-Time Equivalents (FTE) as at 30 June 2016:

Full-Time Equivalents (FTE) as at 30 June 2016			
Classification Stream	**Permanent**	**Temporary**	**Casual**
Managerial and Clerical	290.52	105.93	7.25
Medical (including Visiting Medical officers)	70.44	168.7	0
Nursing	663.95	115.82	23.44
Operational	260.32	45.8	46.6
Trade and Artisans	5	0	0
Health Professional and Technical Officers	171.44	66.24	0
Total	**1461.67**	**502.49**	**77.29**

The Mackay HHS turnover rate for 2015–16 was 13.6% compared to a permanent separation rate for 2014–15 of just over 14%.

Sick leave (paid and unpaid) hours versus occupied FTE for the 2015–16 year was 3.18%.

Interns

Mackay HHS welcomed 44 medical interns to start their careers in 2016. Mackay continues to be one of Queensland's biggest trainers of rural doctors with 11 interns on the Rural Generalist Pathway. All of the interns are Australian university trained with the majority from the University of Queensland and JCU. Four intern places were funded by the Commonwealth Medical Intern Program through our joint venture with Mercy Health and Mackay Mater Hospital. These interns complete core medical and surgical terms at Mackay Mater Hospital and the remainder of their terms at Mackay Base or Proserpine Hospitals. In the 2016 calendar year 35 interns from the Greenslopes Private Hospital will visit Mackay HHS to complete rotations at Mackay Base or Bowen Hospitals – 10 more than 2015. This is an opportunity to showcase the health service and region to a potential future workforce. A significant proportion of Greenslopes' interns have indicated interest in applying for positions in 2017.

Graduate nurses

Mackay HHS welcomed 46 graduate nurses to Mackay Base Hospital and in rural facilities an increase from 40 in 2015. The new nurses were mostly graduates from CQU and JCU. Of the 46 new nurses 16 are working in rural facilities.

Workforce optimisation

Recruitment – improve recruitment processes to ensure timely action to minimise vacancies

- Working more closely with recruitment agencies; creation of a talent pool through Smartjobs and the purchase of LinkedIn Recruiter in April 2016.
- Dedicated human resources staff are allocated to higher demand areas to assist with recruitment processes and vacancy management.

Workforce Development – build and support capacity of the workforce

The delivery of health services at Federal and State Government level continues to experience significant changes. Health workforce planning and development, especially for the clinical workforce, are current areas of significant reform, as the health industry throughout Australia recognises and grapples with major workforce challenges. The Mackay region has experienced significant changes in economic growth and faces regular challenges in attraction and retention and an ageing workforce. Understanding the changes in our workforce, local economy and population demographics and their health needs will be a critical part of ensuring we have a workforce capable of meeting the needs of our communities in future years.

The Mackay HHS began developing the Workforce Strategy 2016–2020 to help Mackay HHS attract and retain a skilled workforce. This should place us in a strong position to meet further challenges.

Learning Environment – developing a learning environment

The learning management system M'y Learn started in January 2016 and provides online access to training and professional development activities.

Staff engagement

Feedback from the annual Working for Queensland Survey drives change and improvement in the workplace. The 2016 Working for Queensland Employee Opinion Survey was carried out between 18 April and 11 May 2016 with a participation rate of 37.4%, an increase from 31% achieved in 2015. The number of staff who report noticing workplace improvements as a result of the survey has increased from 17% in 2015 to 33% in 2016.

Safety, Health and Wellbeing program

The Employee Health and Wellbeing Program was endorsed in 2015–16 with recruitment of a Wellbeing Advisor in September 2015. The program acknowledges the importance of being healthy and active in the workplace. It provides resources and facilitates an environment where employees can participate in healthy lifestyle programs and opportunities. The Employee Health and Wellbeing Program adopts a holistic framework that includes physical, social, emotional, and financial wellbeing.

Flexible working arrangements

Mackay HHS is committed to the provision of flexible work arrangements such as part time work. At 30 June 2016, 37.6% of staff had part-time working arrangements. Tools to support both line managers and employees to understand the options and processes around flexible working arrangements are available.

Performance development

The Performance and Development (PaD) plan process assists employees to have meaningful and productive career discussions. As at 30 June 2016 approximately 73% of staff had a current PaD plan.

Work Health and Safety

The Mackay HHS strives to achieve best practice in the management and performance of our health and safety systems. Key activities included:

- The Workplace Health and Safety Checklist Program evaluates compliance with legislative requirements and reviews identification and management requirements of workplace risks. As at 30 June 2016 100% of work areas had completed the checklist.
- An OHS Audit against AS/NZS4801:2001 and Safer and Healthier Workplace Elements was conducted from 27–29 January 2016 by QRMC Risk Management Pty Ltd. The OHS Audit reported compliance with OHS Policy, Injury Treatment and Management and Claims Management; and noted opportunities for improvement in the area of contractor management, register for legislation and risk methodology.
- A Health and Safety Representative network commenced in 2016 across all Mackay HHS facilities.
- The Safe Practice and Environment Committee met on a monthly basis.
- Audits and inspections were conducted across work areas including hazardous chemicals, healthcare ergonomics, emergency planning, fire safety and occupational violence.
- Fire and evacuation plans, fire signs and diagrams were reviewed.
- There is a continuous review process in place to assess the performance and implementation of preventative strategies for the management of workplace injuries and return to work programs to reduce costs and duration of injuries.

The Mackay HHS WorkCover premium rate continued to remain favourable as a result of the implementation of preventative strategies to manage workplace injuries and return to work programs. The health service continues to achieve positive outcomes against key WorkCover Indicators including WorkCover hours lost compared with FTE which at 0.25% remains below this target of 0.35%.

Occupational Violence Prevention

Physical and verbal abuse towards staff is unacceptable and Mackay HHS is committed to the reduction and impact of violence in the workplace. In December 2015 Mackay HHS formed an Occupational Violence Prevention Sub-Committee to review data, research current best practice to identify an appropriate model of service, monitor training and compliance rates and facilitate engagement with the occupational violence review program.

The Aggressive Behaviour Management training course was delivered 30 times over 60 days and attended by 358 staff. Another 165 staff completed the on-line training component.

Industrial and Employee Relations Framework

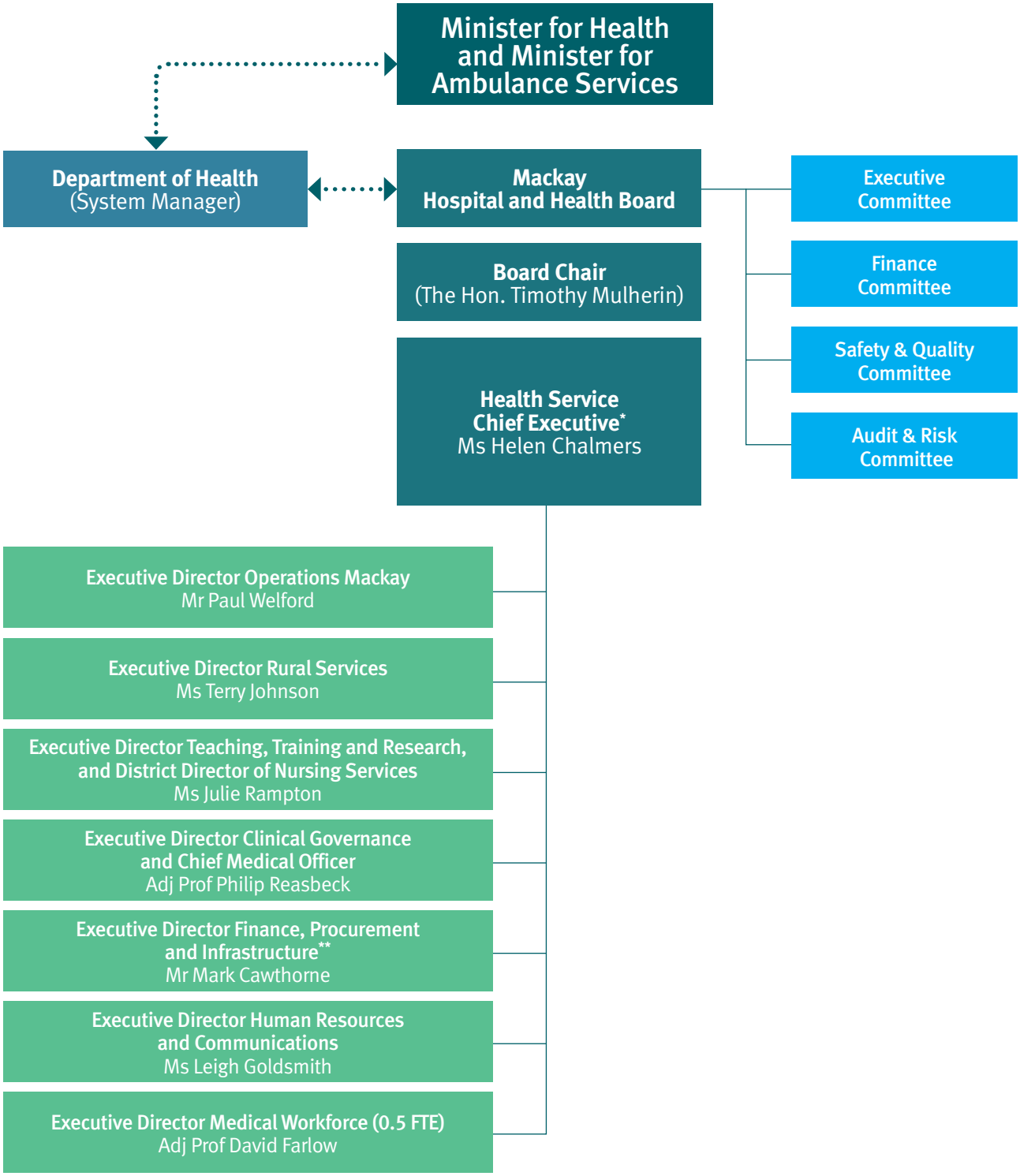
Mackay HHS respects and values its relationships with local unions. A series of regular consultative forums are held to facilitate productive partnerships with industrial representatives. These include the Health and Hospital Service Consultative Forum, local consultative forums and Nursing and Midwifery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

Early retirement, redundancy and retrenchment

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

Our governance

Organisation structure



* *Effective from 6 June 2016, Ms Clare Douglas has been seconded to the Cairns and Hinterland HHS until December 2016.*

** *Mr Cawthorne ceased employment with the Mackay HHS on 1 July 2016. Mr Brett Oates commenced as Executive Director Finance, Procurement and Infrastructure on 8 August 2016.*

Mackay Hospital and Health Board

The MHHB is appointed by the Governor of the State of Queensland acting by and with the advice of the Executive Council on the recommendation of the Queensland Health Minister. The MHHB derives its authority from the HHBA and the *Hospital and Health Boards Regulation 2012* (Qld) (HHBR). 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 *Public Sector Ethics Act 1994* (Qld).

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.

MHHB achievements for 2015–16:

- Development of the Strategic Plan 2016–2020 (effective from 1 July 2016).
- Implementation of the Clinical Services Plan 2015–2018.
- Official opening of the new Mackay Base Hospital on 29 July 2015 by the Minister for Health and Ambulance Services, the Hon. Cameron Dick MP.
- Approved investment in the refurbishment works at Bowen Hospital and Proserpine Hospital, and the redevelopment of Carlyle Street building.
- Approved investment and preparation for Go Live of the Mackay Digital Hospital Program.
- Establishment of Memorandums of Understanding with TAAHC and NQPHN.
- MHHB-led initiatives – Leadership for Senior Managers, and Attraction and Retention Initiatives.

The MHHB meets monthly or as directed by the Chair. The 2015–2016 MHHB Committees structure was:

- Executive Committee
- Safety and Quality Committee
- Finance Committee
- Audit and Risk Committee.

Our governance

The Honourable Timothy Mulherin
Board Chair

The Honourable Mulherin was elected to the Queensland Parliament as the Labor member for Mackay in 1995 until his retirement in 2015. During this time as a cabinet member, he held Ministerial responsibilities for Agriculture, Biosecurity, Fisheries, Forestry Industry Development, Primary Industries Research, Development and Extension, Regional and Rural Communities and Regional Economic Development amongst others.

The Hon. Mulherin commenced as Board Chair of the Mackay HHS on 18 May 2016 for a term until 17 May 2017.

Mr Darryl Camilleri
Deputy Chair

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 and has extensive experience in tax planning, finance and audits.

Originally appointed on 29 June 2012, Mr Camilleri's current term of office commenced 18 May 2016 to 17 May 2017.

Dr Helen Archibald
Board Member

Dr Archibald is a general practitioner at Plaza Medical Mackay as well as an Associate Senior Lecturer at JCU's School of Medicine. She is also the Clinical Director for BreastScreen Queensland Mackay Service.

Originally appointed on 7 September 2012, Dr Archibald's current term of office is 26 June 2015 to 17 May 2018.

Mr David Aprile
Board Member

Mr Aprile is the founding partner of Mackay Day and Night Pharmacy Group. He has served on many local community and government based boards in Mackay and the surrounding area including the CQU Advisory Board and Mackay Chamber of Commerce.

Originally appointed on 29 June 2012, Mr Aprile's current term of office commenced 18 May 2014 to 17 May 2017.

Professor Richard Murray
Board Member

Professor Murray has 23 years' experience in medicine, specialising in 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 JCU and President of the Australian College of Rural and Remote Medicine.

Originally appointed on 29 June 2012, Prof Murray's current term of office commenced 18 May 2016 to 17 May 2019.

Mr John Nugent
Board Member

Mr Nugent has a strong and extensive background in hospital and healthcare management with more than 35 years' experience in that field, including 16 years as the Executive Officer of Mater Misericordiae Hospital, Mackay. He is a director of the North Queensland Primary Healthcare Network.

