Mackay Hospital and Health Service

2019–2020 ANNUAL REPORT

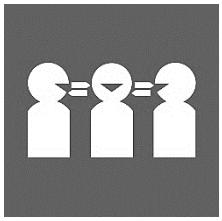
Queensland Government

Accessibility

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

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

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



Content from this annual report should be attributed as: State of Queensland (Mackay Hospital and Health Service) Annual Report 2019-2020.

ISSN 2202-9702 (print) ISSN 2202-9834 (online)

Aboriginal and Torres Strait Islander people are advised that this publication may contain words, names, images and description of people who have passed away.

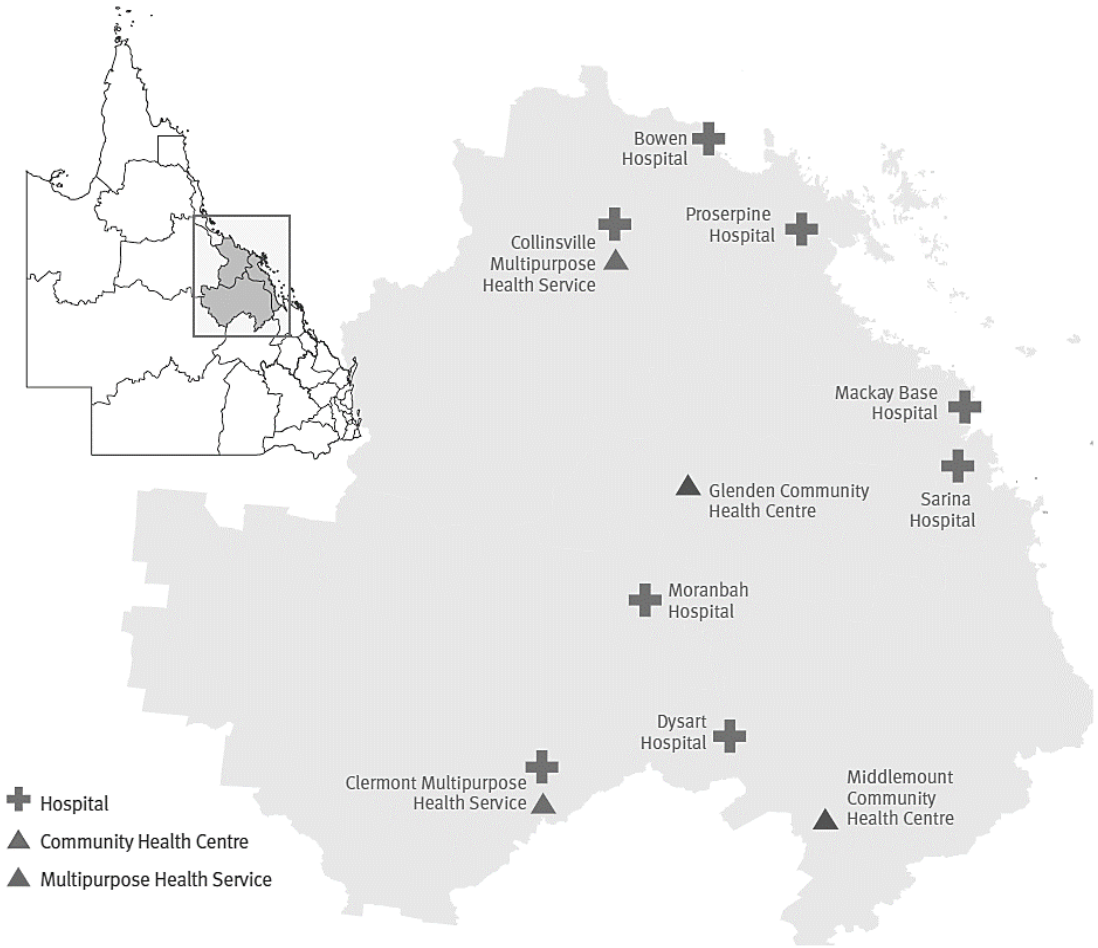
Acknowledgement to Traditional Owners

Mackay Hospital and Health Service (HHS) acknowledges the Traditional Owners of the land and waters of all areas within our geographical boundaries.

We pay respect to the Aboriginal and Torres Strait Islander Elders past, present and those yet to come on whose land we provide health services as we make tracks towards closing the gap.

Recognition of Australian South Sea Islanders

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



Letter of compliance

3 September 2020

The Honourable Steven Miles MP
Deputy Premier, Minister for Health and Minister for Ambulance Services
GPO Box 48
Brisbane QLD 4001

Dear Deputy Premier

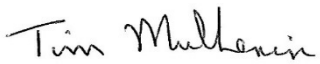
I am pleased to submit for presentation to the Parliament the Annual Report 2019-2020 and financial statements for Mackay Hospital and Health Service.

I certify that this Annual Report complies with:

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

A checklist outlining the annual reporting requirements can be found on pages 75 of this annual report.

Yours sincerely



Tim Mulherin
Chair
Mackay Hospital and Health Board

Contents

Statement on government objectives for the community

The Queensland Government's *Our Future State: Advancing Queensland's Priorities* is a plan to advance Queensland - both now and into the future. Mackay Hospital and Health Service contributes to the priorities of Create jobs in a strong economy; Give all our children a great start; Keep Queenslanders healthy and Be a responsive government though delivery of the strategic objectives and strategies under Mackay HHS's strategic plan.

The strategic objectives of Inspired People, Exceptional Patient Experiences, Excellence in Integrated Care and Sustainable Service Delivery and their strategies outlined under the Mackay HHS Strategic Plan 2016-2020 (2019 update), aligned to the government objectives have been designed to shape the future of health care in our region and to achieve positive outcomes for our communities. The Mackay HHS Strategic Plan also supports the 10-year strategy for health in Queensland, *My health, Queensland's future: Advancing health 2026*. The vision is that by 2026 Queenslanders will be among the healthiest in the world.

Delivering on Queensland Government objectives:

Create jobs *delivered through our Inspired People strategies*

- Modernise our ways to attract, retain and train the best talent through engaging more young Queenslanders in training and work through our Education to Employment program for Aboriginal and Torres Strait Islander Students.
- The investment in our future health care leaders through supporting intakes in 2020 of 76 graduate nurses and 43 intern (doctors).

Give all our children a great start *delivered through our Exceptional Patient Experiences strategies*

- Build a patient centred culture that values the diversity of our community and deliver services across Maternity Services; Special Care Nursery; Paediatrics; Child and Adolescent Unit; and Community Child Health to:
  - increase the number of babies born healthier;
  - increase childhood immunisation rates; and
  - improve wellbeing prior to starting school.

Keep Queenslanders healthy *delivered through Excellence in Integrated Care strategies*

- Working with the Primary Health Network, our community and our partners to reduce risk factors; smoking, drugs and alcohol and obesity. This includes the Let's Shape Up program aimed at reducing obesity and type 2 diabetes rates across the region continues to support increasing the number of Queenslanders with a healthy body weight
- Respond to our community health priorities, with our partners to improve mental health, cancer care, care of the elderly and chronic disease. Our mental health team delivered the Zero Suicide Project including implementation of Staying Safe Pathway to improve response to people experiencing suicidality and increasing access to training for MHHS staff.

Be a responsive government *delivered through Excellence in Integrated Care strategies*

- Creating seamless care by working with the Primary Health Network and our service delivery partners to respond to our community health priorities
- The implementation of ICT and optimising Digital Health across the health service is an enabler of supports closer to home for patients and improves access to information to support patient outcomes.

From the Chair and Chief Executive

It is with great pleasure we present this year's annual report for Mackay HHS and reflect on an extraordinary year that has tested and challenged us all. It's fair to say that when 2019-20 started none of us imagined the second half of the year would require a local response to a global pandemic. The impact of the COVID-19 pandemic response and recovery saw the health service significantly refocus its services in the second half of the 2019-20 year.

We are proud of the professional and compassionate care that our hospital and healthcare workers delivered as we responded to COVID-19. Their commitment to our communities and to each other as has been admirable and once again their resilience has come to the fore to see us through a difficult time. This care is driven by the health service's values of trust, collaboration, teamwork and respect. Our values have guided our response and ensured we have provided a safe and caring place to work. We would like to thank each and every staff member for their work regarding COVID-19 and thank the communities for the role you played to stay well by following public health directives.

The health service's Incident Management Team was activated in March 2020 in response to the pandemic and in the early stages met daily to ensure our health system response would meet the needs of our communities. Considerations ranged from the availability of personal protective equipment to establishing testing clinics, procuring additional ventilators for our Intensive Care Unit and a raft of infrastructure works. Strong working relationships with healthcare partners has been essential to deliver care and co-ordinate a whole-of-community response. We met with private hospitals, residential aged care facilities and the North Queensland Primary Health Network (NQPHN) and General Practitioners (GPs) to work together to keep our communities COVID-19 safe. Liaison with Local and District Disaster Management Groups to work with emergency services, local government and State Government agencies also bolstered our preparedness and response.

We innovated with our care solutions, creating a Virtual Ward in April 2020 to allow COVID-19 positive patients to safely isolate at home while still receiving care and support from medical and nursing staff. A COVID-19 hotline was set up in March 2020 to provide a vital link between our communities and the health service to answer questions about testing and other concerns. Our already impressive use of telehealth escalated, and we were able to build on our existing strong foundations of virtual care to provide an increased amount of specialist consultations to patients in the comfort and safety of their own home.

The COVID-19 response also required infrastructure projects requiring creative and rapid responses to create physical barriers to separate suspected infectious patients from others. Additional isolation bays in the Mackay Base Hospital's (MBH) Intensive Care Unit and a separate waiting room for respiratory patients presenting to MBH's emergency department were built. A separate overflow clinic for COVID-19 testing was also set up in Mackay.

A highlight of the year was the start of 24/7 lifesaving cardiac services for our community. The Cath Lab at MBH now provides around the clock care, saving transfers to Townsville University Hospital.

The opening of a new ward to provide dedicated specialist care for orthopaedic patients allowed us to provide more surgery and increased our bed capacity.

Additional theatre lists were also added to provide more surgery in specialties including gynaecology and trauma. The National Cabinet direction in March 2020 to suspend all but urgent elective surgery has impacted on the ability to deliver as much care to the community as anticipated however we have been able to resume normal service delivery.

The much-anticipated new Sarina Hospital gained momentum with the announcement of $31.5 million from the Queensland Government and Mackay HHS. This funding commitment allowed us to continue talking to the Sarina community to hear their thoughts on the preferred greenfield site for the new hospital.

Our dedicated volunteer community also felt the impact of COVID-19 and in June 2020 we were delighted to welcome their return to our hospitals and community health facilities. Our thanks also go to the Mackay Hospital Foundation volunteers and hospital auxiliaries in Mackay, Proserpine and Bowen, your invaluable service to your communities is appreciated. These collaborative and productive partnerships have at their heart, a better patient journey. Mackay Hospital Foundation joined forces with Ronald McDonald Charities in October 2019 to start fundraising to provide Family Rooms to improve the physical, psychological and social well-being of family members of seriously ill or injured children in hospital.

Connections with community were strengthened with our consumer reference groups in Mackay, Sarina, Proserpine, Bowen, Collinsville, Dysart/Moranbah and Clermont meeting regularly. We also welcomed the establishment of the Mackay Base Hospital Community Group to give our community a further voice in the provision and evaluation of healthcare services. These community groups are a valuable connection with people who access our services as we strive to improve the care we provide.

Our rural facilities continued to demonstrate their ability to delivery outstanding care. Moranbah Hospital attracted national attention with its response to a mine explosion which caused significant injury to five workers. Moranbah Hospital staff worked with several agencies to ensure the workers received initial assessment and treatment before their transfer to a registered burns unit more than 1,000km away in just under 12 hours.

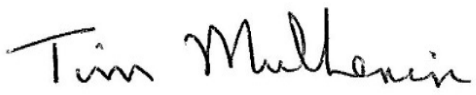
Proserpine Hospital became the first rural facility in Queensland to implement a Stroke Pathway which means timely access to life-saving medication for patients. The health service also benefited from the Rural Doctor Upskilling Program which provides funding to health services to facilitate greater access to training posts within Queensland public hospitals. Three doctors were successful and received $50,000 each to undertake activities to maintain skills in anaesthetics and endoscopy.

Once again, we had a record intake of graduate nurses and intern doctors, strengthening our position as a leading teaching hospital.

Reflecting our community diversity in our organisational leadership and structure has been a strong focus as we take more action to improve health outcomes for our Aboriginal people, Torres Strait Islander people and Australian South Sea Islander population. We have taken steps to increase employment opportunities for First Nations people and look forward to the launch of a new education to employment program in 2020-21.

We thank Mackay Hospital and Health Board (MHHB) members for their years of service and acknowledge the expertise they bring to shaping the strategic direction of the health service. The MHHB has once again provided strong leadership, governance and accountability. The contribution of foundational board member Dr Helen Archibald is acknowledged with her departure after many years of service to the MHHB and as Clinical Director at BreastScreen Mackay. We welcomed the appointment of Helen Caruso to the MHHB, bringing local knowledge and financial expertise to the team.

Looking forward to 2020-21 we are excited to continue our planning for the new Sarina Hospital, the new Medical Imaging Department at Bowen Hospital and the continued expansion of services at MBH. We are particularly proud of our local partnerships with our private healthcare providers across the HHS and we continue to work together for the benefit of our patients and residents. We will strengthen our partnerships by the creation of a Maternity Services Community reference group and the development of our Education to Employment (E2E) program and our Ronald Macdonald Family Rooms.



The Honourable Timothy Mulherin
Board Chair
Mackay Hospital and Health Board

Jo Whitehead
Chief Executive
Mackay Hospital and Health Service

About us

Mackay HHS is an independent statutory body overseen by an appointed Hospital and Health Board, established on 1 July 2012. Our responsibilities are set out in the *Hospital and Health Boards Act 2011* (HHBA) and the *Financial Accountability Act 2009* and subordinate legislation. We operate according to the service agreement with the Department of Health which outlines the services to be provided, the funding arrangements and our performance indicators and targets.

Mackay HHS is responsible for the delivery of public hospital and health services including medical, surgical, emergency, obstetrics, paediatrics, specialist outpatient clinics, mental health, critical care and clinical support services to a population of approximately 172,452 people. The geographical catchment of Mackay HHS spans 90,364 square kilometres, extending from Bowen in the north to St Lawrence in the south, west to Clermont and northwest to Collinsville and includes Proserpine and the Whitsundays. Mackay HHS's Aboriginal and Torres Strait Islander population is 4.9 per cent, higher than the 4 per cent Queensland average. There is also a significant Australian South Sea Islander community in the region.

Strategic direction

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

The MHHB sets the organisation's strategic agenda and monitors outcomes achieved and its performance against the service delivery statement. Mackay HHS's Strategic Plan 2016-2020 (2019 update) sets out four inter-related objectives of Inspired People; Exceptional Patient Experiences; Excellence in Integrated Care and Sustainable Service Delivery each with their own strategies, to achieve Mackay HHS's vision.

Vision, Purpose, Values

Our Vision

Delivering Queensland's Best Rural and Regional Health Care

Our Purpose

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

Our Values

Collaborate | Trust | Respect | Teamwork

Priorities

In 2019-20, in line with our Service Delivery Statement (SDS) we continued to maintain a strong focus on achieving outcomes by creating a diverse and skilled workforce; better access to services; supporting a seamless health system through collaborative partnerships and services matched to community health needs. In alignment with the SDS and the Mackay HHS Strategic Plan 2016-2020 (2019 update), the outcomes achieved and progress towards realising the strategic objectives in 2019-20 were:

Inspired People

Creating a diverse and highly skilled workforce

Graduate Nurses

Mackay HHS welcomed 76 registered nurses and midwives to start their careers this year. This is an increase from 67 last year and is part of our commitment to strengthen nursing and midwifery workforces to ensure we continue to deliver outstanding patient care. Ensuring a pipeline of clinical staff helps us to attract and retain the best talent and supports improvement in average time to recruit for roles and workforce diversity rates.

Education to Employment (E2E)

Mackay HHS is developing an E2E Program for Aboriginal and Torres Strait Islander students to inspire, educate, engage and motivate them through a structured and supported health employment pathway. The program provides students with career information, practical skills and work preparedness while completing Certificate III in Health Services Assistance / Certificate III in Allied Health Assistance in a simulated environment at a health hub. This program supports achieving improving results in the proportion of our total workforce that represents our population ethnicity profile including Aboriginal and Torres Strait Islander people.

