Mackay Hospital and Health Service

ANNUAL REPORT 2020–2021

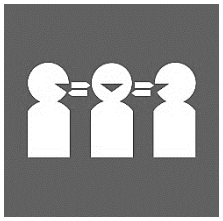
Queensland Government

Accessibility

Information about consultancies, overseas travel, and the Queensland language services policy is available at the Queensland Government Open Data website (qld.gov.au/data). Mackay Hospital and Health Service had nil overseas travel expenditure to report during 2020-2021.

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 2020-2021.

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.

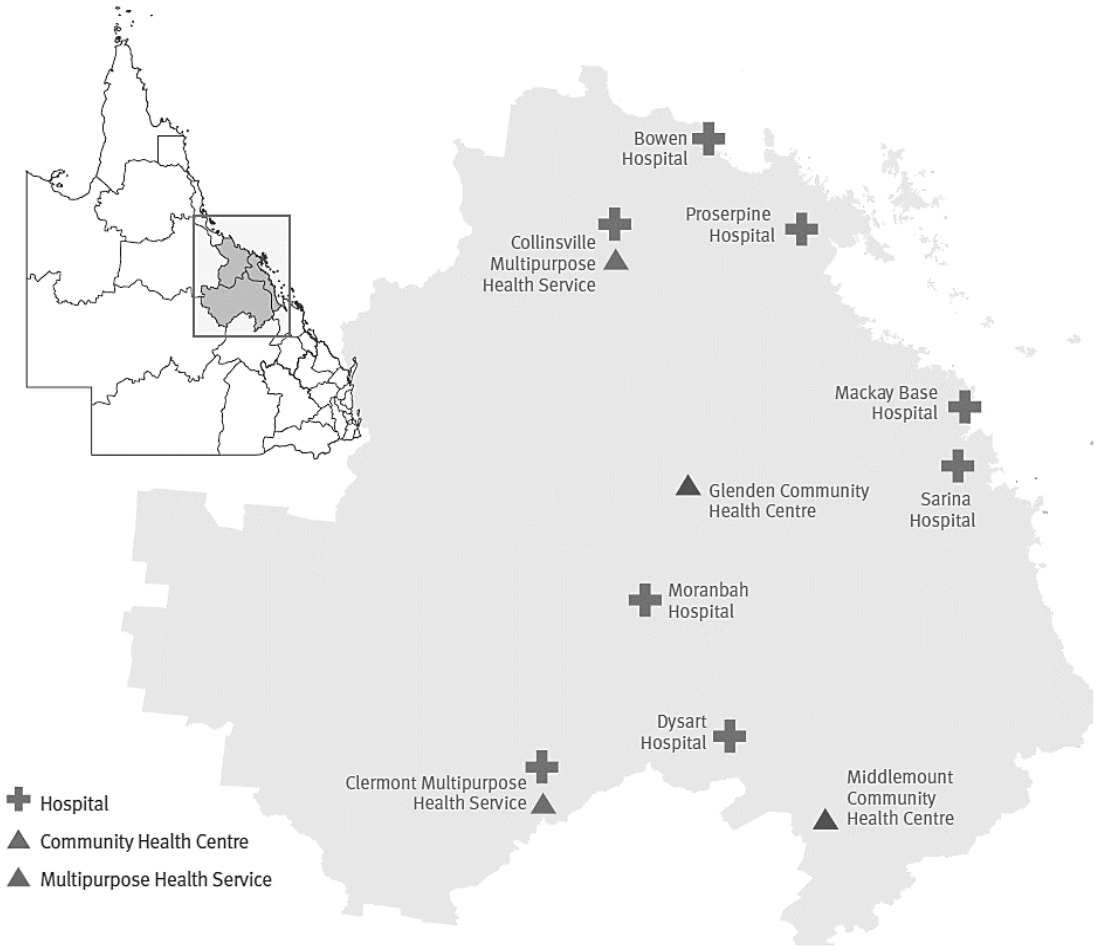
Acknowledgement to Traditional Owners

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

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

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

4 November 2021

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

Dear Minister

I am pleased to submit for presentation to the Parliament the Annual Report 2020-2021 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 69 of this annual report.

Yours sincerely

Darryl Camilleri
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 HHS 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.

Mackay HHS Strategic Plan 2020-2024 contributes to the Queensland Government *Unite and Recovery Plan* by supporting five of its key objectives*:*

Strategic Objectives & Outcomes	Alignment with Queensland Government's objectives
Inspired People • Valued, empowered and accountable staff • Diverse, capable and agile workforce • Safe, caring and supportive culture • Healthy staff who inspire others • Engaged staff embracing opportunities for change and improvement	• Supporting jobs • Growing our regions
Exceptional Patient Experience • Informed and empowered people • Better access to services • Treat our patients as individuals • Care is co-designed with our patients, families, carers and communities • Safe and excellent care –continually improving	• Safeguarding our health • Backing our frontline services
Excellence in Integrated Care • Seamless health and social care system • Navigable health system • Smart and responsible use of technology • Innovative, collaborative and productive partnerships	• Safeguarding our health • Backing our frontline services
Sustainable Service Delivery • Services matched to community health needs • The right service in the right place by the right people at the right time – delivered as close to home as possible • Recognised teaching hospital • Research outcomes translated into action • Smart use of resources to deliverables	• Supporting jobs • Building Queensland • Growing our regions

From the Chair and Chief Executive

The 2020-2021 annual report reflects on another excellent year of financial and operational performance as we work to deliver Queensland's best rural and regional healthcare. Mackay HHS continues to respond to a record demand for public healthcare in our region.

Emergency doctors and nurses have worked hard as we continue to experience growth in emergency department presentations. We have come close to seeing 100,000 people in a year across our eight emergency departments. Impressively, despite the increase in presentations, we treated 100 per cent of our most serious Category 1 presentations within two minutes.

As a health service we have responded to increased emergency demand while also delivering the planned care services, such as elective surgery and specialist outpatient services. In specialist outpatient departments we were able to offer more people their first appointment within the clinically recommended time.

The unprecedented impact of COVID-19 on the delivery of health care continued to be felt and we have worked hard to address the number of elective surgery patients waiting longer than clinically recommended. Although the national cabinet direction to suspend non-urgent elective surgery was undertaken in the financial year prior, the impacts of this suspension continues to be felt in 2020-2021. Despite the backlog and an increase in elective and emergency surgery referrals we finished the end of the financial year with just one patient waiting longer than the clinically recommended time.

The health service has continued to respond to the COVD-19 pandemic. Our efforts in the COVID-19 testing and vaccination space have been tireless. We have been gratified to see the community respond to the need for testing and in 2021-2022 look forward to expanding vaccination opportunities throughout the health service. Our Public Health Unit and the Emergency Management Team have done a lot of the heavy lifting in response to COVID-19 to ensure hospital visitor and movement restrictions are complied with. Proserpine Hospital has also shouldered a lot of the testing load in the Whitsundays. The arrival of a Hologic Panther Fusion machine at Mackay Base Hospital (MBH) to rapidly test for influenza and COVID-19 was very welcomed and has allowed for faster diagnosis and earlier treatment for positive cases.

We are proud to reflect on clinical services that have expanded in 2020-2021. Support for some of our most vulnerable consumers was extended with the opening of a new Crisis Support Space at MBH. This pilot project offers peer support for people having a mental health crisis in a calm and supportive environment with oversight and support from a senior mental health clinician. This pilot is part of the Shifting Minds flagship project 2018-2023 and is one of eight in Queensland.

The health service's commitment to its strategic objective of Sustainable Service Delivery is seen in three key initiatives to deliver care as close to home as possible. We expanded the Hospital in the Home (HiTH) model of care to include 23 virtual beds with remote patient monitoring. This allows people to recover at home while still receiving medical treatment. In Bowen the satellite renal dialysis service at the hospital expanded to allow more people living in Bowen, Collinsville and the Whitsundays to be treated closer to home. The expanded service runs six days a week with three chairs to provide 18 sessions a week.

At MBH a new life-saving procedure to open blocked calcified arteries was performed for the first time in March 2021. Up to 40 patients a year will benefit from this new service and will no longer have to travel to Townsville or Brisbane for this procedure.

Infrastructure projects continue to progress across the health service. In May we commenced construction of a $7 million Medical Imaging and Renal Unit building at Bowen Hospital. This building is future proofed to ensure we have the space to meet the dialysis needs of the Bowen and Collinsville community not only now, but well into the coming years.

Our commitment towards Closing the Gap was strengthened with the commencement of a program we hope will increase the number of people who identify as Aboriginal and Torres Strait Islander in our workforce. We have an ambitious target of 5 per cent which is in line with our population representation. The new Budyubari Bidyiri Kebi Stapal program (meaning Big Dream, Small Steps) commenced with the recruitment of 20 Aboriginal and Torres Strait Islander teenagers. This program will help them gain careers in healthcare through a school-based traineeship and is delivered in partnership with Central Queensland University and Australian Training Works with support from Northern Queensland Primary Health Network (NQPHN). Significantly the health service appointed the first Executive Director Aboriginal and Torres Strait Islander Health to help guide and drive our commitment to achieving health equity.

This year we were saddened by the passing of Board Chair Tim Mulherin. He continued his duties as the Board Chair until the end, providing leadership and strategic direction for our health service. Providing Mackay with a first-class hospital and health care was Tim's passion long before he was appointed Board Chair in 2016. And the Board is honoured to continue his passion and determination to ensure that our consumers receive the best available medical and nursing care. We welcomed new Board members Annabel Dolphin and Tom McMillan and the re-appointment of existing members Professor Richard Murray and Suzanne Brown. The departure of long-serving Board member Leeanne Heaton is acknowledged and we thank her for her service.

There was a change of leadership in the health service with the appointment of Darryl Camilleri as Board Chair and Lisa Davies Jones as Chief Executive. We farewelled former Chief Executive Jo Whitehead who was honoured in the Australia Day Awards with a Public Service Medal for her dedication to healthcare in the region.

To our dedicated volunteers from the Mackay Hospital Foundation and hospital auxiliaries in Mackay, Proserpine, Bowen and Clermont, your invaluable service to your communities is appreciated. These collaborative and productive partnerships have at their heart, a better patient journey.