Originally appointed on 23 August 2013, Mr Nugent's current term of office commenced 18 May 2016 to 17 May 2019.

Ms Suzanne Brown
Board Member

Ms Brown is a Principal and leading commercial solicitor at McKays Solicitors (Mackay). 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 Brown commenced as a Board Member of the Mackay HHS on 18 May 2016 for a term until 17 May 2017.

Ms Karla Steen
Board Member

Ms Steen is a communications and media strategist with more than 17 years' experience in radio and television journalism, corporate communications and marketing. She currently owns a communication and media consultancy and co-launched The Life Approach Pty Ltd.

Ms Steen commenced as a Board Member of the Mackay HHS on 18 May 2016 for a term until 17 May 2017.

Ms Leeanne Heaton
Board Member

Ms Heaton has a diverse range of experience working in healthcare as a registered nurse, registered midwife, paramedic and flight nurse with the Royal Flying Doctor Service. She is Head of Program for undergraduate nursing at CQU. Ms Heaton has been an academic panel member for the Australian Nursing and Midwifery Accreditation Council and is a member of the Australian College of Nursing.

Ms Heaton commenced as a Board Member of the Mackay HHS on 18 May 2016 for a term until 17 May 2017.

Mr Colin Meng
Board Chair

Mr Meng has extensive board and business experience in the Mackay region. Mr Meng has previously served as mayor of the Mackay Regional Council and President of the Mackay Chamber of Commerce.

Mr Meng was the Board Chair of the Mackay HHS from 18 May 2012 until 17 May 2016.

Mr Tom McMillan
Board Member

Mr McMillan is a specialist musculoskeletal physiotherapist (Fellow of the Australian College of Physiotherapists) and a director of the Physio Plus Group. He is a managing director for a range of private health services in the Mackay district and interstate. Mr McMillan is a current national council member of both the Australian College of Physiotherapists and the Australian Physiotherapy Association.

Mr McMillan was a Board Member of the Mackay HHS from 29 June 2012 until 17 May 2016.

Ms Laura Veal
Board Member

Ms Veal has spent more than 25 years as a registered nurse in both the public and private sectors, within metropolitan and rural areas. She has a wealth of grass roots experience across Queensland.

Ms Veal was a Board Member of the Mackay HHS from 7 September 2012 until 17 May 2016.

Mackay Hospital and Health Board Committees

The following committees support the functions of the MHHB. Each operates with terms of reference describing the purpose, duties and responsibilities, composition and membership.

Executive Committee

The Executive Committee provides strategic advice and recommendations to support the Mackay HHS in its role of controlling the Mackay HHS, by working with the Health Service Chief Executive to progress strategic issues identified by the MHHB. The Executive Committee functions under the authority of the MHHB in accordance with section 32B of the HHBA.

Committee membership

- Colin Meng (Chair)*
- Darryl Camilleri
- Dr Helen Archibald
- Tom McMillan*

Meetings are held biannually or as directed by the Committee Chair.

** Membership ceased on 17 May 2016.*

Audit and Risk Committee

The Audit and Risk Committee supports the MHHB in its responsibility for audit and risk oversight and management. This is in accordance with requirements under sections 15, 28 and 35 of the *Financial and Performance Management Standard 2009*, was established under part 7, section 31 of the HHBR. The Audit and Risk Committee functions under the authority of the MHHB in accordance with section 34 of the HHBR.

Committee membership

- Darryl Camilleri (Chair)
- David Aprile
- John Nugent

Meetings are held quarterly or as directed by the Committee Chair.

Finance Committee

The Finance Committee provides advice and recommendations to the MHHB on matters relating to the financial and operational performance of Mackay HHS. The Finance Committee was established under part 7, section 31 of the HHBR. The Finance Committee functions under the authority of the MHHB in accordance with section 33 of the HHBR.

Committee membership

- David Aprile (Chair)
- Darryl Camilleri
- John Nugent

Meetings are held monthly or as directed by the Committee Chair.

Safety and Quality Committee

The Safety and Quality Committee provides strategic advice and recommendations to the MHHB regarding patient safety and quality assurance. The Safety and Quality Committee was established under part 7, section 31 of the HHBR. It functions under authority of the MHHB in accordance with section 32 of the HHBR.

Committee membership

- Dr Helen Archibald (Chair)
- Tom McMillan*
- Prof Richard Murray
- Laura Veal*

Meetings are held quarterly or as directed by Chair.

** Membership ceased on 17 May 2016.*

Board Members	Board Member Meeting Attendance from 1 July 2015 to 17 May 2016					Board Member Meeting Attendance from 18 May 2016 to 30 June 2016				
	MHHB	Finance Committee	Audit and Risk Committee	Safety and Quality Committee	Executive Committee	MHHB	Finance Committee	Audit and Risk Committee	Safety and Quality Committee	Executive Committee
Total Meetings	**10**	**10**	**3**	**4**	**4**	**3**	**2**	**1**	**–**	**–**
Colin Meng	10	–	–	–	4					
Darryl Camilleri	9	10	3	–	4	2	2	1	–	–
Dr Helen Archibald*	9	–	–	4	4	3	–	–	–	–
David Aprile*	9	9	1	–	–	3	2	1	–	–
Tom McMillan*	9	–	–	4	4					
Prof Richard Murray*	7	–	–	4	–	3	–	–	–	–
John Nugent	10	9	3	–	–	3	2	1	–	–
Laura Veal*	9	–	–	4	–					
Hon. Timothy Mulherin						3	–	–	–	–
Suzanne Brown						3	–	–	–	–
Karla Steen						2	–	–	–	–
Leeanne Heaton						3	–	–	–	–

*1. * Members of the MHHB who satisfy the Clinical expertise requirement under section 23(4) of the HHBA.*

2. Total out of pocket expenses claimed during the reporting period totalled $598.88.

Mackay HHS Executive Team

Ms Clare Douglas
Health Service Chief Executive

Ms Douglas has a background in nursing and progressed to a number of nursing management positions in both the public and private health care settings, culminating as the Chief Nursing Officer at the Royal Victorian Eye and Ear Hospital in 2001. She has held positions of General Manager Clinical and Corporate Support, General Manager Box Hill Hospital, General Manager Service Integration and Acting Chief Executive. Ms Douglas' focus is on delivering excellence in regional health care and to promote health prevention to reduce the burden of disease within our community.

Mr Mark Cawthorne
Executive Director Finance, Procurement and Infrastructure

Mr Cawthorne has 25 years' experience in Health Management and Financing in Australia and the Middle East. He has previously held positions of CFO, Deputy CEO and CEO, and served on numerous state-wide and national committees with respect to the health industry. He was the health financing lead on the project to introduce a social health insurance scheme to the country of Qatar, as well as working on that nation's national health strategy and leading the introduction of performance reporting systems for both the public and private sectors.

Ms Terry Johnson
Executive Director Rural Services

Ms Johnson has extensive executive management and leadership experience within QH 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 Helen Chalmers
Acting Health Service Chief Executive

Ms Chalmers is a long-term health professional, having held roles as a Chief Operating Officer, Chief Executive Officer and Chief Finance Officer over the last 25 years. She enjoys being part of a high performing team providing health services in local communities and ensuring high standards of governance and performance. She has worked in Queensland, South Australia and the UK during her health career, and is strongly interested in rural healthcare, acute care, ambulance and emergency services. She is also a surveyor for the Australian Council on Healthcare Standards (ACHS).

Adj Prof Philip Reasbeck
Executive Director Clinical Governance and Chief Medical Officer

Adjunct Professor Reasbeck has a medical degree and a research doctorate from Cambridge University, and specialist qualifications in internal medicine, general and vascular surgery and medical administration. He has worked as a consultant surgeon in the United Kingdom, New Zealand, Hong Kong and Australia, as medical director of an NHS trust in the UK, and as Executive Director of Medical Services at Ballarat Health Services in Victoria. He is an adjunct professor in the Faculty of Health at Federation University Australia and in the College of Medicine and Dentistry at JCU.

Ms Leigh Goldsmith
Executive Director Human Resources and Communication

Ms Goldsmith is a skilled strategic leader with more than 20 years HR, organisational development, strategic and business planning, and change management experience. She has significant Queensland Government experience and more recently has worked as a management consultant with Catholic Education, Sydney Children's Hospital and shared services. Ms Goldsmith's experience has extended across various sectors, including ICT, shared services, health and education.

Ms Julie Rampton
Executive Director Teaching, Training and Research and District Director Nursing Services

Ms Rampton has worked for QH for 35 years, over 20 of those in senior nursing roles. She was the Director of Nursing at the Maryborough Base Hospital before moving to Mackay. She trained in Midwifery at the Royal Women's Hospital in Brisbane. Ms Rampton is a member of the Queensland Nursing and Midwifery Executive Council, and the Nursing and Midwifery Implementation Group for EB8. She is an adjunct professor at CQU.

Mr Paul Welford
Executive Director Operations Mackay

Mr Welford has 20 years' experience in managing healthcare services. Before moving to Mackay, he worked in Qatar's national healthcare system for five years and was accountable for the performance management of health services across four tertiary hospital sites, associated clinical support services and the national ambulance service. He has also worked as the Executive of Major Incident Planning to meet international standards. Mr Welford has worked in healthcare across the North of Scotland region and in London.

Adj Prof David Farlow
Executive Director Medical Workforce

Adjunct Professor Farlow first arrived in the Mackay HHS in 1984. Prior to that, he provided a broad range clinical service and leadership roles within the Whitsunday Health Service. He is the editor and co-author of a self-published children's first aid book "Freya The First Aider". His expertise and experience includes undertaking a range of investigations, service reviews and consultancies for QH. Recently he was awarded an Adjunct Professorial role with JCU School of Medicine and Dentistry.

Health Service Committees

Mackay HHS Executive Committee

This is the primary leadership and management committee of the Mackay HHS, with the capacity to delegate functions to specific committees, when appropriate. Meetings are held twice a month or more frequently if required.

Clinical Governance Committee

The Committee is responsible for the implementation of the clinical governance framework and Mackay HHS Safety and Quality Plan in order to ensure the efficient, safe and effective delivery of clinical services. Meetings are held on a monthly basis.

Credentialing and Scope of Clinical Practice Committee

The Credentialing and Scope of Clinical Practice Committee is responsible for considering an applicant's credentials and requested Scope of Clinical Practice (SOCP) and providing recommendations for defining a SOCP to the Mackay HHS's delegated decision. Meetings are held on a monthly basis.

Clinical Council Committee

The Mackay HHS Clinical Council is the peak clinician led group that provides leadership and input regarding the organisation's imperatives to the Mackay HHS Executive. The Clinical Council provides an opportunity for clinicians and members to engage in planning, priority setting and service improvements. Meetings are held on a bi-monthly basis.

Education and Research Advisory Council

The Education and Research Advisory Committee is responsible for implementing the strategic agenda and providing support for education, training and research across the Mackay HHS. Meetings are held on a quarterly basis.

Emergency and Business Continuity Planning Committee

The Emergency and Business Continuity Planning Committee governs emergency planning and business continuity systems and processes for the Mackay HHS to ensure facilities are prepared to respond to events. Meetings are held on a quarterly basis.

Safe Practice and Environment Committee

The Safe Practice and Environment Committee governs systems and procedures to ensure compliance with Australian Standard 4801 *Safety Management Systems* and relevant *EQuIPNational Standards* to ensure the safety of all Mackay HHS employees, consumers and visitors. Meetings are held on a monthly basis.

Clinical Information and ABF Group

The Clinical Information and ABF Group's primary role is to review clinical data management issues affecting departmental activities, ABF developments and organisational implementation strategies. Meetings are held on a monthly basis.

Ethics and code of conduct

The *Public Sector Ethics Regulation 2010* defines the 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, which came into effect on 1 January 2011. The code of conduct consists 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 change to the document through intranet based modules.

Risk management and accountability

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

Mackay HHS has a risk management policy and integrated Risk Management Framework (RMF) based on the Australian/New Zealand ISO Standard 31000:2009 for risk management. The policy and framework outline Mackay HHS's intent, roles, responsibilities and implementation requirements. The Mackay HHS's RMF 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.

Activities for 2015–2016 include:

- Continued development of in-house capability and knowledge to identify and mitigate risk, and development of the internal audit function;
- External review of the RMF; and
- Risk workshops with MHHB, Executive and middle management.

External scrutiny

Mackay HHS's operations are subject to regular scrutiny from external oversight bodies. These include Queensland Audit Office (QAO), ACHS, Health Quality and Complaints Commission, National Association of Testing Authorities, National Quality Management Committee, Specialist Advisory Committee in General and Acute Care Medicine, ACEM and Emergo Training Disaster Exercise.

ACHS Patient Safety Audit

In May 2016, the Mackay HHS underwent an independent, external patient safety audit by a team from the ACHS. This external audit was against the relevant sections of the HHBA and the HHBR. In the external audit report, it was identified that Mackay HHS is 98.58% compliant with the audited sections of the HHBA and the HHBR with no high priority recommendations arising from the audit. Two low priority recommendations are being managed through appropriate processes.

Patient feedback

Mackay HHS received 1,743 pieces of feedback from consumers with 1,116 compliments and 627 complaints. The top issues were communication, treatment, access, environmental/facility management, and fees/costs. Of these 627 complaints, 550 required further responses and 77 were resolved at frontline at the health service level. Feedback from consumers helped shape service delivery and changed the hospital environment and equipment used.

QH Patient Experience Surveys

The following patient experience surveys were conducted by the Queensland Government Statistician's Office on behalf of QH. It was conducted using computer assisted telephone interviewing.