Exceptional Patient Experiences

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

New Orthopaedics Ward

MBH expanded services with the opening of a dedicated orthopaedics ward. The 16-bed ward opened on 9 March 2020 to support patients having planned surgeries or emergency and trauma surgery. The new ward allows for an additional 800 patient stays each year. This initiative delivers on the outcome of better access to services and facilitates achieving improved wait times and numbers of patients treated for elective surgery.

24/7 Cardiac Catheter Laboratory (Cath Lab)

Life-saving cardiac care at MBH's Cath Lab is now available 24/7 providing more care for people closer to home and supports achieving outcomes of safe and excellent care – continually improving and improved patient experience satisfaction rates. The expanded service means faster care for people who experience a cardiac event and has resulted in fewer transfers to alternative hospitals.

Additional theatre lists
Mackay HHS has continued to expand the amount of surgery performed at the MBH. The additional surgeries include general surgery, gynaecology and orthopaedics. Additional trauma lists have also been added allowing elective surgeries to proceed instead of being rescheduled for more urgent cases. The initiative is aligned with our strategies of striving to have patients seen within recommended clinical timeframes and delivers on the outcome of better access to services, supporting achievement of wait times for elective surgery and specialist outpatient clinics.

Excellence in Integrated Care

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

Breathe Easy Breathe Safe Project
Patients presenting to MBH's emergency department with asthma and chronic obstructive pulmonary disease are being supported to better manage their condition to avoid future medical emergencies. Up to 250 people a month present to the emergency department with respiratory conditions. Nationally it is estimated that 45 percent of patients have sub-optimal control of their conditions and about 80 percent do not use their inhaler device. This project supports reduced wait times for emergency presentations through fewer unnecessary presentations related to the condition and delivers on our strategies of creating seamless care by working with the Primary Health Network and our service delivery partners and responding to our community health priorities with outcomes of seamless healthcare system and collaborative and productive partnerships.

Remote monitoring of home haemodialysis
Wireless technology is helping specialist doctors and nurses keep a closer eye on the kidney health of home dialysis patients in Mackay HHS. Real-time monitoring improves patient outcomes by creating an alert which can be rapidly followed up. The new system has helped reduce emergency department presentations and hospitalisations which in turn improves health outcomes and patient quality of life. This initiative delivers on the outcome of smart use of technology.

Sustainable Service Delivery

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

Telehealth
The use of telehealth in Mackay HHS increased by 30.3 per cent in 2019-20 with a record 10,706 appointments offered.

Patients are now able to use their own device to consult with a specialist with approximately 400 patients a month using this service in April-June 2020. This service supports the outcome of the right service, in the right place and increased telehealth service usage rates.

Virtual ward
COVID-19 positive patients who are clinically well enough to be managed in the community are admitted to the virtual ward, with telehealth used as the model of care. Daily virtual ward rounds are done by nursing and medical staff with patients receiving regular phone calls and assessment. A total of seven patients were admitted to the ward, saving 87 hospital inpatient bed days. This initiative delivers on the outcomes of achieving services matched to community need; the right service, in the right place and value for money.

Aboriginal & Torres Strait Islander Health

Taking action to improve health outcomes for our Aboriginal and Torres Strait Islander and Australian South Sea Islander population:

Mackay HHS is committed to working closely with community members, the Aboriginal and Torres Strait Islander Community Health Service, NQPHN and all government and non-government agencies and health service providers to improve the health status of our local Aboriginal and Torres Strait Islander communities. *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033* is the commitment and work of all staff and volunteers of Mackay HHS.

The Aboriginal and Torres Strait Islander Health Unit continues to implement the Closing the Gap initiatives to improve better health outcomes by supporting hospital patients, travelling more than 36,000kms and helping more than 50 families in their healthcare journey. These initiatives have been supported by the State through funding of approximately $1.7 million in 2019-20. The unit provides cultural support to patients as well as education and resources to staff to improve engagement and outcomes within the acute hospital services and contributes to Aboriginal and Torres Strait Islander people accessing outpatient appointments with a reduction in the patients who fail to attend outpatient appointments.

Mackay HHS's efforts to Close the Gap in Aboriginal and Torres Strait Islander life expectancy gained momentum in 2019-20. The health service created a formal partnership (Connecting Regional Communities Committee) with government and community groups to ensure a united focus to improve health and other outcomes for First Nations people. The Deadly Choices school and community program was also supported with record attendance for activities and free health checks. Walk-in dental treatment for Aboriginal and Torres Strait Islander children and families were also popular while the community-based healthy lifestyle program Supporting Living Strong group continued. The health service also focused on improving it cultural capability by offering Cultural Practice training every moth delivered by a local Yuibera Traditional Custodian.

Aboriginal and Torres Strait Islander health workers are embedded across Mackay HHS to support access, engagement and outcomes.

Our community based and hospital based services

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

Mackay HHS has available beds and bed alternatives plus aged care beds. Facilities include:

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

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

Mackay HHS provides free car parking for patients, families, visitors and staff. Consequently, there was no requirement to issue car parking concessions throughout 2019-20.

Targets and challenges

There are many challenges facing Mackay HHS as we deliver and plan future health services in a complex and dynamic environment. These include continued high growth in demand for public services, economic and population demographic changes, the burden of complex and chronic disease, sustainability of private partners, workforce challenges and community expectations of service access and delivery. In addition, Mackay HHS residents demonstrate high rates of risky behaviours including smoking, obesity and alcohol consumption. The population also continues to age, with older people having the greatest projected increase over the coming years. Further to these challenges, the impact of the COVID-19 pandemic response and recovery required the Mackay HHS to significantly refocus its services from the second half of the 2019-20 year.

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

Collaboration and partnerships, such as the strong one forged with NQPHN, are crucial if we are to respond to the community's health priorities, such as mental health and chronic disease. By working across government and non-government sectors, business and industry, we can make significant gains in improving the health of our community through continuing initiatives like Let's Shape Up, 'Inspire Your Tribe'.

Looking ahead, we expect to see a continued increase in demand for public health services. We will continue our focus on delivering the core services and responding to the community's health priorities, including the COVID-19 response and recovery. Moving forward, our priorities are to deliver on key strategies through collaborative and productive partnerships with our private, public and non-government organisation partners to improve access to health services as close to home as possible and deliver financially viable service models.

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

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

Mackay HHS progressed a range of initiatives during 2019-20 to support achievement of its strategic objectives, as outlined in the table below.

Strategic Objectives & Outcomes	Key Performance Indicators	Results/Achievements
Inspired People • *Valued, empowered and accountable staff* • *Diverse and highly skilled workforce* • *Safe and caring place to work* • *Healthy staff* • *Staff know what's going on and feel listened to*	• Staff survey results • Lost time injury frequency rates • Average time to recruit • Proportion of our total workforce that represents our population ethnicity profile including Aboriginal and Torres Strait Islander people	• Annual Working for Queensland staff survey returned the second highest response rate across HHSs with 1,544 responses (53 per cent). More than 80 per cent of result areas rated above the Queensland Public Sector overall. Results indicate that Mackay HHS achieved the most positive improvement in the areas of organisational leadership and management. • Delivery of Mackay HHS's Leadership Development strategy, including working with Queensland Health Clinical Excellence Queensland to grow and develop our managers and leaders across the Mackay HHS. • Lost time injury frequency rate has positively decreased to 5.15 per million hours worked. This result is supported through increased education and awareness by workplace health and safety representatives. • Average time to recruit staff ranged from 55 days for medical and 67 days for nursing and other staff with overall timings extended due to factors associated with COVID-19. It is recognised that attraction and retention of staff is more challenging in regional and rural areas and the health service is actively working to grow a pipeline of clinical staff. • Increased numbers of graduate intakes with 76 registered nurses and midwives, an increase from 67 last year as part of Mackay HHS's commitment to strengthen nursing and midwifery workforces. • The number of people identifying as Aboriginal and Torres Strait Islander (2 per cent) and non-English speaking background (9.8 per cent) workforce groups increased. People identifying as having a disability remained stable (1.2%). • Commencement of an E2E Program for Aboriginal and Torres Strait Islander students to inspire, educate, engage and motivate them through a structured and supported health employment pathway.
Exceptional Patient Experience • *Improving patient flow and striving for patients to have better access to surgical and outpatient services* • *Better access to services* • *Treat our patients as individuals* • *Listen to our community and consumers* • *Safe and excellent care –continually improving* • *Informed and empowered patients*	• National Safety and Quality health service indicators • Patient complaint response times • Patient experience survey satisfaction rates including cultural appropriateness • Wait times for elective surgery, emergency admissions and specialist outpatients clinics	• Mackay HHS has maintained accreditation against the National Safety and Quality Health Service Standards in Healthcare (second edition). • 98.9 per cent of complaints acknowledged within five days and 90 per cent resolved within 35 days. • Continued patient experience surveys across multiple wards. • Wait times for elective surgery attained 90.1 per cent for category 1 (treated in 30 days); 86.7 per cent for category 2 (treated in 90 days) and 89.9 per cent for category 3 (treated in 365 days). Some services and specialities were impacted from COVID-19. • Increased theatre lists for additional surgeries across general surgery, gynaecology and orthopaedics. • Expanded services at Mackay Base Hospital with the opening of a dedicated orthopaedics ward to support patients having planned surgeries or emergency and trauma surgery. • Wait times for emergency admissions attained 76.8 per cent for emergency department attendances who depart within four hours of their arrival in the department; and for patients attending emergency departments seen within recommended timeframes of 99.2 per cent for category 1 (seen within 2 minutes); 96.0 per cent for Category 2 (seen within 10 minutes); 85.0% for category 3 (seen within 30 minutes); 92.0 per cent for category 4 (seen within 60 minutes) and 98.4 per cent for category 5 (within 120 minutes). • Specialist Outpatient Clinics seen in time results showed improvement with some services and specialities impacted from COVID19.

Strategic Objectives & Outcomes	Key Performance Indicators	Results/Achievements
Excellence in Integrated Care • *Continuing to respond to community health priorities, such as care of the elderly and chronic disease* • *Seamless health care system* • *Help patients to navigate the health system* • *Smart use of technology* • *Collaborative and productive partnerships*	• HealthPathways usage rates • Electronic health record uptake rates • Average duration for delivery of discharge summaries to patient GP • Aboriginal and Torres Strait Islander closing the gap targets	• The Health pathways usage rate saw a 10 per cent increase over the year. Site trainings on how to use health pathways increased by 101 per cent across the year, training an overall 2,563 staff members in the Mackay HHS region. • More than 18,600 view occurrences for the electronic health record indicating continued high usage levels. • Discharge summaries were delivered to local GPs within 48 hours in almost 70 per cent of cases. • Continued to progress our Closing the Gap Plan actions and progress against targets including the proportion of patients who discharge against medical advice (2 per cent) and potentially preventable hospitalisations (5 per cent). Smoking rates for women during pregnancy (26 per cent) and for women during pregnancy who quit by 20 weeks (20 per cent) and attendance by pregnant indigenous women at five or more antenatal classes is has achieved consistently above 90 per cent.[1]
Sustainable Service Delivery • *Services matched to community health needs* • *The right service, in the right place* • *Work with our private and public sector partners* • *Leading teaching hospital* • *Leader in health service research* • *Value for money and operating within our means*	• Telehealth service usage rates • Health service average cost per weighted activity unit • Number of papers published • Retention rates of our junior clinical staff	• Telehealth usage has increased to 10,706 outpatient occasions of service, in comparison to 8,974 in the previous year, accelerated by COVID-19 impacts. • The estimated cost per weighted activity unit was $5,359 impacted by COVID-19 response requirements.[2] • Almost 40 staff members have received academic support and/or grant funding support through Mackay Institute of Research and Innovation to progress their research in a diverse range of clinical areas. Three papers were published within internationally respected journals from clinical areas within allied health (falls prevention) and intensive care (cardiac training methods). • Mackay HHS achieved a 55 per cent retention rate of junior clinical placements. • Continued delivery of a care and career program for trainees to offer support and career counselling.

1. Data for smoking rates are preliminary as Mar-20 FYTD.
2. Cost per weighted activity unit data presented as Mar-20 FYTD.

Governance

Our people

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

Board membership

The Governor-in-Council appoints Board Members based upon the recommendation of the Minister and approves the remuneration arrangements (consistent with the *Remuneration Procedures for Part-Time Chairs and Members of Queensland Government Bodies;* reported on page 59). The MHHB derives its authority from the HHBA and the *Hospital and Health Boards Regulation 2012*. Board Members act in accordance with their duties and abide by the Code of Conduct and Values for the Queensland Public Service in accordance with the *Public Sector Ethics Act 1994*.

The MHHB's functions include: develop strategic direction and priorities; monitor compliance and performance; focus on patient experience and quality outcomes; and ensure evidence-based practice education and research.

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 support to the MHHB in its role of controlling Mackay HHS by:

a. working with the Chief Executive to progress strategic issues identified by the MHHB;
b. monitoring strategic human resources and work health and safety matters; and
c. strengthening the relationship between the MHHB and the Chief Executive to ensure accountability in the delivery of services by Mackay HHS.

Meetings are held quarterly or as directed by the Chair.

Safety and Quality Committee

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

Audit and Risk Committee

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

Finance Committee

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

The impact of the COVID-19 pandemic response required the MHHB to refocus its priorities during the second half of the 2019-20. The MHHB was still able to accomplish the following achievements in 2019-20:

- Finalising the new Strategic Plan for 2020-2024;
- Finalising the Mackay HHS Infrastructure Master Plan;
- Implementing the Employee Health and Wellbeing Framework and Plan 2019-2020;
- Allocating Retained Earnings for the Sarina Hospital Redevelopment; and
- Allocating operational budgets for 2020-2021.

Table 1: Board Member meeting attendance

Board Members	MHHB	Committees			
		Executive	*Audit and Risk*	*Finance*	*Safety and Quality*
Total Meetings	**11**	**3**	**3**	**5**	**3**
Timothy Mulherin *Executive Committee Chair*	9	2		5	
Darryl Camilleri *Audit and Risk Committee Chair*	10	3	3	4	
David Aprile [1] *Finance Committee Chair*	9	3		4	
Helen Archibald [1, 2] *Safety and Quality Committee Chair*	8	2	3		2
Richard Murray [1]	9				2
Suzanne Brown	10	3	3		
Leeanne Heaton	10		2		3
Adrienne Barnett	11				2
Elissa Hatherly [1]	11			5	
Helen Caruso [3]	1				

[1] Board Members who satisfy the Clinical Expertise requirement under section 23(4) of the HHBA.
[2] Board Membership ceased on 17 May 2020.
[3] Board Membership commenced on 18 May 2020.

Total out of pocket expenses claimed during the reporting period totalled $1,009.87.

Due to COVID-19, several Committee meetings were cancelled, and all essential matters were directly managed by the MHHB.

The Honourable Timothy Mulherin
Board Chair | Originally appointed on 18 May 2016, current term is 18 May 2017 to 17 May 2021

The Honourable Mulherin was elected to Queensland Parliament as the Member for Mackay in 1995 until his retirement in 2015. During his time as a Cabinet Minister, 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. He is also a member of the Australian Institute of Company Directors.

Mr Darryl Camilleri
Deputy Board Chair | Originally appointed on 29 June 2012, current term is 18 May 2020 to 31 March 2022

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. He is also a graduate of the Australian Institute of Company Directors.

Mr David Aprile
Board Member | Originally appointed on 29 June 2012, current term is 18 May 2020 to 31 March 2022

Mr Aprile is a practicing pharmacist and a CPA and is a founding partner of a local Mackay Pharmacy and property development group. He has previously served on community and government based boards and advisory groups in Mackay including the CQU Advisory Board and Mackay Chamber of Commerce and shaping Mackay.

Professor Richard Murray
Board Member | Originally appointed on 29 June 2012, current term is 18 May 2019 to 17 May 2021

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

Ms Suzanne Brown
Board Member | Originally appointed on 18 May 2016, current term is 18 May 2017 to 17 May 2021

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

Associate Professor Leeanne Heaton
Board Member | Originally appointed on 18 May 2016, current term is 18 May 2017 to 17 May 2021

Associate Professor 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 Deputy Dean in the School of Nursing and Midwifery at Western Sydney University and holds an adjunct appointment as Associate Professor with CQU. She is Deputy Chair on the Registered Nurse Accreditation Committee for the Australian Nursing and Midwifery Accreditation Council and is a member of the Australian College of Nursing.

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

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

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

Dr Hatherly has worked in the Mackay HHS district since 2002 and currently works as a General Practitioner. She also works in the Family Planning and Well Women's clinic and is an enthusiastic advocate for access to specialist women's health services. Dr Hatherly is also involved in training and supervision of GP trainees for JCU. Her experience includes 12 years at BreastScreen Mackay and Specialist Outpatients clinical roles.