Looking forward to 2021-2022 we are excited to develop and implement our first Health Equity Strategy in partnership with Aboriginal and Torres Strait Islander peoples and local Aboriginal and Torres Strait Islander community-controlled health organisations. A continued focus will also be delivery of the COVID-19 vaccination program. We will continue our collaboration with Mackay Hospital Foundation on projects such as the Ronald McDonald Mackay Family Room and the expansion of the volunteer program to Sarina Hospital.

We also eagerly anticipate construction of the new $31.5 million Sarina Hospital which will be considerably larger than the existing facility with 19 beds and more ensuite bathrooms, along with two renal consultation rooms and new staff accommodation. This is another infrastructure project that has been carefully designed to allow for allow for future expansion of the facility if required. We will also deliver a combined preliminary and detailed business case to investigate options for the Moranbah Hospital redevelopment and deliver the preliminary business case for the Bowen Hospital redevelopment. The preliminary business case for the expansion of MBH is progressing and will look at providing more beds, more surgical capacity and an expanded emergency department. Planning to expand the community mental health service in Mackay is also underway.

Thank you to our staff for the professional and compassionate care you deliver and thank you to all of those who work to enable this care to be delivered. Finally, thank to our communities for your contribution to the co-design of our services and to those who give up their time to participate in our consumer reference groups.

Darryl Camilleri
Board Chair
Mackay Hospital and Health Board

Lisa Davies Jones
Chief Executive
Mackay Hospital and Health Service

About us

Mackay HHS is an independent statutory body overseen by an appointed Hospital and Health Board, established on 1 July 2012. Our responsibilities are set out in the *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 focused on the following key areas specific to the health context – building our health workforce capacity and capability; delivering excellence in care for all patients; working collaboratively with our partners to support streamlined care, particularly for vulnerable people; and working in smart and efficient ways to grow and expand our services for the future.

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

Vision, Purpose, Values

Our Vision

Delivering Queensland's Best Rural and Regional Health Care

Our Purpose

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

Our Values

Collaborate | Trust | Respect | Teamwork

Priorities

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

- **Inspired People** - *Creating a diverse and highly skilled workforce*
- **Exceptional Patient Experiences** - *Improving patient flow and striving for patients to have better access to surgical and outpatient services*
- **Excellence in Integrated Care** - *Continuing to respond to community health priorities, such as care of the elderly and chronic disease*
- **Sustainable Service Delivery** - *Further developing contemporary models of care to help patients to spend less time in hospital*

Aboriginal and Torres Strait Islander Health

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

Working together with our partners increases our opportunities to implement actions that improve health outcomes of our local Aboriginal and Torres Strait Islander communities is a Mackay HHS priority. The health service is committed to working closely with community members, Aboriginal and Torres Strait Islander Community Health Services, NQPHN, all government and non-government agencies and health service providers to improve Aboriginal and Torres Strait Islander peoples life expectancy and child mortality.

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. Improving Aboriginal and Torres Strait Islander health is achieved through monitoring and implementing the Mackay HHS's Closing the Gap Health Plan. The plan outlines key strategies and actions for improving Aboriginal and Torres Strait Islander hospital and health service delivery, strengthening the organisation's Aboriginal and Torres Strait Islander leadership and governance, recruitment, community engagement and partnerships. A total of six Making Tracks towards Closing the Gap Queensland Government funded programs, amounting to approximately $1.77 million, are the health service's key drivers for improving access to outpatient appointments and acute hospital services, chronic disease management coordination, cultural support to patients, development and delivery of cultural practice education and resources to our workforce.

Aboriginal and Torres Strait Islander workforce initiatives, such as the 'Budyubari Bidyiri Kebi Stapal' (meaning Big Dream, Small Steps) education to employment program commenced for Aboriginal and Torres Strait Islander grade 11 and 12 students. Trainees accepted into the program are given the opportunity to experience various work areas as a pathway to enter into further training and employment. As an organisation, more than 850 existing Mackay HHS staff, represented from every occupational stream, participated in Aboriginal and Torres Strait Islander Cultural Capability Program training. Key focus areas in 2021-2022 will be to develop and implement a Mackay HHS Cultural Capability Implementation Action Plan and increase First Nations welcoming environment activities.

To ensure connection with Aboriginal and Torres Strait Islander communities, Mackay HHS staff met with the First Nations Connecting Regional Communities Committee. This Committee is one of the health service's primary points of consultation on local Closing the Gap priorities, including families, children and youth, health, education, economic development, housing and justice.

The Closing the Gap Forum brought together community leaders to:

- Promote and address the challenges experienced in closing the gap between the developmental outcomes of First Nations and non-Indigenous children and youth aged 0-18 years of age.
- Support a community-wide shift to support improvements in early life outcomes which are responsive to our local community's needs.
- Connect local community organisations to partner to enhance support for local First Nations families and integrate service delivery.

The Mackay HHS is committed to improving health equity for First Nations people. In May 2021, Mackay HHS participated in the Mackay Health Equity consultation forum facilitated by Queensland Aboriginal and Islander Health Council. The consultation report from this forum will be used by Mackay HHS to guide the planning and co-design of a Mackay Regional Health Equity Strategy in partnership with Aboriginal and Torres Strait Islander Community Controlled Health Organisations and other health stakeholder groups.

Our community based and hospital based services

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

Mackay HHS facilities include:

- 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 MPHS (acute and aged care beds)
- Collinsville MPHS (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 2020-2021.

Targets and challenges

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

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

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

Looking ahead, we expect to see a continued increase in demand for public health services and continuing challenges in skilled workforce attraction and retention. 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; and vaccination rollout. Moving forward, our priorities are to deliver on key strategies through collaborative and productive partnerships with our private, public and non-government organisation partners and to plan for growth to improve access to health services as close to home as possible and deliver financially viable service models, including virtual care.

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

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

Governance

Our people

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

Board membership

The Governor in Council appoints Board Members based upon the recommendation of the Minister and approves the remuneration arrangements (consistent with the *Remuneration Procedures for Part-Time Chairs and Members of Queensland Government Bodies;* reported on page 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:

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

Meetings are held quarterly or as directed by the Chair.

Safety and Quality Committee

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

Audit and Risk Committee

The Audit and Risk Committee provides support to the MHHB in its responsibility for audit and risk oversight and management and operates in accordance with Queensland Treasury's Audit Committee Guidelines. Meetings are 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.

Some of the key achievements of the MHHB in 2020-2021:

- Appointment of Health Service Chief Executive
- Signed a new Local Primary Healthcare Protocol with NQPHN
- Signed a new Head Agreement with the Mackay Hospital Foundation
- Approved the Employee Engagement Strategy 2020-2024
- Approved the Consumer and Community Engagement Strategy 2020-2024.

Table 1: Board Member meeting attendance

Board Members	MHHB	Committees			
		Executive	*Audit and Risk*	*Finance*	*Safety and Quality*
Timothy Mulherin [1]	1 out of 3	1 out of 1		1 out of 1	
Darryl Camilleri	12 out of 12	4 out of 4	5 out of 5	6 out of 6	
David Aprile [2]	12 out of 12	4 out of 4		6 out of 6	
Richard Murray [2]	10 out of 12	3 out of 4			4 out of 4
Suzanne Brown [3, 5]	8 out of 10	3 out of 3	5 out of 5		
Leeanne Heaton [2, 3]	9 out of 10				3 out of 4
Adrienne Barnett	11 out of 12				3 out of 4
Elissa Hatherly [2]	11 out of 12	3 out of 3	5 out of 5		4 out of 4
Helen Caruso	12 out of 12		5 out of 5	6 out of 6	
Annabel Dolphin [4]	2 out of 2			1 out of 1	
Tom McMillan [2, 5]					

[1] Mr Mulherin passed away on 7 September 2020.
[2] Board Members who satisfy the Clinical Expertise requirement under section 23(4) of the HHBA.
[3] Board Membership ceased on 17 May 2021.
[4] Board Membership commenced on 18 May 2021.
[5] Board Membership commenced on 10 June 2021 (no MHHB meetings scheduled from 10 to 30 June 2021).

Total out of pocket expenses claimed during the reporting period totalled $46.34.

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

Mr Camilleri is the former Deputy Mayor of the Mackay Regional Council and has served as Chair for a number of community organisations. He is also a Chartered Accountant 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 Central Queensland University Advisory Board and Mackay Chamber of Commerce and shaping Mackay.

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

Professor Murray has over 30 years' experience in medicine, specialising in general practice and with a career focus on Aboriginal health, rural and remote medicine, public health, tropical medicine, health professional education and the needs of underserved populations. He is the Deputy Vice Chancellor of the Division of Tropical Health and Medicine at James Cook University (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 10 June 2021 to 31 March 2024

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

Ms Adrienne Barnett
Board Member | Originally appointed on 18 May 2019, current term is 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 region 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.

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

Ms Dolphin is an experienced non-executive director with over 20 years' experience specialising in strategic human resources, business advisory and corporate governance across a diverse range of sectors. She has served as a director and chairperson for several government and non-for-profit organisations over the past 10 years including within the health sector. She is currently the director of RACQ Ltd, director of Dolphin Ventures Pty Ltd, and director for Cooney Investments Pty Ltd t/a Helloworld Travel Mackay and Mt Pleasant.

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

Mr McMillan is a Specialist Musculoskeletal Physiotherapist and experienced board member with governance and management roles across the healthcare spectrum. He is the Executive Director of the Physio Plus Group which provides multidisciplinary allied health services in private practices, private hospitals, disability, aged care, industry and elite sport in two Australian states. Vice-President Australian College of Physiotherapists. Clinical Lead for Australian Digital Health Agency. Member WorkCover Queensland Medical Allied Health Panel.

Executive management

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

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 Central Queensland University 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 a National Health Service trust in the United Kingdom, 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 Ben Wearmouth
Executive Director Corporate Services
Mr Wearmouth has held senior and executive roles across the public sector, private sector and not-for-profit sector over the past 20 years. He has been primarily involved overseeing finance and corporate service functions as well as managing customer service functions and has worked in key regional advocacy roles.