Maternity Specialist Outpatients Clinic

A total of 305 interviews were completed of mothers who visited maternity outpatient clinics in Mackay Base Hospital, and 65 interviews were completed of mothers who visited maternity outpatient clinics in Proserpine Hospital between July and September 2015.

Emergency Department

A total of 306 interviews were completed by patients who visited the emergency department at Mackay Base Hospital, and 288 interviews were completed by patients who visited the emergency department at Proserpine Hospital in August and September 2015.

The Mackay HHS has reviewed all of the results and developed action plans to implement recommendations from these surveys.

QAO Audit – Financial Statements

As a public sector entity, Mackay HHS is subject to an annual audit by the QAO. The QAO Final Management Report provided to the Mackay HHS for 2014–15 financial year contained no significant risks. Lower risk items are being managed through appropriate action plans or additional investigation.

QAO Report – Queensland Public Hospital Operating Theatre Efficiency

In April 2016 QAO finalised the assessment of the efficiency of 39 (including Mackay HHS) of Queensland's 51 public hospitals in managing operating theatres to deliver emergency and elective surgical services. These hospitals all use the same operating room management information system. The Mackay HHS has developed a Theatre Action Plan for identified areas for improvement.

Internal audit

Internal Audit is an integrated component of corporate governance, promoting efficient management and assisting in risk management.

The function operates under the Board charter, consistent with the internal auditors' standards. Internal Audit is an independent and objective assurance activity designed to improve the governance of the Mackay HHS providing reports to the Audit and Risk Committee for the effective, efficient and economical operation of the health service. The Internal Audit function operates with due regard to Queensland Treasury Audit Committee Guidelines.

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 noncompliance 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.

The annual audit plan, endorsed by the Audit and Risk Committee and approved by the MHHB, directs the unit's activities and provides a framework for its effective operation. A risk-based planning approach is used to develop audit plans, including considering risk registers and consulting with internal stakeholders and the QAO. Audit reports include recommendations to address deficiencies in risk treatment and all audit reports are reviewed by the Audit and Risk Committee.

Internal audits conducted during 2015–16 include reviews of:

- IT Systems Access
- Employee Separations
- Review of Procurement of Activity Trackers
- Financial Management Assurance
- Medical Imaging
- Medical Workforce Administration.

Information systems and record keeping

Management of health records and clinical information is the responsibility of the Health Information Unit. Patient clinical records are managed through strict procedures including health records documentation standards, health records management and tracking, health record transportation, security and procedures for accessing health records for research and clinical audits. Health record documentation standard audits are conducted regularly with the criteria based on the standards procedure.

All employees are made aware of their responsibilities regarding security and confidentiality to ensure that management of clinical and non-clinical documentation is undertaken appropriately. Continual improvement to processes ensures that all staff meet record management requirements.

There are procedures in place to ensure that all medical records are archived, retained and destroyed appropriately meeting all legislative requirements pertaining to the Queensland State Archives – Health Sector Retention and Disposal Schedule (Clinical Records) and the General Retention and Disposal Schedule for Administrative Records (Non-Clinical).

Mackay Base Hospital has successfully continued to transition to a fully Integrated Electronic Medical Record (ieMR) site with direct entry into patient records. Key performance indicators are met routinely for the scanning of paper documentation into records (i.e. documentation is available for viewing in the ieMR within 72 hours). A Quality Assurance process is being maintained which will enable the authorised destruction of the Mackay Base Hospital original paper medical records after digitisation in accordance with the Digitisation and Disposal Plan of Scanned Medical Records.

Business Classification Scheme

The Business Classification Scheme (BCS) is a records management tool used to categorise information resources in a consistent and organised manner. It is comprised of a hierarchy of terms that describe the broad business functions of the department and the activities and transactions that enable those functions to be delivered. This assists with creating, accessing, and transferring files.

Principle 7 of Information Standard 40: Recordkeeping (IS40) includes a requirement for public authorities to 'classify records in accordance with a BCS based on an analysis of the public authority's functions and activities.' Under section 47 of the HHBA, the Chief Executive of the Department of Health has issued a Health Service Directive to classify records in accordance with the BCS v2 and subsequent versions (QH-HSD-018:2012).

Mackay HHS adheres to the BCS and the General Retention and Disposal Schedule for Administrative Records.

Open Data

The Queensland Government has committed to releasing as much public service data as possible through its Open Data Initiative. Under the initiative, a large volume of government data, where suitable for release, is published on the following website: **https://data.qld.gov.au/**

Mackay HHS has published the following data on the government's Open Data website:

- Consultancies
- Overseas Travel
- Queensland Language Services Policy.

Health Information Unit

Health information statistics	
Medico-legal – Requests for patient information (releasing patient information through multiple legislative mechanism)	1,808
Medico-Legal-Secure Web Transfer System (STS) – Patient information release with encryption	38,368
Right to Information/Information Privacy (RTI/IP) Applications received (annual)	223
RTI/IP Applications released in full	138
RTI/IP Applications partially released	16
RTI/IP denied in full	1
RTI/IP Applications withdrawn	29
Number of charts coded (MBH and Sarina) (annual)	35,674
Number of chart/current encounter chart movements (annual)	237,883
Daily Average chart movements	649
Number of batches processed onto ieMR	34,782
Number of pages scanned into ieMR	1,169,561
Number of letters transcribed	22,264
Number answered incoming operator calls	378,872

This table represents the movement of health information.

Glossary of 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 Having a short and relatively severe course.

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.

Acute hospital Is generally a recognised hospital that provides acute care and excludes dental and psychiatric hospitals.

Admission The process whereby a hospital accepts responsibility for a patient's care and/or treatment. It follows a clinical decision, based on specified criteria, that a patient requires same-day or overnight care or treatment, which can occur in hospital and/or in the patient's home (for hospital-in-the-home patients).

Admitted patient A patient who undergoes a hospital's formal admission process as an overnight-stay patient or a same-day patient.

Benchmarking Involves collecting performance information to undertake comparisons of performance with similar organisations.

Best practice Cooperative way in which organisations and their employees undertake business activities in all key processes, and use benchmarking that can be expected to lead to sustainable world class positive outcomes.

Chronic a long-term or persistent condition.

Clinical governance A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

Clinical practice Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/or manage illness, together with associated professional activities for patient care.

Clinical workforce Staff who are or who support health professionals working in clinical practice, have healthcare specific knowledge/ experience, and provide clinical services to health consumers, either directly and/or indirectly, through services that have a direct impact on clinical outcomes.

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. The first HHSs commenced on 1 July 2012. Queensland's 16 HHSs replaced the previously existing health service districts.

Hospital-in-the-home Provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.

Immunisation Process of inducing immunity to an infectious agency by administering a vaccine.

Long wait A 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for a category 1 patient, more than 90 days for a category 2 patient and more than 365 days for a category 3 patient.

Medical practitioner A person who is registered with the Medical Board of Australia to practice medicine in Australia, including general and specialist practitioners.

Non-admitted patient A patient who does not undergo a hospital's formal admission process.

Non-admitted patient services An examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit of a health service facility.

Nurse practitioner A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessing and managing clients using nursing knowledge and skills and may include, but is not limited to, direct referral of clients to other healthcare professionals, prescribing medications, and ordering diagnostic investigations.

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

Outpatient service Examination, consultation, treatment or other service provided to non-admitted non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.

Glossary of acronyms

Overnight-stay patient A patient who is admitted to, and separated from, the hospital on different dates (not same-day patients).

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 Patient A public patient is one who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.

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.

Triage category Urgency of a patient's need for medical and nursing care.

ABF	Activity based funding
ACEM	Australasian College of Emergency Medicine
ACHS	Australian Council on Healthcare Standards
BCS	Business Classification Scheme
CAP	Consumer Advisory Partners
CQU	Central Queensland University
FTE	Full-Time Equivalent
GP	General Practitioner
HHS	Hospital and Health Service
HHBA	*Hospital and Health Boards Act 2011* (Qld)
HHBR	*Hospital and Health Boards Regulation 2012* (Qld)
ieMR	Integrated Electronic Medical Record
JCU	James Cook University
Mackay HHS	Mackay Hospital and Health Service
MHHB	Mackay Hospital and Health Board
MPHS	Multi-Purpose Health Service
NQPHN	North Queensland Primary Health Network
PaD	Performance and Development
QAO	Queensland Audit Office
QH	Queensland Health
RMF	Risk Management Framework
RTI/IP	Right to Information/Information Privacy
SOCP	Scope of Clinical Practice
TAAHC	Tropical Australian Academic Health Centre
WAU	Weighted Activity Unit

Compliance checklist

The characteristics of a quality report are that it:

- Complies with statutory and policy requirements
- Presents information in a concise manner
- Is written in plain English
- Provides a balanced account of performance – the good and not so good.

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2009*

ARRs Annual report requirements for Queensland Government agencies

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 8	page 1
Accessibility		
Table of contents	ARRs – section 10.1	page 3
Glossary		pages 32–33
Public availability	ARRs – section 10.2	inside front cover
Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 10.3	
Copyright notice	*Copyright Act 1968* ARRs – section 10.4	
Information Licensing	*QGEA – Information Licensing* ARRs – section 10.5	
General information		
Introductory Information	ARRs – section 11.1	pages 4–5
Agency role and main functions	ARRs – section 11.2	pages 6–7
Operating environment	ARRs – section 11.3	pages 8–16
Non-financial performance		
Government's objectives for the community	ARRs – section 12.1	pages 8–15
Other whole-of-government plans/specific initiatives	ARRs – section 12.2	
Agency objectives and performance indicators	ARRs – section 12.3	
Agency service areas and service standards	ARRs – section 12.4	
Financial performance		
Summary of financial performance	ARRs – section 13.1	page 16
Governance – management and structure		
Organisational structure	ARRs – section 14.1	page 20
Executive management	ARRs – section 14.2	pages 22–23 and 26–27
Government bodies (statutory bodies and other entities)	ARRs – section 14.3	N/A

Summary of requirement	Basis for requirement	Annual Report reference
Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* ARRs – section 14.4	page 28
Queensland public service values	ARRs – section 14.5	page 7
Governance – risk management and accountability		
Risk management	ARRs – section 15.1	page 28
Audit committee	ARRs – section 15.2	page 24
Internal audit	ARRs – section 15.3	page 30
External scrutiny	ARRs – section 15.4	page 29
Information systems and recordkeeping	ARRs – section 15.5	pages 30–31
Governance – human resources		
Workforce planning and performance	ARRs – section 16.1	pages 17–19
Early retirement, redundancy and retrenchment	*Directive No. 11/12 Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	page 19
Open Data		
Consultancies	ARRs – section 17 ARRs – section 34.1	page 31
Overseas travel	ARRs – section 17 ARRs – section 34.2	
Queensland Language Services Policy	ARRs – section 17 ARRs – section 34.3	
Financial Statements		
Certification of Financial Statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	pages 75
Independent Auditor's Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	pages 76–77

Mackay Hospital and Health Service

ABN 8742 789 6923

Annual Financial Statements

For the year ended 30 June 2016

Mackay Hospital and Health Service

Statement of Comprehensive Income

For the year ended 30 June 2016

OPERATING RESULT	Notes	2016 $'000	2015 $'000
Income from Continuing Operations			
User charges and fees	B1-1	28,495	24,908
Funding public health services	B1-2	325,518	305,244
Grants and other contributions	B1-3	7,853	9,997
Other revenue	B1-4	5,044	6,030
Total Revenue		366,910	346,179
Total Income from Continuing Operations		**366,910**	**346,179**
Expenses from Continuing Operations			
Employee expenses	B2-1	34,766	27,403
Health service employee expenses	B2-2	196,878	183,118
Supplies and services	B2-3	107,222	95,451
Depreciation and amortisation	C4-2	26,780	18,757
Revaluation decrement	B2-4	1,983	2,945
Other expenses	B2-5	6,331	5,832
Total Expenses from Continuing Operations		**373,960**	**333,506**
Operating Results from Continuing Operations		**(7,050)**	**12,673**
Other Comprehensive Income			
Items Not Reclassified to Operating Result			
Increase/(decrease) in Asset Revaluation Surplus		(7,073)	(1,017)
Total Items Not Reclassified to Operating Result		(7,073)	(1,017)
Other Comprehensive Income		**(7,073)**	**(1,017)**
Total Comprehensive Income		**(14,123)**	**11,656**

The accompanying notes form part of these statements

Mackay Hospital and Health Service

Statement of Financial Position

As at 30 June 2016

	Note	2016 $'000	2015 $'000
Current Assets			
Cash and cash equivalents	C1-1	60,785	72,799
Receivables	C2-1	12,647	12,403
Inventories	C3-1	3,855	2,191
Total Current Assets		**77,287**	**87,393**
Non-Current Assets			
Property, plant and equipment	C4-2	410,135	435,771
Total Non-Current Assets		**410,135**	**435,771**
Total Assets		**487,422**	**523,164**
Current Liabilities			
Payables	C5-1	18,673	20,275
Total Current Liabilities		**18,673**	**20,275**
Total Liabilities		**18,673**	**20,275**
Net Assets		**468,749**	**502,889**
Equity			
Contributed equity	C6-1	397,806	417,823
Accumulated surplus		56,578	63,628
Asset revaluation surplus	C6-2	14,365	21,438
Total Equity		**468,749**	**502,889**