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

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

Executive management

Ms Jo Whitehead
Health Service Chief Executive
Ms Whitehead is a long-term health professional with more than 30 years of experience in healthcare in the UK and Australia. She has held senior positions working in hospitals of all sizes and for the Department of Health in the UK and is passionate about providing more services for people in their own community. She has a BA (Hons) in History, Post Graduate Diploma in Health Service Management and Post Graduate Certificate in Health Service Economics. She was a foundational member of the Health and Wellbeing Queensland Board. She is also a member of the Australian Institute of Company Directors.

Mr Ivan Franettovich
Executive Director Operations Mackay
Mr Franettovich has worked in Queensland Health for over 20 years in primarily rural and regional settings, several of those within the Mackay HHS, including Moranbah, Dysart and Sarina Hospitals. He has worked clinically as a physiotherapist, in addition to director positions in allied health and operations.

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

Ms Julie Rampton
Executive Director Nursing and Midwifery
Ms Rampton has worked for Queensland Health for over 40 years, 30 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 EB10. She is an adjunct professor at CQU and has post graduate qualifications in management and nursing education.

Adjunct Professor Philip Reasbeck
Executive Director Medical Services
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 College of Medicine and Dentistry at JCU.

Mr Marc Warner
Executive Director Corporate Services
Mr Warner has held senior and executive roles across the Australian and New Zealand public sectors over the past 30 years. He has been accountable for a broad range of corporate service functions; including finance, ICT, procurement, support services, people and capability, and resource management. In addition to providing assurance over financial statements, he has led significant reform and change agendas to drive new approaches to service delivery; specifically, through the design and implementation of innovative public value business and operating models.

Mr Rod Francisco
Executive Director People
Mr Francisco has held leadership roles in HR, logistics and maintenance in Australia and overseas in the local government, manufacturing, chemicals, resources and defence industries. In the HR industry, he is acknowledged as a senior leader being both a Fellow of the Australian Human Resources Institute (elected to the Queensland State Council) and a Certified Practitioner Human Resources. Mr Francisco was one of the first 100 leaders in Australia to successfully achieve the internationally accredited Chartered Manager status through the Institute of Managers and Leaders. He also lectures and tutors in HR subjects at CQU.

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

Organisational structure and workforce profile

Deputy Premier
Minister for Health
Minister for Ambulance Services

Department of Health
System Manager

Mackay Hospital and Health Board

The Hon. Timothy Mulherin
Mr Darryl Camilleri
Mr David Aprile
Prof Richard Murray
Ms Suzanne Brown
Assoc. Prof Leeanne Heaton
Ms Adrienne Barnett
Dr Elissa Hatherly
Mrs Helen Caruso

Executive Committee

Finance Committee

Safety and Quality Committee

Audit & Risk Committee

Health Service Chief Executive Ms Jo Whitehead
Executive Director **Operations Mackay** Mr Ivan Franettovich
Executive Director **Mental Health, Public Health & Rural Services** Ms Terry Johnson
Executive Director **Nursing and Midwifery** Ms Julie Rampton
Executive Director **Medical Services** Adj Prof Philip Reasbeck
Executive Director **Corporate Services** Mr Marc Warner
Executive Director **People** Mr Rod Francisco
Executive Director **Research and Innovation** Assoc. Prof David Farlow

Strategic workforce planning and performance

Mackay HHS employs health professionals and support service staff. Medical, nursing, clinical and non-clinical support staff and volunteers work together to deliver quality care and service to the community. As at 30 June 2020, Mackay HHS had 2,526 full-time equivalent staff.

Mackay HHS permanent FTE separation rate for 2019-20 was 8.2 per cent compared to a permanent FTE separation rate for 2018-19 of 8.6 per cent.

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

Staff	*2015-16*	*2016-17*	*2017-18*	*2018-19*	*2019-20*
Medical	239	267	276	306	322
Nursing	803	848	917	962	1,033
Allied Health	238	250	278	288	304

*Table 3: Greater diversity in our workforce**

Staff	*2015-16*	*2016-17*	*2017-18*	*2018-19*	*2019-20*
Aboriginal and/or Torres Strait Islander	37	41	40	50	53

***** *Workforce is measured in MOHRI – Full-Time Equivalent (FTE). Data presented reflects the most recent pay cycle at year's end.*

Employees across the public service contributed to the COVID-19 pandemic response in a range of different ways. In Mackay HHS, employees contributed to this effort by continuing to deliver essential services in line with normal arrangements and performing different work within Mackay HHS to help respond to emerging need.

Implementation of the People Strategy 2020-24 and Employee Engagement Strategy 2020-24 was deferred to enable our staff to focus on the COVID-19 response and recovery. Extensive consultation was completed prior to the deferment. These strategies will be implemented in 2020-21.

Attract, recruit and retain

During 2019-20, Mackay HHS developed the following initiatives to attract, recruit and retain staff:

- Planned and developed the E2E Program in partnership with local schools, universities, VET sector and community recruiting Aboriginal and Torres Strait Islander school-based students to complete health related training and courses in 2020-21.
- Initiated the New Starters Check-In survey to gain insight into how newly recruited employees are settling into the organisation and to further improve the onboarding processes.
- Redeveloped and modernised Recruitment and Selection Training to assist Hiring Managers and Interview Panel Members with recruitment and selection processes.
- Created and recruited to a new Business Administration Traineeship position (identified).
- Secured and recruited to two Dental Assistant Traineeships positions (identified).

Employee Health and Wellbeing Program

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

The Peer Support Program has 43 trained responders who regularly reach out to peers and engage in psychological first aid. In 2019-20, there were 653 colleagues provided with psychological first aid and links to other supports.

Flexible Working Arrangements

Mackay HHS is committed to the provision of flexible work arrangements such as part time work. At 30 June 2020, 41 per cent of staff had part-time working arrangements. Mackay HHS regularly promotes flexible working arrangements and supports both line managers and employees to understand what options are available.

Diversity

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

Mackay HHS is also committed to gender diversity with:

- 45.5 per cent - Women employed in executive management roles; and
- 55.6 per cent - Women on the Board.

Performance Management and Development

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

Industrial and Employee Relations Framework

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

Early retirement, redundancy and retrenchment

During the period, one employee received a redundancy package at a cost of $75,824.53.

Our risk management

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

Mackay HHS has a risk management policy and integrated Risk Management Framework 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. Mackay HHS's Risk Management Framework defines the processes for risk identification, recording, rating, key controls identification, determination of risk treatment required and regular monitoring and reporting of risks.

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

The HHBA requires annual reports to state each direction given by the Minister to Mackay HHS during the financial year and the action taken by Mackay HHS as a result of the direction. During the 2019-20 period, no directions were given by the Minister to Mackay HHS.

Internal audit

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

The function operates under the Internal Audit Charter, consistent with the internal auditors' standards and Audit Committee Guidelines. Internal audit is an independent and objective assurance activity designed to improve the governance of Mackay HHS providing reports to the Audit and Risk Committee for the effective, efficient and economical operation of the health service. The Internal audit 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 non-compliance with legislation or prescribed requirements
- assisting in risk management and identifying deficiencies in risk management
- bringing a broad range of issues to management's attention, including performance, efficiency and economy
- monitoring whether agreed remedial actions have been undertaken.

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 Queensland Audit Office (QAO). Audit reports include recommendations to address deficiencies in risk treatment and all audit reports are reviewed by the Audit and Risk Committee. Due to the COVID-19 response and recovery, all internal audits were postponed in the second half of 2019-20.

External scrutiny, Information systems and recordkeeping

External scrutiny

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

Mackay HHS participated in the Crime and Corruption Commission's Operation Impala investigation into improper access to and dissemination of confidential information by public sector agencies. Mackay HHS is progressing the implementation of the relevant recommendations (1-6, 8, 13 and 18).

As a public sector entity, Mackay HHS is subject to an annual audit by the QAO. The QAO Final Management Report provided to Mackay HHS for 2018-19 financial year contained no high risks.

Information systems and recordkeeping
Management of health records and clinical information is the responsibility of the Health Information Service. 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) and the General Retention and Disposal Schedule for Administrative Records (Non-Clinical).

MBH has successfully transitioned to a fully Integrated Electronic Medical Record site with direct entry into patient records. Key performance indicators are met routinely for the scanning of paper documentation into records. A quality assurance process is being maintained which will enable the authorised destruction of the MBH original (source) paper medical records after digitisation in accordance with the Digitisation and Disposal Plan of Scanned Medical Records.

The Business Classification Scheme is a records management tool used to categorise information resources in a consistent and organised manner. Mackay HHS adheres to the Business Classification Scheme and the General Retention and Disposal Schedule for Administrative Records.

Queensland Public Service ethics

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

Mackay HHS is committed to upholding the values and standards of conduct outlined in the Code of Conduct for the Queensland Public Service, 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 changes (via on-line training).

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

Human Rights

Mackay HHS has undertaken several actions since the implementation of the *Human Rights Act 2019* (Human Rights Act) took effect on 1 January 2020 to ensure that it was compliant with the Human Rights Act and also building a culture of recognising and respecting human rights in the workplace.

Since June 2019, Mackay HHS has been part of the broader Queensland Health implementation working group and has established an internal working group to oversee and monitor the implementation of the Human Right Act in Mackay HHS. Mackay HHS has undertaken actions within four main areas of the implementation process including:

1. Policy review: All policies are being prioritised for review and compatibility with the Human Right Act, including the review of staff and consumer complaints processes.
2. Public entity engagement: Mackay HHS is engaging with relevant public entities specifically associated with the delivery of services or outcomes on behalf of Mackay HHS.
3. Training for staff: Training has been conducted for leadership groups and for workplaces on awareness and understanding of human rights, the Human Rights Act, and how to recognise and support complaints about human rights breaches. It is expected that there will be Queensland Health specific training packages developed for targeted clinical service delivery areas (i.e. mental health) and for human resources in general.
4. Recording and reporting of complaints: Mackay HHS is required to report bi-monthly to Queensland Health in relation to human rights complaints and is reconfiguring its complaints processes, both for consumers and staff, to ensure that these are recorded appropriately and managed effectively. In 2019-20, Mackay HHS received no human rights complaints.

Confidential information

The HHBA requires annual reports to state the nature and purpose of any confidential information disclosed in the public interest during the financial year. The chief executive did not authorise the disclosure of confidential information confidential information during the reporting period.

Performance

The variance between 2019-20 target and the 2019-20 actual results can be attributed to the impact of the COVID-19 recovery and response. The 2019-20 actual result for elective surgery was impacted by the temporary suspension of non-urgent elective surgeries by the National Cabinet on 25 March 2020. Mackay HHS also made the decision to transition its outpatient appointments to telephone/telehealth reviews where clinically appropriate. The health service's priority for the second half of 2019-20 was on continuing to provide essential services whilst ensuring appropriate COVID-19 response planning.

Service standards

Table 4: Service Delivery Statement

Service Standards	2019-20 Target	2019-20 Actual
Effectiveness measures		
Percentage of patients attending emergency departments seen within recommended timeframes:		
Category 1 (within 2 minutes)	100%	99.2%
Category 2 (within 10 minutes)	80%	96.0%
Category 3 (within 30 minutes)	75%	85.0%
Category 4 (within 60 minutes)	70%	92.0%
Category 5 (within 120 minutes)	70%	98.4%
Percentage of emergency department attendances who depart within four hours of their arrival in the department	>80%	76.8%
Percentage of elective surgery patients treated within clinically recommended times:		
Category 1 (30 days)	>98%	90.1% [1]
Category 2 (90 days)	>95%	86.7%
Category 3 (365 days)	>95%	89.9%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	<2	0.3 [2]
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit	>65%	64.0%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	<12%	13.9% [3]
Percentage of specialist outpatients waiting within clinically recommended times:		
Category 1 (30 days)	70%	70.2% [1]
Category 2 (90 days)	70%	58.4%
Category 3 (365 days)	90%	89.6%
Percentage of specialist outpatients seen within clinically recommended times:		
Category 1 (30 days)	81%	70.8% [1]
Category 2 (90 days)	75%	55.6%
Category 3 (365 days)	97%	88.9%
Median wait time for treatment in emergency departments (minutes)	..	10
Median wait time for elective surgery (days)	..	45
Efficiency Measure		
Average cost per weighted activity unit for Activity Based Funding facilities	$4,590	$5,359 [4]
Other Measures		
Number of elective surgery patients treated within clinically recommended times:		
Category 1 (30 days)	1,179	1,028 [1]
Category 2 (90 days)	1,189	1,248
Category 3 (365 days)	403	410
Number of Telehealth outpatient occasions of service events	8,974	10,706
Total weighted activity units (WAU's)		
Acute Inpatient	41,895	39,384 [5]
Outpatients	10,951	10,410
Sub-acute	2,781	3,284
Emergency Department	11,169	11,127
Mental Health	4,205	3,721
Prevention and Primary Care	1,776	1,485
Ambulatory mental health service contact duration (hours)	>27,854	34,012
Staffing	2,356	2,526

1. Non urgent elective surgery and specialist outpatient services were temporarily suspended as part of COVID-19 preparation. Seen in time performance and service volumes were impacted as a result.
2. The Epidemiology and Research Unit in the Communicable Diseases Branch are unable to provide full year SAB data as resources are redirected to the COVID-19 response. SAB data presented as Mar-20 FYTD and is preliminary.
3. Readmission to acute Mental Health inpatient unit data presented as May-20 FYTD.
4. Cost per WAU data presented as Mar-20 FYTD.
5. Delivery of activity and weighted activity units was impacted by two significant factors in 2019-20; the introduction of a revised Australian Coding Standard "0002 Additional diagnoses" from 1 July 2019, resulted in lower weighted activity units being calculated for admitted patients relative to the same casemix of 2018-19 year and COVID-19 preparation and the temporary suspension of non urgent planned care services reduced the volume of patient activity. Activity data presented is preliminary. Data presented is full year as at 17 August 2020.

Financial summary

Mackay HHS has incurred a financial deficit of $8.78 million for the year ending 30 June 2020. This is compared to the financial deficit in 2018-19 of $4.12 million incurred by Mackay HHS.

Strong financial stewardship in previous years has led to funds being built up by Mackay HHS in retained earnings. The MHHB resolved in the 2019-20 financial year that it would invest retained earnings in initiatives to improve health service delivery to its community. These initiatives included the Tropical Australia Academic Health Centre, Mackay Institute of Research and Innovation, and transformation initiative.

If the reported deficit is adjusted for the MHHB approved spend from retained earnings ($4.36 million) then Mackay HHS's operating deficit for 2019-20 is $4.43 million.

The National Partnership Agreement provides for certain costs associated with the COVID-19 response, however not all COVID-19 costs are eligible for reimbursement. The operating deficit reflects those items not eligible for reimbursement which includes loss of own source revenue, annual leave not taken and the adjustments to workforce cost base that could not be made.

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

Income

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

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

Mackay HHS total income was $493.6 million which includes:

- Activity Based Funding (ABF) for hospital services was 60 per cent or $293.8 million
- Non-ABF funding was 14 per cent or $67.3 million
- User charges comprising patient and non-patient funding was 8 per cent or $37.5 million
- Australian Government grant funding was 15 per cent or $75 million
- Other revenue was 1 per cent or $4.5 million
- Other grant funding was 3 per cent or $15.5 million

Expenses

The total expenses were $502.4 million, an average of $1.4 million a day for providing health services.

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

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

Table 5: Mackay HHS service allocations

Where the money goes	%
Admitted patient services in acute care institutions	55.1
Non-admitted patient services in acute care institutions	16.5
Mental health includes community services	5.9
Nursing homes for the aged	0.7
Patient transport	2.1
Public health services	2.2
Other community health services	12.7
Health administration	4.8

Anticipated maintenance

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

Anticipated maintenance is defined as maintenance that is necessary to prevent the deterioration of an asset or its function, but which has not been carried out. Some anticipated maintenance activities can be postponed without immediately having a noticeable effect on the functionality of the building. All anticipated maintenance items are risk assessed to identify any potential impact on users and services and are closely managed to ensure all facilities are safe. Anticipated maintenance items are identified through the completion of triennial condition assessments, and the value and quantum of anticipated maintenance will fluctuate in accordance with the assessment programs and completed maintenance works.

As of 3 June 2020, Mackay HHS had reported total anticipated maintenance of $1.9 million. Mackay HHS is currently completing a condition assessment program for its major facilities, and the value of anticipated maintenance may vary as a result.

Mackay HHS has the following strategies in place to mitigate any risks associated with these items, including consideration of alternative funding options (Priority Capital Program), and continuing to review anticipated maintenance items to prioritise the most urgent.