Mr Terence Seymour
Executive Director People
Mr Seymour joined Queensland Health in May 2019. Prior to joining Queensland Health, he was the inaugural Executive General Manager Organisational Capability and Change for the Australian Digital Health Agency. In the field of human resources and organisational improvement and transformation, he was a service line leader for the Asia Pacific region with one of the major international business advisory firms.

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 also the Clinical Dean of JCU's School of Medicine and Dentistry (Mackay campus).

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

Organisational structure and workforce profile

Minister for Health and Ambulance Services

Department of Health
System Manager

Mackay Hospital and Health Board

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

Executive Committee

Finance Committee

Safety and Quality Committee

Audit & Risk Committee

Health Service Chief Executive Ms Lisa Davies Jones
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 Ben Wearmouth (acting)
Executive Director People Mr Terence Seymour
Executive Director Research and Innovation Assoc. Prof David Farlow
Executive Director Strategy, Governance and Engagement Ms Janet Geisler

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 2021, Mackay HHS had 2,578 full-time equivalent (FTE) staff.

Mackay HHS permanent FTE separation rate for 2020-2021 was 6.6 per cent compared to a permanent FTE separation rate for 2019-2020 of 8.2 per cent.

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

Staff	*2016-17*	*2017-18*	*2018-19*	*2019-20*	*2020-21*
Medical	267	276	306	322	344
Nursing	848	917	962	1,033	1,060
Allied Health	250	278	288	304	368

*Table 3: Greater diversity in our workforce**

Staff	*2016-17*	*2017-18*	*2018-19*	*2019-20*	*2020-21*
Aboriginal and/or Torres Strait Islander	41	40	50	53	55

***** *Workforce is measured in MOHRI – FTE. Data presented reflects the most recent pay cycle at year's end.*

Attract, recruit and retain

During 2020-2021, Mackay HHS developed the following initiatives to attract, recruit and retain staff:

- Developed the Employee Engagement Strategy 2020-2024.
- Participants of the Budyubari Bidyiri Kebi Stapal (translates to Big Dream, Small Steps) program commenced their Certificate II in Health Support Services (a pre-curser to their Certificate III Allied Health Assistance or Health Services).
- Commenced an Employee Wellbeing Check-in for new employees during their first month at Mackay HHS.
- Continued with Fitness Passport to support well and healthy staff.

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 29 trained responders who regularly reach out to peers and engage in psychological first aid. In 2020-2021, there were 359 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 2021, 43 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:

- 52.3 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

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

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 2020-2021 period, no directions were given by the Minister to Mackay HHS.

Internal audit

Internal audit is an integrated component of corporate governance, promoting efficient management and assisting in risk management. Internal audit is an independent and objective assurance activity designed to improve the governance of Mackay HHS providing reports to the Audit and Risk Committee for the effective, efficient and economical operation of the health service.

The Internal Audit Unit has a central role in improving operational processes and financial practices by:

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

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

External scrutiny, Information systems and recordkeeping

External scrutiny

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

As a public sector entity, Mackay HHS is subject to an annual audit by the QAO. The QAO Final Management Report provided to Mackay HHS for 2019-2020 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 is 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.

Mackay HHS is separately contributing towards Queensland Health's statewide Information Security Annual Return including attestation to the department's information security posture and its compliance with the Queensland Government Enterprise Architecture Information security policy (IS18:2018).

Queensland Public Service ethics

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

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

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

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

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

Human Rights

In 2020-2021, Mackay HHS has assessed 6 complaints where *Human Rights Act 2019* provisions were considered. These complaints were assessed, and there were no complaints considered to breach human rights.

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

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

Some of the initiatives undertaken by Mackay HHS include:

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

Confidential information

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

Performance

Non-financial Performance

Mackay HHS progressed a range of initiatives during 2020-2021 to support achievement of its strategic objectives, as outlined in the table below.

Strategic Objectives	Key Performance Indicators	Results/Achievements
Inspired People	• Progress on staff engagement survey results • Decreased time to recruit • Increased retention (reduced turnover) • Decreased lost time injury frequency rate • Increased leadership development and support, learning circles and communities of practice • Reduced percentage of agency nurse and medical locum annual spend	• The Working for Queensland staff survey returned a result of 62% for agency engagement. Agency engagement results remain above Queensland Public Sector of 60%. • The average time to recruit staff has decreased slightly for nursing (1.12%) and other staff (2.97%), however increased marginally for medical 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. • An increase in staff retention shown through a reduction in separation rates for permanent staff with an average of 6.45%. • Lost time injury frequency rate increased during 2020-2021 to 14.45 per million hours worked. This is primarily attributable to an increase in ergonomic related injuries. Increased education and awareness for safe work practices remains a focus to decrease the lost time injury frequency rate. • Continued delivery of Leadership Development Program with 212 Mackay HHS staff participating in 7 leadership capability programs. • A decrease in agency nurse (27%) and medical locum (8%) spend was achieved in 2020-2021.
Exceptional Patient Experience	• Maintained and improved National Safety and Quality health service indicators • Improved patient experience survey satisfaction rates including cultural appropriateness • Reduced wait times for elective surgery, emergency admissions and specialist outpatient clinics • Improved timeliness of access to care based on need • Increased uptake rates of alternatives to hospital care • Increased clinician and consumer engagement in shaping health care	• Mackay HHS has maintained accreditation against the National Safety and Quality Health Service Standards in Healthcare (second edition). • Patient Reported Experience Measures (PREMs) system implementation was launched in May 2021 to better capture the patient's view of their health care visit and data will be available for comparison in forward years. The rollout of modules for different specialities for the PREMs will continue in 2021-2022. • Wait times for elective surgery attained 88% for Category 1 (treated in 30 days). The delivery of elective surgery was impacted by COVID-19 however there were no Category 1 patients waiting longer than clinically recommended timeframe that were ready for surgery as at 30 June 2021. Overall, elective surgery saw a growth of 21.1% in referrals treated compared to last year, and Mackay HHS achieved results of an additional 12.7% patients that received their care within clinically recommended timeframes. • Wait times for emergency length of stay attained 75% for emergency department attendances who depart within four hours of their arrival in the department. This result means an additional 6,017 more patients were discharged within the timeframe notwithstanding an 11% increase of patients presenting to Mackay HHS emergency departments compared previous year. • Maintained timeliness for patients attending emergency departments which were seen within recommended timeframes of 99.8% for category 1 (seen within 2 minutes); 95.8% for category 2 (seen within 10 minutes); 83.9% for category 3 (seen within 30 minutes); 92.0% for category 4 (seen within 60 minutes) and 98.1% for category 5 (within 120 minutes). • Specialist Outpatient Clinic seen in time results attained improved results for patients in 2020-2021 with 68.1% for Category 1 (seen in 30 days). Overall, outpatient referrals had growth rate of 18.1%, with an increase of 13.3% patients receiving their first outpatient appointment compared to 2019-2020. • Gastrointestinal Endoscopy treated in time results attained improved with 72% for Category 4 (seen in 30 days). Overall, there has been a growth of 7.2% in referrals for gastrointestinal endoscopy procedures. • Uptake rates of alternatives to hospital care increased though the expansion of the HITH model (123% increase in discharges from the service in 2020-2021). • Consumer engagement increased through the launch of the Maternity Community Reference group in February 2021. • To increase clinician engagement with consumers the Toolkit for Partnering with Consumers was launched in September 2020 that aims to support staff to partner with consumers at the service level of the organisation.

Strategic Objectives	Key Performance Indicators	Results/Achievements
Excellence in Integrated Care	• Improved results in our Aboriginal and Torres Strait Islander Closing the Gap targets • Increased local partnership agreements each year and the achievement of milestones • Reduced number of potentially preventable hospitalisations • Increased telehealth and other digital health solutions • Optimised use of patient information systems that are accessible at the point of care	• Continued to improve results in our Closing the Gap targets with an increase in attendance by pregnant indigenous women at five or more antenatal classes achieving 94.4%; improved results for women who attend antenatal visit during first trimester of 65.4%; a decrease in low birthweight rates to 7.5%; an increase of 48.7% in Aboriginal and Torres Strait Islander people that have completed Oral Health courses and a decrease in numbers of potentially preventable hospitalisations to 10.2%. • Continued local partnership agreements with Mackay Hospital Foundation and NQPHN to support initiatives such as the Ronald McDonald House family room at MBH. • The number of potentially preventable hospitalisations overall decreased to 8.2%. • Telehealth usage increased by 29%, to 14,091 outpatient occasion of service events. • Discharge summaries provision was improved with 74% provided within 48 hours.
Sustainable Service Delivery	• Reduced health service average cost per weighted activity unit • Increased innovative models of care/service delivery initiatives implemented • Increased staff engagement in research and evaluation collaborations • Reduced patient journeys as we deliver care closer to home • Increased retention of junior clinical staff • Improved integrated training pathways for all rural generalists • Teaching hospital status recognised • Positive financial operating results achieved	• The estimated cost per weighted activity unit remained consistent with a very slight decrease at $5,356. • Increased innovated models of care/service delivery was achieved through an expansion of the HiTH program pilot enabling patients to receive care in the right setting for an increased number of conditions; through the Breathe Easy Breathe safe program alternative care pathways and improved Asthma and Chronic Obstructive Pulmonary Disease patient outcomes; and a new crisis support space supporting mental health patients. • An increase of 104 staff members received academic support, with 6 staff members receiving grant funding support through Mackay Institute of Research and Innovation to progress their research in a diverse range of clinical areas. • Patient travel was reduced through the expansion of the Bowen renal dialysis service and the MBH's Cardiac Catheter Laboratory expansion to a 24 hours per day, seven days a week. • An increased retention rate to 62% of junior medical officers. • Sustained numbers of rural generalists supported at all levels of training through integrated rural hospital experience at Proserpine Hospital and General Practice terms in Proserpine and Sarina. • Active participation in the North Queensland Regional Training Hub (JCU) as part of a network of training within North Queensland. • Maintain intern accreditation by Prevocational Medical Accreditation Queensland • Reportable operating position surplus of $3.3M.