The accompanying notes form part of these statements

Mackay Hospital and Health Service

Statement of Changes in Equity

For the year ended 30 June 2016

	Contributed equity Note C6-1 $'000	Accumulated surplus $'000	Asset revaluation surplus Note C6-2 $'000	Total equity $'000
Balance as at 1 July 2014	338,924	50,955	22,455	412,334
Operating Result from Continuing Operations	-	12,673	-	12,673
Other Comprehensive Income				
Increase/(decrease) in asset revaluation surplus	-	-	(1,017)	(1,017)
Total Comprehensive Income for the Year	-	12,673	(1,017)	11,656
Transactions with Owners as Owners:				
Net assets transferred	93,654	-	-	93,654
Equity injections - minor capital works	4,002	-	-	4,002
Equity withdrawals - Depreciation funding	(18,757)	-	-	(18,757)
Net Transactions with Owners as Owners	78,899	-	-	78,899
Balance at 30 June 2015	**417,823**	**63,628**	**21,438**	**502,889**
Balance as at 1 July 2015	417,823	63,628	21,438	502,889
Operating Result from Continuing Operations	-	(7,050)	-	(7,050)
Other Comprehensive Income				
Increase/(decrease) in asset revaluation surplus	-	-	(7,073)	(7,073)
Total Comprehensive Income for the Year	-	(7,050)	(7,073)	(14,123)
Transactions with Owners as Owners:				
Net assets transferred	911	-	-	911
Equity injections - minor capital works	5,852		-	5,852
Equity withdrawals - Depreciation funding	(26,780)	-	-	(26,780)
Net Transactions with Owners as Owners	(20,017)	-	-	(20,017)
Balance at 30 June 2016	**397,806**	**56,578**	**14,365**	**468,749**

The accompanying notes form part of these statements

Mackay Hospital and Health Service

Statement of Cash Flows

For the year ended 30 June 2016

	Note	2016 $'000	2015 $'000
Cash flows from operating activities			
Inflows			
User charges and fees		26,496	26,066
Funding public health services		301,139	278,996
Grants and other contributions		7,024	9,948
GST input tax credits from ATO		6,901	5,092
GST collected from customers		485	423
Other receipts		5,247	6,040
		347,292	**326,565**
Outflows			
Employee expenses		(34,402)	(26,714)
Health service employee expenses		(197,899)	(188,125)
Supplies and services		(111,082)	(92,757)
GST paid to suppliers		(7,044)	(5,606)
GST remitted to ATO		(452)	(470)
Other payments		(5,470)	(5,424)
		(356,349)	**(319,096)**
Net cash from/(used by) operating activities	CF-1	**(9,057)**	**7,469**
Cash flows from investing activities	CF-2		
Inflows			
Sales of property, plant and equipment		8	-
Outflows			
Payments for property, plant and equipment		(8,817)	(4,746)
Net cash from/(used by) investing activities		**(8,809)**	**(4,746)**
Cash flows from financing activities			
Inflows			
Equity injections		5,852	4,003
Net cash from/(used by) financing activities		**5,852**	**4,003**
Net increase/(decrease) in cash and cash equivalents		**(12,014)**	**6,726**
Cash and cash equivalents at the beginning of the financial year		72,799	66,073
Cash and cash equivalents at the end of the financial year	C1-1	**60,785**	**72,799**

The accompanying notes form part of these statements

Mackay Hospital and Health Service

Statement of Cash Flows

For the year ended 30 June 2015

NOTES TO THE STATEMENT OF CASH FLOWS

CF-1 RECONCILIATION OF OPERATING RESULT TO NET CASH FROM OPERATING ACTIVITIES

	2016	*2015*
	$'000	*$'000*
Operating Result	(7,050)	12,673
Non-cash movements:		
Depreciation and amortisation	26,780	18,757
Depreciation funding	(26,780)	(18,757)
Revaluation decrement	1,983	2,945
Net (gain)/loss on disposal/revaluation of non-current assets	349	118
Impairment losses	176	289
Donated assets	(829)	(49)
Changes in assets and liabilities:		
(Increase)/decrease in receivables	(2,370)	1,213
(Increase)/decrease in funding receivables	2,401	(7,491)
(Increase)/decrease in GST receivables	(143)	(514)
(Increase)/decrease in inventories	(1,524)	(691)
(Increase)/decrease in prepayments	(481)	199
Increase/(decrease) in accounts payable	(581)	3,832
Increase/(decrease) in accrued contract labour	(1,021)	(5,008)
Increase/(decrease) in GST payable	33	(47)
Net cash from/(used by) operating activities	**(9,057)**	**7,469**

CF-2 NON-CASH INVESTING AND FINANCING ACTIVITIES

Assets received from 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 (refer Note B2-5) as applicable.

Assets received from or liabilities transferred by the Hospital and Health Service as a result of machinery-of-Government or administrative arrangements are set out in the Statement of Changes in Equity and Note C6-1.

The accompanying notes form part of these statements

PREPARATION INFORMATION

GENERAL INFORMATION

The Mackay Hospital and Health Service (MHHS) 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 Hospital and Health Service's 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 43 of the *Financial and Performance Management Standard 2009*. The financial statements comply with Queensland Treasury's Minimum Reporting Requirements for reporting periods beginning on or after 1 July 2015.

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 G2.

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 2014-15 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 Chairman of the Hospital and Health Service, the Chief Executive and the Chief Financial Officer 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; and
- Inventories which are measured at the lower of cost and net realisable 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 three approaches:

- 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, such as a business;
- The cost approach reflects the amount that would be required currently to replace the service capacity of an asset. This method includes the depreciated replacement cost methodology; or
- The income approach converts multiple future cash flows amounts to a single current (i.e. discounted) amount. When the income approach is used, the fair value measurement reflects current market expectations about those future amounts.

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

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 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, Sarina and Bowen including outpatient and primary care clinics.

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

A2 CONTROLLED ENTITIES

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

A2-1 DISCLOSURES ABOUT NON WHOLLY-OWNED CONTROLLED ENTITIES

North Queensland Primary Health Network Limited (NQPHNL) was established as a public company limited by guarantee on 21 May 2015. Mackay Hospital and Health Service is one of six 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) and the Australian College of Rural and Remote Medicine 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 (16.6%), 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 NQPNHL 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.

SECTION B
NOTES ABOUT OUR FINANCIAL PERFORMANCE

B1 REVENUE

B1-1 USER CHARGES AND FEES

	2016 $'000	2015 $'000
Pharmaceutical Benefit Scheme	7,878	7,538
Sales of goods and services	2,050	1,033
Hospital fees	18,567	16,337
	28,495	**24,908**

Accounting Policy – User charges and fees

User charges and fees are recognised as revenues when earned and can be measured reliably with sufficient degree of certainty. This occurs upon delivery of the goods to the customer or completion of the requested services at which time the invoice is raised. Accrued revenue is recognised if the revenue has been earned but not yet invoiced. Revenue in this category primarily consists of hospital fees (private patients), reimbursements of pharmaceutical benefits, and sales of goods and services.

B1-2 FUNDING PUBLIC HEALTH SERVICES

	2016 $'000	2015 $'000
Activity based funding	236,276	221,915
Block funding	41,757	38,934
Teacher training funding	7,808	7,744
Depreciation funding	26,780	18,757
General purpose funding	12,897	17,894
	325,518	**305,244**

Disclosure about funding received to deliver public health services

Funding is provided predominantly by the Department of Health in accordance with a service agreement. The Department of Health receives its funding from the Queensland Government and the Australian Government. The Department purchases delivery of health services based on nationally set funding and efficient pricing models determined by the Independent Hospital Pricing Authority (IHPA). The majority of services are funded on an activity unit basis. Block and other funding is not based on levels of public health care activity. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by MHHS. Funding is received fortnightly in advance. At the end of the financial year, a financial adjustment may be required where the level of services provided is above or below the agreed level. State funding is also provided for depreciation and minor capital works. Funding for depreciation charges is via a non-cash revenue. The Department retains the cash to fund future major capital replacements. This is achieved through a withdrawal of funds from equity refer Note C6-1.

B1-3 GRANTS AND OTHER CONTRIBUTIONS

	2016 $'000	2015 $'000
Australian Government grants		
Home and community care grants	3,559	3,525
Specific purpose payments	2,989	5,063
Total Australian Government grants	6,548	8,588
Other grants		
Other grants*	1,305	1,409
	7,853	**9,997**

* A jointly funded project between the state government and local council to construct a new Dysart medical centre on MHHS land was completed in August 2015. The construction project was managed by the Isaac Regional Council and transferred on practical completion to the MHHS. The replacement cost at the time of the asset transfer was $829 thousand.

Accounting Policy – Grants, contributions, donations and gifts

Grants, contributions, donations and gifts that are non-reciprocal in nature (do not require any goods or services to be provided in return) are recognised in the year in which the Hospital and Health Service obtains control over the funds.

Contributed assets are recognised at their fair value.

B1-4 OTHER REVENUE

	2016 $'000	2015 $'000
Sales proceeds for assets	56	-
Recoveries	4,520	5,778
Other	468	252
	5,044	**6,030**

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.

B2 EXPENSES

B2-1 EMPLOYEE BENEFIT EXPENSE

	2016	*2015*
	$'000	*$'000*
Employee benefits		
Wages and salaries	29,802	23,343
Annual leave levy	1,943	1,512
Employer superannuation contributions	2,028	1,708
Long service leave levy	597	481
Employee related expenses		
Workers compensation premium	67	77
Other employee related expenses	329	282
	34,766	**27,403**
	No.	No.
Full-Time Equivalent Employees*	81	76

*reflecting Minimum Obligatory Human Resource Information (MOHRI)

Accounting Policy – Superannuation

Employer superannuation contributions are paid to QSuper, the superannuation scheme for Queensland Government employees, at rates determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are paid or payable and MHHS's obligation is limited to its contribution to QSuper.

The QSuper scheme has defined benefit and defined contribution categories. 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*.

Board members and Visiting Medical Officers are offered a choice of superannuation funds and MHHS pays superannuation contributions into a complying superannuation fund. Contributions are expensed in the period in which they are paid or payable. MHHS's obligation is limited to its contribution to the superannuation fund. As such no liability is recognised for accruing superannuation benefits in the Hospital and Health Service's financial statements.

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

Accounting Policy – Employee benefits

Wages and salaries due but unpaid at reporting date are recognised 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

Mackay Hospital and Health Service 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 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.

B2-2 HEALTH SERVICE EMPLOYEE EXPENSES

	2016	*2015*
	$'000	*$'000*
Department of Health	196,878	183,118
	196,878	**183,118**

The Hospital and Health Service through service arrangements with the Department of Health has engaged 1,960 (2015: 1,789) 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. Under this arrangement:

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

B2-3 SUPPLIES AND SERVICES

	2016 $'000	2015 $'000
Consultants and contractors~	20,183	14,341
Electricity and other energy	4,316	4,583
Patient travel#	10,465	10,235
Other travel	1,587	1,297
Building services	2,236	1,954
Computer services	2,114	1,585
Communications	3,538	3,321
Repairs and maintenance	11,305	9,048
Operating lease rentals	1,314	1,861
Outsourced supplies and services+	6,112	2,763
Inventories consumed		
Drugs *	11,221	11,838
Clinical supplies and services *	13,023	13,153
Catering and domestic supplies	1,841	1,888
Pathology, blood and parts	9,123	8,798
Other^	8,844	8,786
	107,222	**95,451**

Includes payments for aero medical services provided by Royal Flying Doctors Service.

^ includes ambulance patient travel costs.

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.

*In 2016, stock on hand of $1.843 million was recognised as inventory for the first time.

~Payments for contractors increased in 2016, reflecting the employment of additional medical staff to meet higher patient activity, including initiatives to reduce waiting times for specialist out-patient appointments and elective surgery.

+Outsourcing of services to external organisations increased in 2016 as part of a strategy to further reduce waiting times for outpatients. In addition, services provided under "Hospital in the Homes" program were extended.

B2-4 REVALUATION DECREMENTS

	2016 $'000	2015 $'000
Revaluation decrement*	**1,983**	2,945
	1,983	**2,945**

* Accumulated decrements, recognised as an expense in the current and previous year, totalled $4.928 million at 30 June 2016.

Accounting Policy - Revaluations

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.

B2-5 OTHER EXPENSES

	2016 $'000	2015 $'000
Insurance premiums - QGIF	3,625	3,651
Insurance premiums - Other	58	35
Losses from the disposal of non-current assets	405	118
Special payments		
Ex-gratia payments	15	6
Other legal costs	758	851
Other	1,470	1,171
	6,331	**5,832**

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.

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 2015-16 policy year, the premium was allocated to each HHS according to the underlying risk of an individual insured party.

Special payments represent ex gratia expenditure and other expenditure that the HHS is not contractually or legally obligated to make to other parties. MHHS maintains a register of all special payments greater than $5,000.

B2-6 AUDITOR REMUNERATION

	2016 $	2015 $
Audit services - Queensland Audit Office		
Audit of financial statements	**160,000**	**165,000**

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

SECTION C
NOTES ABOUT OUR FINANCIAL POSITION

C1 CASH AND CASH EQUIVALENTS

	2016 $'000	2015 $'000
Imprest accounts	7	8
Cash at bank*	59,458	71,507
QTC cash funds*	1,320	1,284
	60,785	**72,799**

Cash deposited with Queensland Treasury Corporation earns interest, calculated on a daily basis reflecting market movements in cash funds. The annual effective interest rate was 2.85% (2015: 2.84%).

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 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 2016, amounts of $1.6 million (2015:$1.7 million) in General Trust, $873 thousand (2015:$869 thousand) for excess earnings under Granted Private Practice, were set aside for the specified purposes underlying the contribution.

C2 RECEIVABLES

	2016 $'000	2015 $'000
Trade debtors	5,571	3,384
Payroll receivables	2	3
Less: Allowance for impairment	(390)	(258)
	5,183	3,129
GST receivable	1,119	976
GST payable	(58)	(25)
	1,061	951
Funding public health services	5,772	8,173
Other	631	150
	12,647	**12,403**

Trade debtors includes receivables of $4.15 million. (2015: $2.6 million) from health funds (reimbursement of patient fees), $515 thousand (2015: $135 thousand) from Department of Health (recovery of costs), $151 thousand from NQPHN and $750 thousand (2015: $646 thousand) external debtors.