Mackay Hospital and Health Service

ABN 87 427 896 923

Annual Financial Statements

For the year ended 30 June 2020

Mackay Hospital and Health Service
Statement of Comprehensive Income
For the year ended 30 June 2020

OPERATING RESULT	Notes	2020 $'000	2019 $'000
Income			
User charges and fees	B1-1	37,497	35,546
Funding public health services	B1-2	436,103	404,201
Grants and other contributions	B1-3	15,481	14,952
Other revenue	B1-4	4,514	5,429
Revaluation increment	B1-5	-	54
Total Income		**493,595**	**460,182**
Expenses			
Employee expenses	B2-1	48,674	43,698
Health service employee expenses	B2-2	280,022	256,779
Supplies and services	B2-3	132,077	127,166
Depreciation and amortisation	C5 & C9	29,016	27,387
Other expenses	B2-4	12,584	9,270
Total Expenses		**502,373**	**464,300**
Operating Surplus/(Deficit)		**(8,778)**	**(4,118)**
Other Comprehensive Income			
Items Not Reclassified to Operating Result			
Increase/(decrease) in Asset Revaluation Surplus		8,140	22,673
Other Comprehensive Income		**8,140**	**22,673**
Total Comprehensive Income		**(638)**	**18,555**

The accompanying notes form part of these statements

Mackay Hospital and Health Service
Statement of Financial Position
As at 30 June 2020

	Note	2020 $'000	2019 $'000
Current Assets			
Cash and cash equivalents	C1	31,638	32,445
Receivables	C2	4,380	6,321
Inventories	C3	4,242	4,187
Other assets	C4	6,848	6,127
Total Current Assets		**47,108**	**49,080**
Non-Current Assets			
Property, plant and equipment	C5	386,275	394,319
Right-of-use assets	C9	309	-
Total Non-Current Assets		**386,584**	**394,319**
Total Assets		**433,692**	**443,399**
Current Liabilities			
Payables	C6	25,682	21,774
Accrued employee benefits	C7	2,073	1,599
Lease liabilities	C9	241	-
Other liabilities	C8	3,274	459
Total Current Liabilities		**31,270**	**23,832**
Non-Current Liabilities			
Lease liabilities	C9	48	-
Total Non-Current Liabilities		**48**	**-**
Total Liabilities		**31,318**	**23,832**
Net Assets		**402,374**	**419,567**
Equity			
Contributed equity	C10-1	329,461	345,958
Accumulated surplus		21,461	30,297
Asset revaluation surplus	C10-2	51,452	43,312
Total Equity		**402,374**	**419,567**

The accompanying notes form part of these statements

Mackay Hospital and Health Service
Statement of Changes in Equity
For the year ended 30 June 2020

	Contributed equity Note C10-1 $'000	Accumulated surplus $'000	Asset revaluation surplus Note C10-2 $'000	Total equity $'000
Balance as at 1 July 2018	366,690	34,415	20,639	421,744
Operating Result	-	(4,118)	-	(4,118)
Other Comprehensive Income				
Increase in asset revaluation surplus	-	-	22,673	22,673
Total Comprehensive Income for the Year	-	(4,118)	22,673	18,555
Transactions with Owners as Owners:				
Net assets transferred	423	-	-	423
Equity injections - minor capital works	6,232	-	-	6,232
Equity withdrawals - Depreciation funding	(27,387)	-	-	(27,387)
Net Transactions with Owners as Owners	(20,732)	-	-	(20,732)
Balance at 30 June 2019	**345,958**	**30,297**	**43,312**	**419,567**
Balance as at 30 June 2019	345,958	30,297	43,312	419,567
Net effect of changes in accounting policies/prior year adjustments - refer Note G3	-	(58)		(58)
Balance as at 1 July 2019	345,958	30,239	43,312	419,509
Operating Result	-	(8,778)	-	(8,778)
Other Comprehensive Income				
Increase in asset revaluation surplus		-	8,140	8,140
Total Comprehensive Income for the Year	-	(8,778)	8,140	(638)
Transactions with Owners as Owners:				
Net assets transferred	4,147		-	4,147
Equity injections - minor capital works	8,371	-	-	8,371
Equity withdrawals - Depreciation funding	(29,015)	-	-	(29,015)
Net Transactions with Owners as Owners	(16,497)	-	-	(16,497)
Balance at 30 June 2020	**329,461**	**21,461**	**51,452**	**402,374**

The accompanying notes form part of these statements

Mackay Hospital and Health Service
Statement of Cash Flows
For the year ended 30 June 2020

	Note	2020 $'000	2019 $'000
Cash flows from operating activities			
Inflows			
User charges and fees		39,583	30,253
Funding public health services		407,562	378,956
Grants and other contributions		11,946	11,124
GST input tax credits from ATO		8,208	8,013
GST collected from customers		780	646
Other receipts		4,457	6,271
		472,536	**435,263**
Outflows			
Employee expenses		(48,207)	(43,543)
Health service employee expenses		(277,687)	(255,326)
Supplies and services		(130,044)	(125,629)
GST paid to suppliers		(8,195)	(8,236)
GST remitted to ATO		(726)	(636)
Other payments		(7,849)	(4,863)
		(472,708)	**(438,233)**
Net cash from/(used by) operating activities	CF-1	**(172)**	**(2,970)**
Cash flows from investing activities			
Inflows			
Sales of property, plant and equipment		72	74
Outflows			
Payments for property, plant and equipment		(8,542)	(10,764)
Net cash from/(used by) investing activities		**(8,470)**	**(10,690)**
Cash flows from financing activities	CF-2		
Inflows			
Equity injections		8,371	6,232
Outflows			
Lease payments		(536)	-
Net cash from/(used by) financing activities		**7,835**	**6,232**
Net increase/(decrease) in cash and cash equivalents		**(807)**	**(7,428)**
Cash and cash equivalents at the beginning of the financial year		32,445	39,873
Cash and cash equivalents at the end of the financial year	C1	**31,638**	**32,445**

The accompanying notes form part of these statements

NOTES TO THE STATEMENT OF CASH FLOWS

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

	2020 *$'000*	*2019* *$'000*
Operating Result	(8,778)	(4,118)
Non-cash movements:		
Depreciation and amortisation	29,016	27,387
Depreciation funding	(29,015)	(27,387)
Revaluation increment	-	(54)
Net (gain)/loss on disposal	401	243
Impairment losses	578	355
Donated assets	(100)	(32)
Changes in assets and liabilities:		
(Increase)/decrease in receivables	1,353	(3,933)
(Increase)/decrease in GST receivables	13	(223)
(Increase)/decrease in inventories	(112)	(416)
(Increase)/decrease in contract assets and other assets	(1,235)	3,008
(Increase)/decrease in prepayments	514	(609)
Increase/(decrease) in accounts payable	1,573	1,192
Increase/(decrease) in accrued contract labour	2,335	1,453
Increase/(decrease) in contract and other liabilities	2,757	-
Increase/(decrease) in accrued employee benefits	474	154
Increase/(decrease) in GST payable	54	10
Net cash from/(used by) operating activities	**(172)**	**(2,970)**

CF-2 CHANGES IN LIABILITIES ARISING FROM FINANCING ACTIVITIES

	2020 *$'000*
Lease liabilities	
Balance at 1 July 2019	-
Non-cash movements:	
Net adjustments on adoption of new accounting standards	497
New leases acquired during the year	326
Remeasurement	2
Cashflows:	
Lease repayments	(536)
Balance at 30 June 2020	**289**

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

Assets received or liabilities transferred by the Hospital and Health Service as a result of machinery-of-Government or administrative arrangements are set out in the Statement of Changes in Equity and Note C10-1.

PREPARATION INFORMATION

GENERAL INFORMATION

The Mackay Hospital and Health Service (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 39 of the *Financial and Performance Management Standard 2019*. The financial statements comply with Queensland Treasury's Minimum Reporting Requirements for reporting periods beginning on or after 1 July 2019.

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

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

PRESENTATION

Currency and Rounding

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

Comparatives

Comparative information has been reclassified where required for consistency with the current year's presentation.

Current/Non-Current Classification

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

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

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

AUTHORISATION OF FINANCIAL STATEMENTS FOR ISSUE

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

BASIS OF MEASUREMENT

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

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

Historical Cost

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

Fair Value

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

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

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

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.

THE REPORTING ENTITY

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

SECTION A

HOW WE OPERATE – OUR OBJECTIVES AND ACTIVITIES

A1 OBJECTIVES OF MHHS

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

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

A2 CONTROLLED ENTITIES

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

A2-1 DISCLOSURES ABOUT NON WHOLLY OWNED CONTROLLED ENTITIES

North Queensland Primary Health Network Limited

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 eleven members along with Cairns and Hinterland Hospital and Health Service, Townsville Hospital and Health Service, Torres and Cape Hospital and Health Service, the Pharmacy Guild of Australia (Queensland Branch), the Australian College of Rural and Remote Medicine, Northern Aboriginal and Torres Strait Islander Health Alliance, Queensland Alliance for Mental Health, CheckUP, Australian Primary Healthcare Nurses Association and the Council on the Ageing, with each member holding one voting right in the company.

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

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

As 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.

Tropical Australia Academic Health Centre Limited

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

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

As each member has the same voting entitlement (14%), it is considered that none of the individual members has power or significant influence over TAAHC (as defined by AASB 10 *Consolidated Financial Statements and AASB 128 Investments in Associates and Joint Ventures*). Each member's liability to TAAHC 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 TAAHC is not controlled by Mackay HHS and is not considered a joint operation or an associate of Mackay HHS, financial results of TAAHC are not required to be disclosed in these statements.

SECTION B
NOTES ABOUT OUR FINANCIAL PERFORMANCE

B1 REVENUE

B1-1 USER CHARGES AND FEES

	2020 *$'000*	*2019* *$'000*
Revenue from contracts with customers		
Pharmaceutical Benefit Scheme	12,641	11,097
Sales of goods and services	4,443	4,216
Hospital fees	20,413	20,233
	37,497	**35,546**

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

Revenue from contracts with customers is recognised when MHHS transfers control over a good or service to the customer. The following table provides information about the nature and timing of the satisfaction of performance obligations, significant payment terms, and revenue recognition for MHHS's user charges revenue from contracts with customers.

The adoption of AASB 15 *Revenue from Contracts with Customers* in 2019-20 did not change the timing of revenue recognition for user charges.

Type of good or service	Nature and timing of satisfaction of performance obligations, including significant payment terms	Revenue recognition policies
Pharmaceutical benefits scheme (PBS) - public hospital patients can access medicines listed on the PBS if they are being discharged or attending outpatient day clinics and admitted receiving chemotherapy treatment. Medicare Australia reimburses the cost of the pharmaceutical items at the agreed wholesale price. Patients generally pay a co-payment which is deducted from the Commonwealth reimbursement price.	Performance obligations to receive the subsidy from the Commonwealth include: • each MHHS dispensing facility must have a Medicare Australia provider number; and • have dispensed items on the PBS list using the approved PBS prescription forms. Reimbursements are claimed electronically via PBS Online (either fortnightly or monthly) and submitted to Medicare Australia. Payments from Medicare go directly to MHHS.	Revenue is recognised as medication is distributed to patients, with payments from Medicare received on behalf of the customer (patient).
Sales of goods and services		
Multi-purpose nursing home fees - long term nursing home and psychogeriatric patients are required to contribute towards their daily care, community care, medical services and pharmacy services.	The sole performance obligation is the provision of daily care to eligible Commonwealth aged care clients in MHHS's multipurpose facilities. Specific fees are determined by the Department of Health and are legislated under the *Aged Care Act 1997*. Invoices are raised monthly to residents based on the number of bed days service provided.	Revenue is recognised on provision of the services to the customer.
Home community aged care packages - services provided to eligible Commonwealth clients under an agreement between the State and Commonwealth. Eligible clients are required to make a co-contribution for services provided. The commonwealth's contribution to these services is outlined in Note B1-3 Grants and other contributions	MHHS provides services to eligible clients for home support such as home maintenance, domestic assistance, nursing care etc. The sole performance obligation is the provision of services to eligible clients within the package approved by the Commonwealth. Invoices against individual customers are raised monthly based on the service type, frequency and rate (set by the Department of Health).	Revenue is recognised on provision of services to the customer.
Revenue management of capital projects – the Department of Health purchases services for approved capital projects as part of Queensland Health's capital delivery program.	Performance obligations under the arrangement include: • purchases must be approved as part the capital program by the Department; • all purchases are monitored by the Department and reviewed at the end of the month. Approval from the Department on costs incurred must be received before the invoices and revenue can be raised; • purchases must be within budgeted expenditure limits approved. Invoices raised against the Department of Health are generally settled within 30 days and are based on cost recovery principals.	Revenue is recognised as the services are provided each month and a contract asset representing MHHS's right to consideration for services delivered but not yet billed raised where applicable.
Provision of other goods and services	MHHS provides a range of clinical research and other services to private companies and individuals. These services are generally provided over a 12-month period, with customers simultaneously receiving and consuming benefits provided. Invoices are raised as services are provided. Clinical trials are invoiced in accordance with milestones included in contractual agreements.	Revenue is recognised progressively as services are provided each month and a contract asset representing MHHS's right to consideration for services delivered but not yet billed raised where applicable.

B1-1 USER CHARGES AND FEES (continued)

Accounting Policy - Revenue from contracts with customers (User charges continued)

Type of good or service	Nature and timing of satisfaction of performance obligations, including significant payment terms.	Revenue recognition policies
Hospital fees		
Private patients - public hospital patients have the option to elect to be treated as a private patient when admitted with rates for each service set annually by the Department of Health. These services accounts for approximately 49% of hospital fees.	The sole performance obligation is the delivery of patient care which is recognised over time as provided. Health funds are invoiced, once a patient is discharged and services are clinically coded. This can take 4-6 weeks. The amount paid by health funds may be adjusted when a private health funds accepts a claim. Payment by health funds is typically made within 60 days.	Revenue is recognised over time as patient care provided by MHHS is simultaneously received and consumed by our customers. Where health fund payment rates for services rendered are lower than that established by the Department, discounts are recognised.
Private practice arrangements - senior and visiting medical officers employed by MHHS can elect to treat private patients in MHHS facilities under current employment contracts. Doctors can either assign 100% of private patient billings to MHHS (compensated by additional wage allowances) or alternatively retain professional service revenue after deduction of a service fee to MHHS. Revenue from these arrangements account for 29% of hospital fees charged.	Medical treatment provided to private patients is bulk billed to Medicare Australia, with same day electronic lodgement of claims. Cash payments are received approximately 2 days after lodgement of claim. Assigned revenue - the sole performance obligation is delivery of medical services to private patients. Retention revenue - the sole performance obligation is administrative in nature, with the service fee based on a set % of total medical billings deposited into the private practice trust account during the month.	Assignment revenue is recognised as services are provided to private patients (customers). Service fee revenue from retention doctors is recognised at the end of the month, once all administrative duties associated with the operation of the trust account are completed.
Compensable patients - public hospital patients who have received hospital services for an injury, illness or disease and have an entitlement to receive a compensation payment (e.g. workers' compensation, motor vehicle accidents) are charged for services with claims raised directly against the insurer. Most patients treated by MHHS are worker's compensation clients and represent approximately 12% of hospital fees.	Rates for each service is set annually by the Department of Health in consultation with relevant insurers. The sole performance obligation is the delivery of patient care. Patients must meet relevant claim criteria established under the respective schemes and be approved by the insurers for treatment. WorkCover claims are submitted online daily along with required supporting documents. Cash payments are received approximately 2 days after lodgement of claim.	Revenue is recognised once a patient has been approved for treatment, and services are provided.

B1-2 FUNDING PUBLIC HEALTH SERVICES

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Activity based funding	293,802	270,735
Other grants and contributions		
Block funding	67,270	59,619
Teacher training funding	12,937	11,417
Depreciation funding	29,015	27,387
General purpose funding	33,079	35,043
	436,103	**404,201**

Accounting Policy – Public health services

Revenue from contracts with customers – ABF funding

Revenue is recognised when purchased services are provided to patients on behalf of the Department of Health. Further details on ABF funding is provided in the table below.

Other grants and contributions

Revenue is recognised on receipt of funding under AASB 1058 *Income of Not-for-Profit Entities* where the Service Agreement (SA) does not include sufficiently specific performance obligation. This includes block, teacher, depreciation and most of the other general-purpose funding. Where the SA contains sufficiently specific performance obligations, and MHHS transfers goods or services, the transaction is accounted for under AASB *15 Revenue from Contracts with Customers*, with revenue initially deferred and recognised, as or when, the performance obligations are satisfied.

Disclosure about funding received to deliver public health services

Activity Based Funding (ABF) is provided by the Department of Health for specific public health services. These services are purchased in accordance with an enforceable contract - SA. The SA includes targeted activity service levels, outcomes to be met by MHHS and how MHHS's performance will be measured. The SA is reviewed periodically for changes in activity levels, type of services and the prices of services delivered. Payments received under this agreement represent both the State and Commonwealth contribution to health services. The Commonwealth pays its share of national health funding directly to the Department of Health, for onforwarding to the Hospital and Health Service.