Service standards

The variance between 2020-2021 target and the 2020-2021 actual results was impacted by the National Cabinet decision to temporarily suspend non-urgent elective surgeries. Although this suspension was undertaken in the prior financial year, the flow-on effect continued to be felt in 2020-2021. This flow-on effect also impacted on our specialist outpatients' performance due to the health service's decision to prioritise essential services whilst ensuring appropriate COVID-19 response planning.

Table 4: Service Delivery Statement

Mackay Hospital and Health Service	2020-2021 Target	2020-2021 Actual
Effectiveness measures		
Percentage of emergency department patients seen within recommended timeframes[1]		
• Category 1 (within 2 minutes)	100%	100%
• Category 2 (within 10 minutes)	80%	96%
• Category 3 (within 30 minutes)	75%	84%
• Category 4 (within 60 minutes)	70%	92%
• Category 5 (within 120 minutes)	70%	98%
Percentage of emergency department attendances who depart within 4 hours of their arrival in the department[1]	>80%	75%
Percentage of elective surgery patients treated within the clinically recommended times[2]		
• Category 1 (30 days)	>98%	88%
• Category 2 (90 days)[3]	..	78%
• Category 3 (365 days)[3]	..	82%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days[4]	<2	0.8
Rate of community mental health follow up within 1-7 days following discharge from an acute mental health inpatient unit[5]	>65%	57.6%
Proportion of re-admissions to acute psychiatric care within 28 days of discharge[6]	<12%	17.2%
Percentage of specialist outpatients waiting within clinically recommended times[7]		
• Category 1 (30 days)	70%	66%
• Category 2 (90 days)[8]	..	49%
• Category 3 (365 days)[8]	..	81%
Percentage of specialist outpatients seen within clinically recommended times[9]		
• Category 1 (30 days)	81%	68%
• Category 2 (90 days)[8]	..	56%
• Category 3 (365 days)[8]	..	88%
Median wait time for treatment in emergency departments (minutes)[1]	..	10
Median wait time for elective surgery treatment (days)[2]	..	58
Efficiency measure		
Average cost per weighted activity unit for Activity Based Funding facilities[10]	$4,684	$5,338
Other measures		
Number of elective surgery patients treated within clinically recommended times[2]		
• Category 1 (30 days)	1,179	1,179
• Category 2 (90 days)[3]	..	1,382
• Category 3 (365 days)[3]	..	465
Number of Telehealth outpatients service events[11]	10,895	14,154
Total weighted activity units (WAU)[12]		
• Acute Inpatients	45,334	42,715
• Outpatients	9,841	11,554
• Sub-acute	3,099	3,549
• Emergency Department	11,844	12,246
• Mental Health	3,627	3,850
• Prevention and Primary Care	1,677	1,737
Ambulatory mental health service contact duration (hours)[5]	>27,854	33,404
Staffing[13]	2,597	2,578

1. During the rapid response to the COVID-19 pandemic, facilities utilised existing systems to manage presentations at fever clinics. In some cases, the management of these clinics was closely related to the management of the emergency department meaning that some fever clinic activity was managed via the emergency department systems. As a result, the 2020-2021 Actual includes some fever clinic activity.
2. In preparation for COVID-19 and consistent with the National Cabinet decision, Queensland Health temporarily suspended non-urgent elective surgery in 2019-2020. This has impacted the treat in time performance and has continued to impact performance during 2020-2021 as the system worked to reduce the volume of patients waiting longer than clinically recommended.

3. Given the System's focus on reducing the volume of patients waiting longer than clinically recommended for elective surgery, and the continual impacts to services as a result of responding to COVID-19, treated in time performance targets for category 2 and 3 patients are not applicable for 2020-2021.
4. Staphylococcus aureus (including MRSA) bloodstream (SAB) infections Actual rate is based on data reported between 1 January 2020 and 31 December 2020.
5. Mental Health measures reported as at 22 August 2021.
6. Mental Health readmissions 2020-2021 Actual is for the period 1 July 2020 to 31 May 2021.
7. Waiting within clinically recommended time is a point in time performance report and was impacted by preparing for COVID-19 in 2019-2020.
8. Given the System's focus on reducing the volume of patients waiting longer than clinically recommended for specialist outpatients, and the continual service impacts as a result of responding to COVID-19, seen in time performance targets for category 2 and 3 patients are not applicable for 2020-2021.
9. As a result of preparing for COVID-19, the seen in time performance was impacted in 2019-2020. This impact has continued throughout 2020-2021 as the system has worked to address provision of care to those patients waiting longer than clinically recommended.
10. The 2020-2021 Target varies from the published 2020-2021 Service Delivery Statement due to a change in the WAU phase. All measures are reported in QWAU Phase Q23. The variation in difference of Cost per WAU to target is a result of the additional costs of the COVID-19 pandemic. Data reported as at 23 August 2021.
11. Telehealth data reported as at 23 August 2021.
12. The 2020-21 Target varies from the published 2020-2021 Service Delivery Statement due to a change in the WAU phase. All measures are reported in QWAU Phase Q23. As HHSs have operational discretion to respond to service demands and deliver activity across services streams to meet the needs of the community, variation to target can occur. Data reported as at 23 August 2021.
13. Corporate FTEs are allocated across the service to which they relate. The department participates in a partnership arrangement in the delivery of its services, whereby corporate FTEs are hosted by the department to work across multiple departments.

Financial summary

Mackay HHS has recorded a financial surplus of $3.3 million for the year ending 30 June 2021. This is compared to the financial deficit in 2019-2020 of $8.8 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 2020-2021 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, and Mackay Institute of Research and Innovation.

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 $530 million which includes:

- Activity Based Funding (ABF) for hospital services was 58 per cent or $306.4 million
- Non-ABF funding was 12 per cent or $61.8 million
- User charges comprising patient and non-patient funding was 8 per cent or $40.5million
- Australian Government grant funding was 18 per cent or $95.2million
- Other revenue was 1 per cent or $6.2 million
- Other grant funding was 3 per cent or $15.5 million

Expenses

The total expenses were $526 million, an average of $1.4 million a day for providing health services.

Labour costs within Mackay HHS make up approximately 66 per cent of expenditure with the remaining 34 per cent being non-labour costs such as supplies, services, and depreciation charges.

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

Table 5: Mackay HHS service allocations

Where the money goes	%
Admitted patient services in acute care institutions	50.3
Non-admitted patient services in acute care institutions	14.9
Mental health includes community services	6.9
Nursing homes for the aged	2.4
Patient transport	1.6
Public health services	2.2
Other community health services	16.0
Health administration	5.6

Anticipated maintenance

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

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

As of 30 June 2021, Mackay HHS had reported anticipated maintenance of $4.7 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 2021

Mackay Hospital and Health Service
Statement of Comprehensive Income
For the year ended 30 June 2021

OPERATING RESULT	Notes	2021 $'000	2020 $'000
Income			
User charges and fees	B1-1	40,463	37,497
Funding public health services	B1-2	463,489	436,103
Grants and other contributions	B1-3	15,487	15,481
Other revenue	B1-4	6,194	4,514
Revaluation increment	B1-5	4,365	-
Total Income		**529,998**	**493,595**
Expenses			
Employee expenses	B2-1	54,012	48,674
Health service employee expenses	B2-2	294,511	280,022
Supplies and services	B2-3	134,194	132,077
Depreciation and amortisation	C5 & C9	30,247	29,016
Other expenses	B2-4	13,705	12,584
Total Expenses		**526,669**	**502,373**
Operating Surplus/(Deficit)		**3,329**	**(8,778)**
Other Comprehensive Income			
Items Not Reclassified to Operating Result			
Increase in Asset Revaluation Surplus		2,133	8,140
Other Comprehensive Income		**2,133**	**8,140**
Total Comprehensive Income / (Loss)		**5,462**	**(638)**

The accompanying notes form part of these statements.

Mackay Hospital and Health Service
Statement of Financial Position
As at 30 June 2021

	Note	2021 $'000	2020 $'000
Current Assets			
Cash and cash equivalents	C1	25,235	31,638
Receivables	C2	4,829	4,380
Inventories	C3	3,677	4,242
Other assets	C4	10,820	6,848
Total Current Assets		**44,561**	**47,108**
Non-Current Assets			
Property, plant, and equipment	C5	373,713	386,275
Right-of-use assets	C9	767	309
Total Non-Current Assets		**374,480**	**386,584**
Total Assets		**419,041**	**433,692**
Current Liabilities			
Payables	C6	28,121	25,682
Accrued employee benefits	C7	992	2,073
Lease liabilities	C9	570	241
Other liabilities	C8	3,246	3,274
Total Current Liabilities		**32,929**	**31,270**
Non-Current Liabilities			
Lease liabilities	C9	203	48
Total Non-Current Liabilities		**203**	**48**
Total Liabilities		**33,132**	**31,318**
Net Assets		**385,909**	**402,374**
Equity			
Contributed equity	C10-1	307,534	329,461
Accumulated surplus		24,790	21,461
Asset revaluation surplus	C10-2	53,585	51,452
Total Equity		**385,909**	**402,374**

The accompanying notes form part of these statements.

Mackay Hospital and Health Service
Statement of Changes in Equity
For the year ended 30 June 2021

	Contributed equity Note C10-1 $'000	Accumulated surplus $'000	Asset revaluation surplus Note C10-2 $'000	Total equity $'000
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 in	4,147	-	-	4,147
Equity contributions	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**
Balance as at 30 June 2020	329,461	21,461	51,452	402,374
Operating Result	-	3,329	-	3,329
Other Comprehensive Income				
Increase in asset revaluation surplus	-	-	2,133	2,133
Total Comprehensive Income for the Year	-	3,329	2,133	5,462
Transactions with Owners as Owners:				
Net assets transferred in	840	-	-	840
Equity contributions	7,480	-	-	7,480
Equity withdrawals – Depreciation Funding	(30,247)	-	-	(30,247)
Net Transactions with Owners as Owners	(21,927)	-	-	(21,927)
Balance at 30 June 2021	**307,534**	**24,790**	**53,585**	**385,909**

The accompanying notes form part of these statements.