All known bad debts were written-off as at 30 June 2016. In 2016, $184 thousand (2015:$206 thousand) was written-off. All receivables within terms and expected to be fully collectible are considered of good credit quality based on recent collection history. Credit risk management strategies are detailed in Note D2.

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, while other receivables may take longer than twelve months. No interest is charged and no security is obtained.

Disclosure – Credit Risk Exposure of Receivables

Credit risk is the potential for financial loss arising from a counterparty defaulting on its obligations. The maximum exposure to credit risk at balance date for receivables is the gross carrying amount of those assets inclusive of any allowance for impairment.

No collateral is held as security and no credit enhancements relate to receivables held by the MHHS. In terms of collectability, receivables will fall into one of the following categories:

- within terms and expected to be fully collectible
- within terms but impaired
- past due but not impaired
- past due and impaired

The collectability of receivables is assessed periodically with provision being made where receivables are impaired. Note C2-1 details the accounting policies for impairment of receivables, including the loss events giving rise to impairment and the movements in the provision for impairment.

C2-1 IMPAIRMENT OF RECEIVABLES

Throughout the year, MHHS assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes financial difficulties of the debtor, changes in debtor credit ratings and current outstanding accounts over 120 days. The allowance for impairment reflects MHHS's assessment of the credit risk associated with receivable balances and is determined based on historical rates of bad debts (by category) over the past three years and management judgement. The allowance for impairment reflects the occurrence of loss events. If no loss events have arisen in respect of a particular debtor or group of debtors, no allowance for impairment is made in respect of that debt/group of debtors. If MHHS determines that an amount owing by such a debtor does become uncollectible (after appropriate range of debt recovery actions), that amount is recognised as a bad debt expense and written-off directly against receivables. In other cases where a debt becomes uncollectible but the uncollectible amount exceeds the amount already allowed for impairment of that debt, the excess is recognised directly as a bad debt expense and written-off directly against receivables. Impairment loss expense for the current year regarding receivables is $390 thousand (2015:$258 thousand).

C2 RECEIVABLES (continued)

Disclosure – Individually impaired receivables position (aged)

Mackay Hospital and Health Service does not individually impair receivables.

Disclosure - Movement in allowance for impairment for receivables

	2016	*2015*
	$'000	*$'000*
Balance at beginning of the year	258	319
Amounts written off during the year	(184)	(206)
Increase/(decrease) in allowance recognised in operating result	316	144
Balance at the end of the year	**390**	**258**

Disclosure - Ageing of past due but not impaired trade receivables

	2016	*2015*
	$'000	*$'000*
Not overdue	7,509	8,940
Overdue		
Less than 30 days	2,597	1,726
30 to 60 days	1,187	809
60 to 90 days	515	351
Greater than 90 days	839	577
Total	**12,647**	**12,403**

C3 INVENTORIES

	2016	*2015*
	$'000	*$'000*
Inventories held for distribution - at cost		
Pharmaceutical drugs*	2,062	2,000
Clinical supplies*	1,787	187
Catering and domestic	6	4
	3,855	**2,191**

Accounting Policy – Inventories

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

*Clinical supplies and pharmaceutical drugs, held for use in the wards and throughout the hospital and health facilities, are recognised as inventory for the first time in 2015-16.

C4 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION

C4-1 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 and Land Improvements	$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 a comprehensive 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.

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, including all other costs incurred in getting the assets ready for use, including architects' fees and engineering design fees.

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 of property plant and equipment 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.

C4 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

Measurement of property plant and equipment using historical cost

Plant and equipment, is measured at historical cost net of accumulated depreciation and accumulated impairment losses in accordance with NCAP. The carrying amounts for plant and equipment at cost is not materially differ from their fair value.

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 by the use of 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 Chief Finance Officer. The appointment of the independent valuer was undertaken following pre-approval through a Department of Health process.

Comprehensive revaluations are undertaken at least once every five years. However, if a particular asset class experiences significant and volatile changes in fair value, that class is subject to specific appraisal in the reporting period, where 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 kept up-to-date 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 warrants 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 adjusted for the cost to bring an asset to current standards. Buildings are measured at fair value by applying either, a revised estimate of individual asset's depreciated 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 particular circumstances.

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. In that case, it is recognised as income. A decrease in the carrying amount on revaluation is charged as an expense, to the extent it exceeds the balance, if any, in the revaluation surplus relating to that asset class.

On revaluation buildings are revalued using a cost valuation method (e.g. Depreciated replacement cost). Accumulated depreciation is adjusted to equal the difference between the gross amount and the carrying amount, after taking into account 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 future economic benefits 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 put to use 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. In accordance with Queensland Treasury's *Non-current Asset Policy 2*, MHHS has determined all specialised health service buildings with a gross replacement value of $3 million or more are complex in nature and warrant componentisation (separate useful lives assigned to component parts). These building comprise six components:

- Structural fabric of building
- External fabric
- Internal finishes
- Internal fabric
- Fittings
- Building services

Useful lives for assets revalued are amended progressively as assets are inspected by the valuers.

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.

C4 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

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

Class	Depreciation rates
Buildings and Improvements	
- Structural fabric of building	0.9 to 6.3%
- External fabric	0.9 to 6.3%
- Internal fabric	1.5 to 11.1%
- Internal finishes	1.7 to 11.1%
- Fittings	2 to 10%
- Building services	1.7 to 7.1%
- Land improvements	1.4 to 2.9%
- Other buildings including residential	0.9 to 7.7%
Plant and equipment including artworks	1.0 - 20.0%

In the prior period, Building and Improvements had depreciated between1% to 9% and Plant and equipment had rates of 3% to 20%.

Impairment of non-current assets

Key judgement and estimate: All non-current physical assets are assessed for indicators of impairment on an annual basis. If an indicator of possible impairment exists, management determines the asset's recoverable amount (higher of value in use and fair value less costs to sell).

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 an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of its recoverable amount, but so that the increased carrying amount does not exceed the carrying amount that would have been determined had no impairment loss been recognised for the asset in prior years. A reversal of an impairment loss is recognised as income, unless the asset is carried at a revalued amount, in which case the reversal of the impairment loss is treated as a revaluation increase.

C4 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

C4-2 PROPERTY, PLANT AND EQUIPMENT - BALANCES AND RECONCILIATIONS OF CARRYING AMOUNT

2016	Land (at fair value) $'000	Buildings (at fair value) $'000	Plant and equipment (at cost) $'000	Capital works in progress (at cost) $'000	Total $'000
Gross	14,105	529,215	48,902	955	593,177
Less: Accumulated depreciation	-	(157,618)	(25,424)	-	(183,042)
Carrying amount at 30 June 2016	**14,105**	**371,597**	**23,478**	**955**	**410,135**
Represented by movements in carrying amount:					
Carrying amount at 1 July 2015	16,173	395,541	23,318	739	435,771
Transfers in - practical completion projects from the Department	-	1,198	-	-	1,198
Transfers in from other Queensland Government entities	-	-	1	-	1
Acquisitions	-	2,980	5,085	752	8,817
Donated assets	-	829	-	-	829
Disposals	-	(212)	(145)	-	(357)
Transfers out to other Queensland Government entities	(85)	(161)	(42)	-	(288)
Transfers between classes	-	536	-	(536)	-
Net revaluation increments/(decrements)	(1,983)	(7,073)	-	-	(9,056)
Depreciation expense	-	(22,041)	(4,739)	-	(26,780)
Carrying amount at 30 June 2016	**14,105**	**371,597**	**23,478**	**955**	**410,135**

C4-2 PROPERTY, PLANT AND EQUIPMENT - BALANCES AND RECONCILIATIONS OF CARRYING AMOUNT (continued)

2015	Land (at fair value) $'000	Buildings (at fair value) $'000	Plant and equipment (at cost) $'000	Capital works in progress (at cost) $'000	Total $'000
Gross	16,173	489,183	45,910	739	552,005
Less: Accumulated depreciation	-	(93,642)	(22,592)	-	(116,234)
Carrying amount at 30 June 2015	**16,173**	**395,541**	**23,318**	**739**	**435,771**
Represented by movements in carrying amount:					
Carrying amount at 1 July 2014	18,925	316,625	24,096	511	360,157
Transfers in - practical completion projects from the Department	1,201	93,549	-	-	94,750
Transfers in from other Queensland Government entities	-	-	595	-	595
Acquisitions	-	804	3,202	739	4,745
Donated assets	-	-	49	-	49
Disposals	-	-	(118)	-	(118)
Transfers out to other Queensland Government entities	(749)	(933)	(7)	-	(1,689)
Transfers between classes	-	440	71	(511)	-
Net revaluation increments/(decrements)	(3,204)	(757)	-	-	(3,961)
Depreciation expense	-	(14,187)	(4,570)	-	(18,757)
Carrying amount at 30 June 2015	**16,173**	**395,541**	**23,318**	**739**	**435,771**

C4 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION (continued)

C4-3 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 and Mines.

MHHS's land was last comprehensively revalued based on specific appraisals by the State Valuation Service effective 30 June 2015. 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 take into account 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.

Land indices were applied in 2016 reflecting approximate market movements in land valuations since June 2015. The State Valuation Service provided appropriate indices derived from data on land sales in the respective areas during the previous year. Indexation resulted in a decrement of $1.9 million (2015: $3.2 million) to the carrying amount of land.

Buildings

MHHS engaged independent quantity surveyors, AECOM Pty Ltd in 2015-16 to comprehensively revalue all buildings with a replacement cost exceeding $3 million, and calculate relevant indices for all other assets. In determining the values reported in the accounts for MHHS buildings we have relied on the information provided by the independent valuers and quantity surveyors.

The balance of assets have had indices applied, approximating movement in market prices for labour and other key resource inputs, as well as changes in design standards as at reporting date. Refer to Note D1-4 for further details on the revaluation methodology applied.

The revaluation program resulted in a decrement of $7millon (2015: decrement $757 thousand) to the carrying amount of buildings.

Depreciation buildings

Change in estimate

Queensland Treasury's *Non-Current Asset Policies for the Queensland Public Sector No 2* requires where significant components of a building are replaced at varying intervals i.e. different useful lives, and the impact is material to depreciation expense, componentisation is to be applied. An assessment of the actual replacement cycle for components within special purpose buildings (representing 92% of buildings controlled by MHHS) and the impact on depreciation expense was undertaken in 2015-16 with material differences in depreciation noted. All hospital buildings with a gross replacement value of $3 million or more were comprehensively revalued as at 1 July 2015.

Useful lives were reassessed by AECOM as part of the valuation. Remaining useful life (RUL) has declined significantly for hospital buildings, in both rural and urban environments, reflecting 2015-16 physical building condition assessments and asset replacement/refurbishment practices within MHHS. Previously, useful life was determined based on a standard model applied across the State. In 2015-16, AECOM modified these assumptions to reflect historical experience and current asset replacement plans within MHHS facilities. This has resulted in depreciation expense increasing $6.7 million in the current year. The impact on depreciation expense over the next five years will decline slightly, with estimates ranging from $6 million in 2016-17 to $4.8 million by 2020-21.

Depreciation expense on buildings and land improvements increased by $255 thousand as a result of revaluations as at 30 June 2015.

C5 PAYABLES

C5-1 PAYABLES

	2016	*2015*
	$'000	*$'000*
Trade creditors	11,151	12,459
Accrued labour - Department of Health	6,070	7,091
Other	1,452	725
	18,673	**20,275**

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, gross of applicable trade and other discounts. The amounts are unsecured and normally settled within 30 - 60 days.

C6 EQUITY

C6-1 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 2016 MHHS received $5.8 million (2015 $4 million) 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:

During this year a number of assets have been transferred under this arrangement.	*2016* *$'000*	*2015* *$'000*
Transfer in - practical completion of projects from the Department*	1,198	94,750
Net transfer of property, plant and equipment "from/to" the Department	(85)	(1,122)
Net transfers equipment between HHS	(202)	26
	911	**93,654**

*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 to MHHS.

- Equity withdrawal of funds by the Department of Health on behalf of the State, MHHS received $26.8 million funding in 2016 (2015 $18.7 million) 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.

C6-2 ASSET REVALUATION SURPLUS BY ASSET CLASS

	2016 *$'000*	*2015* *$'000*
Land		
Balance at the beginning of the financial year	-	260
Revaluation increments/(decrements)	**-**	(260)
Balance at the end of the financial year	**-**	**-**
Buildings		
Balance at the beginning of the financial year	21,438	22,195
Revaluation increments/(decrements)	(7,073)	(757)
Balance at the end of the financial year	**14,365**	**21,438**
Total	**14,365**	**21,438**

Accounting Policy - Asset revaluation surplus

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

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 sufficient relevant and reliable observable inputs are not available for similar assets/liabilities.

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

Fair value measurement hierarchy

MHHS does not recognise any financial assets or financial liabilities at fair value.

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.

D1-2 CATEGORISATION OF ASSETS AND LIABILITIES MEASURED AT FAIR VALUE

	Level 2		Level 3		Total	
	$'000		*$'000*		*$'000*	
	2016	*2015*	*2016*	*2015*	*2016*	*2015*
Land	14,105	16,173	-	-	14,105	16,173
Buildings	-	-	371,597	395,541	371,597	395,541

D1-3 LEVEL 3 FAIR VALUE MEASUREMENT - RECONCILIATION

	Buildings	
	2016	*2015*
	$'000	*$'000*
Carrying amount at 1 July	395,541	316,625
Transfers in - practical completion projects from the Department	1,198	93,549
Acquisitions	2,980	804
Transfers out to other Queensland Government entities	(161)	(933)
Donated assets	829	-
Transfer between asset classes	536	440
Disposals	(212)	-
Net revaluation increments/(decrements)	(7,073)	(757)
Depreciation charge	(22,041)	(14,187)
Carrying amount at 30 June	**371,597**	**395,541**

D1 FAIR VALUE MEASUREMENT (continued)

D1-4 LEVEL 3 FAIR VALUE MEASUREMENT - SIGNIFICANT VALUATION INPUTS AND IMPACT ON FAIR VALUE

The fair value of health service buildings is computed by quantity surveyors, AECOM. The methodology is known as the Depreciated Replacement Cost valuation technique. The major variables in determining the valuation include:

- Replacement cost estimates;
- Remaining useful life estimates;
- Cost to bring to current standards; and
- Condition rating.