During 2019-20 additional funding was provided under the *National Partnership Agreement on COVID-19 Response* to meet costs directly attributed to the treatment of COVID-19 patients (diagnosed or suspected), and additional costs of activities directed at preventing the spread of COVID-19. In 2019-20 $4.233 million was received for COVID-19.

Cash funding (ABF and Block) from the department is received fortnightly for State payments, while Commonwealth payments are received on a monthly basis.

Smaller hospitals are supported through block funding where the technical requirements of applying ABF are not able to be satisfied, and there is an absence of economies of scale, that means some services would not be financially viable. Teacher training grants are provided to support the MHHS and are calculated based on the numbers of doctors, clinical graduates and research positions. Block and teacher training funding, although under an enforceable agreement, do not contain sufficiently specific performance obligations and are recognised as revenue when received.

Other general-purpose funding supports the provision of a wide range of services for primary and community healthcare and includes other services that fall outside the scope of the National funding model. These are state-funded and have specific conditions attached. Recognition of revenue for other "general purpose" funding is dependent on the specific performance obligations attached to each funding sub-type. Where the obligations are not sufficiently specific, revenue is recognised as it is received. Funding with sufficiently specific obligations, are recognised over time as the services/goods are provided and obligations met with the price implicit in the SA.

Depreciation funding is provided to offset depreciation charges incurred by MHHS. This is a non-cash revenue and is offset with an equity withdrawal for the same amount refer Statement of Changes in Equity refer Note C10-1. There is no transfer of goods and services to a third party, with depreciation revenue recognised as revenue as received under AASB 1058.

Type of good or service	Nature and timing of satisfaction of performance obligations, including significant payment terms.	Revenue recognition policies
Activity based services	MHHS delivers public health care services to eligible public patients or all patients for communicable diseases under the SA. The Department of Health's purchasing model determines the volume and type of services to be purchased from MHHS, the prices that 'activity based' services are purchased, and any efficiency adjustments applied. SA is reviewed periodically and updated for changes in activities and the prices of services delivered as service demands and state priorities change. MHHS's obligations under the SA are measured as follows: • Public health care services (targets set per service stream e.g. inpatients, outpatients, emergency) – Weighted Activity Unit (WAU); • Oral health services - Weighted Occasions of Service Unit (WOO); • Breast Screen Queensland – per number of services provided (WOO) and include incentive funding where specific criteria are met; Subject to departmental consideration and available pooled funds across the state, additional funding may be paid by the department for identified purchasing incentives where activity exceeds the target set in SA.	Revenue is recognised as activity is delivered over time by multiplying the activity units by the Queensland Efficiency Price (QEP) or other prices in the contract. In general, revenue is not deferred as new activity targets are set in the following financial year. Revenue is not recognised where activity is expected to exceed targets as information to reliably measuring the actual activity is not finalised until late 2020. An adjustment is made in the subsequent year for any variance between estimated activity and final activity.

B1-3 GRANTS AND OTHER CONTRIBUTIONS

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Home and community care grants	4,000	3,880
Specific purpose payments	6,614	5,719
Other grants and contributions		
Other grants	1,111	1,557
Services received below fair value	3,756	3,796
	15,481	**14,952**

Accounting Policy – Services received below fair value

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

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

Accounting Policy – Grants, contributions, donations and gifts

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

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

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

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

Contributed assets are recognised at their fair value.

Disclosure – Grants and contributions

MHHS has several grant arrangements that relate to funding of activity-based services, primarily related to aged care clients and the provisions of specialist medical training. The arrangements outlined below have been identified as having sufficiently specific performance obligations under enforceable grant agreements and comprised 55% of total grants and contributions received. The remaining grants, although under enforceable agreements, do not contain sufficiently specific performance obligations, and are recognised upon receipt.

Grants – recognised as performance obligations are satisfied

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

Type of good or service	Nature and timing of satisfaction of performance obligations, including significant payment terms.	Revenue recognition policies
Commonwealth Home and Community Care - purchased services include a range of activities performed at client's homes including personal and wellness care, patient care and home maintenance. The number of hours/trips per annum and applicable rates are included in agreed work activity plan.	MHHS provides services to eligible Commonwealth clients for home support services under a two-year agreement between the State and Commonwealth. Performance obligations under the arrangement include: • the Commonwealth approved client must have been approved for a home community aged care package; and • the services provided to the client must align with the package approved by the Commonwealth. Payments from the Commonwealth government are made quarterly in advance.	Amounts received are recognised as contract liabilities until performance obligations are satisfied. Revenue is recognised as services are performed. Where activity levels contracted are not fully delivered at year end, and exceed the level allowed for carryover into the next year, a funding payable is raised.
Improving Access to Primary Care in Rural and Remote Areas - COAG s19(2) Exemptions Initiative - under a Memorandum of Understanding between the State and Commonwealth governments, MHHS receives payment through Medicare Australia for services provided to patients presenting to rural and remote health facilities.	Performance obligations under the arrangement include: • the facility must be approved to provide the services – Schedule A of the MOU; • MHHS medical staff must have provided treatment to public patients in the emergency department. Claims for services performed are lodged electronically, with amounts received based on Medicare item numbers and rates set by the Commonwealth.	Revenue is recognised as services are provided to patients. The use of funds generated under this arrangement are restricted and must be used for community maintenance programs.
Specialist Training Program - training to eligible medical specialists under contract agreements with multiple medical colleges. The trainee must be a member of the medical college and is the recipient of the service.	Performance obligations under the contracts include: • approved training placement within the specified area of interest (i.e. anaesthesia, emergency medicine) and in the specified regional location; and • the duration of the training. Where training ceases prior to the minimum service period specified in the contract (usually 3 months), no grant funding is provided. Entitlement to funding is also dependent on the number of FTE training positions agreed and occupied. Payments from the colleges are made in areas on a bi-annual basis upon receipt and acceptance of performance reports, financial acquittals and trainee details.	Once the minimum training period specified in the contract has been satisfied, revenue is recognised over time as services are simultaneously received and consumed by the trainee. A contract asset representing MHHS's right to consideration for services delivered but not yet billed is raised where applicable.

B1-3 GRANTS AND OTHER CONTRIBUTIONS (continued)

Type of good or service	Nature and timing of satisfaction of performance obligations, including significant payment terms.	Revenue recognition policies
Commonwealth transition care - provides services to eligible Commonwealth aged care clients for transitional care under an agreement between the State and Commonwealth. Rates for services provided are included in schedule.	Performance obligations under the arrangement include: • MHHS must hold an allocation of places for flexible care subsidies; and • provide health care services to Commonwealth approved transition care recipients, in line with approved care plan. Payments from the Commonwealth are advanced at the beginning of the month. At the end of the month, claims are lodged with the department including details on persons visited and duration of visit. A subsequent adjustment either up or down is made by the department.	Amounts received are recognised as contract liabilities until performance obligations are satisfied. Revenue is recognised as services are provided to aged care customers. A contract asset representing MHHS's right to consideration for services delivered but not yet billed raised where applicable.
Aged care packages – provides personal care services and other personal assistance to person over 65 years in the home under an agreement between the State and Commonwealth. Rates for services are dependent on the approved level of the home care package assessed by Commonwealth to approved recipients. MHHS has approval for a set number of home care packages.	The sole performance obligations under the arrangement is to provide personal care services to approved Commonwealth recipients based on agreed levels of care. Payments from the Commonwealth are advanced at the beginning of the month. At the end of the month, claims are lodged with the department including details by care recipient id, level of care and number of days provided. A subsequent adjustment to revenue either up or down is made by the Department of Human Services.	Amounts received are recognised as contract liabilities until performance obligations are satisfied. Revenue is recognised as services are provided to aged care customers. A contract asset representing MHHS's right to consideration for services delivered but not yet billed raised where applicable.

B1-4 OTHER REVENUE

	2020	*2019*
	$'000	*$'000*
Recoveries	4,193	5,109
Other	321	320
	4,514	**5,429**

Accounting Policy – Other revenue

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

B1-5 LAND REVALUATION INCREMENT

	2020	*2019*
	$'000	*$'000*
Revaluation increments - land	-	54
	-	54

Accounting Policy - Revaluations

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

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

Decrements in land values in prior years were reflected as an expense in the operating statement, resulting in accumulated losses carried forward of $5.748 million at 30 June 2020 (2019: $5.748 million).

B2 EXPENSES

B2-1 EMPLOYEE BENEFIT EXPENSE

	2020	*2019*
	$'000	*$'000*
Employee benefits		
Wages and salaries	41,703	37,357
Annual leave levy	2,655	2,408
Employer superannuation contributions	3,009	2,697
Long service leave levy	976	778
Employee related expenses		
Workers compensation premium	60	86
Other employee related expenses	271	372
	48,674	**43,698**
	No.	No.
Full-Time Equivalent Employees*	102	94

*reflecting Minimum Obligatory Human Resource Information (MOHRI)

Accounting Policy – Superannuation

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

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

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

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

Accounting Policy – Employee benefits

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

Accounting Policy – Workers' compensation premiums

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 paid by MHHS to cover the cost of employee's accruing annual leave and long service leave entitlements (including leave loading and on-costs).

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

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

B2-2 HEALTH SERVICE EMPLOYEE EXPENSES

	2020	*2019*
	$'000	*$'000*
Department of Health	280,022	256,779
	280,022	**256,779**

The Hospital and Health Service through service arrangements with the Department of Health has engaged 2,424 (2019: 2,294) full time equivalent persons at 30 June 2020. As well as direct payments to the department, premium payments made to WorkCover Queensland representing compensation obligations are included in this category 2020: $1.462 million (2019: $1.997 million).

Accounting Policy – Health service employee expense

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

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

B2-3 SUPPLIES AND SERVICES

	2020	*2019*
	$'000	*$'000*
Contractors and consultants		
Medical	20,796	18,556
Other	1,414	1,688
Electricity and other energy	5,097	5,422
Patient travel	11,091	10,580
Other travel	1,420	1,879
Building services	2,216	1,909
Computer services	3,369	2,240
Communications	6,471	4,706
Repairs and maintenance	11,274	10,089
Lease expenses	226	695
Outsourced medical services	13,105	14,334
Inventories consumed		
Drugs	15,993	15,171
Clinical supplies and services	19,335	17,448
Catering and domestic supplies	1,455	1,676
Pathology, blood and parts	12,170	10,816
Other	6,645	9,957
	132,077	**127,166**

Accounting Policy – Inventories consumed

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

Accounting Policy Lease expenses

Lease expenses include lease rentals for short-term leases, leases of low-value assets and variable lease payments. Refer to Note C-9 for breakdown of lease expenses and other lease disclosures.

B2-4 OTHER EXPENSES

	2020	*2019*
	$'000	*$'000*
Insurance premiums - QGIF	4,686	4,022
Insurance premiums - Other	51	24
Impairment trade receivables	521	235
Services received free of charge	3,756	3,796
Losses from the disposal of non-current assets	401	243
Special payments		
Ex-gratia payments	1	4
Other legal costs	238	22
Funding expense	1,614	45
Other	1,316	879
	12,584	**9,270**

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 2019-20 policy year, the premium was allocated to each HHS according to the underlying risk of an individual insured party.

Disclosure – Special payments and services received free of charge

Special payments represent ex gratia expenditure and other expenditure that 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.

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

B2-5 AUDITOR REMUNERATION

	2020	*2019*
	$	*$*
Audit services - Queensland Audit Office		
Audit of financial statements	194,000	160,000

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

SECTION C
NOTES ABOUT OUR FINANCIAL POSITION

C1 CASH AND CASH EQUIVALENTS

	2020 $'000	2019 $'000
Imprest accounts	5	7
Cash at bank*	30,192	31,018
QTC cash funds*	1,441	1,420
	31,638	**32,445**

Cash deposited with Queensland Treasury Corporation earns interest, calculated daily reflecting market movements in cash funds. The annual effective interest rate was 0.86% (2019: 2.38%).

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 2020, amounts of $2.372 million (2019: $2.087 million) in General Trust, including $1.546 million (2019: $1.352 million) for excess earnings under Granted Private Practice, set aside for the specified purposes underlying the contribution.

C2 RECEIVABLES

	2020 $'000	2019 $'000
Trade debtors	4,426	6,090
Less: Loss allowance	(800)	(590)
	3,626	5,500
GST receivable	870	883
GST payable	(116)	(62)
	754	821
	4,380	**6,321**

Accounting Policy – Receivables

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

Disclosure – Receivables

The closing balance of receivables arising from contracts with customers at 30 June 2020 is $4.426 million (1 July 2019: $6.090 million)

C2-1 IMPAIRMENT OF RECEIVABLES

Accounting Policy – Impairment of receivables

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

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

Where there is no reasonable expectation of recovery of monies owing by a debtor, the debt is written-off by directly reducing the receivable against the loss allowance. This occurs when a third default notice has been issued (normally after 120 days) and debt enforcement activity has ceased. If the amount of debt written off exceeds the loss allowance, the excess is recognised as an impairment loss. The amount of impairment losses recognised for trade debtors is disclosed in Note C2-1 below.

C2 RECEIVABLES (continued)

Disclosure – Credit risk exposure of receivables

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

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

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

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

IMPAIRED RECEIVABLES

Disclosure - Ageing of past due but not individually impaired receivables

	2020			2019		
	Gross receivables	*Loss rate*	*Expected credit losses*	*Gross receivables*	*Loss rate*	*Expected credit losses*
Aging	*$'000*	*%*	*$'000*	*$'000*	*%*	*$'000*
Current	817	1.6%	13	204	14.9%	30
31 to 60 days	1,188	3.3%	39	2,218	2.2%	50
61 to 90 days	923	6.5%	60	927	11.6%	108
> 90 days	1,498	46.2%	692	2,743	14.7%	402
Total	**4,426**		**804**	**6,092**		**590**

Disclosure - Movement in loss allowance for trade debtors

	2020	*2019*
	$'000	*$'000*
Balance at beginning of the year	590	502
Amounts written off during the year	(311)	(146)
Increase/(decrease) in allowance recognised in operating result	521	234
Balance at the end of the year	**800**	**590**

C3 INVENTORIES

	2020	*2019*
	$'000	*$'000*
Inventories held for distribution - at cost		
Pharmaceutical drugs	1,331	1,309
Clinical supplies	2,892	2,868
Catering and domestic	19	10
	4,242	**4,187**

Accounting Policy – Inventories

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

C4 OTHER ASSETS

	2020	*2019*
	$'000	*$'000*
Prepayments	594	1,108
Contract assets	3,469	4,117
Other	2,785	902
	6,848	**6,127**

Accounting Policy – Other assets

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

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

Disclosure – Contract assets

Contract assets arise from contracts with customers and are transferred to receivables when MHHS's right to payment becomes unconditional, this usually occurs when the invoice is issued to the customer.

The Department of Health owed $3.776 million (2019: $2.117 million) at 30 June to MHHS including $991 thousand in contract assets (2019: $2.117 million) for project management and purchases of additional health service activity, and $2.785 million (2019: $nil) for other funding to support the provision of health services (other assets). For further details on the nature of these transactions refer to Note B1-2.

C5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION

C5-1 ACCOUNTING POLICIES

Property, Plant and Equipment

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

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

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

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

Componentisation of Complex Assets

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

Acquisition of Assets

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

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

Measurement using historical cost

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

Measurement using fair value

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

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

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

Revaluation of property measured at fair value

Land and building classes measured at fair value, are assessed on an annual basis either by comprehensive valuations or using appropriate and relevant indices undertaken by independent professional valuers/quantity surveyors. For financial reporting purposes, the revaluation process for MHHS is managed by the finance unit with input from the infrastructure branch and Chief Finance Officer. The appointment of the independent valuer was undertaken as part of a market tender process.

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

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

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

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

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

For buildings, accumulated depreciation is adjusted to equal the difference between the gross amount and the carrying amount, after considering accumulated impairment losses and changes in remaining useful life. This is generally referred to as the 'gross method'.

Depreciation

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

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

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

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

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

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

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

Class	Depreciation rates
Buildings and Improvements	
- Structural fabric of building	0.9 to 10.0%
- External fabric	0.9 to 10.0%
- Internal fabric	0.9 to 10.0%
- Internal finishes	1.4 to 20.0%
- Fittings	2.0 to 9.1%
- Building services	1.4 to 12.5%
- Land improvements	1.2 to 3.3%
- Other buildings including residential	0.9 to 33.3%
Plant and equipment including artworks	1.0 to 33.3%

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

Indicators of impairment and determining recoverable amount

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

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

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

For all other remaining assets measured at cost, and assets held for the generation of cash flows, recoverable amount is equal to the higher of the fair value less costs of disposal and the asset's value in use.