Mackay Hospital and Health Service
Statement of Cash Flows
For the year ended 30 June 2021

	Note	2021 $'000	2020 $'000
Cash flows from operating activities			
Inflows			
User charges and fees		37,491	39,583
Funding public health services		433,983	407,562
Grants and other contributions		11,161	11,946
GST input tax credits from ATO		7,945	8,208
GST collected from customers		917	780
Other receipts		6,058	4,457
		497,555	**472,536**
Outflows			
Employee expenses		(55,086)	(48,207)
Health service employee expenses		(303,653)	(277,687)
Supplies and services		(123,666)	(130,044)
GST paid to suppliers		(8,139)	(8,195)
GST remitted to ATO		(974)	(726)
Other payments		(9,613)	(7,849)
		(501,131)	**(472,708)**
Net cash used in operating activities	CF-1	**(3,576)**	**(172)**
Cash flows from investing activities			
Inflows			
Sales of property, plant, and equipment		113	72
Outflows			
Payments for property, plant, and equipment		(9,854)	(8,542)
Net cash used in investing activities		**(9,741)**	**(8,470)**
Cash flows from financing activities	CF-2		
Inflows			
Equity injections		7,480	8,371
Outflows			
Lease payments		(566)	(536)
Net cash provided by financing activities		**6,914**	**7,835**
Net decrease in cash and cash equivalents		**(6,403)**	**(807)**
Cash and cash equivalents at the beginning of the financial year		31,638	32,445
Cash and cash equivalents at the end of the financial year	C1	**25,235**	**31,638**

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

	2021	*2020*
	$'000	*$'000*
Operating Result	3,329	(8,778)
Non-cash movements:		
Depreciation and amortisation	30,247	29,016
Depreciation funding	(30,247)	(29,016)
Services Received Free of Charge	4,166	3,756
Services Provided Below Fair Value	(4,166)	(3,756)
Revaluation increment - Land	(4,365)	-
Net loss on disposal	253	401
Impairment losses	104	578
Donated assets	(267)	(100)
Changes in assets and liabilities:		
(Increase)/decrease in receivables	184	1,353
(Increase)/decrease in GST receivables	(194)	13
(Increase)/decrease in inventories	79	(112)
(Increase)/decrease in contract assets and other assets	(2,282)	(1,235)
(Increase)/decrease in prepayments	(1,690)	514
Increase/(decrease) in accounts payable	11,581	1,573
Increase/(decrease) in accrued contract labour	(9,142)	2,335
Increase/(decrease) in contract and other liabilities	(27)	2,757
Increase/(decrease) in accrued employee benefits	(1,081)	474
Increase/(decrease) in GST payable	(57)	54
Net cash used in operating activities	**(3,576)**	**(172)**

CF-2 CHANGES IN LIABILITIES ARISING FROM FINANCING ACTIVITIES

	2021	*2020*
	$'000	*$'000*
Lease liabilities		
Balance at 1 July	289	-
Non-cash movements:		
Net adjustments on adoption of new accounting standards	-	497
New leases acquired during the year	1,091	326
Remeasurement	(41)	2
Cashflows:		
Lease repayments	(566)	(536)
Balance at 30 June	**773**	**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 because of Machinery-of-Government or administrative arrangements are set out in the Statement of Changes in Equity and Note C10-1.

PREPARATION INFORMATION

GENERAL INFORMATION

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

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

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

COMPLIANCE WITH PRESCRIBED REQUIREMENTS

The Hospital and Health Service has prepared these financial statements in compliance with section 62 (1) of the *Financial Accountability Act 2009* and section 39 of the *Financial and Performance Management Standard 2019.* The financial statements comply with Queensland Treasury's Minimum Reporting Requirements for reporting periods beginning on or after 1 July 2020.

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

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

PRESENTATION

Currency and Rounding

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

Comparatives

Comparative information reflects the audited 2019-20 financial statements.

Current/Non-Current Classification

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

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

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

AUTHORISATION OF FINANCIAL STATEMENTS FOR ISSUE

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

BASIS OF MEASUREMENT

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

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

Historical Cost

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

Fair Value

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

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

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

BASIS OF MEASUREMENT (continued)

Present Value

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

Net realisable value

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

THE REPORTING ENTITY

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

SECTION A

HOW WE OPERATE – OUR OBJECTIVES AND ACTIVITIES

A1 OBJECTIVES OF MHHS

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

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

A2 CONTROLLED ENTITIES

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

A2-1 DISCLOSURES ABOUT NON-WHOLLY OWNED CONTROLLED ENTITIES

North Queensland Primary Healthcare Network Limited

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

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

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

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

Tropical Australia Academic Health Centre Limited

Tropical Australia Academic Health Centre Limited (TAAHCL) was established as a public company limited by guarantee on 3 June 2019. Mackay Hospital and Health Service is one of seven members along with Cairns and Hinterland Hospital and Health Service, James Cook University, North Queensland Primary Healthcare Network Limited, 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 TAAHCL is James Cook University, Queensland. The Company's principal purpose is the advancement of health through the promotion of the study and research of health topics of special importance to people living in the tropics.

As each member has the same voting entitlement (14%), it is considered that none of the individual members has power or significant influence over TAAHCL (as defined by AASB 10 *Consolidated Financial Statements and AASB 128 Investments in Associates and Joint Ventures*). Each member's liability to TAAHCL is limited to $10. TAAHCL is legally prevented from paying dividends to its members and its constitution also prevents any income or property of the Company being transferred directly or indirectly to or amongst the Members.

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

SECTION B

NOTES ABOUT OUR FINANCIAL PERFORMANCE

B1 REVENUE

B1-1 USER CHARGES AND FEES

	2021	*2020*
	$'000	*$'000*
Revenue from contracts with customers		
Pharmaceutical Benefit Scheme	13,907	12,641
Sales of goods and services	5,244	4,443
Hospital fees	21,312	20,413
	40,463	**37,497**

Accounting Policy – User Charge

Revenue from contracts with customers

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

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

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

B1 REVENUE (continued)

B1-1 USER CHARGES AND FEES (continued)

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

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

B1 REVENUE (continued)

B1-2 FUNDING PUBLIC HEALTH SERVICES

	2021	*2020*
	$'000	*$'000*
Revenue from contracts with customers		
Activity based funding	306,445	293,802
Other grants and contributions		
Block funding	61,844	67,270
Teacher training funding	13,021	12,937
Depreciation funding	30,247	29,015
General purpose funding	51,932	33,079
	463,489	**436,103**

Disclosure about funding received to deliver public health services

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

The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by MHHS. Cash funding from the Department of Health is received fortnightly for State payments and monthly and quarterly for Commonwealth payments and is recognised as revenue as the performance obligations under the service agreement are discharged. Commonwealth funding in 2020-21 $152.819 mil (2020: $151.496 mil).

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

Additional funding has been provided under the *National Partnership Agreement on COVID-19 Response* to meet costs directly attributed to the treatment of COVID-19 patients (diagnosed or suspected), and additional costs of activities directed at preventing the spread of COVID-19. In 2020-21 $7.592 mil funding (2020: $4.233 mil) was received for COVID-19.

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

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

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

Accounting Policy – Public health services

Activity Based Funding

Activity based funding (ABF) is provided according to the type and number of services purchased by the Department of Health, multiplied by the Queensland Efficiency Price (QEP) or other prices in the SA. ABF funding is received for inpatients, critical care, sub and non- acute, emergency department, mental health, and outpatients.

Ordinarily, activity-based funding is recognised as public health services are delivered, however, due to the impacts of COVID-19 activity-based funding was guaranteed by the Commonwealth government for 2019-20 and 2020-21 financial years under the National Health Reform Agreement. As such, the Department of Health will not make any adjustments for under or over delivery against activity-based funding targets.

Other public health service revenue

Non-ABF funding is received for other services MHHS has agreed to provide under the Service Agreement. This includes block, teacher, depreciation, and most of the other general-purpose funding. This funding has specific conditions attached that are not related to activity covered by ABF. The funding is received in cash fortnightly in advance.

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

Recognition of revenue for other "general purpose" funding is dependent on the specific performance obligations attached to each funding sub-type. Where the obligations are not sufficiently specific, revenue is recognised as it is received. Funding with sufficiently specific obligations, are recognised over time as the services/goods are provided and obligations met with the price implicit in the SA.

B1 REVENUE (continued)

B1-3 GRANTS AND OTHER CONTRIBUTIONS

	2021 $'000	2020 $'000
Revenue from contracts with customers		
Home and community care grants	4,059	4,000
Specific purpose payments	5,708	6,614
Other grants and contributions		
Other grants	1,554	1,111
Services received below fair value	4,166	3,756
	15,487	**15,481**

Accounting Policy – Services received below fair value

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

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

Accounting Policy – Grants, contributions, donations, and gifts

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

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

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

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

Contributed assets are recognised at their fair value.

Disclosure – Grants and contributions

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

Grants – recognised as performance obligations are satisfied

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

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

B1 REVENUE (continued)

B1-3 GRANTS AND OTHER CONTRIBUTIONS (continued)

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

B1-4 OTHER REVENUE

	2021 *$'000*	*2020* *$'000*
Recoveries	6,109	4,193
Other	85	321
	6,194	**4,514**

Accounting Policy – Other revenue

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

B1-5 REVALUATION INCREMENT

	2021 *$'000*	*2020* *$'000*
Revaluation increments - land	4,365	-
	4,365	**-**

Accounting Policy - Revaluations

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

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

Decrements in land values in prior years were reflected as an expense in the operating statement, resulting in accumulated losses carried forward of $1.383 mil at 30 June 2021 (2020: $5.748 mil).