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. The valuation assumes a replacement building will provide the same service function and form (shape and size) as the original building but built consistent with current building standards. Area estimates were compiled by measuring floor areas of Project Services e-plan room or drawings obtained from MHHS. Refurbishment costs were derived from specific projects and are therefore indicative of actual costs.

Significant judgement is also used to assess the remaining service potential of the facility, given local climatic and environmental conditions and records of the current condition of the facility.

The 'cost to bring to current standards' is the estimated cost of refurbishing the asset to bring it to current design standards and in an "as" new condition. This estimated cost is linked to the condition factor of the building assessed by the quantity surveyor. It is also representative of the deemed remaining useful life of the building.

The condition of the building is based on visual inspection, asset condition data, guidance from asset managers and previous reports. In assessing the condition of a building the ratings as per the International Infrastructure Management Manual were applied. The condition rating of an asset is used as a mechanism to determine the cost to bring to current standards and also to estimate the remaining life. 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. Presently all major refurbishments are funded by the Department of Health.

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	2016 $'000	2015 $'000
Financial assets			
Cash and cash equivalents	C1-1	60,785	72,799
Receivables	C2-1	12,647	12,403
Total		**73,432**	**85,202**
Financial liabilities			
Financial liabilities at amortised cost - comprising:			
Payables	C5-1	18,673	20,275
Total		**18,673**	**20,275**

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 active management of accrual accounts
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 sufficient funds are available to meet employee and supplier obligations at all times. An approved debt facility of $3 million (2015: $3 million) under whole-of-Government banking arrangements to manage any short term cash shortfalls has been established. No funds have been withdrawn against this debt facility as at 30 June 2016 (2015: Nil).

All financial liabilities are current in nature and will be due and payable within twelve months. As such no discounting has been applied.

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.

Fair value

Cash and cash equivalents are measured at fair value. The fair value of trade receivables and payables is assumed to approximate the value of the original transaction, less any allowance for impairment.

D3 CONTINGENCIES

(a) Litigation in Progress

As at 30 June 2016, the following cases were filed in the courts naming the State of Queensland acting through the Mackay Hospital and Health Service as defendant:

	2016 Number of cases	2015 Number of cases
Supreme Court	1	-
District Court	-	-
Magistrates Court	-	-
Tribunals, commissions and boards	1	2
	2	**2**

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 - refer Note B2-5. As at 30 June 2016, MHHS has 27 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).

Tribunals, commissions and board figures represent the matters that have been referred to QGIF for management. MHHS's legal advisers and management believe it would be misleading to estimate the final amounts payable (if any) in respect of the litigation before the courts at this time.

D4 COMMITMENTS

(a) Non-cancellable operating lease commitments

MHHS has non-cancellable operating leases relating predominantly to office and residential accommodation. Lease payments are generally fixed, but with escalation clauses on which contingent rentals are determined. No lease arrangements contain restrictions on financing or other leasing activities.

	2016 $'000	*2015 $'000*
Commitments under operating leases at reporting date are exclusive of GST and are payable as follows:		
No later than 1 year	108	226
Later than 1 year but no later than 5 years	-	21
Total	**108**	**247**

(b) Capital expenditure commitments

	2016 $'000	*2015 $'000*
Material classes of capital expenditure commitments exclusive of GST, contracted for at reporting date but not recognised in the accounts are payables as follows:		
Building		
No later than 1 year	5,608	-
Total	**5,608**	**-**
Plant and Equipment		
No later than 1 year	53	316
Total	**53**	**316**

D5 EVENTS AFTER THE BALANCE DATE

Non adjusting events

MHHS deems the identified events after the reporting period to be non-adjusting events. Accordingly, MHHS will not adjust any amounts recognised in its financial statements relating to the non-adjusting events. No other matter or circumstance has arisen since 30 June 2016 that has significantly affected, or may significantly affect MHHS's operations, the results of those operations, or MHHS's state of affairs in future financial years.

D6 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE

At the date of authorisation of the financial report, the expected impacts of new or amended Australian Accounting Standards issued but with future commencement dates are set out below:

AASB 124 – Related Party Disclosures

From reporting periods beginning on or after 1 July 2016, MHHS will need to comply with the requirements of AASB 124 *Related Party Disclosures*. That accounting standard requires a range of disclosures about the remuneration of key management personnel, transactions with related parties/entities, and relationships between parent and controlled entities. MHHS already discloses information about the remuneration expenses for key management personnel (refer to Note G1) in compliance with requirements from Queensland Treasury. Therefore, the most significant implications of AASB 124 for MHHS's financial statements will be the disclosures to be made about transactions with related parties, including transactions with key management personnel or close members of their families.

Effective from reporting periods beginning on or after 1 July 2016, a revised version of AASB 124 will apply to the MHHS. AASB 124 requires disclosures about the remuneration of key management personnel (KMP), transactions with related parties, and relationships between parent and controlled entities.

The MHHS already discloses detailed information about remuneration of its KMP, based on Queensland Treasury's Financial Reporting Requirements for Queensland Government Agencies. Due to the additional guidance about the KMP definition in the revised AASB 124, the MHHS will be assessing whether its responsible Minister should be part of its KMP from 2016-17. If the responsible Minister is assessed as meeting the KMP definition, no associated remuneration figures will be disclosed by the MHHS, as it does not provide the Minister's remuneration. Comparative information will continue to be disclosed in respect of KMP remuneration.

The most significant implications of AASB 124 for the MHHS are the required disclosures about transactions between the MHHS and its related parties (as defined in AASB 124). For any such transactions, from 2016-17, disclosures will include the nature of the related party relationship, as well as information about those transactions' terms/conditions and amounts, any guarantees given/received, outstanding receivables/ payables, commitments, and any receivables where collection has been assessed as being doubtful. In respect of related party transactions with other Queensland Government controlled entities, the information disclosed will be more high level, unless a transaction is individually significant. No comparative information is required in respect of related party transactions in the 2016-17 financial statements.

AASB 15 *Revenue from Contracts with Customers*

This standard will become effective from reporting periods on or after 1 January 2018 and contains much more detailed requirements for the accounting for certain types of revenue from customers. Depending on the specific contractual terms, the new requirements may potentially result in a change to the timing of revenue from sales of MHHS's goods and services, such that some revenue may need to be deferred to a later reporting period to the extent that MHHS has received cash but has not met its associated obligations (such amounts would be reported as a liability - unearned revenue in the meantime). MHHS is yet to complete its analysis of current arrangements for sale of its goods and services, but at this stage does not expect a significant impact on its present accounting practices.

AASB 9 Financial Instruments and AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014)

These Standards will become effective from reporting periods beginning on or after 1 January 2018. The main impacts of these standards on MHHS are that they will change the requirements for the classification, measurement, impairment and disclosures associated with MHHS's financial assets. AASB 9 will introduce different criteria for whether financial assets can be measured at amortised cost or fair value.

MHHS has commenced reviewing the measurement of its financial assets against the new AASB 9 classification and measurement requirements. However, as the classification of financial assets at the date of initial application of AASB 9 will depend on the facts and circumstances existing at that date, MHHS's conclusions will not be confirmed until closer to that time. At this stage, and assuming no change in the types of transactions entered into, the carrying value of MHHS's current receivables is not expected to change.

Another impact of AASB 9 relates to calculating impairment losses for MHHS's receivables. Assuming no substantial change in the nature of MHHS's receivables, as they don't include a significant financing component, impairment losses will be determined according to the amount of lifetime expected credit losses. On initial adoption of AASB 9, MHHS will need to determine the expected credit losses for its receivables by comparing the credit risk at that time to the credit risk that existed when those receivables were initially recognised.

MHHS will not need to restate comparative figures for financial instruments on adopting AASB 9 as from 2018-19. However, changed disclosure requirements will apply from that time. A number of one-off disclosures will be required in the 2018-19 financial statements to explain the impact of adopting AASB 9. Assuming no change in the types of financial instruments that MHHS enters into, the most likely ongoing disclosure impacts are expected to relate to the credit risk of financial assets subject to impairment.

AASB 16 Leases was issued in February 2016 and applies to annual reporting beginning on or after 1 January 2019. This standard introduces a single lessee accounting model and requires a lessee to recognise assets and liabilities for all leases (both operating and finance) with a term of more than 12 months, unless the underlying asset is of low value. A lessee is required to recognise a right-of-use asset representing its right to use the underlying asset and a lease liability representing its obligations to make lease payments. Lessors continue to classify leases as operating or finance. Presently MHHS has minimal non-cancellable operating leases with a term exceeding 12 months and as such it is not anticipated that the impact of changes to the accounting standards for leases will have a material impact.

All other Australian accounting standards and interpretations with new or future commencement dates are either not applicable to MHHS's activities, or have no material impact on the MHHS.

SECTION E
NOTES ON OUR PERFORMANCE COMPARED TO BUDGET

E1 BUDGETARY REPORTING DISCLOSURES

This section discloses MHHS's original published budgeted* figures for 2015-16 compared to actual results, with explanations of major variances, in respect of MHHS's Statement of Comprehensive Income, Statement of Financial Position and Statement of Cash Flows. A budget to actual comparison, and explanations of major variances, has not been included for the Statement of Changes in Equity, as major variances relating to that statement have been addressed in explanations of major variances for other statements.

E2 BUDGET TO ACTUAL COMPARISON – STATEMENT OF COMPREHENSIVE INCOME

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

		Original SDS Budget	*Reclassified SDS Budget	Actual	Reclassified SDS Budget V Actual	
	Variance	2016	2016	2016	Variance	Variance % of Budget
	Notes	$'000	$'000	$'000	$'000	Budget
OPERATING RESULT						
Income from Continuing Operations						
User charges and fees	V1.	319,070	21,862	28,495	6,633	30%
Funding public health services	V2.	-	297,208	325,518	28,310	10%
Grants and other contributions		8,342	8,342	7,853	(489)	(6%)
Interest		65	-	-	-	0%
Other revenue		235	300	5,044	4,744	1581%
Total Revenue		**327,712**	**327,712**	**366,910**	**39,198**	
Total Income from Continuing Operations		**327,712**	**327,712**	**366,910**	**39,198**	
Expenses from Continuing Operations						
Employee expenses		33,912	33,912	34,766	854	3%
Health service employee expenses	V3.	169,069	169,069	196,878	27,809	16%
Supplies and services	V4.	99,983	96,367	107,222	10,855	11%
Depreciation and amortisation	V5.	23,659	23,659	26,780	3,121	13%
Grants and subsidies		14	-	-	-	0%
Impairment losses		218	-	-	-	0%
Revaluation decrement		-	-	1,983	1,983	100%
Other expenses		857	4,705	6,331	1,626	35%
Total Expenses from Continuing Operations		**327,712**	**327,712**	**373,960**	**46,248**	
Operating Results from Continuing Operations		**-**	**-**	**(7,050)**	**(7,050)**	
Other Comprehensive Income						
Items Not Recyclable to Operating Result						
Increase/(decrease) in Asset Revaluation Surplus		24,484	24,484	(7,073)	(31,557)	(129%)
Total Items Not Recyclable to Operating Result		**24,484**	**24,484**	**(7,073)**	**(31,557)**	
Total Comprehensive Income		**24,484**	**24,484**	**(14,123)**	**(38,607)**	

Note:
*Original Published Budget from the Service Delivery Statement (SDS) has been reclassified to improve transparency and analysis with comparatives by remapping particular budgeted transactions on the same basis as reported in actual financial statements (reclassified SDS Budget). Reclassification has occurred for:

Statement of Comprehensive Income:

- *User charges in the original SDS has been dissected into User charges and Funding public health services.*
- *Interest revenue has been rolled into other revenue as immaterial for actual reporting.*
- *Grants and subsidies and impairment losses in original SDS have been rolled into Other expenses as immaterial by size for individual reporting. Premiums paid for Queensland Government Insurance Fund have been reclassified from supplies and services to Other expenses, consistent with their disclosure in the actual reporting.*
- *Bank charges included in Other expenses in original SDS has been reclassified as Supplies and services.*

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

E2-2 EXPLANATION OF MAJOR VARIANCES - STATEMENT OF COMPREHENSIVE INCOME

In analysing the financial statements it should be noted that while the Statement of Comprehensive Income and the Statement of Financial Position are prepared based on accrual concepts, the Statement of Cash Flows discloses cash inflows and outflows of MHHS. This will cause some differences in amounts recorded under each line on the different statements.

V1. User charges

User charges exceeded budget by $6.633 million for the year ended 30 June 2016. The increase is primarily attributable to improved sales of goods and services $1.821 million, and higher hospital fees $4.812 million.

Patient activity was considerably higher than forecast at the time of the Budget, resulting in increased claims against the Pharmaceutical Benefits and Child Dental Benefits Schemes; higher revenue from private patients, including private bed charges and improved sales of prosthetics. Recoveries generated under the Private Practice arrangements with doctors also generated fees exceeding budget expectations.

V2. Funding public health services

The increase relates to additional funding provided through amendments to the Service Agreement between Mackay Hospital and Health Service and the department. Additional funding was provided for higher service activity $15.748 million, enterprise bargaining agreements $4.677 million, depreciation expense $5.714 million, changes in funding arrangements for multipurpose health centres and workers compensation claims $1.463 million and backlog maintenance funding $708 thousand.