Value in use is equal to the present value of the future cash flows expected to be derived from the asset, or where MHHS no longer uses an asset and has made a formal decision not to reuse or replace the asset, the value in use is the present value of net disposal proceeds.

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

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

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

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

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

2020	Land (Level 2) $'000	Buildings (Level 3) $'000	Plant and equipment (at cost) $'000	Capital works in progress (at cost) $'000	Total $'000
Gross	13,735	578,790	52,698	7,810	653,033
Less: Accumulated depreciation	-	(237,381)	(29,377)	-	(266,758)
Carrying amount at 30 June 2020	**13,735**	**341,409**	**23,321**	**7,810**	**386,275**
Represented by movements in carrying amount:					
Carrying amount at 1 July 2019	13,735	349,174	24,041	7,369	394,319
Transfers in - practical completion projects from the Department of Health		4,147			4,147
Acquisitions		896	4,809	2,837	8,542
Donated assets	-	-	100	-	100
Disposals	-	(119)	(354)	-	(473)
Transfers between classes	-	2,396	-	(2,396)	-
Net revaluation increments/(decrements)	-	8,140	-	-	8,140
Depreciation expense	-	(23,225)	(5,275)	-	(28,500)
Carrying amount at 30 June 2020	**13,735**	**341,409**	**23,321**	**7,810**	**386,275**

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

2019	Land (Level 2) $'000	Buildings (Level 3) $'000	Plant and equipment (at cost) $'000	Capital works in progress (at cost) $'000	Total $'000
Gross	13,735	562,587	52,759	7,369	636,450
Less: Accumulated depreciation	-	(213,413)	(28,718)	-	(242,131)
Carrying amount at 30 June 2019	**13,735**	**349,174**	**24,041**	**7,369**	**394,319**
Represented by movements in carrying amount:					
Carrying amount at 1 July 2018	13,681	341,778	23,754	8,864	388,077
Transfers in - practical completion projects from the Department of Health	-	349	-	-	349
Transfers in from other Queensland Government entities	-	-	74	-	74
Acquisitions	-	653	4,654	5,457	10,764
Donated assets	-	-	32	-	32
Disposals	-	(10)	(307)	-	(317)
Transfers between classes		6,947	5	(6,952)	-
Net revaluation increments/(decrements)	54	22,673	-	-	22,727
Depreciation expense	-	(23,216)	(4,171)	-	(27,387)
Carrying amount at 30 June 2019	**13,735**	**349,174**	**24,041**	**7,369**	**394,319**

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

C5-3 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, Mines and Energy.

All land holdings were comprehensively revalued as at 30 June 2020 by SVS. There was significant uncertainty in relation to the Mackay Base Hospital site so a second valuation was sought. These were materially different and potentially reflected uncertainties around potential use and the impact of COVID-19. As a result of the uncertainty the Mackay HHS Board agreed to retain all existing values and undertake further valuations during 2020/21 once these uncertainties had been addressed.

Buildings

In 2020 MHHS completed its four-year rolling building valuation program (2017 to 2020). As part of this program independent quantity surveyors, AECOM Pty Ltd were engaged to comprehensively revalue all buildings (with a replacement cost exceeding $3 million) over this period and calculate an annual index for all other assets. Refer to Note D1-2 for further details on the revaluation methodology applied. Twenty-two buildings were comprehensively revalued in 2020.

The revaluation program resulted in an increment of $8.140 million or 2.5% increase (2019: increment $22.673 million) to the carrying amount of buildings.

C6 PAYABLES

	2020 *$'000*	*2019* *$'000*
Trade creditors	14,035	12,462
Accrued labour - Department of Health	11,647	9,312
	25,682	**21,774**

Payables of $15.966 million (2019: $12.450 million) were owing to the Department of Health at 30 June including trade creditors $4.319 million (2019: $3.129 million), accrued labour $11.647 million (2019: $9.312 million).

Accounting Policy – Payables

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

C7 ACCRUED EMPLOYEE BENEFITS

	2020 *$'000*	*2019* *$'000*
Wages outstanding	1,902	1,459
Long service leave levy payable	45	-
Superannuation accrued	126	140
	2,073	**1,599**

Accounting Policy – Accrued employee benefits

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

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

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

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

C8 OTHER LIABILITIES

	2020	*2019*
	$'000	*$'000*
Contract liabilities	605	334
Unearned revenue	2,669	125
	3,274	**459**

Accounting policy – Other liabilities

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

Disclosure – Contract liabilities

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

Most contract liabilities represent unearned revenue for patient fees and goods and services from Commonwealth (2020: $605 thousand, 2019: $334 thousand) and (other liabilities) public health funding received by HHS to be returned to DoH (2020: $2.316 million, 2019: $125 thousand) refundable general grants from private companies (2020: $172 thousand, 2019: nil). For further details on the nature of these transactions refer to Note B1-2.

C9 RIGHT OF USE ASSETS AND LEASE LIABILITIES

A new accounting standard AASB16 *Leases* came into effect in 2019-20, resulting in significant changes to MHHS's accounting for leases for which it is a lessee. The transitional impacts of the new standard are disclosed in Note G3.

C9-1 LEASES AS LESSEE

	2020
	$'000
Right-of-use assets	
Gross value	825
Less Accumulated depreciation	(516)
Carrying amount at 30 June 2020	**309**
Represented by movements in carrying amount:	
Balance at 1 July 2019	497
Additions	326
Remeasurement	2
Depreciation	(516)
Balance at 30 June 2020	**309**
Lease liabilities	
Current	241
Non-Current	48
Total	**289**

Accounting policy – Measurement of lease liability and Right-of-Use (ROU) assets at commencement date

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

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

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

A right-of-use asset and a lease liability are recognised at the lease commencement date.

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

Disclosures - Leases as lessee

Details of leasing arrangements as lessee

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

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

The average lease term is 12 months and implicit interest rates range from 1.6% to 2.8% Lease payments are allocated between principal component of the lease liability and the interest expense.

Motor vehicles

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

C10 EQUITY

C10-1 CONTRIBUTED EQUITY

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

- Cash equity contributions fund purchases of equipment, furniture and fittings associated with capital work projects managed by MHHS. In 2020 MHHS received $8.4million (2019 $6.2 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;

- Equity withdrawal of funds by the Department of Health on behalf of the State, MHHS recognised $29.0 million funding in 2020 (2019 $27.4 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.

During this year several assets have been transferred under this arrangement.	*2020* *$'000*	*2019* *$'000*
Transfer in - practical completion of projects from the Department of Health*	4,147	349
Net transfers equipment between HHS	-	74
	4,147	**423**

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

C10-2 ASSET REVALUATION SURPLUS BY ASSET CLASS

	2020 *$'000*	*2019* *$'000*
Buildings		
Balance at the beginning of the financial year	43,312	20,639
Revaluation increments/(decrements)	8,140	22,673
Total	**51,452**	**43,312**

Accounting Policy - Asset revaluation surplus

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

D1 FAIR VALUE MEASUREMENT

D1-1 ACCOUNTING POLICIES AND BASIS FOR FAIR VALUE MEASUREMENT

What is fair value?

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

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

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

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

Fair value measurement hierarchy

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

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

Level 1	represents fair value measurements that reflect unadjusted quoted market prices in active markets for identical assets and liabilities;
Level 2	represents fair value measurements that are substantially derived from inputs (other than quoted prices included within level 1) that are observable, either directly or indirectly; and
Level 3	represents fair value measurements that are substantially derived from unobservable inputs.

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

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

D1-2 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 Current Replacement Cost (CRC) valuation technique. CRC is the price that would be received for the asset, based on the estimated cost to a market participant buyer to acquire or construct a substitute asset of comparable utility, adjusted for obsolescence.

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

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

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

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

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

D1 FAIR VALUE MEASUREMENT (continued)

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

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

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

D2 FINANCIAL RISK DISCLOSURES

D2-1 FINANCIAL INSTRUMENT CATEGORIES

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

Category	Note	2020 $'000	2019 $'000
Financial assets at amortised cost			
Cash and cash equivalents	C1	31,638	32,445
Receivables	C2	4,380	6,321
Total		**36,018**	**38,766**
Financial liabilities at amortised cost			
Financial liabilities - comprising:			
Payables	C6	25,682	21,774
Lease liabilities	C9	289	-
Total		**25,971**	**21,774**

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

D2-2 FINANCIAL RISK MANAGEMENT

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

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

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

Credit risk is further discussed in Note C2 Receivables.

Liquidity risk

Liquidity risk is the risk that MHHS will not have the resources required at a particular time to meet its obligations to settle its financial liabilities. MHHS is exposed to liquidity risk through its trading in the normal course of business and aims to reduce the exposure to liquidity risk by ensuring that enough funds are always available to meet employee and supplier obligations. An approved debt facility of $3 million (2019: $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 2020 (2019: 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.

D2-3 LIQUIDITY RISK – CONTRACTUAL MATURITY OF FINANCIAL LIABILITIES

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

	2020	Contractual maturity			2019	Contractual maturity	
	Total	*< 1 Yr*	*1-5 Yrs*	*> 5 Yrs*	Total	*< 1 Yr*	*1-5 Yrs*
	$'000	*$'000*	*$'000*	*$'000*	**$'000**	*$'000*	*$'000*
Payables	**25,390**	25,390	-	-	**21,774**	21,774	-
Leased liabilities	**292**	220	72	-	-	-	-
	25,682	**25,610**	**72**	-	**21,774**	**21,774**	-

D3 CONTINGENCIES

(a) Litigation in progress

As at 30 June 2020, the following cases were filed in the courts naming the State of Queensland acting through the Mackay Hospital and Health Service as defendant:

	2020 Number of cases	2019 Number of cases
Supreme Court	3	3
District Court	1	1
Tribunals, commissions and boards	-	2
	4	**6**

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 B2-4. As at 30 June 2020, MHHS has 30 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) Capital expenditure commitments

	2020 *$'000*	*2019* *$'000*
Commitments for capital expenditure at reporting date (inclusive of non-recoverable GST input tax credits) are payable:		
Building		
No later than 1 year	161	-
Total	**161**	-
Plant and Equipment		
No later than 1 year	1,063	387
Total	**1,063**	**387**

D5 OTHER MATTERS

On 1 August 2019, Mackay HHS implemented a new state-wide enterprise resource program (ERP) S4/HANA which replaced the twenty- year old FAMMIS ERP. Extensive work has been completed to ensure transition of data from the old system to the new was complete and ongoing processes reliable.

No other matters or circumstances has arisen since 30 June 2020 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 1059 Service Concession Arrangements: Grantors

AASB 1059 will first apply to MHHS's financial statements in 2020-21. This standard defines service concession arrangements and applies a new control concept to the recognition of service concession assets and related liabilities. Mackay Hospital and Health Service has reviewed current contractual arrangements in line with this standard. No impact is anticipated. Contracts entered post 1 July 2020 will be assessed considering the new accounting standard.

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

D7 SUBSEQUENT EVENTS

There are no matters or circumstances that have arisen since 30 June 2020 that have significantly affected or may significantly affect the options of Mackay North Hospital and Health Service's operations, the results of those operations, of the HHS's state of affairs in future financial year.

D8 SIGNIFICANT FINANCIAL IMPACTS FROM COVID-19 PANDEMIC

The following significant transactions were recognised by Mackay HHS during the 2019-20 financial year in response to the COVID-19 pandemic.

Operating Statement	*$'000*
Significant expense transactions arising from COVID-19	
Costs incurred in response to COVID-19 epidemic	4,233
Annual Leave not taken (est)	2,100
Additional impairment of receivables	167
Total	**6,500**
Significant revenue transactions arising from COVID-19	
Additional revenue received to fund COVID-19 related expenses	4,233
Total	**4,233**
Other significant revenue impacts arising from COVID-19	
Waived collection of café licence revenues from April to June 2020	15
Own Source Revenue lost (est)	1,500
Total	**1,515**

Balance Sheet	*$'000*
Significant changes in assets arising from COVID-19	
Additional impairment of receivables	**167**

SECTION E
NOTES ON OUR PERFORMANCE COMPARED TO BUDGET

E1 BUDGETARY REPORTING DISCLOSURES

This section discloses MHHS's original published budgeted figures for 2019-20 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. Note original published budget from the Service Delivery Statement (SDS) has been reclassified to improve transparency and analysis by remapping budgeted transactions on the same basis as reported in actual financial statements.

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

	Variance Notes	Actual 2020 $'000	Original SDS Budget 2020 $'000	SDS Budget V Actual Variance $'000
OPERATING RESULT				
Income				
User charges and fees	V1.	37,497	29,548	7,949
Funding public health services		436,103	417,968	18,135
Grants and other contributions	V2.	15,481	13,071	2,410
Other revenue	V3.	4,514	3,279	1,235
Revaluation increment		-	-	-
Total Income		**493,595**	**463,866**	**29,729**
Expenses				
Employee expenses*	V4.	48,674	43,474	5,200
Health service employee expenses**	V5.	280,022	262,179	17,843
Supplies and services	V6.	132,077	121,357	10,720
Depreciation and amortisation		29,016	27,424	1,592
Other expenses	V7.	12,584	9,432	3,152
Total Expenses		**502,373**	**463,866**	**38,507**
Operating Results		**(8,778)**	-	**(8,778)**
Other Comprehensive Income				
Items Not Reclassified to Operating Result				
Increase/(decrease) in Asset Revaluation Surplus		8,140	-	8,140
Total Comprehensive Income		**(638)**	-	**(638)**

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

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.

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

V1. User charges and fees

User charges exceeded budget by $7.950 million for the year ended 30 June 2020 primarily reflecting higher Pharmaceutical Benefit Scheme Reimbursements (PBS) $4.003 million reflecting a combination of increased patient activity and mix of prescribed drugs. Revenue from reimbursement of costs incurred for managing capital projects of behalf of the Department of Health was $3.484 million and not budgeted.

Cash inflows for user charges and fees exceeded the SDS budget by $10.340 million largely consistent with the reasons set out above combined with higher cash receipts through improved billing processes in 2020.

V2. Grants and other contributions

Grants and other contributions exceeded budget by $2.410 million primarily due to higher patient activity as the Commonwealth releases more aged care packages than budgeted resulting in increased federal grant funding of $1.547 million and additional federal funding to support the training of specialists in rural environments of $623 thousand.

Cash inflows exceeded budget by $2.632 million largely consistent due to the reasons set out above.

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

V3. Other revenue

Other revenue exceeded budget by $1.235 million due to additional junior doctor training positions of $550 thousand and reimbursements for extension of support for the rollout of new clinical and financial information systems of $343 thousand.

V4. Employee expenses*

Employee expenses were $5.2 million higher compared to budget which included $0.465 million for initiatives, approved by the Board, to improve health service delivery. It also includes $2.352 million for initiatives that were transacted post the original SDS such as increasing Cardiac Catheter Laboratory service. There was also a component of annual leave not taken as a result of COVID-19 which was $0.313 million.

V5. Health service employee expenses**

Health Service Employee Expenses were $17.843 million higher compared to budget which included $2.651 million for initiatives, approved by the Board, to improve health service delivery. It also includes $13.426 million for more orthopaedic beds and other initiatives that were transacted post the original SDS as well as reimbursement of COVID related expenditure. There was also a component of annual leave not taken as a result of COVID-19 which was $1.787 million and some expenditure that was offset by other revenue increases such as increased interns outsourced to private providers.

V6. Supplies and Services

Supplies and Services were $10.72 million compared to budget which included $1.242 million for initiatives, approved by the Board, to improve health service delivery. It also includes $5.260 million for performance stabilization and other initiatives that were transacted post the original SDS. $3.484 million of capital expense reimbursements (offset by revenue) also had an impact on supplies and services expense, however nil impact on the overall position.

V7. Other Expenses

Other Expenses were $3.152 million higher than budget due to $1.445 million departmental funding deferred under new revenue standards not anticipated at budget time and increased insurance premiums of $0.664 million.