B2 EXPENSES

B2-1 EMPLOYEE EXPENSES

	2021 $'000	2020 $'000
Employee benefits		
Wages and salaries	46,390	41,703
Annual leave levy	2,924	2,655
Employer superannuation contributions	3,421	3,009
Long service leave levy	1,087	976
Employee related expenses		
Workers compensation premium	58	60
Other employee related expenses	132	271
	54,012	**48,674**

	No.	No.
B2-1A NUMBER OF EMPLOYEES (Full-Time Equivalent)		
Number of employees	**112**	**102**

*reflecting Minimum Obligatory Human Resource Information (MOHRI)

Accounting Policy – Superannuation

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

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

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

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

Accounting Policy – Wages and salaries

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

Accounting Policy – Workers' compensation premiums

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

Accounting Policy – Sick leave

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

Accounting Policy – Annual leave and long service leave

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

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

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

Accounting Policy – COVID response leave

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

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

Accounting Policy – Recoveries of Employee Expenses

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

B2 EXPENSES (continued)

B2-2 HEALTH SERVICE EMPLOYEE EXPENSES

	2021 *$'000*	*2020* *$'000*
Department of Health	**294,511**	**280,022**

B2-2A NUMBER OF EMPLOYEES (Full-Time Equivalent)

Number of health service employees	**2,467**	**2,424**

The Hospital and Health Service through service arrangements with the Department of Health has engaged 2,467 (2020: 2,424) full time equivalent persons at 30 June 2021. As well as direct payments to the department, premium payments made to WorkCover Queensland representing compensation obligations are included in this category 2021: $1.499 mil (2020: $1.462 mil).

Accounting Policy – Health service employee expense

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

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

Accounting Policy – Recoveries of Health Service Employee Expenses

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

B2-3 SUPPLIES AND SERVICES

	2021 *$'000*	*2020* *$'000*
Contractors and consultants		
Medical	16,850	20,796
Other	1,235	1,414
Electricity and other energy	4,186	5,097
Patient travel	9,996	11,091
Other travel	920	1,420
Building services	2,102	2,216
Computer services	3,370	3,369
Communications	6,047	6,471
Repairs and maintenance	10,905	11,274
Lease expenses	422	226
Outsourced medical services	12,726	13,105
Inventories consumed		
Drugs	20,754	15,993
Clinical supplies and services	22,654	19,335
Catering and domestic supplies	1,381	1,455
Pathology, blood, and parts	13,310	12,170
Other	7,336	6,645
	134,194	**132,077**

Accounting Policy – Consultants and contractors

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

Accounting Policy – Distinction between grants and procurement

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

Accounting Policy – Inventories consumed

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

Accounting Policy - Lease expenses

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

B2 EXPENSES (continued)

B2-4 OTHER EXPENSES

	2021 $'000	2020 $'000
Insurance premiums - QGIF	5,083	4,686
Insurance premiums - Other	52	51
Impairment trade receivables	382	521
Services received free of charge	4,166	3,756
Losses from the disposal of non-current assets	323	401
Special payments		
Ex-gratia payments	17	1
Other legal costs	676	238
Funding expense	1,678	1,614
Other	1,328	1,316
	13,705	**12,584**

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 2020-21 policy year, the premium was allocated to each HHS according to the underlying risk of an individual insured party.

Disclosure – Special payments and services received free of charge

Special payments represent ex gratia expenditure and other expenditure that MHHS is not contractually or legally obligated to make to other parties. MHHS maintains a register of all special payments greater than $5,000. In FY21 one ex gratia payment exceeding $5,000 was paid under a deed of settlement for $10,188 to an MHHS vendor in resolution of a contract dispute.

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

	2021 $'000	2020 $'000
Audit services - Queensland Audit Office		
Audit of financial statements	**164**	**194**

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

SECTION C

NOTES ABOUT OUR FINANCIAL POSITION

C1 CASH AND CASH EQUIVALENTS

	2021	*2020*
	$'000	*$'000*
Imprest accounts	5	5
Cash at bank*	23,780	30,192
QTC cash funds*	1,450	1,441
	25,235	**31,638**

Cash deposited with Queensland Treasury Corporation earns interest, calculated daily reflecting market movements in cash funds. The annual effective interest rate was 0.51% (2020: 0.86%).

Accounting Policy – Cash and cash equivalents

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

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

*MHHS receives cash contributions primarily from private practice clinicians and external entities to provide for education, study, and research in clinical areas. Contributions are also received from benefactors in the form of gifts, donations, and bequests for stipulated purposes. At 30 June 2021, amounts of $2.580 mil (2020: $2.370 mil) in General Trust, including $1.701 mil (2020: $1.546 mil) for excess earnings under Granted Private Practice, set aside for the specified purposes underlying the contribution.

C2 RECEIVABLES

	2021	*2020*
	$'000	*$'000*
Trade debtors	4,890	4,426
Less: Loss allowance	(1,066)	(800)
	3,824	3,626
GST receivable	1,064	870
GST payable	(59)	(116)
	1,005	754
	4,829	**4,380**

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 2021 is $4.89 mil (1 July 2020: $4.426 mil)

C2-1 IMPAIRMENT OF RECEIVABLES

Accounting Policy – Impairment of receivables

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

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

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

C2 RECEIVABLES (continued)

C2-1 IMPAIRMENT OF RECEIVABLES (continued)

Disclosure – Credit risk exposure of receivables

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

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

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

MHHS's patient activity is heavily influenced by movements in regional population. Depending on the status of the tourism, agricultural and mining sectors the region experiences significant fluctuations in population, with a large proportion of the workforce transient in nature and includes overseas/interstate visitors requiring treatment. Economic growth has been determined as the most relevant forward-looking 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.

Impairment group - Trade debtors:

	2021			2020		
	Gross receivables	*Loss rate*	*Expected credit losses*	*Gross receivables*	*Loss rate*	*Expected credit losses*
Aging	*$'000*	*%*	*$'000*	*$'000*	*%*	*$'000*
Current	2,308	0.6%	15	817	1.6%	13
31 to 60 days	1,009	4.2%	42	1,188	3.3%	39
61 to 90 days	444	12.8%	57	923	6.5%	60
> 90 days	1,128	84.4%	952	1,498	46.2%	692
Total	**4,889**		**1,066**	**4,426**		**804**

Disclosure - Movement in loss allowance for trade debtors

	2021	*2020*
	$'000	*$'000*
Balance at beginning of the year	800	590
Amounts written off during the year	(116)	(311)
Increase in allowance recognised in operating result	382	521
Balance at the end of the year	**1,066**	**800**

C3 INVENTORIES

	2021	*2020*
	$'000	*$'000*
Inventories held for distribution - at cost		
Pharmaceutical drugs	1,248	1,331
Clinical supplies	2,418	2,892
Catering and domestic	11	19
	3,677	**4,242**

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

	2021 $'000	2020 $'000
Prepayments	2,284	594
Contract assets	6,269	3,469
Other	2,267	2,785
	10,820	**6,848**

Accounting Policy – Other assets

Prepayments include $0.975 mil for COVID Response Leave.

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

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

Disclosure – Contract assets

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

The Department of Health owed $5.732 mil (2020: $3.776 mil) at 30 June to MHHS including $3.464 mil in contract assets (2020: $0.991mil) for project management and purchases of additional health service activity, and $2.267 mil (2020: $2.785 mil) for other funding to support the provision of health services (other assets). For further details on the nature of these transactions refer to Note B1-2.

C5 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION

C5-1 ACCOUNTING POLICIES

Property, Plant and Equipment

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

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

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

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

Componentisation of Complex Assets

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

Acquisition of Assets

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

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

Measurement using historical cost

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

Measurement using fair value

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

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

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

C5-1 ACCOUNTING POLICIES (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 five years. However, if a particular asset class experiences significant and volatile changes in fair value, that class is subject to specific appraisal in the reporting period, where practical, regardless of the timing of the last specific appraisal. Where assets have not been specifically appraised in the reporting period, their previous valuations are materially maintained via the application of relevant indices. MHHS uses indices to provide a valid estimation of the assets' fair values at reporting date.

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

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

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

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

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	0.93 to 11.11%
- External fabric	0.93 to 11.11%
- Internal fabric	0.93 to 10.0%
- Internal finishes	1.39 to 16.67%
- Fittings	1.39 to 9.09%
- Building services	1.39 to 12.50%
- Land improvements	1.22 to 3.33%
- Other buildings including residential	0.91 to 7.14%
Plant and equipment including artworks	1.00 to 20.00%

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

C5-1 ACCOUNTING POLICIES (continued)

Indicators of impairment and determining recoverable amount

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

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

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

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

2021	Land (at fair value) (Level 2) $'000	Buildings (at fair value) (Level 3) $'000	Plant and equipment (at cost) $'000	Capital works in progress (at cost) $'000	Total $'000
Gross	18,100	585,474	58,887.0	2,016	664,477
Less: Accumulated depreciation	-	(257,762)	(33,002)	-	(290,764)
Carrying amount at 30 June 2021	**18,100**	**327,712**	**25,885**	**2,016**	**373,713**
Represented by movements in carrying amount:					
Carrying amount at 1 July 2020	13,735	341,409	23,321	7,810	386,275
Transfers in - practical completion projects from the Department of Health	-	740	160	-	900
Acquisitions	-	578	7,513	1,763	9,854
Donated assets	-	-	267	-	267
Disposals	-	(220)	(146)	-	(366)
Transfers out to other Queensland Government entities	-	-	(60)	-	(60)
Transfers between classes	-	6,863	694	(7,557)	-
Net revaluation increments	4,365	2,133	-	-	6,498
Depreciation expense	-	(23,791)	(5,864)	-	(29,655)
Carrying amount at 30 June 2021	**18,100**	**327,712**	**25,885**	**2,016**	**373,713**

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	-	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 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 Resources.

All land holdings were revalued as at 30 June 2021 by SVS. Comprehensive valuations were performed for material land parcels, with desktop valuations undertaken on the balance of properties.

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

The revaluation program resulted in an increment of $4.365 mil (2020: nil) to the carrying amount of land.

Buildings

In 2021 MHHS commenced its five-year rolling building valuation program (2021 to 2025). As part of this program independent quantity surveyors, AECOM Pty Ltd were engaged to comprehensively revalue all buildings (with a replacement cost exceeding $500,000) 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. Fourteen buildings were comprehensively revalued in 2021.

The revaluation program resulted in an increment of $2.133 mil or 4% increase (2020: increment $8.140 mil) to the carrying amount of buildings.

C6 PAYABLES

	2021	*2020*
	$'000	*$'000*
Trade creditors	25,616	14,035
Accrued labour - Department of Health	2,505	11,647
	28,121	**25,682**

Trade creditors include $18.512 mil (2020: $6.817 mil) were owing to the Department of Health at 30 June plus other trade creditors of $7.104 mil (2020: $7.218 mil).