V3. Health service employee expenses

Health service employee expenses were $196.878 million at 30 June 2016 compared to $169.069 million per the SDS budget.

This increase primarily reflects higher than anticipated demand for hospital services and the settlement of employee wage bargaining negotiations funded after the 2015-16 budget was finalised.

The cost of settlement of enterprise bargaining agreements was approximately $9 million.

Patient activity targets (PQWAU) increased 27% in 2016 over previous years. In addition, 2016 included a number of initiatives, approved by the Board, to improve health service delivery to the community such as reduction of waiting times for specialist outpatient appointments, improving elective surgery within clinically recommended timeframes, and preparation for enhanced clinical information systems – the Digital Hospital. These services were funded out of retained earnings and included employment of additional staff.

The number of full time equivalent (FTE) positions at 30 June 2016 has increased by 171 FTEs to 1,960 representing a further $19 million increased costs. This represents a 10% growth in FTEs since 2015.

V4. Supplies and services

Supplies and services expenditure exceeded SDS original budget by $10.855 million at 30 June 2016. The increase is primarily attributable to higher patient activity. The original PQWAU target for the financial year was 39,751, this compares against achieved activity of 50,504 in 2016, an improvement of 27%. To provide these additional patient services, costs were incurred above that forecast at budget time. In particular, the employment of additional temporary medical staff and outsourcing of clinical services added a further $9.180 million to supplies and services. Repairs and maintenance were also higher as further works were undertaken as part of the Backlog Maintenance Programme.

V5. Depreciation and amortisation

Useful lives were reassessed by AECOM as part of the building valuation process. Remaining useful life (RUL) declined for hospital buildings, reflecting 2016 physical building condition assessments and asset replacement/refurbishment practices within MHHS. This has resulted in depreciation expense increasing $3.121 million over that estimated in the SDS budget.

E3 BUDGET TO ACTUAL COMPARISON – STATEMENT OF FINANCIAL POSITION

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

	Variance Notes	Original SDS Budget 2016 $'000	*Reclassified SDS Budget 2016 $'000	Actual 2016 $'000	Reclassified SDS Budget V Actual Variance $'000	Reclassified SDS Budget V Actual Variance % of Budget
Current Assets						
Cash and cash equivalents		61,971	61,971	60,785	(1,186)	(2%)
Receivables	V6.	5,769	6,125	12,647	6,522	106%
Inventories		1,685	1,685	3,855	2,170	129%
Other		427	-	-	-	0%
Total Current Assets		**69,852**	**69,781**	**77,287**	**7,506**	
Non-Current Assets						
Property, plant and equipment	V7.	490,117	490,117	410,135	(79,982)	(16%)
Total Non-Current Assets		**490,117**	**490,117**	**410,135**	**(79,982)**	
Total Assets		**559,969**	**559,898**	**487,422**	**(72,476)**	
Current Liabilities						
Payables	V8.	15,279	15,291	18,673	3,382	22%
Accrued employee benefits		25	-	-	-	0%
Unearned revenue		58	-	-	-	0%
Total Current Liabilities		**15,362**	**15,291**	**18,673**	**3,382**	
Total Liabilities		**15,362**	**15,291**	**18,673**	**3,382**	
Net Assets		**544,607**	**544,607**	**468,749**	**(75,858)**	
Equity	V9.	**544,607**	**544,607**	**468,749**	**(75,858)**	

Note:
*Original Published Budget from the Service Delivery Statement (SDS) has been reclassified to improve transparency and analysis with comparatives by remapping particular budgeted transactions on the same basis as reported in actual financial statements (reclassified SDS Budget). Reclassification has occurred for:

Statement of Financial Position:

- Other assets have been rolled into receivables due to immaterial size for actual reporting.
- GST payable has been offset with GST receivable to align with the treatment required in the reporting of actual under Queensland Treasury's *Financial Reporting Requirements*.
- Accrued employee benefits and unearned revenue in original SDS have been aggregated into Payables due to immateriality in size.

E3-2 EXPLANATION OF MAJOR VARIANCES - STATEMENT OF FINANCIAL POSITION

V6. Receivables

Receivables increased $6.522 million from $6.125 million per the SDS budget to $12.647 million for the year ended 30 June 2016 primarily as a result of higher public health funding owing by the Department of Health at year end than forecast.

Funding for public health services is received fortnightly in advance. At the end of the financial year, an adjustment may be required where the level of services provided is above or below the agreed level. Public health funding owing by the department at the end of 2016 was $5.77 million. This was not anticipated at the time of the budget.

V7. Property, plant and equipment

Property plant and equipment was $79.982 million lower than $490.117 million forecast at the time of the budget. This is due to a number of contributing factors.

At the time of the budget, property plant and equipment was forecast to be $38.248 million higher, at the beginning of the year, than realised (budget estimated actuals 2015: $474.019 million compared to actuals $435.771 million). This has impacted the balance at 30 June 2016.

Also contributing to the decline was differences in fair values for property in 2016 with results $33.540 million lower than forecast. Original SDS budget assumed market growth in land values of 3% and escalation in replacements costs for buildings of 6%; a combined upward movement in values of $24.484 million. AECOM in their 2016 building valuation report, noted no effective growth in tender price construction contracts due to slowing demand in the region. In addition, land values in 2016 have been adversely impacted by the significant downturn in the coal mining industry, with mining sites closing and slower demand for large scale residential development in Mackay. A decrement in land values of $1.983 million was recognised in 2016. Downward revisions to remaining useful life for buildings in 2016, as part of the valuation process, further contributed to lower property values $7.073 million. The budget assumed no change to useful life.

Assets transferred from the Department of Health were lower by $9.839 million than forecast at the time of the budget, reflecting the early completion of redevelopment projects in 2015.

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

V7. Property, plant and equipment - continued

Partially offsetting these declines, were additional refurbishment projects, up $4.581 million on budget estimates refer V14. In 2016, the new medical facility at Dysart was gifted to MHHS as part of a joint initiative for regional Queensland by the Department of State Development, the Isaac Regional Council and Queensland Health. This was not recognised at the time of the budget.

V8. Payables

Payables increased $3.382 million from $15.291 million at the time of the budget to $18.673 million. This reflects increased accrued labour expenses and locum costs in line with higher than anticipated FTEs and patient activity levels refer V3 and V4.

V9. Equity

Equity is a combination of three areas: contributed equity, accumulated surplus and asset revaluation surplus. Equity was $75.858 million lower than the SDS budget as a result of:

- At the time of the budget, contributed equity was forecast to be $27.339 million higher, at the beginning of the year, than realised (budget estimated actuals 2015: $445.162 million compared to actuals $417.823 million). This has impacted the balance at 30 June 2016. This has been further reduced by higher equity withdrawals of $3 million, representing the clawback of additional depreciation funding by the Department during the year. Partially offsetting these declines were increased funding injections for replacement of health technology equipment $1.616 million.
- A $12.673 million surplus in 2015 was partially offset by a deficit of $7.050 million in 2016. At the time of the 2015-16 SDS budget both 2015 and 2016 original budget forecasts included a balanced position (nil). During 2016, the board endorsed additional initiatives to deliver enhanced services including the reduction of waiting times for specialist and elective surgery, expansion of cardiac services and preparations for improved clinical information systems.
- Asset revaluation reserve was $53.341 million lower than forecast as a result of continuing declines in land and building valuations. For two consecutive years, MHHS has experienced a slowing in demand for land and construction projects. This is reflected in current valuation reports. The budget forecast growth in values, 3% for land and 6% for buildings refer V7.

E4 BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOWS

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

	Variance Notes	Original SDS Budget 2016 $'000	*Reclassified SDS Budget 2016 $'000	Actual 2016 $'000	Reclassified SDS Budget V Actual Variance $'000	Variance % of Budget
Cash flows from operating activities						
Inflows						
User charges and fees	V10.	318,913	21,705	26,496	4,791	22%
Funding public health services	V11.	-	273,549	301,139	27,590	10%
Grants and other contributions		8,342	8,342	7,024	(1,318)	(16%)
Interest receipts		65	-	-	-	0%
GST input tax credits from ATO		-	5,328	6,901	1,573	30%
GST collected from customers		-	-	485	485	0%
Other receipts		5,563	300	5,247	4,947	1649%
		332,883	**309,224**	**347,292**	**38,068**	
Outflows						
Employee expenses		**(33,912)**	**(33,912)**	**(34,402)**	(490)	1%
Health service employee expenses	V12.	**-**	**(169,069)**	**(197,899)**	(28,830)	17%
Grants and subsidies		**(14)**	**-**	**-**	-	0%
Supplies and services	V13.	**(282,553)**	**(104,536)**	**(111,082)**	(6,546)	6%
GST paid to suppliers		**-**	**(5,332)**	**(7,044)**	(1,712)	32%
GST remitted to ATO		**-**	**-**	**(452)**	(452)	0%
Other payments		**(857)**	**(4,487)**	**(5,470)**	(983)	22%
		(317,336)	**(317,336)**	**(356,349)**	**(39,013)**	
Net cash from/(used by) operating activities		**15,547**	**(8,112)**	**(9,057)**	**(945)**	
Cash flows from investing activities						
Inflows						
Sales of property, plant and equipment		-	-	8	8	0%
Outflows						
Payments for property, plant and equipment	V14.	(4,236)	(4,236)	(8,817)	(4,581)	108%
Net cash from/(used by) investing activities		**(4,236)**	**(4,236)**	**(8,809)**	**(4,573)**	
Cash flows from financing activities						
Inflows						
Equity injections	V15.	4,236	4,236	5,852	1,616	38%
Outflows						
Equity withdrawals		(23,659)	-	-	-	0%
Net cash from/(used by) financing activities		**(19,423)**	**4,236**	**5,852**	**1,616**	
Net increase/(decrease) in cash and cash equivalents		**(8,112)**	**(8,112)**	**(12,014)**	**(3,902)**	
Cash and cash equivalents at the beginning of the financial year		70,083	70,083	72,799	2,716	4%
Cash and cash equivalents at the end of the financial year		**61,971**	**61,971**	**60,785**	**(1,186)**	

E4 BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOWS (continued)

Note:
*Original Published Budget from the Service Delivery Statement (SDS) has been reclassified to improve transparency and analysis with comparatives by remapping particular budgeted transactions on the same basis as reported in actual financial statements (reclassified SDS Budget). Reclassification has occurred for:

- *User charges in original SDS have been dissected into User charges and Funding public health services. User charges in original SDS included funding for depreciation of $23.659 million which is a non-cash transaction and excluded from the Statement of Cash Flows in audited financial statements. The other side to this transaction is an equity withdrawal of $23.659 million which has also been removed from SDS Cash flows from financing activities.*
- *Other receipts in the original SDS has been further dissected into GST input tax credits from ATO and other receipts. Interest receipts have been rolled into other receipts as immaterial for actual reporting.*
- *Supplies and services in the original SDS has been further dissected into Health service employee expenses, GST paid to suppliers and Supplies and services. Premiums paid for Queensland Government Insurance Fund have been reclassified from supplies and services to Other expenses, consistent with their disclosure in the actual reporting.*
- *Grants and subsidies in original SDS have been rolled into Other payments as immaterial by size for individual reporting. Bank charges included in Other expenses in original SDS has been reclassified as Supplies and services.*

E4-2 EXPLANATION OF MAJOR VARIANCES - STATEMENT OF CASH FLOWS

V10. User charges and fees

Actual cash flows exceeded SDS budget by $4.791 million. The key contributors to this are largely consistent with the reasons set out in V1 adjusted for high receivables from health funds of approximately $1 million.

V11. Funding public health services

Actual cash flows for funding public health services exceeded SDS budget by $27.590 million. The increase relates to additional funding provided through amendments to the Service Agreement between Mackay Hospital and Health Service and the department. Additional funding was provided for increases in service activity, and enterprise bargaining agreements.

V12. Health service employee expenses

Actual cash flows exceeded budget by $28.830 million. The key contributors to this are largely consistent with the reasons set out in V3 adjusted for higher accrued health service labour costs of approximately $1 million.

V13. Supplies and services

Actual cash flows exceeded budget by $6.546 million. The key contributors to this are largely consistent with the reasons set out in V4 adjusted for differences in movements between forecasts in the SDS budget and actuals for trade payables ($6.671 million), inventory ($1.644 million) and prepaid expenses ($442 thousand).

V14. Cash flows - Payments for property, plant and equipment

Payments for property, plant and equipment were higher by $4.581 million than budgeted. This represents infrastructure improvements funded from retained cash surpluses (including Carlyle Street and Moranbah) and capitalisation of works undertaken in facilities at Bowen, Collinsville, Clermont, Dysart and Proserpine. In addition purchases of health technology equipment in 2016 were higher than forecast at budget.

V15. Cash flows – Equity injections

Higher than forecast health technology equipment purchases in 2015-16 has been matched by higher equity injections from the Department of Health.

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.