E3 BUDGET TO ACTUAL COMPARISON – STATEMENT OF FINANCIAL POSITION

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

	Variance Notes	Actual 2020 $'000	Original SDS Budget 2020 $'000	SDS Budget V Actual Variance $'000
Current Assets				
Cash and cash equivalents		31,638	32,070	(432)
Receivables	V8.	4,380	2,290	2,090
Inventories		4,242	4,075	167
Other assets		6,848	9,922	(3,074)
Total Current Assets		**47,108**	**48,357**	**(1,249)**
Non-Current Assets				
Property, plant and equipment		386,275	388,100	(1,825)
Right of use assets	V9.	309	-	309
Total Non-Current Assets		**386,584**	**388,100**	**(1,516)**
Total Assets		**433,692**	**436,457**	**(2,765)**
Current Liabilities				
Payables	V10.	25,682	21,311	4,371
Accrued employee benefits		2,073	1,809	264
Lease liabilities	V9.	241	-	241
Other liabilities	V11.	3,274	834	2,440
Total Current Liabilities		**31,270**	**23,954**	**7,316**
Non-Current Liabilities				
Lease liabilities		48	-	48
Total Non-Current Liabilities		**48**	-	**48**
Total Liabilities		**31,318**	**23,954**	**7,364**
Net Assets		**402,374**	**412,503**	**(10,129)**
Equity		**402,374**	**412,503**	**(10,129)**

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

V8. Receivables

Receivables were $986 thousand lower than Budget which included the GST impact of a significant capital works program from prior year and higher levels of patient activity.

V9. Right of Use Assets

Original Budget did not reflect the introduction of new accounting standard AASB 16 Leases which came into effect on 1 July 2019 and consequently does not include any Right of Use Assets or Lease liabilities. From 1 July 2019 the majority of MHHS's former operating leases, other than QFLEET arrangements, are now recognised on-balance sheet as right-of-use assets and lease liabilities. On transition right-of-use assets were measured at an amount equal to the lease liability ($497 thousand) for further details on this standard and its impact on the financial records refer Note G3-1. Movements in Right of Use Assets and Lease Liabilities throughout the year are detailed in Note C9-1 and CF-2.

V10. Payables

Payables increased $4.37 million due primarily to higher accrued labour expenses $815 thousand reflecting a 7% increase in FTEs over original budget and purchases of medical equipment $462 thousand and construction works $804 thousand undertaken on facilities in Bowen and Proserpine.

V11. Other Liabilities

Other liabilities increased $2.439 million reflecting the return of $2.315 million in funding to the Department of Health largely provided for COVID-19 and delivery of specific health programs impacted by COVID 19 induced delays.

E4 BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOWS

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

	Variance Notes	Actual 2020 $'000	Original SDS Budget 2020 $'000	SDS Budget V Actual Variance $'000
Cash flows from operating activities				
Inflows				
User charges and fees	V1.	39,583	29,282	10,301
Funding public health services		407,562	390,544	17,018
Grants and other contributions	V2.	11,946	9,314	2,632
GST input tax credits from ATO		8,208	8,403	(195)
GST collected from customers		780	607	173
Other receipts	V3.	4,457	3,279	1,178
		472,536	**441,429**	**31,107**
Outflows				
Employee expenses		(48,207)	(43,239)	(4,968)
Health service employee expenses		(277,687)	(260,616)	(17,071)
Supplies and services		(130,044)	(121,807)	(8,237)
GST paid to suppliers		(8,195)	(9,144)	949
GST remitted to ATO		(726)	(566)	(160)
Other payments		(7,849)	(5,042)	(2,807)
		(472,708)	**(440,414)**	**(32,294)**
Net cash from/(used by) operating activities		**(172)**	**1,015**	**(1,187)**
Cash flows from investing activities				
Inflows				
Sales of property, plant and equipment		72	(26)	98
Outflows				
Payments for property, plant and equipment	V12.	(8,542)	(4,323)	(4,219)
Net cash from/(used by) investing activities		**(8,470)**	**(4,349)**	**(4,121)**
Cash flows from financing activities				
Inflows				
Equity injections	V13.	8,371	4,223	4,148
Outflows				
Payment of lease liabilities		(536)	-	(536)
Net cash from/(used by) financing activities		**7,835**	**4,223**	**3,612**
Net increase/(decrease) in cash and cash equivalents		**(807)**	**889**	**(1,696)**
Cash and cash equivalents at the beginning of the financial year		32,445	31,181	1,264
Cash and cash equivalents at the end of the financial year		**31,638**	**32,070**	**(432)**

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

V12. Cash flows - Payments for property, plant and equipment

Payments for property, plant and equipment in 2020 were higher by $4.219 million than budgeted reflecting additional Health Technology Equipment Replacement (HTER) funding, completion of infrastructure refurbishments including Mackay Block B air conditioning.

V13. Cash flows – Equity injections

Cash flows from equity injections increased $4.148 million as a result of higher funding approvals by the Department of Health during the year for the Mackay Base Hospital and rural infrastructure projects, purchases of medical equipment, and an increase in funding for PCP projects by the Department of Health refer V12.

SECTION F
WHAT WE LOOK AFTER ON BEHALF OF THIRD PARTIES

F1 TRUST TRANSACTIONS AND BALANCES

The Hospital and Health Service acts in a fiduciary trust capacity in relation to patient trust accounts. Consequently, these transactions are not recognised in the financial statements. Trust activities are included in the audit performed annually by the Auditor-General of Queensland. The cumulative value of transactions and balances in patient fiduciary trust accounts were equal to or less than $1,000 in 2020 and 2019.

F2 GRANTED PRIVATE PRACTICE

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

	2020 $'000	2019 $'000
Receipts		
Billings - (Doctors and Visiting Medical Officers)	9,493	6,963
Interest	2	11
Total receipts	**9,495**	**6,974**
Payments		
Payments	9,164	5,764
Hospital and Health Service recoverable administrative costs	1,742	1,308
Hospital and Health Service - Education/travel/research fund	15	11
Total payments	**10,921**	**7,083**
Closing balance of bank account under a trust fund arrangement not yet disbursed and not restricted cash	**864**	**535**

SECTION G
OTHER INFORMATION

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES

Details of Key Management Personnel

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

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

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration Policies

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

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

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

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

Short-term employee expenses which include:

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

Long term employee expenses include amounts expensed in respect of long service leave entitlements earned.
Post-employment expenses include amounts expensed in respect of employer superannuation obligations.
Termination benefits include payments in lieu of notice on termination and other lump sum separation entitlements (excluding annual and long service leave entitlements) payable of termination of employment or acceptance of an offer of termination of employment.

Performance bonuses are not paid under the contracts in place.

Board remuneration

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

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

Board Position	Date of appointment	Date of resignation
Deputy Chair	29 June 2012	-
Board member	29 June 2012	-
Board member	29 June 2012	-
Board member	7 September 2012	17 May 2020
Chairperson	18 May 2016	-
Board member	18 May 2016	-
Board member	18 May 2016	-
Board member	18 May 2019	-
Board member	18 May 2019	-
Board member	18 May 2020	-

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

KMP Remuneration Expense

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

2020

Position (date resigned if applicable)	*Short Term Employee Expenses*		*Long term Employee Expenses*	*Post-Employment Expenses*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*			
	$'000	*$'000*	*$'000*	*$'000*	*$'000*
Health Service Chief Executive	278	11	6	24	319
Executive Director, Corporate Services	178	-	4	17	199
A/Executive Director, Corporate Services	44	-	1	4	49
Executive Director Operations Mackay	204	-	4	20	228
Executive Director, Mental Health, Public Health & Rural Services	184	-	4	18	206
A/Executive Director, Mental Health, Public Health & Rural Services	33	-	1	3	37
Executive Director, People	190	-	4	19	213
Executive Director, Medical Services & CMO	497	-	11	39	547
Executive Director, Research & Innovation	504	-	11	37	552
Executive Director Nursing & Midwifery	234	-	5	19	258

2019

Position (date resigned if applicable)	*Short Term Employee Expenses*		*Long term Employee Expenses*	*Post-Employment Expenses*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*			
	$'000	*$'000*	*$'000*	*$'000*	*$'000*
Health Service Chief Executive	302	12	6	27	347
Executive Director, Corporate Services	186	-	4	18	208
Executive Director Operations Mackay (1 July - 5 October 2018)	53	-	1	5	59
Executive Director Operations Mackay (8 October - 30 June 2019)	145	-	3	14	162
Executive Director, Mental Health, Public Health & Rural Services	197	-	4	20	221
A/Executive Director, People (1 July to 31 January 2019)	170	-	-	-	170
Executive Director, People (13 May - 30 June 2019)	20	-	-	2	22
Executive Director, Medical Services	473	-	9	37	519
Executive Director, Research & Innovation	502	3	10	37	552
Executive Director Nursing & Midwifery, Education & Support Services	212	-	4	19	235

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration paid or owing to board members during 2019-20 was as follows:

Board Member	*Short Term Employee Expenses*		*Post-Employment Expenses*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*		
	$'000	*$'000*	*$'000*	*$'000*
Chairperson	82	-	8	90
Deputy Chair	50	-	5	55
Board Member	47	-	4	51
Board Member	43	-	4	47
Board Member* (resigned 17 May 2020)	44	-	4	48
Board Member (appointed 18 May 2020)	5	-	0	5
Board Member	46	-	4	50
Board Member	46	-	4	50
Board Member	43	-	4	47
Board Member	43	-	4	47

Remuneration paid or owing to board members during 2018-19 was as follows:

Board Member	*Short Term Employee Expenses*		*Post-Employment Expenses*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*		
	$'000	*$'000*	*$'000*	*$'000*
Chairperson	83	-	8	91
Deputy Chair	50	-	5	55
Board Member	44	-	4	48
Board Member	43	-	4	47
Board Member*	50	-	5	55
Board Member resigned 17/5/2019	42	-	4	46
Board Member	43	-	4	47
Board Member resigned 17/5/2019	43	-	4	47
Board Member	43	-	4	47
Board Member appointed 18/5/2019	4	-	-	4
Board Member appointed 18/5/2019	3	-	-	3

*Occupant is employed as a Visiting Medical Officer (VMO) in addition to their role as a Board member by MHHS. These duties are not aligned in any way with Board activities. Remuneration paid does not include wages received as a VMO.

G2 RELATED PARTY TRANSACTIONS

Transactions with other Queensland Government-controlled entities

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

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

Entity – Department of Health	2020 $'000	2019 $'000
Revenue	443,819	412,306
Expenditure	320,616	295,018
Asset	3,790	2,717
Liability	18,464	12,557

Department of Health

MHHS's primary source of funding is provided by the Department of Health, with payments made in accordance with a service agreement. The signed service agreements are published on the Queensland Government website and are publicly available. Revenue under the service arrangement was $436.1 million for the year ended 30 June 2020 (2019: $404.2 million). For further details on the purchase of health services by the Department of Health refer to Note B1-2.

The Hospital and Health Service, through service arrangements with the Department of Health, has engaged 2,424 (2019: 2,293) full time equivalent persons. In accordance with the Hospital and Health Boards Act 2011, the employees of the Department of Health are referred to as health service employees. In 2020, $278.6 million (2019: $254.8 million) was paid to the Department for Health service employees. The terms of this arrangement are fully explained in Note B2-2.

The Department of Health centrally manages, on behalf of Hospital and Health Services, a range of services including pathology testing, pharmaceutical drugs, clinical supplies, patient transport, telecommunications and technology services. These services are provided on a cost recovery basis. In 2020, these services totalled $38.3 million (2019: $36.4 million). In addition, MHHS receives corporate services support from the Department at no cost refer to Note B1-3. Corporate services received include payroll services, financial transactions services (including accounts payable and banking services), administrative services and information technology services. In 2020, the fair value of these services was $3.8 million (2019: $3.8 million).

Any associated receivables or payables owing to the Department of Health at 30 June 2020 are separately disclosed in Note C2 and Note C6. No impairment has been applied to these balances.

The Department of Health also provides funding from the State as equity injections to purchase property, plant and equipment. All construction of major health infrastructure is managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department of Health to MHHS. Where costs are borne by the Hospital and Health Service on departmental funded projects, the Department of Health reimburses MHHS for those costs. In 2020, $3.5 million (2019: $3.1 million) in recoveries was recognised.

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

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

Transactions with other related parties

All transactions in the year ended 30 June 2020 between Mackay Hospital and Health Service and key management personnel, including their related parties were on normal commercial terms and conditions and were immaterial in nature and dollar.

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

Accounting standards applied for the first time

Three new accounting standards were applied for the first time in 2019-20:

- AASB 16 *Leases*
- AASB 15 *Revenue from Contracts with Customers*
- AASB 1058 *Income of Not-for-Profit Entities*

The effect of adopting these new standards are detailed in Notes G3-1 to G3-4. No other accounting standards or interpretations that apply to MHHS for the first time in 2019-20 have any material impact on the financial statements.

Accounting standards early adopted

No Australian Accounting Standards have been early adopted for 2019-20.

G3-1 AASB 16 LEASES

MHHS applied AASB 16 *Leases* for the first time in 2019-20. MHHS applied the modified retrospective transition method and has not restated comparative information for 2018-19, which continues to be reported under AASB117 *Leases* and related interpretations.

The nature and effect of changes resulting from the adoption of AASB 16 are described below.

Definition of a lease

AASB 16 introduced new guidance on the definition of a lease.

For leases and lease-like arrangements existing at 30 June 2019, MHHS elected to apply the practical expedient to grandfather the previous assessments made under AASB 117 and Interpretation 4 *Determining Whether an Arrangement contains a Lease* about whether those contracts contained leases. However, arrangements were reassessed under ASB16 where no formal assessment had been done in the past or where lease agreements were modified on 1 July 2019.

Amendments to former operating leases for motor vehicles

In 2018-19, the Department of Housing and Public Works (DHPW) provided access to motor vehicles under government-wide frameworks through QFLEET. These agreements had been categorised as operating leases under AASB 117.

Effective 1 July 2019, the framework agreements that govern QFLEET were amended with the result that these arrangements would not meet the definition of a lease under AASB 16 and therefore are exempt from lease accounting. From 2019-20 onward, the costs for these services are expensed as supplies and services expenses when incurred. The new accounting treatment is due to a change in the contractual arrangements rather than a change in accounting policy. The comparative numbers for 2018-19 have been reclassified.

Changes to lessee accounting

Previously, MHHS classified its leases as operating or finance leases based on whether the lease transferred significantly all the risks and rewards incidental to ownership of the underlying asset to MHHS. This distinction between operating and finance leases no longer exist for lessee accounting under AASB 16. From 1 July 2019, all leases, other than short-term leases and leases of low value assets, are now recognised on balance sheet as lease liabilities and right-of-use assets.

Lease liabilities

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

Lease payments included in the measurement of the lease liability comprise the following:

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

The discount rate used is the interest rate implicit in the lease, or MHHS's incremental borrowing rate if that rate cannot be readily determined.

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

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

G3-1 AASB 16 LEASES (continued)

Right-of-use assets

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

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

Right-of-use assets will subsequently give rise to a depreciation expense and be subject to impairment.

Right-of-use assets differ in substance from leased assets, previously recognised under finance leases, in that the asset represents the intangible right to use the underlying asset rather than the underlying asset itself.

Short-term leases and leases of low value assets

MHHS has elected to recognise lease payments for short-term leases and leases of low value assets as expenses on a straight-line basis over the lease term, rather than accounting for them on balance sheet. This accounting treatment is like that used for operating leases under AASB 117.

Changes to lessor accounting

Lessor accounting remains largely unchanged under AASB16. Leases are still classified as either operating or finance leases. However, the classification of subleases now references the right-of-use asset arising from the head lease, instead of the underlying asset.

Transitional impact

Former operating leases as lessee

The majority of MHHS's former operating leases, other than QFLEET arrangements, are now recognised on-balance sheet as right-of-use assets and lease liabilities.

On transition, lease liabilities were measured at the present value of the remaining lease payments discounted using MHHS's incremental borrowing rate at 1 July 2019. The weighted average incremental borrowing rate applied at the date of initial adoption was 1.32%. The right-of-use assets were measured at an amount equal to the lease liability. New right-of-use assets were tested for impairment on transition and none were found to be impaired.

On transition, MHHS used practical expedients to:

- not recognise right-of-use assets and lease liabilities for leases that end within 12 months of the date of initial application and leases of low value assets; exclude initial direct costs from the measurement of right-of-use assets; and used hindsight when determining the lease term.

The change in accounting policy affected the following items in the Statement of Financial Positions on 1 July 2019:

- Right-of-use assets (buildings) $498 thousand; and
- Lease liabilities $498 thousand.

No transitional adjustments were required for leases in which MHHS is the lessor.

A reconciliation of lease commitments at 30 June 2019 to lease liabilities recognised at 1 July 2019 is as follows:

	2020
	$'000
Operating lease commitment at 30 June 2019 as disclosed in the 2018-19 financial statements	315
Less short-term lease exemptions	(56)
	259
Add/less adjustments due to reassessments of lease terms	248
Less discounting using the incremental borrowing rate	(9)
Lease liabilities recognised at 1 July 2019	**498**

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

G3-2 AASB 15 REVENUE FROM CONTRACTS WITH CUSTOMERS

MHHS applied AASB 15 *Revenue from Contracts with Customers* for the first time in 2019-20. The nature and effect of changes resulting from the adoption of AASB15 are described below.

Step1 – identify the contract with the customer	Grant funding that MHHS receives may contain a contract with a customer and thus fall within the scope of AASB 15. This is the case where the funding agreement requires MHHS to transfer goods or services to third parties on behalf of the grantor, it is enforceable, and it contains sufficiently specific performance obligations.
Step 2 - identify the performance obligations in the contract	This step involves firstly identifying all the activities MHHS is required to perform under the contract, and determining which activities transfer goods or services to the customer. Where there are multiple goods or services transferred, MHHS must assess whether each good or service is a distinct performance obligation or should be combined with other goods or services to form a single performance obligation. To be within the scope of AASB 15, the performance obligations must be 'sufficiently specific', such that MHHS is able to measure how far along it is in meeting the performance obligations.
Step 3 – determine the transaction price	When the consideration in the contract includes a variable amount, MHHS needs to estimate the variable consideration to which it is entitled and only recognise revenue to the extent that it is highly probably a significant reversal of the revenue will not occur. This includes sales with a right of return, where the amount expected to be refunded is estimated and recognised as a refund liability instead of revenue.
Step 4 – allocate the transaction price to the performance obligations	When there is more than one performance obligation in a contract, the transaction price must be allocated to each performance obligation, generally this needs to be done on a relative stand-alone selling price basis.
Step 5 – Recognise revenue when or as MHHS satisfies performance obligations	Revenue is recognised when MHHS transfers control of the goods or services to the customer. A key judgement is whether a performance obligation is satisfied over time or at a point in time. And where it is satisfied over time, MHHS must also develop a method for measuring progress towards satisfying the obligation.

Other changes arising from AASB 15

AASB15 also specifies the accounting for incremental costs of obtaining a contract and costs directly related to fulfilling a contract.

The standard requires contract assets (accrued revenue) and contract liabilities (unearned revenue) to be shown separately and requires contract assets to be distinguishes from receivables.

There are extensive new disclosures, which have been included in Notes B1-1, B1-2, B1-3, C4 and C8.

Transitional impact

AASB15 also specifies the accounting for incremental costs of obtaining a contract and costs directly related to fulfilling a contract.

Transitional policies adopted are as follows:

- MHHS applied the modified retrospective transition method and has not restated comparative information for 2018-19, which continue to be reported under AASB 118 *Revenue*, AASB 111 *Construction Contracts*, and related interpretations.
- MHHS elected to apply the standard retrospectively to all contracts, including completed contracts, at 1 July 2019. Completed contracts include contracts where MHHS had recognised all the revenue in prior periods under AASB 1004 *Contributions*.
- MHHS applied a practical expedient to reflect, on transition, the aggregate effect of all contract modification that occurred before 1 July 2019.

To align with the new terminology in AASB15, and improve the clarity of disclosures, several new line items have been included on the face of the financial statements and new notes created. These include:

- Other assets are disclosed as a separate line item in the Statement of Financial Position. Previously, prepayments, accrued revenue and other assets were included in receivables. Accrued revenue arising from contracts with customers has been renamed contract assets. Disclosure about these assets is now included in Note C4.
- Other liabilities are disclosed as a separate line item in the Statement of Financial Position. Unearned revenue has been renamed Other liabilities; repayable funding is now also part of this note. Unearned revenue arising from contracts with customers has been renamed contract liabilities. Disclosure about these liabilities in now included in Note C8.
- Reclassification of income from contracts managed on behalf of the Department of Health for capital projects. While the recognition of revenue has not changed under the new accounting standards, the nature of these transactions is more reflective of income generated under User charges and fees rather than Other revenue.

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

G3-2 AASB 15 G3-2 AASB 15 REVENUE FROM CONTRACTS WITH CUSTOMERS (continued)

Grants and contributions

Commonwealth grant arrangements identified as contracts with customers within the scope of AASB 15 included the following cases.

- Commonwealth aged care programs to provide services to eligible Commonwealth clients either in multipurpose health facilities or at client's home. The services purchased are included as activity targets in agreements between the Commonwealth and State. Rates and level of care are specified in schedules within the contracts. Payments are made in advance and acquitted against delivered activity, usually within the same month. The recognition of revenue under AASB 15 has not resulted in any significant change in the amounts recorded throughout the year.
- Home and community care - performance obligations are to deliver a range of specified services in accordance with agreed targets on an annual basis to Commonwealth's clients in their homes. Payments are made quarterly in advance by the Commonwealth and acquitted at the end of the year. Previously revenue was recognised as it was received. Under AASB15, revenue is now recognised as the services are provided, resulting in changes to the timing of revenue recognition throughout the year. At 30 June 2019, targets for these services had not been fully delivered. 1 July 2019 on transition to AASB 15, a contract liability of $57 thousand was recognised.
- Rural and remote primary care (s19 COAG exemption) - performance obligations are to provide clinical services in the Emergency Department of specified facilities to public patients. Payments are made post receipt of claims lodged (electronically) with Medicare. As the payment terms under this agreement ensure cash was provided at the same time as services were provided, there has been no impact on transition.

The following table summarises the transitional adjustments on 1 July 2019 relating to the adoption of AASB 15. The net impact is recognised as an adjustment to opening accumulated surplus.

	1 July 2019 $'000
Other current liabilities – contract liabilities	57
Accumulated surplus	(57)

G3-3 AASB 1058 INCOME OF NOT-FOR-PROFIT ENTITIES

MHHS applied AASB 1058 *Income of Not-for-Profit Entities* for the first time in 2019-20. The nature and effect of changes resulting from the adoption of AASB1058 are described below.

Scope and revenue recognition under AASB 1058

AASB 1058 applies to transactions where MHHS acquires an asset for significantly less than fair value principally to enable MHHS to further its objective, and to the receipt of volunteer services.

MHHS's revenue line items recognised under this standard from 1 July 2019 include Funding public health services, Grants and other contribution, and some Other revenue.

General revenue recognition framework

The revenue recognition framework for in scope transactions, other than specific-purpose capital grants, is as follows.

1. Recognise the asset – e.g. cash, receivables, PP&E, a right-of-use asset or an intangible asset

2. Recognise related amounts – e.g. contributed equity, a financial liability, a lease liability, a contract liability or a provision; (grants and donations in many cases can have nil related amounts)

3. Recognise the difference as income upfront

Specific-purpose capital grants

In contrast with previous standards such as AASB 1004, AASB 1058 allows deferral of income from capital grants where:

- the grant requires MHHS to use the funds to acquire or construct a recognisable non-financial asset (such as a building) to identified specifications;
- the grant does not require MHHS to transfer the asset to other parties; and
- the grant agreement is enforceable.

For these capital grants, the funding received is initially deferred in an unearned revenue liability and subsequently recognised as revenue as or when MHHS satisfies the obligations under the agreement.

Volunteer services

Under AASB 1058, MHHS will continue to recognise volunteer services only when the services would have been purchased if they had not been donated, and the fair value of the services can be measured reliability. This treatment is the same as in prior years.

AASB 1058 optionally permits the recognition of a broader range of volunteer services, however MHHS has elected not to do so.

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

G3-3 AASB 1058 INCOME OF NOT-FOR-PROFIT ENTITIES

Transitional policies adopted are as follows:

- MHHS applied the modified retrospective transition method and has not restated comparative information for 2018-19. They continue to be reported under relevant standards applicable in 2018-19, such as AASB 1004.
- MHHS elected to apply the standard retrospectively to all contracts, including completed contracts, at 1 July 2019. Completed contracts are contracts where MHHS had recognised all the revenue in prior periods under AASB 1004.
- MHHS applied a practical expedient to not remeasure at fair value assets previously acquired for significantly less than fair value and originally recorded at cost.

Revenue recognition for MHHS Funding public health services and most grants and contributions will not change under AASB 1058, as compared to AASB 1004. Revenue will continue to be recognised when MHHS gains control of the asset (e.g. cash or receivable) in most instances.

A few of MHHS's grants will fall within the scope of AASB 15 *Revenue from Contracts with Customers*, the transitional impacts are disclosed in Note G3-2 above.

G3-4 IMPACT OF ADOPTION OF AASB 15 AND AASB 1058 INCOME IN THE CURRENT PERIOD

Adoption of AASB 15 and AASB 1058 in 2019-20 has not materially impacted the current period's financial statements.

G4 TAXATION

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

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

G5 CLIMATE RISK DISCLOSURE

Climate Risk Assessment

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

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

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

Mackay Hospital and Health Service

Management Certificate

For the year ended 30 June 2020

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

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

b) the financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Mackay Hospital and Health Service for the financial year ended 30 June 2020 and of the financial position of the Hospital and Health Service at the end of that year, and

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

The Honourable Timothy Mulherin
Chair, Mackay Hospital and Health Board
27/8/2020

Ms Jo Whitehead
Chief Executive Officer
27/8/2020

Mr Marc Warner
Executive Director, Corporate Services
27/8/2020

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INDEPENDENT AUDITOR'S REPORT

To the Board of Mackay Hospital and Health Service

Report on the audit of the financial report

Opinion

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

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2020, and its financial performance and cash flows for the year then ended

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

The financial report comprises the statement of financial position as at 30 June 2020, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

Basis for opinion

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

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

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

Key audit matters

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

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Specialised buildings valuation ($341.4 million)

Refer to Note C5 in the financial report.

Key audit matter	How my audit addressed the key audit matter

Buildings were material to Mackay Hospital and Health Service at balance date and were measured at fair value.
 	
For 2020 Mackay Hospital and Health Service performed a revaluation of its buildings using relevant indices and comprehensive valuation.
 	
The current replacement cost method comprises:
• gross replacement cost, less
• accumulated depreciation.
 	
Mackay Hospital and Health Service derived the gross replacement cost of its buildings at the balance date using unit prices that required significant judgements for:
• identifying the components of buildings with separately identifiable replacement costs
• developing a unit rate for each of these components, including:
  ○ estimating the current cost for a modern substitute (including locality factors and oncosts)
  ○ identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so, estimating the adjustment to the unit rate required to reflect this difference.
• The measurement of accumulated depreciation involved significant judgements for forecasting the remaining useful lives of building components.
 	
The significant judgements required for gross replacement cost and useful lives are also significant judgements for calculating annual depreciation expense.
 	
Using indexation required:
• Significant judgement in determining the indexation factors that reflected the estimated change, since the previous balance date, in the cost inputs used in developing the gross replacement.
• Reviewing previous assumptions and judgements used in the determination of fair value in intervening years between the comprehensive valuation to ensure ongoing validity of assumptions and judgements used.
	My procedures included, but were not limited to:
	• Assessing the adequacy of management's review of the valuation process and results.
	• Reviewing the scope and instructions provided to the valuer.
	• Assessing the appropriateness of the valuation methodology and the underlying assumptions with reference to common industry practices.
	• Assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices
	• Assessing the competence, capabilities and objectivity of the experts used to develop the models.
	• For unit rates associated with buildings that were comprehensively revaluated this year, on a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate.
	• Evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices..
	• Evaluating useful life estimates for reasonableness by:
	  ▫ reviewing management's annual assessment of useful lives
	  ○ at an aggregated level, reviewing asset management plans for consistency between renewal budgets and the gross replacement cost of assets
	  ○ ensuring that no building asset still in use has reached or exceeded its useful life
	  ○ enquiring of management about their plans for assets that are nearing the end of their useful life
	  ○ reviewing asset listings with an inconsistent relationship between condition and remaining useful life.
	• Where changes in useful lives were identified, evaluating whether the effective dates of the changes applied for depreciation expense were supported by appropriate evidence.

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Reliance on shared service provider

Refer Note D5

Key audit matter	How my audit addressed the key audit matter

• The Department of Health (the department) is the shared service provider to Mackay Hospital and Health Service for the management of the financial management information system, and processing of accounts payable transactions in the system.
• The Department replaced its primary financial management information system on 1 August 2019.
• The financial management system is used to prepare the general-purpose financial statements. It is also the general ledger and it interfaces with other software that manages revenue, payroll, and certain expenditure streams. Its modules are used for inventory and accounts payable management.
• The replacement of the financial management system increased the risk of fraud and error in the control environment of the Department and Mackay Hospital and Health Service.
• The implementation of the financial management system was a significant business and IT project for the Department and Mackay Hospital and Health Service. It included:
  • designing and implementing IT general controls and application controls
  • cleansing and migrating of vendor and open purchase order master data
  • ensuring accuracy and completeness of closing balances transferred from the old system to the new system
  • establishing system interfaces with other key software programs
  • establishing and implementing new workflow processes.
	I have reported issues relating to internal control weaknesses identified during the course of my audit to those charged with governance.
	My procedures included, but were not limited to:
	• assessing the appropriateness of the IT general and application level controls including system configuration of the financial management system by:
	  ○ reviewing the access profiles of users with system wide access
	  ○ reviewing the delegations and segregation of duties
	  ○ reviewing the design, implementation, and effectiveness of the key general information technology controls.
	• validating account balances from the old system to the new system to verify the accuracy and completeness of data migrated
	• documenting and understanding the change in process and controls for how material transactions are processed, and balances are recorded
	• assessing and reviewing controls temporarily put in place due to changing system and procedural updates
	• Undertaking significant volume of sample testing to obtain sufficient appropriate audit evidence, including:
	  ○ verifying the validity of journals processed pre and post go-live
	  ○ verifying the accuracy and occurrence of changes to bank account details
	  ○ comparing vendor and payroll bank account details
	  ○ verifying the completeness and accuracy of vendor payments, including testing for potential duplicate payments
	• Assessing the reasonableness of:
	  ○ the inventory stocktakes for completeness and accuracy
	  ○ the mapping of the general ledger to the financial statement line items.

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Responsibilities of the entity for the financial report

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

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

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

Report on other legal and regulatory requirements

Statement

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2020:

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

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

Prescribed requirements scope

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

C. G. Strickland

31 August 2020

C G Strickland
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

Glossary

Terms

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

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

Chronic A long-term or persistent condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sub-Acute Somewhat acute; between acute and chronic.

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

Acronyms

ABF Activity based funding
Cath Lab Cardiac Catheter Laboratory
E2E Education to Employment
FTE Full-Time Equivalent
GP General Practitioner
HHS Hospital and Health Service
HHBA *Hospital and Health Boards Act 2011*
JCU James Cook University
MBH Mackay Base Hospital
MHHB Mackay Hospital and Health Board
NQPHN Northern Queensland Primary Health Network
QAO Queensland Audit Office

Checklist

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister/s	ARRs – section 7	3
Accessibility	Table of contents Glossary	ARRs – section 9.1	4 74
	Public availability	ARRs – section 9.2	1
	Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 9.3	1
	Copyright notice	*Copyright Act 1968* ARRs – section 9.4	1
	Information Licensing	*QGEA – Information Licensing* ARRs – section 9.5	1
General information	Introductory Information	ARRs – section 10.1	6-7
	Machinery of Government changes	ARRs – section 10.2, 31 and 32	Not applicable
	Agency role and main functions	ARRs – section 10.2	8
	Operating environment	ARRs – section 10.3	8-10
Non-financial performance	Government's objectives for the community	ARRs – section 11.1	5
	Other whole-of-government plans / specific initiatives	ARRs – section 11.2	10
	Agency objectives and performance indicators	ARRs – section 11.3	8-12
	Agency service areas and service standards	ARRs – section 11.4	20
Financial performance	Summary of financial performance	ARRs – section 12.1	21
Governance – management and structure	Organisational structure	ARRs – section 13.1	16
	Executive management	ARRs – section 13.2	15
	Government bodies (statutory bodies and other entities)	ARRs – section 13.3	Not applicable
	Public Sector Ethics	*Public Sector Ethics Act 1994* ARRs – section 13.4	19
	Human Rights	*Human Rights Act 2019* ARRs – section 13.5	19
	Queensland public service values	ARRs – section 13.6	19
Governance – risk management and accountability	Risk management	ARRs – section 14.1	18
	Audit committee	ARRs – section 14.2	13
	Internal audit	ARRs – section 14.3	18
	External scrutiny	ARRs – section 14.4	18
	Information systems and recordkeeping	ARRs – section 14.5	18
Governance – human resources	Strategic workforce planning and performance	ARRs – section 15.1	17
	Early retirement, redundancy and retrenchment	Directive No.04/18 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	17
Open Data	Statement advising publication of information	ARRs – section 16	1
	Consultancies	ARRs – section 33.1	https://data.qld.gov.au
	Overseas travel	ARRs – section 33.2	
	Queensland Language Services Policy	ARRs – section 33.3	
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	68
	Independent Auditor's Report	FAA – section 62 FPMS – section 46 ARRs – section 17.2	69-73

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

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