Accounting Policy – Payables

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

C7 ACCRUED EMPLOYEE BENEFITS

	2021	*2020*
	$'000	*$'000*
Wages outstanding	960	1,902
Long service leave levy payable	-	45
Superannuation accrued	32	126
	992	**2,073**

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

	2021	*2020*
	$'000	*$'000*
Contract liabilities	1,243	605
Unearned Revenue	2,003	2,669
	3,246	**3,274**

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 2021: $1.243 mil (2020: $0.6mil) and (unearned revenue liabilities) public health funding received by HHS to be returned to DoH 2021: $1.725 mil (2020: $2.316 mil) refundable general grants from private companies 2021: nil (2020: $0.172mil). For further details on the nature of these transactions refer to Note B1-2.

C9 RIGHT OF USE ASSETS AND LEASE LIABILITIES C9-1 LEASES AS LESSEE

	2021	*2020*
	$'000	*$'000*
Right-of-use assets		
Gross value	1,289	825
Less Accumulated depreciation	(522)	(516)
Carrying amount at 30 June	**767**	**309**
Represented by movements in carrying amount:		
Balance at 1 July	309	497
Additions	1,091	326
Remeasurement	(41)	2
Depreciation	(592)	(516)
Balance at 30 June	**767**	**309**
Lease liabilities		
Current	570	241
Non-Current	203	48
Total	**773**	**289**

Disclosures - Leases as lessee

Details of leasing arrangements as lessee

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

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

Motor vehicles

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

Accounting policy – Measurement of ROU Assets

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

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

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

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

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

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

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

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

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

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

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

C10 EQUITY

C10-1 CONTRIBUTED EQUITY

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

- Cash equity contributions fund purchases of equipment, furniture and fittings associated with capital work projects managed by MHHS. In 2021 MHHS received $7.5 mil (2020 $8.4 mil) funding from the State as equity injections throughout the year. These outlays are paid by the Department of Health on behalf of the State.

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

- Equity withdrawal of funds by the Department of Health on behalf of the State, MHHS recognised $30.2 mil funding in 2021 (2020 $29.0 mil) from the Department of Health to account for the cost of depreciation. However, as depreciation is a non-cash expenditure item, the Health Minister has approved a withdrawal of equity by the State for the same amount, resulting in a non-cash revenue and non-cash equity withdrawal.

During this year several assets have been transferred under this arrangement.	*2021* *$'000*	*2020* *$'000*
Transfer in - practical completion of projects from the Department of Health*	740	4,147
Net transfer of property, plant, and equipment from the Department of Health	160	-
Net transfers of property, plant and equipment to other Queensland Government entities	(60)	-
	840	**4,147**

*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

	2021 *$'000*	*2020* *$'000*
Buildings		
Balance at the beginning of the financial year	51,452	43,312
Revaluation increments	2,133	8,140
Total	**53,585**	**51,452**

Accounting Policy - Asset revaluation surplus

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

See Note B1-5 for Land Revaluation.

SECTION D

NOTES ABOUT RISKS AND OTHER ACCOUNTING UNCERTAINTIES

D1 FAIR VALUE MEASUREMENT

D1-1 ACCOUNTING POLICIES AND BASIS FOR FAIR VALUE MEASUREMENT

What is fair value?

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

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

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

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

Fair value measurement hierarchy

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

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

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

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

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

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

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

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)

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

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

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

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

D2 FINANCIAL RISK DISCLOSURES

D2-1 FINANCIAL INSTRUMENT CATEGORIES

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

Category	Note	2021 $'000	2020 $'000
Financial assets at amortised cost			
Cash and cash equivalents	C1	25,235	31,638
Receivables	C2	4,829	4,380
Total		**30,064**	**36,018**
Financial liabilities at amortised cost			
Payables	C6	28,121	25,682
Lease liabilities	C9-1	773	289
Total		**28,894**	**25,971**

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

D2-2 FINANCIAL RISK MANAGEMENT

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

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

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

Credit risk is further discussed in Note C2 Receivables.

Liquidity risk

Liquidity risk is the risk that MHHS will not have the resources required at a particular time to meet its obligations to settle its financial liabilities. MHHS is exposed to liquidity risk through its trading in the normal course of business and aims to reduce the exposure to liquidity risk by ensuring that enough funds are always available to meet employee and supplier obligations. An approved debt facility of $6 mil (2020: $3 mil) under WOG 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 2021 (2020: Nil).

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

Interest risk

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

D2 FINANCIAL RISK DISCLOSURES (continued)

D2-3 LIQUIDITY RISK – CONTRACTUAL MATURITY OF FINANCIAL LIABILITIES

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

	2021	**Contractual maturity**			**2020**	**Contractual maturity**	
	Total	***< 1 Yr***	***1-5 Yrs***	***> 5 Yrs***	**Total**	*< 1 Yr*	*1-5 Yrs*
	$'000	*$'000*	*$'000*	*$'000*	**$'000**	*$'000*	*$'000*
Payables	**28,121**	28,121	-	**-**	**25,682**	25,682	-
Leased liabilities	**776**	573	203	**-**	**292**	220	72
	28,897	**28,694**	**203**	**-**	**25,974**	**25,902**	**72**

D3 CONTINGENCIES

(a) Litigation in progress

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

	2021 Number of cases	2020 Number of cases
Supreme Court	4	3
District Court	1	1
	5	**4**

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 2021, MHHS has 8 claims currently managed by QGIF, some of which may never be litigated or result in payments to claims (excluding initial notices under Personal Injuries Proceedings Act).

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

	2021	*2020*
	$'000	*$'000*
Commitments for capital expenditure at reporting date (inclusive of non-recoverable GST input tax credits) are payable:		
Building		
No later than 1 year	51	161
Total	**51**	**161**
Plant and Equipment		
No later than 1 year	2,394	1,063
Total	**2,394**	**1,063**

D5 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE

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

D6 EVENTS AFTER BALANCE SHEET DATE

There are no matters or circumstances that have arisen since 30 June 2021 that have significantly affected or may significantly affect MHHS' operations, the results of those operations, or the HHS's state of affairs in future financial years.

D7 SIGNIFICANT FINANCIAL IMPACTS FROM COVID-19 PANDEMIC

The following significant transactions were recognised by Mackay HHS during the 2020-21 financial year in response to the COVID-19 pandemic.

	2021	*2020*
STATEMENT OF COMPREHENSIVE INCOME	*$'000*	*$'000*
Significant revenue transactions arising from COVID-19		
Additional funds for COVID-19 related expenses	7,592	4,233
Additional funds for COVAX related expenses	1,051	-
Additional funds for COVID Response Leave - front line staff backfill	624	-
Waived collection of café licence revenues	(26)	(15)
Own Source Revenue lost	-	(1,500)
Total Revenues	**9,241**	**2,718**
Significant expense transactions arising from COVID-19		
Costs incurred in response to COVID-19 epidemic	7,592	4,233
Costs incurred in response to COVAX	1,051	-
Annual Leave not taken	-	2,100
COVID Response Leave taken	700	-
Impairment of receivables	(14)	167
Total Expenses	**9,329**	**6,500**
Net Impact	**(88)**	**(3,782)**

	2021	*2020*
STATEMENT OF FINANCIAL POSITION	*$'000*	*$'000*
Significant changes in assets and liabilities arising from COVID-19		
Provision for impairment of receivables	(153)	(167)
COVID Response Leave Prepayment	975	-
Net Impact Assets	**822**	**(167)**
COVID Response Leave Liability	118	-
Net Impact Liabilities	**118**	**-**

SECTION E

NOTES ON OUR PERFORMANCE COMPARED TO BUDGET

E1 BUDGETARY REPORTING DISCLOSURES

This section discloses MHHS's original published budgeted figures for 2020-21 compared to actual results, with explanations of major variances, in respect of MHHS's Statement of Comprehensive Income. Note original published budget from the Service Delivery Statement (SDS) has been reclassified to improve transparency and analysis by remapping budgeted transactions on the same basis as reported in actual financial statements.

E2 BUDGET TO ACTUAL COMPARISON – STATEMENT OF COMPREHENSIVE INCOME

	Variance Notes	Actual 2021 $'000	Original SDS Budget 2021 $'000	SDS Budget V Actual Variance $'000
OPERATING RESULT				
Income				
User charges and fees	V1.	40,463	32,341	8,122
Funding public health services		463,489	440,534	22,955
Grants and other contributions		15,487	14,893	594
Other revenue		6,194	5,270	394
Revaluation increment		4,365	-	4,365
Total Income		**529,998**	**493,038**	**36,430**
Expenses				
Employee expenses*	V2.	54,012	47,766	6,246
Health service employee expenses**		294,511	288,891	5,620
Supplies and services	V3.	134,194	118,691	15,118
Depreciation and amortisation		30,247	28,261	1,986
Other expenses	V4.	13,705	9,429	4,131
Total Expenses		**526,669**	**493,038**	**33,101**
Operating Results		**3,329**	**-**	**3,329**
Other Comprehensive Income				
Items Not Reclassified to Operating Result				
Increase in Asset Revaluation Surplus		2,133	-	2,133
Total Comprehensive Income		**5,462**	**-**	**5,462**

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

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

V1. User charges and fees

Sales of goods and services exceeded budget by $6.0 mil primarily reflecting increased Pharmaceutical Benefit Scheme Reimbursements (PBS) due to a combination of increased patient activity and changes to drugs prescribed with different treatments applied to allow better outcomes for patients. These drugs had improved rebate rates. Revenue for managing capital projects on behalf of the Department of Health totalled $3.2 mil, which is not able to be forecast at the time of the budget. All construction of major health infrastructure is managed and funded by the Department of Health. Where costs are borne by the Hospital and Health Service on departmental funded projects, the Department of Health reimburses MHHS for those costs. Overall hospital fees increased 12% over budgeted position due to higher revenues from doctors under the right of private practice arrangements driven by higher patient levels.

V2. Employee expenses

The increase of $6.246mil is largely related to COVID due to reduced outsourcing caused by COVID restrictions resulting in increased insourcing of medical staff. Further increase resulted from $1.6mil additional funding during the year related to planned care volume targets.

V3. Supplies and Services

Supplies and services were higher than budget mainly due to additional funding for various initiatives awarded after the initial budget including $5.6mil for planned and unplanned care, $3.1mil for COVID and COVAX to reimburse MHHS for incurred expenditure and $3.2 mil of capital expense reimbursements (offset by revenue).

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

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

V4. Other Expenses

Other Expenses were higher than budget due to additional funding awarded after original budget negotiations were finalised. Additional funding includes $2.4 mil additional funding for COVID and COVAX not anticipated at budget time and increased insurance premiums of $0.4 mil.

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 2021 and 2020.

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:

	2021 $'000	2020 $'000
Receipts		
Billings - (Doctors and Visiting Medical Officers)	8,993	9,493
Interest	13	2
Total receipts	**9,006**	**9,495**
Payments		
Payments	9,064	9,164
Hospital and Health Service recoverable administrative costs	1,576	1,742
Hospital and Health Service - Education/travel/research fund	130	15
Total payments	**10,770**	**10,921**
Closing balance of bank account under a trust fund arrangement not yet disbursed and restricted cash	**793**	**864**

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.
Executive Director, Strategy, Governance and Engagement	Responsible to the Chief Executive for leadership and development of frameworks and systems for integrated planning, strategy management, governance, risk, audit and performance monitoring within the Mackay Hospital and Health Service.

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 The Premier and Cabinet, titled *"Remuneration procedures for part-time chairs and member of Queensland Government bodies*". Under the procedure, Hospital and Health Services are assessed as 'Governance' entities and grouped into different levels of a remuneration matrix based on a range of indicators including revenue/budget, net and total assets, independence, risk, and complexity.

Board Position	Date of appointment	Date of resignation
Chairperson	18 May 2021	-
Chairperson	18 May 2016	7 September 2020
Deputy Chair	29 June 2012	17 May 2021
Board member	29 June 2012	-
Board member	29 June 2012	-
Board member	18 May 2016	-
Board member	18 May 2016	17 May 2021
Board member	18 May 2019	-
Board member	18 May 2019	-
Board member	18 May 2020	-
Board member	18 May 2021	-
Board member	10 June 2021	-

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.

2021

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 (resigned 30 November 2020)	123	10	3	11	147
Health Service Chief Executive (appointed 2 November 2020) (taking handover)	213	-	5	19	237
Executive Director, Corporate Services (resigned 15 October 2020)	52	-	1	5	58
A/Executive Director, Corporate Services (28 September - 30 June 2021)	146	-	3	13	163
A/Executive Director Operations Mackay (full year)	190	-	4	18	212
Executive Director, Mental Health, Public Health & Rural Services	192	-	4	19	215
Executive Director, People (resigned 12 October 2020)	26	-	0	2	28
Executive Director, People (appointed 7 December 2020)	103	-	2	11	116
Executive Director, Medical Services & CMO	481	-	11	37	529
Executive Director, Research & Innovation	512	3	11	40	566
Executive Director, Nursing & Midwifery	256	-	5	25	287
Executive Director, Strategy, Governance and Engagement	166	-	4	19	188

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

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

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

Board Member	*Short Term Employee Expenses*		*Post-Employment Expenses*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*		
	$'000	*$'000*	*$'000*	*$'000*
Chairperson (resigned 7 September 2020)	17	-	2	19
Board Member (1 July 2020 to 10 September 2020) Deputy Board Chair (11 September 2020) A/Chairperson (11 September 2020 to 17 May 2021) and Chairperson (appointed 18 May 2021)	78	-	7	85
Board Member	47	-	4	51
Board Member	47	-	4	51
Board Member (term ceased 17 May 2021 and new term started 10 June 2021)	44	-	4	48
Board Member	46	-	4	50
Board Member (resigned 17 May 2021)	39	-	4	43
Board Member	43	-	4	47
Board Member	48	-	5	52
Board Member (appointed 18 May 2021)	5	-	0	5
Board Member (appointed 10 June 2021)	2	-	0	2

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

*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	**2021 $'000**	**2020 $'000**
Revenue	471,317	443,819
Expenditure	336,115	320,616
Asset	5,732	3,790
Liability	21,017	18,464

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 $463.5.0 mil for the year ended 30 June 2021 (2020: $436.1 mil). For further details on the purchase of health services by the Department of Health refer to Note B1-2.

MHHS, through service arrangements with the Department of Health, has engaged 2,467 (2020: 2,424) 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 2021, $292.7 mil (2020: $278.6 mil) was paid to the Department for Health service employees. The terms of this arrangement are fully explained in Note B2-2.

The Department of Health centrally manages, on behalf of Hospital and Health Services, a range of services including pathology testing, pharmaceutical drugs, clinical supplies, patient transport, telecommunications, and technology services. These services are provided on a cost recovery basis. In 2021, these services totalled $39.3 mil (2020: $38.3 mil). In addition, MHHS receives corporate services support from the Department at no cost refer to Note B1-3. Corporate services received include payroll services, financial transactions services (including accounts payable and banking services), administrative services and information technology services. In 2021, the fair value of these services was $4.2 mil (2020: $3.8 mil).

Any associated receivables or payables owing to the Department of Health at 30 June 2021 are separately disclosed in Note C2 and Note C6. No impairment has been applied to these balances.

The Department of Health also provides funding from the State as equity contributions to purchase property, plant, and equipment. All construction of major health infrastructure is managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department of Health to MHHS. Where costs are borne by MHHS on departmental funded projects, the Department of Health reimburses MHHS for those costs. In 2021, $3.2 mil (2020: $3.5 mil) in recoveries was recognised.

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

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

Transactions with people/entities related to Key Management Personnel

All transactions in the year ended 30 June 2021 between Mackay Hospital and Health Service and key management personnel, including their related parties were on normal commercial terms and conditions and were immaterial in nature and dollar.

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

Accounting standards applied for the first time

No accounting standards or interpretations that apply to MHHS for the first time in 2020-21 have any material impact on the financial statements.

Accounting standards early adopted

No Australian Accounting Standards have been early adopted for 2020-21.

G4 TAXATION

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

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

G5 CLIMATE RISK DISCLOSURE

Climate Risk Assessment

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

MHHS has not identified any material climate related risks relevant to the financial report at the reporting date, however, constantly monitors the emergence of such risks under the Queensland 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 2021

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 2021 and of the financial position of Mackay Hospital and Health Service at the end of that year, and

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

Darryl Camilleri
Chair, Mackay Hospital and Health Board
27/8/2021

Ms Lisa Davies Jones
Chief Executive Officer
27/8/2021

Mr Ben Wearmouth
A/Executive Director, Corporate Services
27/8/2021

Queensland Audit Office
Better public services

INDEPENDENT AUDITOR'S REPORT

To the Board of Mackay Hospital and Health Service

Report on the audit of the financial report

Opinion

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

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2021, 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 2021, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

Basis for opinion

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

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

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

Key audit matters

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

Queensland Audit Office
Better public services

Specialised buildings valuation ($327.7 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 2021 Mackay Hospital and Health Service performed a comprehensive revaluation of 14 material buildings / site improvements with the remainder subject to indexation.
 	
The current replacement cost method comprises:
• gross replacement cost, less
• accumulated depreciation.
 	
Mackay Hospital and Health Service derived the gross replacement cost of its buildings at the balance date using unit prices that required significant judgements for:
• identifying the components of buildings with separately identifiable replacement costs
• developing a unit rate for each of these components, including:
  ○ 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.

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.

Queensland Audit Office
Better public services

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 2021:

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.

31 August 2021

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
FTE Full-Time Equivalent
GP General Practitioner
HHS Hospital and Health Service
HHBA *Hospital and Health Boards Act 2011*
HiTH Hospital in the Home
JCU James Cook University
MBH Mackay Base Hospital
MHHB Mackay Hospital and Health Board
NQPHN Northern Queensland Primary Health Network
PREMs Patient Reported Experience Measures
QAO Queensland Audit Office
WAU Weighted Activity Unit

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 68
	Public availability	ARRs – section 9.2	1
	Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 9.3	1
	Copyright notice	*Copyright Act 1968* ARRs – section 9.4	1
	Information Licensing	*QGEA – Information Licensing* ARRs – section 9.5	1
General information	Introductory Information	ARRs – section 10	6-7
Non-financial performance	Government's objectives for the community and whole-of-government plans/specific initiatives	ARRs – section 11.1	5
	Agency objectives and performance indicators	ARRs – section 11.2	8-10, 18-19
	Agency service areas and service standards	ARRs – section 11.3	20-21
Financial performance	Summary of financial performance	ARRs – section 12.1	22
Governance – management and structure	Organisational structure	ARRs – section 13.1	14
	Executive management	ARRs – section 13.2	13
	Government bodies (statutory bodies and other entities)	ARRs – section 13.3	Not applicable
	Public Sector Ethics	*Public Sector Ethics Act 1994* ARRs – section 13.4	17
	Human Rights	*Human Rights Act 2019* ARRs – section 13.5	17
	Queensland public service values	ARRs – section 13.6	17
Governance – risk management and accountability	Risk management	ARRs – section 14.1	16
	Audit committee	ARRs – section 14.2	11
	Internal audit	ARRs – section 14.3	16
	External scrutiny	ARRs – section 14.4	16
	Information systems and recordkeeping	ARRs – section 14.5	16-17
	Information Security attestation	ARRs – section 14.6	Not applicable
Governance – human resources	Strategic workforce planning and performance	ARRs – section 15.1	15
	Early retirement, redundancy and retrenchment	Directive No.04/18 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	15
Open Data	Statement advising publication of information	ARRs – section 16	1
	Consultancies	ARRs – section 33.1	qld.gov.au/data
	Overseas travel	ARRs – section 33.2	Nil
	Queensland Language Services Policy	ARRs – section 33.3	qld.gov.au/data
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	63
	Independent Auditor's Report	FAA – section 62 FPMS – section 46 ARRs – section 17.2	64-67

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

ANNUAL REPORT 2020–2021
Mackay Hospital and Health Service
www.mackay.health.qld.gov.au