	2016 $'000	2015 $'000
Patient Trust receipts and payments		
Receipts		
Patient trust receipts	2	6
Total receipts	2	6
Payments		
Patient trust payments	2	6
Total payments	2	6
Increase/decrease in net patient trust assets	-	-
Patient trust assets opening balance		-
Patient trust assets closing balance	-	-
Patient trust assets		
Current assets		
Cash at bank and on hand	-	-
Patient trust and refundable deposits	-	-
Total	-	-

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 subject to performance measures 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. Receipts and payments relating to both the granted private practice arrangements and right of private practice system during the financial year are as follows:

	2016 $'000	2015 $'000
Receipts		
Billings - (Doctors and Visiting Medical Officers)	7,161	7,662
Interest	14	12
Total receipts	**7,175**	**7,674**
Payments		
Payments	6,672	7,144
Hospital and Health Service recoverable administrative costs	414	442
Hospital and Health Service - Education/travel/research fund	26	64
Total payments	**7,112**	**7,650**
Closing balance of bank account under a trust fund arrangement not yet disbursed and not restricted cash	**757**	**693**

SECTION G
OTHER INFORMATION

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES

Details of Key Management Personnel

The following details for key executive management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of MHHS during 2015-16. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Position	Responsibilities	Current Incumbents	
		Contract classification and appointment authority	Date appointed to position (date resigned from position)
Health Service Chief Executive - Ms Clare Douglas	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.	s24 & s70 Appointed by Board under Hospital and Health Board Act 2011 (Section 7 (3)).	15 September 2014 to 5 June 2016
A/Health Service Chief Executive - Ms Helen Chalmers			6 June 2016
Executive Director, Operations Mackay - Ms Rhonda Morton	Responsible to the Chief Executive for the strategic and operational management of the service divisions within Mackay, and corporate services functions of the MHHS.	HES 2 Appointed by Chief Executive	1 July 2013 to 4 December 2015
Executive Director, Operations Mackay - Ms Helen Chalmers			14 January 2016 to 5 June 2016
Executive Officer, Finance, Procurement & Infrastructure - Mr Mark Cawthorne	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.	HES 2 Appointed by Chief Executive	1 July 2013 to 1 July 2016
Executive Director, Rural Services - Ms Terry Johnson	Responsible to the Chief Executive for the leadership and operational management of the rural facilitates within the MHHS.	HES 2 Appointed by Chief Executive	1 July 2013
Executive Director, People and Culture - Ms Leila Barrett	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.	HES 2 Appointed by Chief Executive	21 Oct 2013 to 7 August 2015
Executive Director, HR & Communications - Ms Leigh Goldsmith			Acting 27 July to 29 November Permanent 30 November 2015
Executive Director, Clinical Governance & Chief Medical Officer - Dr Philip Reasbeck	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.	MMOI1-MMOI2 Appointed by Chief Executive	1 March 2016
A/Executive Director, Clinical Services - Dr Yi Mein Koh			12 January 2015 to 12 February 2016
Executive Director, Medical Workforce & Clinical Dean - Dr David Farlow	Responsible to the Chief Executive for leadership of a sustainable medical workforce, including staff optimisation, expertise and service delivery. Provides postgraduate medical specialty training and research, and executive leadership, strategic focus, authoritative counsel in relation to research and innovation.	MMOI2 Appointed by Chief Executive	25 January 2016
Executive Director, Teaching, Training & Research - Ms Julie Rampton	Responsible to the Chief Executive for strategic and professional leadership of nursing workforce across MHHS.	NRG11 Appointed by Chief Executive	1 July 2012

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration Policies

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 76 of the Act 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 are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu on termination, regardless of the reason for termination.

Performance bonuses are not paid under the contracts in place.

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*).

Board Member	Position	Date of appointment	Resignation
Mr Colin Meng	Chairperson	29 May 2012	17 May 2016
Mr Darryl Camilleri	Deputy Chair	29 June 2012	-
Mr David Aprile	Board member	29 June 2012	-
Mr Tom McMillian	Board member	29 June 2012	17 May 2016
Professor Richard Murray	Board member	29 June 2012	-
Dr Judith (Helen) Archibald	Board member	10 September 2012	-
Ms Laura Veal	Board member	10 September 2012	17 May 2016
Mr John Nugent	Board member	23 August 2013	-
Mr Timothy Mulherin	Chairperson	18 May 2016	-
Ms Suzanne Brown	Board member	18 May 2016	-
Ms Karla Sheen	Board member	18 May 2016	-
Ms Leeanne Heaton	Board member	18 May 2016	-

KMP Remuneration Expense

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

2016

Position (date resigned if applicable)	*Short Term Employee Expenses*		*Long term Employee Expenses*	*Post Employment Expenses*	*Termination Benefits*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*				
	$'000	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*
Health Service Chief Executive Ms Clare Douglas (1 July to 5 June 2016)	292	12	6	27	-	337
A/Health Service Chief Executive Ms Helen Chalmers (6 June to 30 June 2016)	13	-	-	1	-	14
Executive Director, Operations Mackay Ms Rhonda Morton (1 July to 4 December 2015)	73	-	1	5	3	82
Executive Director, Operations Mackay Ms Helen Chalmers (14 January to 5 June 2016)	71	-	1	7	-	79
Executive Director, Finance, Procurement & Infastructure Mr Mark Cawthorne (resigned 1 July 2016)	188	-	4	19	-	211
Executive Director, Rural Services Ms Terry Johnson	173	1	3	16	-	193
Executive Director, People and Culture Ms Leila Barrett (1 July to 7 August 2015)	26	-	-	-	48	74
Executive Director, HR & Communications Ms Leigh Goldsmith (27 July to 30 June 2016)	199	13	2	11	-	225
Executive Director, Clinical Governance & Chief Medical Officer Dr Philip Reasbeck (1 March to 30 June 2016)	153	11	3	12	-	179
A/Executive Director, Clinical Governance & Chief Medical Officer Dr Yi Mein Koh (1 July to 12 February 2016)*	345	-	7	26	-	378
Executive Director, Medical Workforce & Clinical Dean Dr David Farlow (25 January to 30 June 2016)*	220	3	4	17	-	244
Executive Director Teaching, Training and Research Ms Julie Rampton	181	-	3	20	-	204

* Dr David Farlow was on extended leave from January 2015 to January 2016. During this period, the position of Executive Director, Clinical Governance & Chief Medical Officer was occupied by Dr Yi Mein Koh. On return to active duties, Dr Farlow was appointed as the Executive Director, Medical Workforce & Clinical Dean.

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

2015

Position (date resigned if applicable)	*Short Term Employee Expenses*		*Long term Employee Expenses*	*Post Employment Expenses*	*Termination Benefits*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*				
	$'000	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*
Health Service Chief Executive Ms Clare Douglas	258	3	5	23	-	289
A/Health Service Chief Executive Ms Danielle Hornsby	32	-	1	4	-	37
Chief Operations Officer Ms Rhonda Morton	149	-	3	14	-	166
Chief Finance Officer Mr Mark Cawthorne	175	-	3	17	-	195
Executive Director Rural Services Ms Terry Johnson	176	-	3	17	-	196
Executive Director, People and Culture Ms Leila Barrett	190	-	4	15	-	209
Executive Director Clinical Services Dr David Farlow	417	1	9	28	-	455
A/Executive Director Clinical Services Dr Yi Mein Koh	190	-	4	15	-	209
District Director Nursing Services Ms Julie Rampton	206	-	4	20	-	230
Executive Director Allied Health Ms Danielle Hornsby	38	-	-	5	-	43
A/Executive Director Allied Health Ms Clare Badenhorst	85	-	-	3	-	88

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration paid or owing to board members during 2015-16 was as follows:

Board Member	*Short Term Employee Expenses*		*Post Employment Expenses*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*		
	$'000	*$'000*	*$'000*	*$'000*
Mr Colin Meng (1 July to 17 May 2016)	70	-	7	77
Mr Darryl Camilleri	48	-	5	53
Mr David Aprile	45	-	4	49
Mr Tom McMillan (1 July to 17 May 2016)	41	-	4	45
Professor Richard Murray	42	-	4	46
Dr Judith (Helen) Archibald	43	-	4	47
Ms Laura Veal (1 July to 17 May 2016)	39	-	4	43
Mr John Nugent	44	-	5	49
Mr Timothy Mulherin (18 May to 30 June 2016)	13	-	-	13
Ms Suzanne Brown (18 May to 30 June 2016)	7	-	-	7
Ms Karla Steen (18 May to 30 June 2016)	7	-	-	7
Ms Leeanne Heaton (18 May to 30 June 2016)	7	-	-	7

Remuneration paid or owing to board members during 2014-15 was as follows:

Board Member	*Short Term Employee Expenses*		*Post Employment Expenses*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*		
	$'000	*$'000*	*$'000*	*$'000*
Mr Colin Meng	79	-	7	86
Mr Darryl Camilleri	50	-	4	54
Mr David Aprile	47	-	4	51
Mr Tom McMillan	44	-	4	48
Professor Richard Murray	43	-	4	47
Dr Judith (Helen) Archibald	39	-	4	43
Ms Laura Veal	44	-	4	48
Mr John Nugent	44	-	4	48

G2 FIRST YEAR APPLICATION OF NEW ACCOUNTING STANDARDS OR CHANGES IN POLICY

Mackay Hospital and Health Service did not voluntarily change any of its accounting policies during 2015-16.

Accounting standards early adopted for 2015-16

Two Australian Accounting Standards have been early adopted for the 2015-16 year as required by Queensland Treasury. These are:

AASB 2015-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101 [AASB 7, AASB 101, AASB 134 & AASB 1049]

- The amendments arising from this standard seek to improve financial reporting by providing flexibility as to; the ordering of notes, the identification and location of significant accounting policies and the presentation of sub-totals, and provides clarity on aggregating line items. It also emphasises only including material disclosures in the notes.
- MHHS has applied this flexibility in preparing the 2015-16 financial statements, including co-locating significant accounting policies with the related breakdowns of financial statement figures in the notes.

AASB 2015-7 Amendments to Australian Accounting Standards – Fair Value Disclosures of Not-for-Profit Public Sector Entities [AASB 13]

- This standard amends AASB 13 Fair Value Measurement and provides relief to not-for-profit public sector entities from certain disclosures about property, plant and equipment that is primarily held for its current service potential rather than to generate future net cash inflows. The relief applies to assets under AASB 116 Property, Plant and Equipment which are measured at fair value and categorised within Level 3 of the fair value hierarchy (refer to Note D1-1).
- As a result, the following disclosures are no longer required for those assets. In early adopting the amendments, the following disclosures have been removed from the 2015-16 financial statements:
    - disaggregation of certain gains/losses on assets reflected in the operating result;
    - quantitative information about the significant unobservable inputs used in the fair value measurement;
    - a description of the sensitivity of the fair value measurement to changes in the unobservable inputs.

Accounting Standards Applied for the First Time in 2015-16

No new Australian Accounting Standards effective for the first time in 2015-16 had any material impact on this financial report.

G3 TAXATION

MHHS is a State body as defined under the Income *Tax Assessment Act 1936* and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). 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 Commonwealth is managed centrally by the department, with payments/ receipts made on behalf of the MHHS reimbursed to/from the department on a monthly basis. GST credits receivable from, and GST payable to the ATO, are recognised on this basis. Refer to Note C2.

Mackay Hospital and Health Service

Management Certificate

For the year ended 30 June 2016

These general purpose financial statements have been prepared pursuant to section 62(1) of the *Financial Accountability Act 2009* (the Act), section 43 of the *Financial and Performance Management Standard 2009* 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 2016 and of the financial position of the Hospital and Health Service at the end of that year; and

c) these assertions are based on an appropriate system of internal controls and risk management processes being effective, in all material respects, with respect to financial reporting throughout the reporting period.

The Honourable Timothy Mulherin	Ms. Helen Chalmers Bachelor of Economics Chartered Accountant (ACA)	Mr Brett Oates Bachelor of Commerce Associate CPA (ASA)
Chair, MHH Board	A/Chief Executive Officer	Chief Finance Officer
25/8/2016	25/8/2016	25/8/2016

QAO certified statements

Mackay Hospital and Health Service

Independent Auditor's Report

To the Board of Mackay Hospital and Health Service

Report on the Financial Report

I have audited the accompanying financial report of Mackay Hospital and Health Service, which comprises the statement of financial position as at 30 June 2016, 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 significant accounting policies and other explanatory information, and certificates given by the Chair, Acting Chief Executive Officer and Chief Finance Officer.

The Board's Responsibility 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 prescribed accounting requirements identified in the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2009*, including compliance with Australian Accounting Standards. The Board's responsibility also includes such internal control as the Board determines is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on the audit. The audit was conducted in accordance with the *Auditor-General of Queensland Auditing Standards*, which incorporate the Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit is planned and performed to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation of the financial report that gives a true and fair view in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control, other than in expressing an opinion on compliance with prescribed requirements. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Board, as well as evaluating the overall presentation of the financial report including any mandatory financial reporting requirements approved by the Treasurer for application in Queensland.

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

Independence

The *Auditor-General Act 2009* promotes the independence of the Auditor-General and all authorised auditors. The Auditor-General is the auditor of all Queensland public sector entities and can be removed only by Parliament.

The Auditor-General may conduct an audit in any way considered appropriate and is not subject to direction by any person about the way in which audit powers are to be exercised. The Auditor-General has for the purposes of conducting an audit, access to all documents and property and can report to Parliament matters which in the Auditor-General's opinion are significant.

Opinion

In accordance with s.40 of the *Auditor-General Act 2009* –

(a) I have received all the information and explanations which I have required; and

(b) in my opinion –

(i) the prescribed requirements in relation to the establishment and keeping of accounts have been complied with in all material respects; and

(ii) the financial report presents a true and fair view, in accordance with the prescribed accounting standards, of the transactions of the Mackay Hospital and Health Service for the financial year 1 July 2015 to 30 June 2016 and of the financial position as at the end of that year.

Other Matters - Electronic Presentation of the Audited Financial Report

Those viewing an electronic presentation of these financial statements should note that audit does not provide assurance on the integrity of the information presented electronically and does not provide an opinion on any information which may be hyperlinked to or from the financial statements. If users of the financial statements are concerned with the inherent risks arising from electronic presentation of information, they are advised to refer to the printed copy of the audited financial statements to confirm the accuracy of this electronically presented information.

D J OLIVE FCPA
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane