North West Hospital and Health Service

2019–2020 ANNUAL REPORT

Queensland Government

Purpose of the report

This annual report details the non-financial and financial performance of the North West Hospital and Health Service during financial year 2019–2020.

It highlights the achievements, performance, outlook and financial position of the North West Hospital and Health Service and satisfies the requirements of the *Financial Accountability Act 2019*, the *Financial and Performance Management Standard 2019* and detailed requirements set out in the Annual Report Requirements for Queensland Government agencies.

Warning: Aboriginal peoples and Torres Strait Islander peoples should be aware that this publication may contain the names of people who have passed away.

Open data

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

Public availability statement

An electronic copy of this report is available at www.health.qld.gov.au/nwhhs
Hard copies of the annual report are available by phoning the Senior Public Relations Officer on (07) 4744 4871. Alternatively, you can request a copy by emailing NWHHS_Communication@health.qld.gov.au.

Interpreter Service Statement

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on telephone (07) 4744 4871 and we will arrange an interpreter to effectively communicate the report to you.

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Acknowledgement of traditional custodians

The North West Hospital and Health Service respectfully acknowledges the Elders past and present and the Traditional Owners of the land, sea and waterways which we service and declare the North West Hospital and Health Service's commitment to reducing inequalities between Indigenous and non-Indigenous health outcomes in line with the National Indigenous Reform Agreement (Closing the Gap).

Recognition of Australian South Sea Islanders

North West Hospital and Health Service formally recognises the Australian South Sea Islanders as a distinct cultural group within our geographical boundaries. The Northwest Hospital and Health Service 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.

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3 September 2020

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

Dear Deputy Premier

I am pleased to deliver for presentation to the Parliament the Annual Report 2019–2020 and financial statements for North West 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 at page 30 of this annual report.

Yours sincerely,

Paul Woodhouse

Chair

North West Hospital and Health Board

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Statement on Queensland Government objectives for the community

The health service's priorities are set in the *North West Hospital and Health Service Strategic Plan 2017–2021*. This plan contributes to the Queensland Government's objectives for the community, through the delivery of quality, person-centred care, reflecting and responding to the needs of the community it serves.

The health service's priorities align with the Queensland Government's objectives for the community, *Our Future State: Advancing Queensland's Priorities* which tackle key health challenges by:

- Keep Queenslanders healthy: by providing quality, evidence-based healthcare for our consumers, focusing on patient-centred care and collaborating with our partners to ensure we provide integrated care to the people of the North West region, while also investing in wellbeing initiatives to improve the health and wellness of our remote communities.
- Give all our children a great start: by providing excellent care in the antenatal period, including specified Aboriginal and Torres Strait Islander antenatal services, and in child health by providing a range of services across our region. North West Hospital and Health Service promotes wellness activities and health literacy by providing healthier food and drinks in healthcare facilities, and a range of dietetic and wellness services.
- Creating jobs in a diverse economy: North West Hospital and Health Service continues to be one of the largest employers in the region, employing 803 full-time equivalent positions.

From the Chair and the Executive

As one of Queensland's remote regions, distance and geography continue to remain two of our more unique challenges. We are focused on bringing better care to our consumers, their families and their carers, by consulting with them in the communities in which they live, and where possible, delivering services closer to home. We continue to address these challenges, working in partnership with our staff, stakeholders, patients and the community.

Over the last 12 months, strategic partnerships have continued to play a dominant role in our health service. Our experienced Consumer Advisory Group, and all our consumer representatives provide a valued voice and perspective, which has positively shaped how we plan, deliver and review our services.

As in previous years, we have maintained a high standard of service delivery – a result of managing waitlists, responsible financial management, and the quality of the care we provide. North West Hospital and Health Service (North West HHS) puts our communities front and centre of our activities, and it is this collaborative approach that enables us to deliver outstanding results.

Earlier this year, North West HHS successfully underwent assessment against the requirements of the National Safety and Quality Health Service (NSQHS) standards. The standards provide a nationally consistent benchmark for the level of care consumers should expect from health service organisations. Accreditation is an essential independent evaluation of the quality of care provided to the community and part of our long-term commitment to quality and patient safety.

During 2019–2020, North West HHS has continued to focus efforts on improving Indigenous health outcomes and lessen the burden of disease in the North West.

One of our biggest priorities continues to be our commitment to Closing the Gap in health outcomes for Aboriginal people and Torres Strait Islander people and increasing our workforce diversity with a commitment to greater representation of our First Nations people within our workforce as part of our pathways to inclusion *North West HHS Aboriginal and Torres Strait Islander Workforce Strategy 2019–2026*.

We also highlight the continued success of the tri-partite Lower Gulf Strategy, a collaborative program between North West HHS, Gidgee Healing and the Western Queensland Primary Health Network, to integrate culturally safe community-controlled health care across our indigenous communities.

We also welcomed the introduction of the new Cardiac Outreach Service, a collaboration between North West HHS and Townsville HHS, which aims to improve the coordination of care of heart patients and provide more care in communities, creating a reduction in patient travel requirements.

Our community can be very proud of the significant investment in their local health infrastructure. In 2019–2020, the Julia Creek Multipurpose Health Service was officially opened, providing significant benefits for all patients in the McKinlay Shire who will experience better facilities and improved services.

We were also delighted to open the Mount Isa Hospital's newly refurbished Intensive Care Unit. The Intensive Care Unit (ICU) is a crucial part of any hospital, and this renovation reflects our commitment to providing patients and their visitors with the infrastructure required to ensure a comfortable hospital experience.

This annual reporting period, we faced the impact of the COVID-19 pandemic. Our pandemic response saw a significant refocus of our services and priorities in the second half of the 2019–2020 year. During this time, our staff and the executive leadership team have undertaken extensive preparation on COVID-19 response and recovery to ensure the continuation of healthcare for our community.

Our strategy focused on:

- Increasing use of communication technologies, such as Telehealth, Teledental, Telepharmacy and TeleCare as well as, where possible, providing more acute care closer to home.
- Increasing travel and accommodation arrangements for those required to travel for treatment.
- Working closely with health partners to ensure our people can access the health services they need.
- Boosting our remote sites medical workforce and capability.

Looking forward, we expect the impact of the COVID-19 pandemic, and the overall economic consequences to shape our short- and long-term health care operations. In 2020–2021, we remain focused on achieving our strategic objectives while continuing the COVID-19 response and recovery.

I want to acknowledge and thank our staff for their continued hard work, dedication and commitment to protecting our community while maintaining the highest quality service standards.

This year saw the appointment of Mr Terry Mehan to the North West HHS Board. We welcome Terry and his extensive experience and health sector knowledge as an essential addition to the board. Dr Katie Panaretto, whose experience in public health and general practice is invaluable to our overall strategy was reappointed to the board.

In closing, we thank each of our board members for their commitment, support and guidance over the past year. Finally, I acknowledge the keen interest and support of the Honourable Steven Miles MP, Deputy Premier, Minister for Health and Minister for Ambulance Services and the Director-General, Dr John Wakefield, and their respective staff.

Paul Woodhouse
Chair

Dr Karen Murphy
Acting Chief Executive

About us

The North West Hospital and Health Service was established on 1 July 2012 under the *Hospital and Health Boards Act 2011*.

The North West HHS aspires to be Queensland's leading Hospital and Health service delivering excellence in rural and remote health. For a rural and remote health service provider, this means providing access to clinical and clinical support services in specific locations throughout the region to deliver the right response on time by our skilled staff.

Mount Isa also has a Royal Flying Doctor Service base providing rural retrievals, transfers and numerous primary health care activities including clinics at the health centres in the North West.

We operate according to the service agreement with the Department of Health, which identifies the services to be provided, funding arrangements, performance indicators and targets to ensure the expected health outcomes for our communities are achieved. This service agreement is negotiated annually and is available publicly via the Queensland Health website at www.health.qld.gov.au.

We are also dedicated to fulfilling our role as a significant contributor to the Queensland health service landscape through continuing with integrated models of care with other hospital and health services, and clinical networks.

Partners:

Fundamental to the early intervention and prevention models of care, improved health equity and access to healthcare for the communities we serve are the partnership models we have developed, which include:

- Gidgee Healing, the regional Aboriginal Community Controlled Health Service for North West Queensland
- Western Queensland Primary Health Network
- The Ramsay Street General Practice, Cloncurry Shire Council and the Rural Health Management Services
- Other outreach allied health and medical service commissioners and providers, including CheckUp, the Deadly Ears and Indigenous Respiratory Outreach Care (IROC) programs
- The Royal Flying Doctor Service, which provides emergency evacuations and other primary health care services
- Queensland Ambulance Service and the Queensland Police Service
- Centacare, Headspace and other charitable or not for profit enterprises
- Shire Councils
- Universities and other education providers, including Centre for Rural and Remote Health, hosted by James Cook University.

Strategic Direction

North West Hospital and Health Service Strategic Plan 2017–2021 was reviewed and updated in June 2020 to ensure a continuation of our objectives for the period up until 30 June 2021. Our five key strategic objectives contribute to achieving our vision of healthier communities as well as guide our annual priorities. Each of the strategic objectives is further defined through several key strategies for actioning through operational plans and health service planning with the engagement of the community and our healthcare partners.

Vision, Purpose, Values

Our Vision

To be Queensland's leading Hospital and Health Service delivering excellence in remote healthcare to our patients.

Our Purpose

To embrace change, to forge close partnerships, and to work closely with our communities to improve the health of people across North West Queensland.

Our Values

To adhere to the five Queensland Public Service Values of putting customers first, being courageous, putting ideas into action, unleashing potential and empowering people.

Priorities

During 2019–2020, North West HHS has continued to focus efforts on improving Indigenous health outcomes and lessen the burden of disease in the North West, including:

- Continued success of tri-partite Lower Gulf Strategy, a collaborative program between North West Hospital and Health Service, Gidgee Healing and the Western Queensland Primary Health Network, to integrate culturally safe community-controlled health care across Doomadgee, Normanton and Mornington Island – all of which face significant co-morbidities.
- Supporting the Mornington Island Health Action Plan and Strategy 2019–2024 driven by the community-controlled Mornington Island Health Council comprising seven key action areas for family-driven health.
- A range of strategic partnerships have been developed with North West HHS leading the Mental Health, Alcohol, Tobacco and Other Drugs Services, Sexual Health and Oral Health workstreams.
- Productive working relations with Mornington Island Health Council, and the range of key partners across the region, to deliver the Council's vision for a safe, thriving and healthy community.

2020 saw the introduction of the new Cardiac Outreach Service, a collaboration between North West HHS and Townsville Hospital and Health Service which aims to improve the coordination of care of heart patients and provide more care in communities, creating a reduction in patient travel requirements.

Julia Creek Multipurpose Health Service was officially opened in August 2019, providing significant benefits for all patients in the McKinlay Shire who will experience better facilities and improved services that have been co-designed to meet the unique needs of the community.

During 2020–2021, we will focus further efforts on improving Indigenous health outcomes and lessen the burden of disease in the North West.

Aboriginal and Torres Strait Islander Health

North West HHS is committed to working closely with our communities, Aboriginal Community Controlled Health Service, Western Queensland Primary Health Network and other key stakeholders to improve the health status of our local Aboriginal communities. We continued to mark culturally significant weeks with events and as part of our commitment to improving health outcomes for Aboriginal and Torres Strait Islander peoples. During 2019–2020 North West HHS enrolled four existing staff into diploma level studies to assist with vertical career succession opportunities and launched our Aboriginal and Torres Strait Islander Workforce Strategy.

Key achievements for 2019–2020 include:

Executive Director Aboriginal and Torres Strait Islander Health

Following a national recruitment process and in line with North West HHS commitment to maximising employment opportunities across all streams, including senior executive-level positions, Christine Mann, commenced as Executive Director Aboriginal and Torres Strait Islander Health in July 2019. Christine is a Woppaburra woman, raised and schooled mainly in Mount Isa. The Executive Director Aboriginal and Torres Strait Islander Health will help transform North West HHS's services to improve the health outcomes of Aboriginal and Torres Strait Islander people through building strong partnerships and contributing to the design and delivery of the broader organisation's strategic plan. The role also maintains a strong focus on Closing the Gap.

Cultural Practice Program

The Cultural Practice Program is delivered monthly for employees by Mr Shaun Solomon, Head of Indigenous Health at the Centre for Rural and Remote Health. The program embeds the four guiding principles of the *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033*. These principles are respect and recognition, communication, relationships and partnerships and capacity building. Compliance in this program for the reporting period was 86 per cent with a peak during the year at 90 per cent. Ongoing high importance is placed on attendance at this program within the North West HHS to continue to develop the knowledge and skills that will enable every person to best contribute through their role to improving health outcomes for Aboriginal people and Torres Strait Islander peoples.

Aboriginal and Torres Strait Islander Workforce Strategy 2019–2026

Improving the health of the North West's Aboriginal and Torres Strait Islander community is a key priority for the North West HHS. We operate to be more responsive to the needs of Aboriginal and Torres Strait Islander people. A key factor is a concerted effort to employ Aboriginal and Torres Strait Islander people at all levels of our organisation and to embed ways of knowing and doing in practice. In December 2019, North West HHS launched the *North West HHS Aboriginal and Torres Strait Islander Workforce Strategy 2019–2026* with the aim of increasing the Aboriginal and Torres Strait Islander workforce to 26 per cent.

The six key focus areas of the strategy are: recruitment; retention; workforce profile; leadership and governance; inclusive workplaces; and community engagement.

Closing the Gap

North West HHS has several programs targeted towards closing the gap for Aboriginal and Torres Strait Islander residents. These are funded under the *Making Tracks Investment Strategy 2019–2021* and is administered by the Aboriginal and Torres Strait Islander Health Branch. These programs are listed below:

Table 1: Closing the Gap programs

Project name	Funding ($)
Discharge Against Medical Advice (DAMA) Initiative	243, 788
Indigenous Health led Chronic Disease Management and Prevention for Aboriginal and Torres Strait Islander people within North West HHS	1,568,483
Sexual Health Outreach and Screening (Mornington Island, Mount Isa and Doomadgee)	742,998
Indigenous Alcohol, Tobacco and Other Drugs (ATODs) Youth Program	143,727
Supported Dialysis Services to Remote Communities	414,350
Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033	110,000
Mornington Island Community Care Initiative	275,286
Healthy Skin Indigenous Infection, Prevention and Control Program	197,500
Healthy Piccaninnies	455,771
Cultural Executive Adviser	231,135
North QLD STI Action Plan – Director Program Management	87,670
Total (excluding GST)	**4,470,708**

The health service continues to experience challenges associated with the following:

- Reduce Discharge Against Medical Advice (DAMA) to less than three per cent of patients seen. Discharge against medical advice, where patients elect to leave facilities without prior completion of treatment. This is a particular issue within emergency departments but is reducing following the introduction of Indigenous Patient Liaison Officers to support patients receiving care. The 2018–2019, DAMA rate for Aboriginal and Torres Strait Islander patients was 5.5 per cent. In this reporting period, the DAMA rate was 6.4 per cent which is a 0.9 per cent increase from 2018–2019.
- Reduce Potential Preventable Hospitalisations (PPH) by 15 per cent. In the 2019–2020 reporting period, the PPH rate was 19.6 per cent. In this reporting period, the PPH rate was 20.2 per cent, which is a 0.6 per cent increase. The North West HHS aims to reduce potentially preventable hospitalisations, by the earlier intervention of patients, and further engagement with GP providers.

Our community and hospital-based services

The North West HHS has an estimated resident population of 27,345.

The Australian Bureau of Statistics estimates the average age for all residents is 31.4 years, which is lower than the Queensland median age of 37.3 years.

The percentage of Indigenous persons living in the North West is 30.6 per cent, compared to four per cent within all of Queensland. In particular, the two Local Government Areas of Doomadgee and Mornington Island have populations in which 86 per cent or more of the population identify as Indigenous.

In addition to our rich Aboriginal culture, the Australian Bureau of Statistics census population data for 2016 also indicates that 11.8 per cent of the local community – or 3,845 people – were born overseas.

The most common countries included New Zealand, the Philippines, United Kingdom, India, South Africa, Papua New Guinea, Fiji and Germany. Consequently, around 6.6 per cent of the population – or around 2,136 people – stated that they commonly speak a language other than English at home.

Our community's health

The North West HHS region is unique in several ways, as we continue to have:

- a higher proportion of children
- a higher proportion of males
- a higher proportion of Aboriginal peoples and Torres Strait Islander peoples
- challenges associated with providing health care services to dispersed populations in remote locations.
- an aging population
- a high proportion of fly-in, fly-out workers requiring access to health services.

Although considerable steps have been – and continue to be – taken to ensure innovative, efficient, effective and culturally appropriate health care, issues of significant impact for people living in the region remain:

- smoking
- poor nutrition
- harmful consumption of alcohol and other drugs
- obesity and weight problems
- physical inactivity
- early discharge against medical advice
- emotional and psychological and social well-being factors associated with mental health.

Caring for our communities

We have continued to enhance and strengthen the governance of quality and safety across our organisation over the past year. We have also provided greater support to our consumers and carers to actively participate in the improvement of the patient experience, and patient health outcomes.

During 2019–2020 the North West HHS achieved accreditation, ensuring we meet or exceed the National Safety and Quality Health Service Standards (NSQHS) set by the Australian Commission on Safety and Quality in Health Care.

Engaging with our communities

North West HHS prides itself on its wide-reaching community engagement practices. We actively listen to, involve and empower our consumers, carers and their families in everything we do.

Supported by North West HHS Partnering with Consumers committee, the community advisory groups and networks throughout the North West continue to engage with local health providers, including the North West Hospital and Health Service. Our executives regularly attend the meetings in Julia Creek, Cloncurry, Burketown, Karumba and Normanton. The Health Council on Mornington Island has been running for 13 years and continues to provide valuable local advice to the Hospital and Health Service. Doomadgee Health Council, Yellagungimara, meets regularly with the Hospital and Health Service, and these meetings are aligned with visits from the Chief Executive and the Board whenever possible. We also continue to work with Close the Gap Advisory Groups in our discrete Aboriginal communities to help advise us on specific cultural ways and protocols.

The 2019–2020 Consumer Advisory Group survey reports 88 per cent of respondents view North West HHS as a trusted and respected organisation, and 76 per cent of surveyed consumers are satisfied or very satisfied with the North West HHS's level of engagement with consumers.

We aim to work more closely with these groups, and with staff, to develop and co-design services, programs and activities for the wider health benefit of our North West communities.

Patient satisfaction is continually measured and subsequently addressed, by ongoing feedback collection though patient liaison officer, survey opportunities, social media monitoring, and anecdotal evidence.

The 2019 Community and Primary Health Care Patient Satisfaction Survey reported 94 per cent of patients were happy or very happy with the service received. More than 95 per cent rated the quality of service received as either high or very high quality.

Mount Isa City

Mount Isa Hospital

Mount Isa Hospital is the primary referral centre within the North West HHS.

Patients from other facilities across the North West region who require specialist treatment and care are referred to either the Mount Isa Hospital or to other major hospitals within Queensland, including Townsville, Cairns and Brisbane. North West HHS also utilises Telehealth to enable patients and facilities to access specialist appointments and reviews.

Specialist outreach patient services are managed from the hospital, which is the major hub for Telehealth services across the entire North West service area, with five primary health care clinics and six hospital sites having access to 24/7 medical and nursing and midwifery support for the advice and management of lower risk emergency department presentations and other outpatient care.

Mount Isa Hospital Auxiliary

Donations during 2019-2020 include:

Auxiliary - $1000; Glencore and Cloncurry community and organisations – $45,000 for scalp cooling machine, Cancer Care Unit; Glencore - $45,000 GeneXpert IV-4 instrument, cartridge and nasal swab collection kit; Mount Isa Rodeo Queen Quest Entrant, Bron Myers - $35,716; Mount Isa City Council and the Showman's Guild of Australasia - $3400 for Children's Ward Hospitality Cart; Rotary Club of Mount Isa – furniture for Special Care Nursery.

Mornington Shire

Mornington Island Hospital and Aboriginal Community Health Centre

Mornington Island Hospital provides 24-hour acute inpatient and accident and emergency care, Maternal Health; Mental Health; Dental; Diabetes Education and Renal Services.

Following the transition to community control, Gidgee Healing Aboriginal Medical Service provides primary and community health care from the community health building. Plans to expand the primary care facility are underway.

The model of care includes clinical review, health education and promotion programs. Examples of programs are Deadly Ears; Child and adult respiratory (lung health) care - provided by the Indigenous Respiratory Outreach Care Program; Women's health and child Health; Allied health services; Cardiac and respiratory services; Sexual health; Alcohol and Other Drugs counselling.

Doomadgee Shire

Doomadgee Hospital and Community Health Centre

Doomadgee Hospital provides 24-hour acute inpatient and accident and emergency care. The Doomadgee Hospital strives to provide culturally appropriate care by employing a number of Aboriginal and Torres Strait Islander health workers, nursing, medical, administration and operational staff.

Carpentaria Shire

Normanton Hospital

Normanton Hospital can provide respite/palliative care services and private admissions. The facility offers 24-hour acute inpatient and accident and emergency care. Outpatient services include general outpatients, dressings, pathology, immunisations, staff vaccination clinic, rheumatic heart program and medical clinic.

Normanton's community health services include Aboriginal health workers, clinical nurse consultant and administration services offering a range of services including discharge planning, home visits, health screening, patient liaison and advocacy, education and support, visiting clinics including Australian Hearing Services, delivery of medication and patient recall for various other clinics including hospital-based clinics.

Carpentaria Shire

Karumba Primary Health Clinic

Karumba Primary Health Clinic provides a low-risk ambulatory care service provided by nursing, administration and operational staff.

The facility provides a nurse-led 24-hour acute and emergency on-call service; patients requiring higher levels of care are transferred for management to a higher-level facility by Queensland Ambulance Service or the Royal Flying Doctors Service.

In addition to services offered by the nurse practitioner, CheckUp provides doctors for skin check clinics, Women's Health GP, general practitioner including Telehealth services for complex patient care and psychology services (both face-to-face and via telephone are available). This unique and innovative model of care is the first of its kind in Queensland.

Cloncurry Shire

Cloncurry Multipurpose Health Service

Cloncurry Multipurpose Health Service provides rural and remote hospital services including an inpatient facility, a residential aged care facility, an emergency department and an outpatient department.

Community health services provide an aged care assessment team, sexual health, chronic disease management, diabetes education, mental health, alcohol and drug service, school health, child and youth health, women's health, palliative care, physiotherapy, dietician, and optometry services. North and West Remote Health provides allied health services and diabetes education.

Cloncurry Shire

Dajarra Primary Health Clinic

Dajarra functions as a nurse practitioner-led primary health care model providing emergency, outpatient, visiting specialist and chronic disease health to the community through a variety of options including traditional appointments, walk-in service, hospital-based ambulance and visiting specialist services.

Visiting services include the Royal Flying Doctor Service, endocrinology, cardiology, child health nurse, women's health nurse, dentistry, diabetes nurse practitioner and the North and West Remote Health team which consists of diabetes nurse educator, podiatry, occupational therapy and exercise physiologist.

McKinlay Shire

Julia Creek Multipurpose Health Service

A general hospital was established in 1972 and was transformed into the McKinlay Shire Multipurpose Health Service, also known as Julia Creek Hospital. The new hospital was completed 30 June 2019.

The health service provides rural and remote hospital services, including an emergency department, general ward and a general practice clinic.

The facility coordinates visiting specialist services including dental, mental health, optometry, allied health, women's health, child health and diabetes education.

McKinlay Shire

McKinlay Primary Health Clinic

McKinlay Primary Health Clinic provides low-risk ambulatory, acute and preventative care provided by nursing and operational staff.

The McKinlay Primary Health Clinic provides a nurse-led 24-hour acute and emergency on-call service. The clinic focuses on chronic disease management, preventative health, health promotion and health education.

Burke Shire

Burketown Primary Health Clinic

Burketown Primary Health Clinic provides low-risk ambulatory care provided by nursing, administration and operational staff. The Burketown Primary Health Clinic encompasses a nurse-led and visiting Medical Officer model of care.

Visiting services include allied health services, Mobile Women's Health, Indigenous Cardiac Outreach Program, endocrinology, diabetes nurse practitioner, ophthalmology and breast screening.

Mount Isa City

Camooweal Primary Health Clinic

Camooweal Primary Health Clinic provides emergency treatment as well as low-risk ambulatory, acute and preventative care nursing, administration and operational staff.

The Camooweal Primary Health Clinic is a nurse-led facility, providing 24-hour acute and emergency on-call service with a hospital-based ambulance. The clinic incorporates the advanced nurse model and nurse practitioner model of care and focuses on chronic disease management, preventative health, health promotion and health education. The clinic offers pharmacy services, child health, immunisation, school-based wellness health checks and community home visits.

Boulia Shire

Urandangi Health Clinic

Home to around 20 people, Urandanji is serviced by the North West Remote Health and Royal Flying Doctors Service, who provide regular clinics in Urandangi including Maternal, Child and Youth and Women's Health.

Targets and challenges

North West HHS continues to provide health services to our remote communities throughout the North West, presenting challenges with both transport and logistics, while still supporting the health service to innovate and better meet the diverse health needs of our communities. The health service understands it must become sustainable and deliver services that align with best practice patient care. The successful transformation of the health service toward a sustainable future is a priority.

Targets

Collaboration and partnerships: we are committed to developing and supporting partnerships with community advisory groups, primary health, and other care providers, to ensure we continue to work collaboratively with individuals, families and communities to optimise their experience within our health service.

The completion of discharge summaries assists with ensuring continuity of care from North West HHS to General Practitioners. North West HHS aims to have discharge summaries provided within 48 hours. Due to challenges including single-post change-overs, the percentage of patients receiving discharge summaries within 48 hours varies from 24 per cent to 100 per cent between North West HHS's 12 facilities. Processes are being reviewed to improve targets in this area across North West HHS.

Leading innovative practices: through the use of information and communication technologies infrastructure – through Telehealth, Teledental, Telepharmacy, and TeleCare (palliative care).

Innovative practices and programs, that are backed by evidence-based research, continue to be implemented and recorded, with 2019–2020 seeing the introduction of:

- Smart referrals and clinical prioritisation criteria for referral to services provided throughout Mount Isa Hospital
- ShiftMatch to manage staffing and improve patient flow
- The continuation of the Frail and Older persons initiative
- The introduction of the Nurse Practitioner Model of Care across a number of North West HHS remote sites.

Recruitment and retention strategy: building capacity by attracting skilled and culturally capable staff who enjoy the challenges of rural and remote health provision will strengthen our relationship between North West HHS and our North West communities and enhance our ability to provide continuity of care.

Challenges

With these opportunities, our strategic plan also acknowledges that the ongoing effective management of the following core risk areas are central to ensuring that high-quality health services continue to be delivered to the people we serve across North West Queensland:

- We will establish and monitor formal partnerships and agreements such as Lower Gulf Strategy, to overcome fragmented funding agreements and expand organisational capacity.
- Risk of patient harm due to failure of clinical governance systems or human error – clinical governance framework in place with regular review of risk management system
- Inability to provide services due to severe weather events – disaster management plan in place
- Failure of Information and Communications Technology (ICT) infrastructure – regular review of maintenance schedule and formalisation of agreement with eHealth Queensland for monitoring and management of non-enterprise ICT
- Inability to sustain service delivery due to failure to recruit and retain staff – recruitment and retention strategy in place and tracking of vacancies and recruitment processes.

Governance

Our people

Board membership

Under the *Hospital and Health Boards Act 2011*, the Hospital and Health Board must consist of five or more members appointed by the Governor in Council for terms of up to four years.

Collectively, the Board serves to strengthen local decision-making and accountability by promoting local consumer, community and clinician engagement and setting the local health system planning and coordination agenda, including financial management and oversight.

The North West HHS Board met on 14 occasions during the reporting period.

As at 30 June 2020, membership comprised:

Paul Woodhouse	**Board Chair** **Chair, Engagement Committee** **Chair, Executive Committee**
	Appointed initially as inaugural Chair of the North West HHS Board on 18 May 2012, Paul was reappointed on 18 May 2019, until 17 May 2021. Paul is a primary producer and currently serves as a member of the North West Minerals Province Stakeholder Advisory Committee. Former roles include Chair of the Queensland Hospital and Health Board Chairs, Mayor of McKinlay Shire, Health Minister's Infrastructure Advisory Panel and the Northern Australia Health Roundtable.
Dr Don Bowley	**Deputy Board Chair** **Member, Executive Committee** **Member, Finance Audit and Risk Management Committee** **Member, Quality Safety and Risk Committee** **Member Engagement Committee**
	Don was initially appointed on 29 June 2012, and reappointed on 18 May 2019, until 17 May 2021. Don is the Senior Medical Officer at the Mount Isa Base of the Royal Flying Doctor Service (Queensland Section) and has 26 years of experience with the service. Don is an Adjunct Associate Professor with the Centre for Rural and Remote Health, James Cook University. He is the Chair of the Western Queensland Primary Health Network's Northern Clinical Chapter and a member of the Clinical Council.
Dr Christopher Appleby	**Chair, Finance Audit and Risk Management Committee** **Member, Executive Committee** **Member, Quality Safety and Risk Committee**
	Chris was appointed to the board 9 November 2012, and reappointed on 18 May 2019, until 17 May 2021, and has a 20-year career in the design of innovative models of rural primary health care. He has co-owned and operated general practice medical centres in rural communities through North West Queensland and the Sunshine Coast. Chris has a Bachelor of Science (Honours), a Master of Business Administration and a Doctorate of Philosophy in Pharmacology, a Certificate in Governance Practice and is a Graduate of the Australian Institute of Company Directors.

Karen (Kari) Arbouin	**Chair, Quality Safety and Risk Committee** **Member, Finance Audit and Risk Management Committee** **Member, Executive Committee**
	Kari was appointed on 18 May 2013 and reappointed on 18 May 2019, until 17 May 2021. With 20 years' experience in the tertiary education sector, Kari is an Associate Vice Chancellor for Central Queensland University, a registered nurse and a practising midwife. She currently holds a Board position on the inaugural North Queensland Defence Advisory Board and Townsville City Council's Smart Precinct Pty Ltd. and holds academic qualifications in health, business, law and public health.
Dr Kathryn Panaretto	**Member, Finance Audit and Risk Management Committee** **Member, Quality Safety and Risk Management Committee** **Member, Engagement Committee**
	Appointed initially on 18 May 2016, Kathryn was reappointed on 18 May 2020 for a term which expires on 31 March 2024. Kathryn is a GP and Public Health Physician with a background in primary health care, having worked as a general practitioner at Mount Isa's Gidgee Healing and with the Remote Women's Health clinics at Julia Creek and Cloncurry. She has spent 20 years working in Aboriginal Health in Queensland. She is an Adjunct Professor at James Cook University and the University of Queensland, and committee member of the General Practice and Primary Care Clinical Committee of the Medicare Benefits Schedule Review Taskforce (2017–2020).
Susan Sewter	**Member, Quality Safety and Risk Management Committee**
	Susan was appointed to the North West HHS Board on 18 May 2019. Her current term expires on 31 March 2022. Born in Cloncurry, Susan has lived-in North-West Queensland for more than 40 years. Her father is Gangalidda, and her mother is Lardil with connections to Waanyi. She has more than ten years' experience as Chairperson for the Mornington Island Health Council, is a qualified teacher and was elected as Mayor of Mornington Shire Council from 2004-2008.
Catrina Felton-Busch	**Member, Finance Audit and Risk Management Committee**
	Catrina was appointed to the North West HHS Board on 18 May 2019. Her current term expires on 31 March 2022. She is a Yangkaal and Gangalidda woman from Mornington Island who currently lives and works on Kalkadoon country in Mount Isa for James Cook University. As the Associate Professor, Remote Indigenous Health and Workforce at James Cook University, Catrina holds a Bachelor of Arts (Monash University) and a Master of Public Health (James Cook University) and is currently undertaking doctoral studies with James Cook University. Catrina is also a fellow of the Australian Rural Leadership Foundation.

Karen Read	**Member, Finance Audit and Risk Management Committee**
	Karen was appointed to the North West HHS Board on 18 May 2019. Her current term expires on 31 March 2022. She has an Associate Diploma and Bachelor of Business. She is a Fellow of the Australian Society of CPAs, a graduate of the Australian Institute of Company Directors and a Member of the Australasian Mutual Institute. She chairs the North Queensland Branch of CPA Australia and is a member of the Regional Committee for the Australian Institute of Company Directors and has a 29-year career in mining. Karen was awarded a High Achievement Award for Women in Mining by Queensland Resources Council in 2008 and was 2009 state winner and a national finalist in Telstra Businesswoman's Awards in the private and corporate sector.
Terry Mehan	**Member, Finance Audit and Risk Management Committee** **Member, Quality Safety and Risk Management Committee**
	Terry was appointed to the North West HHS Board on 18 May 2020. His current term expires on 31 March 2024. Terry is a graduate of the Australian Institute of Company Directors and holds a Certificate in Governance Practice, and has more than 30 years' experience as a senior manager, executive and strategic leader in healthcare in New South Wales and Queensland. Terry has worked with PricewaterhouseCoopers as an advisor and acted as interim Chief Executive at North West, Torres and Cape and Metro North Hospital and Health Services as well being appointed Administrator of Cairns and Hinterland Hospital Health Service. Terry has also completed several AusAID assignments in Papua New Guinea and Tonga.

Table 2: Board & Committee Meeting Attendance

Member	Position	Board	Finance, Audit and Risk Management Committee	Quality, Safexty and Risk Committee	Engagement Committee	Executive Committee	Elders Advisory Forum
Paul Woodhouse	Board Chair and Committee Chair	14/14	4/11	2/8	2/2	1/1	2/2
Dr Don Bowley OAM	Deputy Board Chair and Member	9/14	9/11	6/8	1/2	1/1	
Karen (Kari) Arbouin	Member and Committee Chair	11/14	9/11	7/8	1/2	1/1	
Dr Christopher Appleby	Member and Committee Chair	14/14	11/11	8/8	2/2	1/1	
Dr Kathryn Panaretto	Member	12/14	10/11	8/8			
Karen Read	Member	14/14	11/11	2/8	1/2		
Catrina Fulton-Busch	Member	12/14	9/11	2/8	1/2		
Susan Sewter	Member	8/14	1/11	1/8	2/2		
Terry Mehan	Member (from 18 May 2020)	2/14	2/11	1/8			

Out of pocket expenses for the Board members for the reporting period totalled $916.62.

Our committees

The *Hospital and Health Boards Act 2011*, and supporting *Hospital and Health Regulation 2012*, require Hospital and Health Boards to establish a range of prescribed committees relating to audit, safety and quality, finance and the executive management of the service.

The North West Hospital and Health Board has also established a number of non-prescribed committees, namely an Engagement Committee and an Elders Advisory Forum.

These committees do not replace or replicate executive management responsibilities and delegations, or the reporting lines and responsibilities of either internal audit or external audit functions.

Executive Committee

Clear lines of accountability and strong lines of communication between the Board and the North West HHS Chief Executive are essential.

Membership, at minimum, must comprise either the Board Chair or Deputy Chair (who will then Chair the committee) and at least two other Board members, of whom one must be a clinician. The North West HHS Chief Executive is also required to attend each meeting.

Under section 32B of the Act, its function is to support the Board in its role of Hospital and Health Service oversight, by working with the North West HHS Chief Executive to progress strategic issues.

The Executive Committee met once during the reporting period.

Finance, Audit and Risk Management Committee

The Finance, Audit and Risk Management Committee comprises the two prescribed committees relating to finance and audit. The role of this committee is to provide independent assurance and assistance to the North West HHS Board on a range of matters.

Key activities and achievements for 2019–2020 included:

- monitoring the work program and monitoring and closing off the recommendations made by Internal Auditors, O'Connor Marsden & Associates, including the development of the 2020–2021 audit schedule
- receiving regular updates from the new external auditors appointed by the Queensland Audit Office for a five-year term with regards to financial audit processes and asset valuation process and received regular updates from the Queensland Audit Office
- ongoing executive participation at Finance Audit and Risk Management meetings by the Executive Management Team
- monitoring the ongoing implementation and revision of the *North West HHS Risk Management Framework*.

Looking ahead for 2020–2021, the committee will:

- continue monitoring expenditure against service agreement components, ensuring the financial sustainability of the North West HHS
- provide ongoing review of supporting information, communication and technology systems to ensure efficiency and effectiveness of financial and other reporting and decision making.

Quality, Safety and Risk Committee

The Quality, Safety and Risk (QSR) Committee ensures the provision of effective governance frameworks across the North West HHS and promotes the delivery of safe and quality clinical patient services.

Key activities and achievements for 2019–2020 included:

- continuing oversight and monitoring of quality, safety and risk across the North West HHS, informed by a Clinical Governance Scorecard and Riskman incident reporting system, both of which were initially introduced during the previous financial year
- continued review of patient waitlists, with all Category 1 elective surgical patients receiving their care within clinically recommended times, zero long waits for first specialist outpatient appointments and not ready for care patients waiting longer than clinically recommended for a gastrointestinal endoscopy as at 30 June 2020
- monitoring hand hygiene compliance and other mandatory reporting, including occupational violence
- monitoring the reporting and investigation of three Severity Assessment Code incidents, with significantly improved review and response rate timelines.

Looking ahead for 2020–2021, the committee will:

- continue to monitor quality, safety and risk performance of the North West HHS and making recommendations to the Board as required
- further develop governance processes for local research-related activities and clinical and health education initiatives in relation to strategic direction and priorities, including Indigenous participation in the workforce and the services provided by the North West HHS.

Engagement Committee

The Engagement Committee promotes effective relationships and communication between consumers, communities and workforce across the North West region.

Elders Advisory Forum

The Forum membership is comprised of the former members of the North West HHS Elder's Advisory Committee which is further strengthened by inviting wider representation from each community served by North West HHS facilities.

Executive management

As at 30 June 2020, the North West HHS Executive Management Team comprised:

Dr Karen Murphy	**Acting Chief Executive**
	Karen has been a medical leader for several years in a variety of healthcare settings. She has worked in clinical and non-clinical leadership roles, with her clinical experience going back to the early 1980s. She commenced in the position of Acting Chief Executive in January 2020, after 12 months as Executive Director of Medical and Clinical Services. Before working at North West HHS, Karen spent nine years as an Executive Director of Medical Services in Western Australia. Karen has been at the forefront of some significant change management and clinical service redesign work, especially within the Australian healthcare sector. She understands well the challenges of maintaining engagement through change. She is looking forward to continuing to help develop services to focus on providing care closer to home for all patients and their families and continuing to improve health outcomes for Queenslanders.
Michelle Garner	**Executive Director Nursing, Midwifery and Clinical Governance**
	Michelle has held the position of Executive Director of Nursing and Midwifery since 2008, and with the 2017 executive tier restructure, her title was changed to Executive Director Nursing, Midwifery and Clinical Governance. The Executive Director Nursing, Midwifery and Clinical Governance is the professional lead for nursing and midwifery services and is accountable for the nursing and midwifery workforce and governance and education within the North West HHS. Michelle holds a Bachelor of Nursing, Graduate Diploma in Advanced Critical Care Nursing, and a Masters of Nurse Practitioner. Michelle is an Adjunct Associate Professor with James Cook University and the Mount Isa Centre for Rural and Remote Health. She is a member of the Queensland Executive Directors of Nursing and Midwifery Forum, Queensland Nursing and Midwifery Executive Council, Nursing and Midwifery Implementation Group and the Queensland Clinical Senate. Michelle is also the state lead for current Queensland Government Election Commitment for 3,000 Nurses.
Dr Simi Sachdev	**Acting Executive Director of Medical and Clinical Services**
	Simi was appointed to the Acting Executive Director of Medical and Clinical Services role in March 2020. Simi has been travelling and working in locum Executive Medical Director positions in Australian hospitals for over 25 years. Over her career, Simi has gained extensive experience in various rural and metropolitan hospitals ranging in size from 150 to 600-bed capacity. Simi is a leader in her field with a reputation as an innovative and analytical problem solver, with a particular interest in streamlining outdated processes to improve operational efficiency. Simi holds a Bachelor of Medicine and a master's in health planning. She is also a Fellow of the College of Medical Administrators, and the Australian College of Health Service Executives, and holds registration with the Australian Health Practitioner Regulation Agency.
Rod Margetts	**Interim Chief Financial Officer**
	Rod Margetts was appointed Interim Chief Finance Officer in August 2019. Rod brings a wealth of experience and success in strategic financial management to the North West HHS, having been Chief Finance Officer (CFO) for the Sunshine Coast HHS for six years before forming his business consultancy practice in January 2015. Since that date, Rod has successfully completed over 35 assignments across twelve HHS's, eHealth Queensland and the Department of Health. These assignments have included complex five-year financial forecasting, commercial advisory work, workforce and business analytics, interspersed with Interim CFO roles with the South West, Cairns and Hinterland and Townsville HHS's. A Chartered Accountant by profession (CAANZ), Rod brings a balance of strategic leadership and executive management experience together with high-level skills in operational finance, health funding and business analysis to the role of Interim CFO.

Peter Patmore	**Acting Executive Director of People Planning and Culture**
	Peter is a highly experienced senior human resource and organisational change manager, with a broad range of skills and experiences within both the Tasmanian and Queensland Health systems. During his 23 years in Queensland Health, Peter has worked at both the Senior Director and Executive Officer levels within both the Department of Health and various Hospital and Health Services. His roles have been diverse and include leadership of significant organisational change agendas ranging from system-wide services; machinery of government changes; industrial relations reform; enterprise agreement negotiations; and program and project delivery. Some of his significant undertakings at the state-wide level over the past decade have involved the transition to a National Registration and Accreditation Scheme; the transition of the Queensland Ambulance Service to Queensland Health; award modernisation and enterprise bargaining negotiations; and the change management aspects of Queensland Health's move to S4/HANA.
Christine Mann	**Executive Director Aboriginal and Torres Strait Islander Health**
	Christine was awarded the role of Executive Director Aboriginal and Torres Strait Islander Health in July 2019 and was previously the Director of Cultural Capability and Engagement. The Executive Director of Aboriginal and Torres Strait Islander Health is a new Executive Management position created to help transform services to improve the health outcomes of Aboriginal and Torres Strait Islander people. Christine is a Woppaburra woman who has spent most of her life living in Mount Isa and holds a Bachelor of Social Work and Graduate Certificate in Public Sector Management. Her social work background led to working in several positions in Queensland, interstate and overseas in the area of child protection, the private sector and health. She is also an Adjunct Associate Professor, clinical and professional, with the Centre for Rural and Remote Health.

Organisational structure and workforce profile

In accordance with the *Hospital and Health Boards Act 2011*, the North West HHS Board is accountable to the local community and the Deputy Premier, Minister for Health and Minister for Ambulance Services for the services provided by the North West HHS.

The Health Service Chief Executive is accountable to the Board for ensuring patient safety through effective executive leadership and day to day operational management of all local hospital and health services, as well as the associated support functions.

Achieving the ambitions articulated through the *North West Hospital and Health Service Strategic Plan 2017–2021* (Revised June 2020) requires good governance which includes robust organisational structures, clear accountabilities and a shift from acute models of care to an integrated primary health care model which focuses on preventative health care in the North West Queensland communities. It is also supporting stronger integration of clinically-led acute services across Mount Isa Hospital.

Changes to employer arrangements came into effect from 15 June 2020. These changes mean the Director-General will employ all non-executive health service employees in HHS's as system manager of Queensland Health. The changes ensure we have clear and consistent employer arrangements for non-executive health service employees in all Hospital and Health Services and reflects the fact that staff work for the health of all Queenslanders, regardless of the Hospital and Health Service they are based in.

The North West HHS organisational structure, as at 30 June 2020, was as follows:

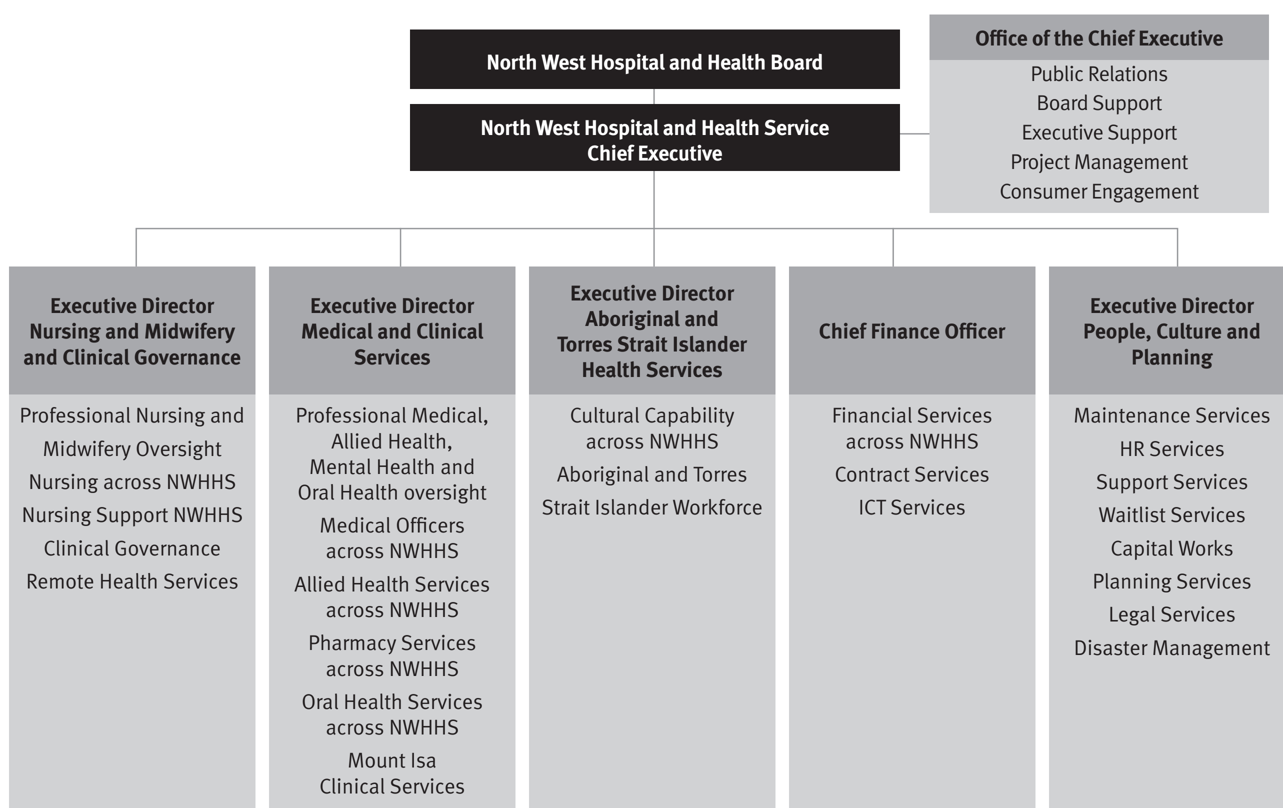

Table 3: More doctors and nurses*

	2015–16	2016–17	2017–18	2019–19	2019–20
Medical staff [a]	53	61	60	64	66
Nursing staff [a]	289	314	327	336	358
Allied Health staff [a]	45	54	52	48	59

Table 4: Greater diversity in our workforce*

	2015–16	2016–17	2017–18	2019–19	2019–20
Persons identifying as being First Nations [b]	66	76	69	63	66

Note: ** Workforce is measured in MOHRI – Full-Time Equivalent (FTE). Data presented reflects the most recent pay cycle at year's end. Data presented is to Jun-20.* ***Source:*** *[a] DSS Employee Analysis, [b] Queensland Health MOHRI, DSS Employee Analysis*

Strategic workforce planning and performance

The North West HHS has developed a comprehensive strategic workforce plan, workforce framework and operational workforce plan to attract and retain a highly-skilled workforce to service the needs of the communities we serve.

The North West HHS employed 803 full-time equivalent staff as at 30 June 2020. Our committed and highly valued team continue to be our focus to meet the challenges of an ageing workforce and the changing needs of our communities.

The North West HHS is committed to a diverse and inclusive workplace.

At the end of the financial year:

The majority of our staff continue to be permanently employed, which remains unchanged from the previous financial year. On average, across all staff disciplines, three per cent were long term temporary employees (greater than two years).

The permanent staff separation rate for the reporting period was 12 per cent.

To strengthen our response to the COVID-19 pandemic, the North West HHS employed extra casual clinical, administration and operational staff to keep our focus on service delivery.

Flexible and remote working arrangements were also used, where possible.

Workforce engagement

We aim to cultivate a highly skilled and committed workforce who drive quality patient care. To achieve this, the North West HHS uses an annual staff survey to ensure staff feel engaged, supported and have development opportunities.

The 2019 Working for Queensland survey reported that 79 per cent of North West HHS respondents felt satisfied with the safety, health and wellness aspect of their employment. Additionally, 78 per cent of staff felt satisfied with the performance and development opportunities at North West HHS. Both survey areas saw a reduction in respondent satisfaction from the 2018 survey, reduced by three per cent and five per cent, respectively.

Throughout 2019–2020, quarterly staff forums were held to provide updates on actions taken in response to staff feedback and surveys. The forums offer the opportunity for further staff feedback. Ongoing actions taken to address feedback include leader development workshops, reward and recognition framework, and flexible working opportunities.

Workforce diversity and Inclusion

In designing and providing appropriate healthcare for each of our discrete communities, North West HHS seeks to ensure that our workforce is reflective of the communities we serve as well as becoming a leader in promoting workforce diversity and inclusion.

Workplace health and wellbeing

The well-being of people is the focus of the North West HHS. The service is committed to protecting the people who work in the hospitals and healthcare facilities and those who access the health services and visit the sites.

The development of a detailed health, safety and well-being plan as well our current *Occupational Violence and Aggressive Behaviour Management Strategic Framework* will ensure that the North West HHS provides a safe environment for staff, patients and visitors.

The development of our COVID-19 Safety Plan, as well as the implementation of our COVID-19 Workplace Assessment Tool, enabled the North West HHS to continue to meet directives and guidelines whilst still being able to provide quality healthcare.

The North West HHS recognises the health benefits of working and is committed to ensuring employees receive the support they need to return to work safely, and where possible, participate in a staged early return-to-work program following illness or injury.

The North West HHS WorkCover premium remains below the industry standard.

Early retirement, redundancy and retrenchment

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

Our risk management

The *Hospital and Health Boards Act 2011* requires annual reports to state each direction given by the Minister to the HHS during the financial year and the action taken by North West HHS as a result of the direction. During the 2019-20 period, no directions were given by the Minister to the North West HHS.

Internal audit

The *Financial Accountability Act 2009* requires each accountable officer and statutory body to establish and maintain appropriate systems of internal control and risk management.

During the reporting period, the North West HHS worked closely with Internal Auditors, O'Connor Marsden & Associates, which undertook a range of operational reviews regarding:

- Recruitment and selection
- Business continuity
- Planning
- Financial Management Practice Manual (FMPM) and Financial Delegations Review, Data Quality – Clinical Incident Register and Workplace, Health and Safety Register
- Financial assurance review, asset management and planning.

Following each audit, a range of practical recommendations and other observations were provided to enhance our internal processes and procedures further. These were either fully implemented by 30 June 2020 or are continuing to be actioned.

We will continue to work closely with O'Connor Marsden & Associates and both the Finance Audit and Risk Management and Quality, Safety and Risk committees during the 2020–2021 financial year in relation to an ongoing work program that will further consolidate and strengthen its internal controls.

External audit, information systems and recordkeeping

The Queensland Auditor-General holds a statutory appointment as auditor of all public sector entities and is responsible for reporting independently to Parliament on a range of matters including conducting financial audits and undertaking performance audits of important aspects of public services—examining efficiency and effectiveness and sharing opportunities to apply best practice.

The 2019–2020 financial statements are provided from page 30 of this annual report.

Code of Conduct and Public Service Ethics

North West HHS is committed to its values of Innovation, Respect, Engagement, Accountability, Caring and Honesty.

We are committed to upholding the values and standards in the Code of Conduct for the Queensland Public Service. All staff are required to undertake training related to the Code of Conduct for the Queensland Public Service and more specifically, ethics, integrity and accountability.

Code of Conduct requirements are included in the terms of employment in all appointment letters and training is provided in the central orientation program and via online training modules. Human Resource Officers are also available to provide in-house training where requested.

Information systems and record-keeping

All North West HHS employees have specific responsibilities regarding security, confidentiality and the management of records and other information accessible to them during the course of their work. Staff understand their responsibilities in accordance with the *Information Privacy Act 2009*.

Our skilled staff are responsible for the management of central information systems and record keeping. The Medical Records Unit is responsible for the lifecycle management of clinical records, including audit. Staff are informed of audit results and are involved in continuous improvement activities.

Administration officers responsible for processing medical records complete mandatory training, and ongoing competency assessments, to ensure they comply with record-keeping requirements. Individual service areas manage non-clinical records. To assist in maintaining a high level of service, written and electronic support resources are available to staff.

Medical records are currently tracked with the Hospital-Based Corporate Information System (HBCIS) database. Clinical records are retained and disposed of in accordance with the Health Sector (Clinical Records) Retention and Disposal Schedule (QDAN 683) and public records in accordance with the *Public Records Act 2002*.

All photo consent forms have transitioned from paper-based records to digital record-keeping.

The Communicare system is an integrated patient information application for Primary Health Care services with application across all North West HHS facilities. It provides a comprehensive real-time electronic health record for accessing each patient's demographics, social and family history, adverse reactions, medications, pathology and clinical history.

Financial system renewal

The Financial System Renewal (FSR) project facilitated the upgrade of the SAP financial application to S/4HANA, going live across Queensland Health on 1 August 2019.

Human rights

The North West HHS is committed to embedding human rights in all that we do. We endeavour to exercise our operations in a principled way, compatible with human rights, by putting people first in all our actions, decisions and interactions.

Queensland's new *Human Rights Act 2019* came into effect on 1 January 2020.

The previous anti-discrimination HR policy was renamed 'anti-discrimination, human rights and vilification', and amended to include the human rights complaints process.

All patient complaints are thoroughly assessed for human rights violations by a panel of executive members and Healthcare Standards staff.

In the financial year 2019-2020, there was one complaint that was assessed as a potential human rights breach. The legal case is still pending.

During the COVID-19 pandemic, North West HHS continued to provide healthcare for our community consistent with the *Human Rights Act 2019*.

This was achieved by:

- Increased use of communication technologies, such as Telehealth, Teledental, Telepharmacy and TeleCare.
- Increasing travel and accommodation arrangements for those required to travel for treatment.
- Working closely with health partners to ensure our people can access the health services they need.
- Boosting our remote sites medical workforce and capability.

Confidential information

The *Hospital and Health Boards Act 2011* requires annual reports to state the nature and purpose of any confidential information disclosed in the public interest during the financial year. The Health Service Chief Executive did not authorise the disclosure of confidential information during the reporting period.

Our performance

Service standards

During 2019–2020, North West HHS continued to meet, and in most cases exceed, service targets in several areas, including: emergency department length of stay; elective surgery and specialist outpatients waiting times and long waits.

Our performance against 2019–2020 Service Delivery Statement targets, as summarised in the following table:

Table 5: Service Standards – Performance Statement North West Hospital and Health Service 2019–2020

Service standards	Target	Actual
Effectiveness measures		
Percentage of patients attending emergency departments seen within recommended timeframes: [a]		
Category 1 (within 2 minutes)	100%	**100.0%**
Category 2 (within 10 minutes)	80%	**94.2%**
Category 3 (within 30 minutes)	75%	**83.1%**
Category 4 (within 60 minutes)	70%	**82.4%**
Category 5 (within 120 minutes)	70%	**98.3%**
Percentage of emergency department attendances who depart within four hours of their arrival in the department: [a]	>80%	**87.1 %**
Percentage of elective surgery patients treated within clinically recommended times: [b]		
Category 1 (30 days)	>98%	**100.0%**[1]
Category 2 (90 days)	>95%	**100.0%**
Category 3 (365 days)	>95%	**100.0%**
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days: [c]	<2	**0.0**[2]
Percentage of specialist outpatients waiting within clinically recommended times: [e]		
Category 1 (30 days)	98%	**66.4%**[1]
Category 2 (90 days)	95%	**87.2%**
Category 3 (365 days)	95%	**94.5%**
Percentage of specialist outpatients seen within clinically recommended times: [e]		
Category 1 (30 days)	98%	**97.0%** [1]
Category 2 (90 days)	95%	**97.0%**
Category 3 (365 days)	95%	**99.4%**
Median wait time for treatment in emergency departments (minutes) [a]	-	**10**
Median wait time for elective surgery (days) [b]	-	**26**
Efficiency measure		
Average cost per weighted activity unit for Activity Based Funding facilities [f,g]	$5,019	**$5,334**[3]
Other measures		
Number of elective surgery patients treated within clinically recommended times: [b]		
Category 1 (30 days)	230	**208**[1]
Category 2 (90 days)	253	**277**
Category 3 (365 days)	231	**190**
Number of Telehealth outpatient occasions of service events [h]	5,579	**5,447**
Total weighted activity units (WAU's): [g]		
Acute Inpatient	10,966	**11,668** [4]
Outpatients	2,945	**2,840**
Sub-acute	966	**983**
Emergency Department	5,600	**5,852**
Mental Health	351	**300**
Prevention and Primary Care	333	**283**
Ambulatory mental health service contact duration (hours) [d]	>7,591	**7,104**
Staffing [i]	781	**803**

Notes to Table 5 on previous page:

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

Source: *a Emergency Data Collection, b Elective Surgery Data Collection, c Communicable Diseases Unit, d Mental Health Branch, e Specialist Outpatient Data Collection, f DSS Finance, g GenWAU, h Monthly Activity Collection, I DSS Employee Analysis.* ***Note:*** *Targets presented are full year targets as published in 2019-20 Service Delivery Statements.*

A summary of subsequent delivery against targets as at 30 June 2020 is:

- 100 per cent of Category 1 patients were seen in time against a target of 100 per cent. This is a 2.6 per cent improvement compared to the same time last year.
- Elective surgery patients treated within clinically recommended times at North West HHS with Category 1, Category 2, and Category 3, waiting times exceeding targets.
- The target of Telehealth consultations for 2019–2020 was 5579. As at 30 June 2020, a total of 5447 consultations were provided.

  Although slightly below target, Telehealth numbers are monitored monthly, and North West HHS Service has continued to increase Telehealth utilisation year on year, delivering a 1.6 per cent increase overall in 2019–2020.
- Achieving the Cost per Weighted Activity Unit target continues to remain challenging, given the unique funding model applied to Mount Isa Hospital. The Mount Isa Hospital is the only rural and remote provider funded by the ABF model, which does not consider higher costs associated with service delivery in remote settings.

  Further effort will be directed towards achieving the 2020–2021 targets.
- Although an additional 646 hours of ambulatory mental health service contact was provided in comparison to the previous financial year, a further effort will also be taken towards achieving the 2020–2021 target.

Financial summary

Total revenue received by North West HHS for 2019–2020 totalled $201.1 million, up from $193.0 million in 2018–2019.

Expenditure for the year totalled $209.1 million, with an $8 million operating deficit for the year. North West HHS strives to achieve a balanced budget and maintain a sustainable financial position in order to meet the health care needs of our community.

The North West HHS executive is working closely with the Department of Health to develop and implement a range of multi-year strategies to address the underlying deficit, recognising there are complex financial challenges in operating remote hospital and health services in western Queensland. The strategies incorporate improvements in revenue streams as well as ensuring efficiency and effectiveness is achieved in areas of expenditure.

North West HHS did not overdeliver in activity against the Activity Based Funding health services target in 2019-2020. This was due to the COVID-19 pandemic, as payment for the additional health services delivered has not been yet received.

Labour cost remains proportionally high at 64 per cent of total expenditure, the same as the 2018–2019 level. Patient travel remains a major and integral part of our service provision, making up 5.3 per cent of total expenditure in 2019–2020, the same as the 2018–2019 level.

Expenditure on drugs remains proportionally consistent with 2018–2019 levels.

Other expenditure dropped marginally from 23.5 per cent of the total expenditure in 2018–19, down to 22.6 per cent in 2019–20.

Expenditure is further itemised in the financial statements.

Open data

Additional annual report disclosures – relating to expenditure on consultancy, overseas travel and implementation of the Queensland Language Services Policy are published on the Queensland government's open data website, available via www.data.qld.gov.au

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 3 June 2020, the North West HHS had reported anticipated maintenance of 34.6 million.

The North West HHS continues to negotiate with the Department to obtain Priority Capital Program funding for any historical structural maintenance requirements.

Glossary

Activity-based funding (ABF): Funding framework for public health care services delivered across Queensland based on standardised costs of health care services, referred to as ‘activities’. The ABF framework applies to those facilities which are operationally large enough to support the framework. For the North West Hospital and Health Service, this currently applies to the Mount Isa Hospital only, with all other hospital facilities receiving block funding (see definition below).

Ambulatory care: Care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics.

Block funding: Block funding is typically applied for small public hospitals where there is an absence of economies of scale that means some hospitals may not be financially viable under Activity Based Funding.

COVID-19: A disease caused by a new strain of coronavirus. ‘CO’ stands for corona, ‘VI’ for virus, and ‘D’ for disease. Formerly, this disease was referred to as ‘2019 novel coronavirus’ or ‘2019-nCoV.

Deadly Ears: Queensland Health’s State-wide Aboriginal and Torres Strait Islander Ear Health Program for children. Middle ear disease, medically known as otitis media, affects up to 8 out of 10 Aboriginal and Torres Strait Islander children living in remote communities and is conducive to hearing loss, which impacts upon health, child development and educational outcomes of children, their families and communities.

Emergency Department: Dedicated area of a hospital organised and administered to provide emergency care to those in the community who perceive the need for, or are in need of, acute or urgent care.

Human rights: Human rights are moral principles or norms that describe certain standards of human behaviour and are regularly protected as natural and legal rights in municipal and international law.

North and West Remote Health: A not-for-profit primary health care company, recognised as a significant Commonwealth and State Government primary health care organisation, servicing 14 Local Government Areas and 39 communities across an area of over 600,000 kilometres of remote Queensland.

Outpatient: A non-admitted, non-emergency patient provided with a service such as an examination, consultation, treatment or other service.

Performance indicator: Measures the extent to which agencies are achieving their objectives.

Primary care: First level healthcare, including health promotion, advocacy and community development, provided by general practitioners (GPs) and a range of other healthcare professionals.

Primary Health Networks (PHNs): Established by Federal Government with the key objectives of increasing the efficiency and effectiveness of medical services for patients – particularly those at risk of poor health outcomes – and improving coordination of care to ensure patients receive the right care in the right place at the right time.

Royal Flying Doctor Service (RFDS): A not-for-profit organisation, supported by the Commonwealth, State and Territory Governments but also relying heavily on fundraising and donations from the community to purchase and medically-equip its aircraft, and to finance other major capital initiatives. Today, the RFDS has a fleet of 63 aircraft operating from 21 bases located across the nation and provides medical assistance to over 290,000 people every year.

Service standard: A standard of efficiency and effectiveness to which an agency will deliver services within its budget. Standards define a level of performance that is appropriate for the service and are expected to be achieved.

Strategic plan: A short, forward-looking document to set direction and provide local objectives and strategies to ensure alignment with the government’s objectives for the community.

Telehealth: The delivery of health services and information using telecommunication technology, including:

- Live interactive video and audio links for clinical consultations and education.
- Store and forward systems to enable the capture of digital images, video, audio and clinical data stored on a computer and forwarded to another location to be studied and reported on by specialists.
- Remote reporting and provision of clinical advice associated with diagnostic images.
- Other services and equipment for home monitoring of health.

Compliance checklist

Summary of requirement	Basis for requirement	Annual report reference	
Letter of compliance	• A letter of compliance from the accountable officer or statutory body to the relevant Minister/s	ARRs – section 7	4
Accessibility	• Table of contents • Glossary	ARRs – section 9.1	5 28
	• Public availability	ARRs – section 9.2	Inside front cover
	• Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 9.3	Inside front cover
	• Copyright notice	*Copyright Act 1968* ARRs – section 9.4	Inside front cover
	• Information Licensing	QGEA – Information Licensing ARRs – section 9.5	Inside front cover
General information	• Introductory Information	ARRs – section 10.1	7-8
	• Machinery of Government changes	ARRs – section 10.2, 31 and 32	Not applicable
	• Agency role and main functions	ARRs – section 10.2	9-10
	• Operating environment	ARRs – section 10.3	11-14
Non-financial performance	• Government's objectives for the community	ARRs – section 11.1	6
	• Other whole-of-government plans / specific initiatives	ARRs – section 11.2	14
	• Agency objectives and performance indicators	ARRs – section 11.3	25-26
	• Agency service areas and service standards	ARRs – section 11.4	25-26
Financial performance	• Summary of financial performance	ARRs – section 12.1	27
Governance – management and structure	• Organisational structure	ARRs – section 13.1	21
	• Executive management	ARRs – section 13.2	19-20
	• Government bodies (statutory bodies and other entities)	ARRs – section 13.3	17
	• Public Sector Ethics	*Public Sector Ethics Act 1994* ARRs – section 13.4	23
	• Human Rights	*Human Rights Act 2019* ARRs – section 13.5	24
	• Queensland public service values	ARRs – section 13.6	9
Governance – risk management and accountability	• Risk management	ARRs – section 14.1	23
	• Audit committee	ARRs – section 14.2	18
	• Internal audit	ARRs – section 14.3	23
	• External scrutiny	ARRs – section 14.4	23
	• Information systems and recordkeeping	ARRs – section 14.5	23
Governance – human resources	• Strategic workforce planning and performance	ARRs – section 15.1	22
	• Early retirement, redundancy and retrenchment	*Directive No.04/18 Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	22
Open Data	• Statement advising publication of information	ARRs – section 16	Inside front cover
	• Consultancies	ARRs – section 33.1	https://data.qld.gov.au
	• Overseas travel	ARRs – section 33.2	https://data.qld.gov.au
	• Queensland Language Services Policy	ARRs – section 33.3	https://data.qld.gov.au
Financial statements	• Certification of financial statements	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	From page 29
	• Independent Auditor's Report	FAA – section 62 FPMS – section 46 ARRs – section 17.2	Following financial statements

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

Financial Statements 2019–2020
as at 30 June 2020

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STATEMENT OF COMPREHENSIVE INCOME

	Notes	2020 $'000	2019 $'000
Income			
User charges and fees	A1-1	**6,624**	8,323
Funding for public health services	A1-2	**190,580**	179,186
Grants and other contributions	A1-3	**2,635**	2,026
Other revenue	A1-4	**1,301**	3,475
Total income		**201,140**	193,010
Expenses			
Employee expenses	A2-1	**109,617**	102,523
Health service employee expenses	A2-2	**3,611**	-
Other supplies and services	A2-2	**82,632**	79,583
Grants and subsidies	A2-3	**1,015**	720
Depreciation and amortisation	B5, B9	**9,970**	8,365
Interest on lease liabilities	B9	**29**	-
Revaluation decrement	A2-4	**78**	-
Other expenses	A2-5	**2,543**	1,818
Total expense		**209,495**	193,009
Operating result for the year		**(8,355)**	1
Other comprehensive income			
Items that will not be subsequently reclassified to operating result:			
Increase/(decrease) in asset revaluation surplus		**11,445**	(1,146)
Total other comprehensive income		**11,445**	(1,146)
Total comprehensive income		**3,090**	(1,145)

North West Hospital and Health Service

As at 30 June 2020

STATEMENT OF FINANCIAL POSITION

	Notes	2020 $'000	2019 $'000
Current assets			
Cash and cash equivalents	B1	**591**	4,139
Receivables	B2	**2,078**	1,326
Inventories	B3	**1,358**	1,097
Other	B4	**405**	2,018
Total current assets		**4,432**	8,580
Non-current assets			
Property, plant and equipment	B5	**125,951**	119,322
Right-of-use assets	B9	**2,060**	-
Total non-current assets		**128,011**	119,322
Total assets		**132,443**	127,902
Current liabilities			
Bank overdraft	B6	**2,843**	-
Payables	B7	**13,680**	5,976
Lease liabilities	B9	**316**	-
Accrued employee benefits		**950**	4,594
Other	B8	**-**	378
Total current liabilities		**17,789**	10,948
Non-current liabilities			
Lease liabilities	B9	**1,710**	-
Total non-current liabilities		**1,710**	-
Total liabilities		**19,499**	10,948
Net assets		**112,944**	116,954
Equity			
Contributed equity		**88,131**	95,232
Accumulated surplus		**(9,904)**	(1,550)
Asset revaluation surplus	B10	**34,717**	23,272
Total equity		**112,944**	116,954

North West Hospital and Health Service

For the year ended 30 June 2020

STATEMENT OF CHANGES IN EQUITY

	Contributed equity $'000	Accumulated surplus $'000	Asset revaluation surplus $'000	Total equity $'000
Balance as at 1 July 2018	91,514	(1,551)	24,418	114,381
Accumulated surplus adjustment	-	-	-	-
Balance as at 1 July 2018	91,514	(1,551)	24,418	114,381
Operating Result	-	1	-	1
Total other comprehensive income				
- Increase/(decrease) in asset revaluation surplus (Note B5)	-	-	(1,146)	(1,146)
Transactions with owners				
- Non-appropriated equity injections	11,643	-	-	11,643
- Non-appropriated equity withdrawals	(8,368)	-	-	(8,368)
- Non-appropriated equity asset transfers	443	-	-	443
Balance at 30 June 2019	95,232	(1,550)	23,272	116,954
Balance as at 1 July 2019	**95,232**	**(1,550)**	**23,272**	**116,954**
Accumulated surplus adjustment				**-**
Balance as at 1 July 2019	**95,232**	**(1,550)**	**23,272**	**116,954**
Operating Result	**-**	**(8,355)**		**(8,355)**
Net effect of changes in accounting policies / prior year adjustments				-
Total other comprehensive income			.	
- Increase/(decrease) in asset revaluation surplus (Note B5)			**11,445**	**11,445**
Transactions with owners				
- Non-appropriated equity injections	2,834	1		2,835
- Non-appropriated equity withdrawals	(9,935)	-	-	(9,935)
- Non-appropriated equity asset transfers		-	-	-
Balance at 30 June 2020	**88,131**	**(9,904)**	**34,717**	**112,944**

North West Hospital and Health Service

For the year ended 30 June 2020

STATEMENT OF CASH FLOWS

	Notes	2020 $'000	2019 $'000
Cash flows from operating activities			
Inflows:			
User charges, fees and funding for public health		**188,386**	174,612
Grants and other contributions		**2,297**	1,754
GST collected from customers		**344**	320
GST input tax credits from ATO		**5,244**	6,061
Insurance Recoveries		**-**	2,284
Other		**342**	2,603
Outflows:			
Employee expenses		**(114,080)**	(102,902)
Supplies and services		**(77,604)**	(77,282)
Grants and subsidies		**(1,015)**	(720)
GST paid to suppliers		**(5,336)**	(5,932)
GST remitted to ATO		**(362)**	(294)
Other		**(2,051)**	(1,900)
Net cash used by operating activities		**(3,835)**	(1,396)
Cash flows from investing activities			
Inflows:			
Sales of property, plant and equipment		**4**	82
Outflows:			
Payments for property, plant and equipment		**(5,061)**	(13,841)
Net cash used in investing activities		**(5,057)**	(13,759)
Cash flows from financing activities			
Inflows:			
Equity injections		**2,835**	11,643
Outflows:			
Lease payments		**(334)**	-
Net cash provided by financing activities		**2,501**	11,643
Net increase/(decrease) in cash and cash equivalents		**(6,391)**	(3,512)
Cash and cash equivalents at the beginning of the financial year		**4,139**	7,651
Cash and cash equivalents at the end of the financial year	**B1**	**(2,252)**	4,139

*Cash and equivalents include a bank overdraft that are repayable on demand and form an internal part of NWHHS cash management.

North West Hospital and Health Service

For the year ended 30 June 2020

STATEMENT OF CASH FLOWS

NOTES TO THE STATEMENT OF CASH FLOWS

	2020 $'000	2019 $'000
Operating result from continuing operations	**(8,355)**	1
Adjustments for:		
Depreciation and amortisation	**9,970**	8,365
Depreciation and amortisation funding	**(9,935)**	(8,368)
Net (gain) on disposal of property, plant and equipment	**(1,355)**	-
Net (gain)/loss on disposal of property, plant and equipment	**1,480**	(6)
Asset valuation decrement	**78**	-
Changes in assets and liabilities:		
(Increase)/decrease in receivables	**(752)**	(18)
(Increase)/decrease in inventories	**(261)**	(133)
(Increase)/decrease in contract assets	**1,679**	-
(Increase)/decrease in prepayments	**(66)**	1,134
Increase/(decrease) in contract liabilities	**603**	
Increase/(decrease) in accrued health services labour (DOH)	**3,611**	-
Increase/(decrease) in accrued employee benefits	**(3,644)**	568
Increase/(Decrease) in contract liabilities and unearned revenue	**(378)**	230
Increase/(decrease) in payable	**3,490**	(3,169)
Net cash from operating activities	**(3,835)**	(1,396)

BASIS OF FINANCIAL STATEMENT PREPARATION

General Information

The North West Hospital and Health Service (North West HHS) is a not-for-profit statutory body under the *Hospital and Health Boards Act 2011* and is domiciled in Australia. The North West HHS is responsible for providing public sector health services to communities within the area assigned under the Hospital and Health Boards Regulation 2012. Its principal place of business is:

30 Camooweal Street

Mount Isa QLD 4825

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

The ultimate parent entity is the State of Queensland.

Controlled entities

The North West HHS does not have any controlled entities.

Investment in Western Queensland Primary Care Collaborative Limited

Western Queensland Primary Care Collaborative Limited (WQPCC) was registered in Australia as a public company limited by guarantee on 22 May 2015. North West HHS is one of three founding members with Central West HHS and South West HHS, each holding one voting right in the company. The principal place of business of WQPCC is Mount Isa, Queensland. Each founding member is entitled to appoint one Director to the Board of the company.

Since formation, 12 additional members have been added to the company membership. On 12 January 2018 the constitution of WQPCC was amended to allow the transition from a public-sector entity to a non-public sector entity to meet the requirements of the WQPCC funding agreement with the Commonwealth. At this time the Queensland Audit Office were consulted and agreed to the amendment of the Constitution to remove the Auditor-General from auditing WQPCC.

WQPCC's principal purposes is to increase the efficiency and effectiveness of health services for patients in Western Queensland, particularly those at risk of poor health outcomes; and improve co-ordination to facilitate improvement in the planning and allocation of resources enabling the providers to provide appropriate patient care in the right place at the right time. These purposes align with the strategic objective of North West HHS to integrate primary and acute care services to support patient wellbeing.

Each member's liability to WQPCC is limited to $10. WQPCC's constitution legally prevents it from paying dividends to the members and also prevents the income or property of the company being transferred directly or indirectly to the members. This does not prevent WQPCC from making loan repayments to North West HHS or reimbursing North West HHS for goods or services delivered to WQPCC.

North West HHS's interest in WQPCC is immaterial in terms of the impact on North West HHS's financial performance because it is not entitled to any share of profit or loss or other income of WQPCC. Accordingly, the carrying amount of North West HHS's investment and subsequent changes in its value due to annual movements in the profit and loss of WQPCC are not recognised in the financial statements.

North West HHS does not have any contingent liabilities or other exposures associated with its interests in WQPCC.

Investment in Tropical Australian Academic Health Centre Limited

Tropical Australian Academic Health Centre Limited (TAAHCL) registered as a public company limited by guarantee on 3 June 2019. North West Hospital and Health Service is one of seven founding members along with Cairns and Hinterland Hospital and Health Service, Mackay Hospital and Health Service, Torres and Cape Hospital and Health Service, Townsville Hospital and Health Service, Northern Queensland Primary Health Network and James Cook University. Each founding member holds two voting rights in the company and is entitled to appoint two directors.

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

As each member has the same voting entitlement (14.3%), 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's constitution prevents any income or property of the company being transferred directly or indirectly to or amongst the members. Each member must pay annual membership fees as determined by the board of TAAHCL.

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

Statement of Compliance

The financial statements:

- have been prepared in compliance with section 62(1) of the *Financial Accountability Act 2009* and section 43 of the *Financial and Performance Management Standard 2019*;
- are general purpose financial statements prepared on a historical cost basis, except where stated otherwise;
- are presented in Australian dollars;
- have been rounded to the nearest $1,000 or, where the amount is $500 or less, to zero unless the disclosure of the full amount is specifically required;

- present reclassified comparative information where required for consistency with the current year's presentation;
- have been prepared in accordance with all applicable new and amended Australian Accounting Standards and Interpretation as well as the Queensland Treasury's Minimum Reporting Requirements for the year ended 30 June 2020, and other authoritative pronouncements.

Authorisation of financial statements for issue

The general-purpose financial statements are authorised for issue by the Chair and the Chief Executive, at the date of signing the Management Certificate.

Further information

For information in relation to North West HHS's financial statements:

- Email nwhhs.finance@health.qld.gov.au or
- Visit the NWHHS website at: www.health.qld.gov.au/mt_isa

A NOTES ABOUT FINANCIAL PERFORMANCE

This section considers the income and expenses of North West Hospital and Health Service.

A1 INCOME

Note A1-1: User charges and fees

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Sales of goods and services	**1,871**	2,998
Pharmaceutical benefits scheme	**3,147**	3,649
Hospital fees	**1,606**	1,676
Total user charges and fees	**6,624**	8,323

User charges and fees are recognised as revenue when earned and can be measured reliably with a sufficient degree of certainty. This involves either invoicing for related goods/services once the goods have been delivered to the customer of the services completed and/or the recognition of accrued revenue for revenue earned but not yet invoiced.

Revenue in this category primarily consists of hospital fees (patients who elect to utilise their private health cover) and sales of goods and services which includes reimbursements of pharmaceutical benefits.

Note A1-2: Funding for public health services

	2020 $'000	2019 $'000
Revenue from contracts with government agencies		
Activity based funding	**90,143**	83,446
Block funding	**49,691**	35,608
General Purpose Funding	**40,811**	51,764
Depreciation funding	**9,935**	8,368
Total funding for public health services	**190,580**	179,186

Funding is provided predominantly by the Department of Health (DOH) for specific public health services purchased by the Department in accordance with a service agreement. DOH receives most of its funding revenue for funding from the Queensland Government and the Commonwealth. Activity based funding is based on an agreed number of activities, per the service agreement and a state-wide price by which relevant activities are funded. Block funding is not based on levels of public health care activity. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by North West HHS. The funding from the Department is received fortnightly in advance. At the end of the financial year, a financial adjustment may be required where the level of service provided is above or below the agreed level.

The service agreement between the Department of Health and North West HHS specifies that the Department funds North West HHS's depreciation and amortisation charges via non-cash revenue. The Department retains the cash to fund future major capital replacements. This transaction is shown in the Statement of Changes in Equity as a non-appropriated equity withdrawal.

Cash funding from the Department of Health is received fortnightly for State payments and monthly for Commonwealth payments and is accrued based on days in the month.

Note A1-3: Grants and other contributions

	2020 $'000	2019 $'000
Other grants and contributions		
State Government grants	**409**	37
Grants from other bodies	**760**	623
Other donations and contributions	**111**	90
Services received below fair value	**1,355**	1,276
Total grants and contributions	**2,635**	2,026

Grants and contributions are transactions where North West HHS receives funds to further its objectives. Where an agreement is enforceable and contains sufficiently specific performance obligations for North West HHS 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. A contract asset representing North West HHS's right to consideration for services delivered but not yet billed will be raised where applicable. 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.

North West HHS receives corporate services support from the Department of Health for no direct cost. Corporate services received would have been purchased if they were not provided by the Department of Health and include payroll services, accounts payable and banking

services. The fair value of corporate services received in 2019-20 are estimated by the Department of Health as $1.062 million (2019: $0.989 million) for payroll services and $0.293 million (2019: $0.280 million) for accounts payable and banking services. An equal amount of expense is recognised as services below fair value, under other expenses, refer Note A2-3.

Note A1-4: Other revenue

	2020 $'000	2019 $'000
Interest	**7**	18
Insurance recoveries	**-**	2,284
Other[1]	**1,294**	1,173
Total other revenue	**1,301**	3,475

[1]Other predominantly relates to salary recoveries and other ad-hoc reimbursements.

Revenue recognition for other revenue is based on either invoicing for related goods, services and/or the recognition of accrued revenue based on estimated volumes of goods or services delivered.

A2 EXPENSES

Note A2-1: Employee expenses

	2020 $'000	2019 $'000
Employee expenses		
Wages and salaries	**88,891**	83,515
Annual leave levy	**9,112**	8,530
Employer superannuation contributions	**8,789**	7,849
Long service leave levy	**2,144**	1,736
Redundancies	**304**	321
Workers compensation premium	**377**	572
Total employee expenses	**109,617**	102,523

*Wages and salaries include $0.993m on-off pro-rata payments for 794 full time equivalent employees (announced in September 2019)

Effective 15 June 2020, a legislative change to the employer arrangements within Queensland Health was implemented. From this date, all non-executive employees of the North West Hospital and Health Service (i.e. other than senior executives, senior medical officers and visiting medical officers) became the employees of the Director-General, Queensland Health. Direct labour postings, in addition to related assets and liabilities including accrued employee benefits, for these employees will be classified from employee expense to contract labour expense. These changes were a result of the Government's implementation of recommendations from the "Advice on Queensland Health's governance framework report", issued in June 2019 and introduce consistency of employment arrangements for non-executive staff across all Queensland Health entities.

The amount reclassified for the period 15 June - 30 June 2020 was $3.611M which is disclosed on the face of the Statement of comprehensive income.

Salaries and wages due but unpaid at reporting date are recognised in the statement of financial position at the remuneration rates expected to apply at the time of settlement.

Workers' compensation insurance is a consequence of employing employees but is not counted in an employee's total remuneration package. They are not employee benefits and are recognised separately as employee related expenses.

Annual leave, long service leave and sick leave

Under the Queensland Government's Annual Leave Central Scheme and Long Service Leave Central Scheme, levies are payable by North West HHS to cover the cost of employees' annual leave (including leave loading and on-costs) and long service leave. No provisions for long service leave or annual leave are recognised in North West HHS financial statements as the provisions for these schemes are reported on a Whole-of-Government basis pursuant to AASB 1049 Whole of Government and General Government Sector Financial Reporting. These levies are expensed in the period in which they are paid or payable. Amounts paid to employees for annual leave and long service leave are claimed from the schemes quarterly in arrears. Non-vesting employee benefits such as sick leave is recognised as an expense when taken.

Superannuation

Superannuation schemes comprise of defined benefit and defined contribution categories. Employer superannuation contributions are paid to employee nominated superannuation funds, however payments to the defined benefit superannuation scheme for Queensland Government employees are at rates determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are paid, or payable and North West HHS's obligation is limited to the rate determined by the Treasurer on the advice of the State Actuary. 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.

Key management personnel and remuneration disclosures are detailed in Note D1.

Number of full time equivalent employees (FTE)*	2020 No.	2019 No.
Total FTE as at 30 June 2020	**31**	747

*reflecting Minimum Obligatory Human Resource Information (MOHRI)

Effective 15 June 2020, 763 FTE employees became employees of the Director General due to a legislative change within Queensland Health.

Note A2-2: Health service employee expenses

	2020 $'000	2019 $'000
Department of Health	**3,611**	-
Total health service employee expenses	**3,611**	-

Health Services Employee Expenses

The North West HHS through service agreements with the Department of Health has engaged 763 full time equivalent persons at 30 June 2020.

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

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

Note A2-2: Supplies and services

	2020 $'000	2019 $'000
Medical consultancies and contract labour	**9,619**	9,825
Other consultancies and contract labour	**14,025**	12,064
Electricity and other energy	**2,151**	2,414
Patient travel	**16,283**	16,861
Other travel	**3,406**	3,630
Water	**986**	527
Building services	**1,140**	421
Computer services	**1,114**	558
Motor vehicles	**278**	277
Communications	**2,801**	3,109
Repairs and maintenance	**5,144**	4,481
Minor plant and equipment	**737**	554
Rental expenses	**4,566**	4,590
Drugs	**4,138**	4,322
Outsourced service delivery	**3,619**	3,422
Clinical supplies and services	**3,389**	3,609
Catering and domestic supplies	**1,666**	1,715
Pathology and blood supplies and services	**4,629**	4,273
Services received below fair value	**1,355**	1,276
Other	**1,586**	1,655
Total supplies and services	**82,632**	79,583

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

Lease expenses: Lease expenses include lease rentals for short-term leases, leases of low value assets and variable lease payments. Refer to Note B9 for breakdown of lease expenses and other lease disclosures.

[1] Outsourced service delivery consists of externally provided radiology services and blue care fees.

[2] Services received below fair value relates to corporate services support from the Department of Health. An equal amount of revenue is recognised as donations under grants and contributions, refer Note A1-3

Note A2-3: Grants and subsidies

	2020 $'000	2019 $'000
Public hospital support services	**1,015**	720
Total grants and subsidies	**1,015**	720

Public hospital support services include grants provided to James Cook University for patient rehabilitation services and Gidgee Healing for community health services.

Note A2-4: Revaluation decrements

	2020 $'000	2019 $'000
Revaluation decrement	**78**	-
Total Revaluation decrement	**78**	-

Note A2-5: Other expenses

	2020 $'000	2019 $'000
External audit fees	**174**	197
Other audit fees	**140**	109
Insurance	**1,484**	1,212
Inventory written off	**114**	110
Net (gain)/loss from disposal of property, plant and equipment	**125**	(6)
Other legal costs	**16**	183
Special payments	**2**	25
Other	**488**	(12)
Total other expenses	**2,543**	1,818

Total audit fees paid or payable in the 2019-20 financial year were $0.314 million (2019: $0.306 million); equating to $0.174 million (2019: $0.185 million) paid or payable to Queensland Audit Office, $0.14million (2019: $0.19million) for internal audit fees. There are no non-audit services included in these amounts.

The HHS's non-current physical assets and other risks are insured through the Queensland Government Insurance Fund (QGIF), premiums being paid on a risk assessment basis.

Certain losses of public property are insured with the QGIF. Upon notification by QGIF of the acceptance of the claims, revenue will be recognised for the agreed settlement amount and disclosed as Other Revenues.

B NOTES ABOUT OUR FINANCIAL POSITION

This section provides information on the assets used in the operation of NWHHS's service and the liabilities incurred as a result.

B1 CASH AND CASH EQUIVALENTS

	2020 $'000	2019 $'000
Cash at bank and on hand	**341**	3,889
Queensland Treasury Corporation cash fund	**250**	250
Cash and cash equivalents in the statement of financial position	**591**	4,139
Bank overdrafts used for cash management purposes	**(2,843)**	-
Total cash and cash equivalents in the statement of cash flows	**(2,252)**	4,139

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.

North West HHS's bank accounts are grouped with the whole of Government set-off arrangement with Commonwealth Bank of Australia. As a result, North West HHS does not earn interest on surplus funds. Interest earned on the aggregate set-off arrangement balance accrues to the Consolidated Fund.

Overdraft Facility

North West HHS has approval from Queensland Treasury to operate bank accounts in overdraft up to a limit of $4,000,000 (2019: $1,500,000) of which $2,843,000 has been drawn down and is disclosed in note B1.

B2 RECEIVABLES

Note B2-1: Receivables

	2020 $'000	2019 $'000
Trade receivables	**1,803**	1,217
Payroll receivables	**8**	(1)
Less: Loss allowance	**(294)**	(341)
	1,517	875
GST input tax credits receivable	**578**	486
GST payable	**(17)**	(35)
	561	451
Total receivables	**2,078**	1,326

Receivables are measured at their carrying amount less any impairment, which approximates their fair value at reporting date. Trade receivables are initially recognised at the amount invoiced to customers for services provided with settlement being 30 days from invoice date. Other receivables generally arise from transactions outside the usual operating activities of the HHS and are recognised at their assessed values. Receivables includes end of year funding accrual of $1.067 million (2019: nil).

The maximum exposure to credit risk at balance date for receivables is the gross carrying amount of those assets inclusive of any provisions for impairment.

The HHS assesses whether there is objective evidence that receivables are impaired or uncollectible on an ongoing basis. Objective evidence includes financial difficulties of the debtor, the class of debtor, changes in debtor credit ratings and default or delinquency in payments (more than 60 days overdue). When there is evidence that an amount will not be collected it is provided for and then written off. If receivables are subsequently recovered the amounts are credited against other expenses in the statement of comprehensive income when collected.

NWHHS uses a provision matrix to calculate percentages based on historical credit loss experience, adjusted by current conditions and forward-looking data to calculate the expected credit losses.

The individually impaired receivables mainly relate to ineligible patients without insurance.

Disclosure – Receivables

The closing balance of receivables arising from contracts with customers at 30 June 2020 is $0.736 million (1 July 2019: $1.12 million).

The previous year comparative figure has been reclassed as a result of the adoption of AASB 15 and AASB1058. Refer to note E4-1

Note B2-2: Ageing of receivables

	2020			2019		
	Gross receivables	**Loss rate**	**Expected credit loss**	**Gross receivables**	**Loss rate**	**Expected credit loss**
	$'000	**%**	**$'000**	**$'000**	**%**	**$'000**
Ineligible patients	**294**	**80.00%**	**235**	**270**	**75%**	**203**
Inpatient	**48**	**1.00%**	**0**	**66**	**12%**	**8**
Outpatient	**61**	**80.00%**	**49**	**60**	**80%**	**48**
Other	**1,400**	**0.70%**	**10**	**821**	**10%**	**82**
Total receivables	**1,803**		**294**	**1,217**		**341**

	Gross receivables	**Loss rate**	**Expected credit loss**	**Gross receivables**	**Loss rate**	**Expected credit loss**
	$'000	**%**	**$'000**	**$'000**	**%**	**$'000**
Not overdue	**1,333**	**0%**		**406**	**0%**	**-**
Less than 30 days	**35**	**0%**		**219**	**0%**	**-**
30 to 60 days	**57**	**0%**		**251**	**0%**	**-**
60 to 90 days	**21**	**60%**	**(13)**	**33**	**100%**	**(33)**
More than 90 days	**357**	**79%**	**(281)**	**308**	**100%**	**(308)**
Total receivables	**1,803**		**(294)**	**1,217**		**(341)**

B3 INVENTORIES

	2020	2019
	$'000	**$'000**
Clinical supplies and equipment	**1,299**	1,093
Other	**59**	**4**
Total inventories	**1,358**	1,097

Inventories consist mainly of clinical supplies and pharmaceuticals held for distribution to hospital and health service facilities. Inventories are measured at weighted average cost, adjusted for obsolescence. Unless material, inventories do not include supplies held for ready use in the wards throughout the hospital and health service facilities.

B4 OTHER ASSETS

	2020	2019
	$'000	**$'000**
Current		
Other prepayments	**261**	195
Contract assets	**144**	1,823
Total other assets	**405**	2,018

Disclosure – Contract Assets

Contract assets arise from contract with customers and are transferred to receivables when North West HHS right to payment becomes unconditional, this usually occurs when the invoice is issued to the customer. Accrued revenue that do not arise from contracts with customers are reported as part of other significant changes in contract assets balances during the year.

The previous year comparative figure has been reclassed as a result of the adoption of AASB 15 and AASB1058. Refer to note E4-1

B5 PROPERTY, PLANT AND EQUIPMENT

Note B5-1: Balances and reconciliation of carrying amounts

	Land (at fair value) $'000	Buildings (at fair value) $'000	Plant and equipment (at cost) $'000	Capital works in progress (at cost) $'000	Total $'000
Year ended 30 June 2019					
Opening net book value	4,186	100,410	8,127	1,902	114,625
Acquisitions	-		1,147	12,700	13,847
Disposals	-	(72)	(10)	-	(82)
Revaluation increments/ (decrements)	-	(1,146)	-	-	(1,146)
Transfer of assets from Department of Health	-	-	443	-	443
Transfer of assets between asset classes	-	7,842	475	(8,317)	-
Depreciation expense	-	(6,943)	(1,422)	-	(8,365)
Carrying amount at 30 June 2019	4,186	100,091	8,760	6,285	119,322
At 30 June 2019					
At cost/fair value	4,186	248,773	16,946	6,285	276,190
Accumulated depreciation	-	(148,682)	(8,186)	-	(156,868)
Carrying amount at 30 June 2019	4,186	100,091	8,760	6,285	119,322
Year ended 30 June 2020					
Opening net book value	**4,186**	**100,091**	**8,760**	**6,285**	**119,322**
Acquisitions		**1,848**	**1,169**	**2,044**	**5,061**
Disposals	**-**	**-**	**(130)**	**-**	**(130)**
Revaluation increments/(decrements)	**(1,517)**	**12,885**	**-**	**-**	**11,368**
Transfer of assets from Department of Health	**-**	**-**	**-**	**-**	**-**
Transfer of assets between asset classes	**-**	**7,317**	**-**	**(7,317)**	**-**
Depreciation expense	**-**	**(8,212)**	**(1,458)**	**-**	**(9,670)**
Carrying amount at 30 June 2020	**2,669**	**113,929**	**8,341**	**1,012**	**125,951**
At 30 June 2020					
At cost/fair value	**2,669**	**283,360**	**17,612**	**1,012**	**304,653**
Accumulated depreciation	**-**	**(169,431)**	**(9,271)**	**-**	**(178,702)**
Carrying amount at 30 June 2020	**2,669**	**113,929**	**8,341**	**1,012**	**125,951**

Note B5-2: Accounting Policies

Property, Plant and Equipment

Recognition threshold

Items of a capital nature with a cost or other value equal to or more than the following thresholds and with a useful life of more than one year or greater are recognised at acquisition. Items below these values are expensed.

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

Key Judgement:

North West HHS has a comprehensive annual maintenance program for its buildings. Expenditure is only capitalised if it increases the service potential or useful life of the existing asset. Maintenance expenditure that merely restores original service potential (arising from ordinary wear and tear) is expensed.

Acquisition

Actual cost is used for the initial recording of all non-current asset acquisitions. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use. Any training costs are expensed as incurred.

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 at the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation.

Assets acquired at no cost or for nominal consideration, other than from an involuntary transfer from another Queensland Government entity, are recognised at their fair value at date of acquisition in accordance with *AASB 116 Property, Plant and Equipment.*

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. Where the complex asset qualifies for recognition, components are then separately recorded when their value is significant relative to the total cost of the complex asset.

When a separately identifiable component (or group of components) of significant value is replaced, the existing component(s) is derecognised. The replacement component(s) are capitalised when it is probable that future economic benefits from the significant component will flow to the department in conjunction with the other components comprising the complex asset and the cost exceeds the asset recognition thresholds specified above.

Components are valued on the same basis as the asset class to which they relate. The accounting policy for depreciation of complex assets, and estimated useful lives of components, are disclosed below.

The HHS's complex assets are its special purpose buildings.

Subsequent measurement

Land and buildings are subsequently measured at fair value as required by Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector. 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. 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.

Plant and equipment is measured at cost less any accumulated depreciation and accumulated impairment losses in accordance with Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector. The carrying amounts for such plant and equipment at cost is not materially different from their fair value.

Depreciation

Property, plant and equipment is depreciated on a straight-line basis progressively over its estimated useful life to the HHS. Land is not depreciated. Assets under construction (work-in-progress) are not depreciated until they are ready for use.

Key Estimate - Management estimates the useful lives and residual values of property, plant and equipment based on the expected period of time over which economic benefits from use of the asset will be derived. Management reviews useful life assumptions on an annual basis having given consideration to variables including historical and forecast usage rates, technological advancements and changes in legal and economic conditions. North West HHS has assigned nil residual values to all depreciable assets.

For each class of depreciable assets, the following useful lives were used:

Class	Useful Life
Buildings and Improvements	26 – 88 years
Plant and Equipment	5 – 30 years

Impairment

Key Judgement and Estimate: All property, plant and equipment assets 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, the HHS determines the asset's recoverable amount under AASB 136 *Impairment of Assets*. Recoverable amount is equal to the higher of the fair value less costs of disposal and the asset's value in use subject to the following:

- As a not-for-profit entity, certain property, plant and equipment of the HHS is held for the continuing use of its service capacity and not for the generation of cash flows. 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. As a consequence, AASB 136 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, 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 the HHS 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.

An impairment loss is recognised immediately in the Statement of Comprehensive Income, unless the asset is carried at a revalued amount. When the asset is measured at a revalued amount, the impairment loss is offset against the asset revaluation surplus of the relevant class to the extent available.

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

loss been recognised for the asset in prior years. A reversal of an impairment loss is recognised as income, unless the asset is carried at a revalued amount, in which case the reversal of the impairment loss is treated as a revaluation increase.

Note B5-3: Valuation

Non-current physical assets measured at fair value are revalued, where required, so that the carrying amount of each class of asset does not materially differ from its fair value at the reporting date. This is achieved by engaging independent, professionally qualified valuers to determine the fair value for each class of property, plant and equipment assets at least once every five years. However, if a particular asset class experiences significant and volatile changes in fair value, that class is subject to specific appraisal in the reporting period, where practical, regardless of the timing of the last specific appraisal.

In the intervening years, North West HHS uses appropriate publicly available cost indices for the region and asset type to form the basis of a management valuation for relevant asset classes in addition to management's engagement of independent, professionally qualified valuers to perform a "desktop" valuation. A desktop valuation involves management providing updated information to the valuer regarding additions, deletions and changes in key assumptions. The valuer then determines suitable indices which are applied to each asset class.

North West HHS engaged AECOM to revalue land and buildings in the 2019/20 financial year. In determining the values reported in the accounts for North West HHS land and buildings we have relied on the information provided by the independent valuers.

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

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.

All assets and liabilities of North West 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 in level 1) that are observable, either directly or indirectly; and

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

Land Component

AECOM performed a desktop assessment for movements in fair value, as at 30 June 2020, related to land assets controlled by North West HHS.

Level 2 input evidence is available for North West HHS and therefore the Direct Comparison Approach has been utilised to assess the value of freehold land owned by North West HHS.

Under this approach, properties have been directly compared to recent sales evidence, after first making appropriate adjustments for variations in:

- shape
- location
- land area
- topography and
- planning.

Values have been applied to land in accordance with this approach, to Mt Isa, Camooweal, Dajarra, Cloncurry, Julia Creek, Normanton and Karumba.

In Burketown, McKinlay, Doomadgee and Mornington Island, where the leasehold land is held by the local Council on behalf of the Queensland Government and leased to various users, including North West HHS, no value has been attributed to land due to the absence of any interest/tenure to North West HHS.

Building Component

Buildings were comprehensively revalued by AECOM as at 30 June 2020.

The assessment of physical deterioration, functional (technical)/economic (external) obsolescence and remaining economic life of the Buildings has been assessed on an elemental basis in accordance with the schedule of Building Elements published by the Australian Institute of Quantity Surveyors.

The age of Buildings and the elements within them has been based upon site inspections, interviewing site personnel and a review of the documents that has been made available. The remaining effective lives of Buildings have been based on the valuer's professional opinion, discussions with North West HHS personnel, industry available information and schedules of effective lives published in Australian Tax Rulings.

The Gross Replacement Cost has been based on the building as it stands today and does not include any design upgrades in accordance with current building standards. An allowance for builder's preliminaries, profit and professional fees has been included. Allowances for additional costs due to remote locations has also been considered and incorporated

North West HHS has classified land and buildings into the three levels prescribed under the accounting standards.

	Level 2 $'000	Level 3 $'000	Total $'000
2019			
Land	4,186	-	4,186
Buildings	-	100,091	100,091
Fair value at 30 June 2019	4,186	100,091	104,277
2020			
Land	**2,669**		**2,669**
Buildings		**113,929**	**113,929**
Fair value at 30 June 2020	**2,669**	**113,929**	**116,598**

The following table details a reconciliation of level 3 movements:

	Buildings $'000
Fair value at 30 June 2018	100,410
Additions	(72)
Transfers between fair value hierarchy	-
Transfers in (Department of Health)	7,842
Transfers in (work-in-progress)	-
Transfers out	(6,943)
Depreciation	
Gains recognised in other comprehensive income:	
Increase in asset revaluation reserve	(1,146)
Fair value at 30 June 2019	100,091
Fair value at 30 June 2019	**100,091**
Additions	**1,848**
Transfers in (Department of Health)	**-**
Transfers in (work-in-progress)	**7,317**
Transfers out	**-**
Depreciation	**(8,212)**
Gains recognised in other comprehensive income:	
Increase in asset revaluation reserve	**12,885**
Fair value at 30 June 2020	**113,929**

B6 BANK OVERDRAFT

	2020 $'000	2019 $'000
Bank overdraft	**2,843**	-
Total bank overdraft	**2,843**	-

B7 PAYABLES

These amounts represent liabilities for goods and services provided to NWHHS prior to the end of financial year which are unpaid. The amounts are unsecured and are usually paid within 60 days of recognition. Trade and accruals are presented as current liabilities unless payment is not due within 12 months from the reporting date. They are recognised initially at their fair value and subsequently measured at amortised cost using the effective interest method.

	2020 $'000	2019 $'000
Trade payables	**9,379**	5,889
Contract Liabilities	**690**	87
Accrued labour - Department of Health	**3,611**	-
Total payables	**13,680**	5,976

The previous year comparative figure has been reclassed as a result of the adoption of AASB 15 and AASB1058. Refer to note E4-1

B8 OTHER LIABILITIES

	2020 $'000	2019 $'000
Current		
Unearned revenue	-	378
Total Current Other Liabilities	-	378

B9 RIGHT OF USE ASSETS AND LEASE LIABILITIES

Note B9-1: Leases as a lessee

	Land $'000	Buildings $'000	Plant and equipment $'000	Total $'000
Year ended 30 June 2019				
Year ended 30 June 2020				
Opening balance 1 July		**2,076**		**2,076**
Additions		**284**		**284**
Disposals	-	-	-	-
Depreciation expense	-	**(300)**	-	**(300)**
Carrying amount at 30 June 2020	-	**2,060**	-	**2,060**

	2020 $'000	2019 $'000
Current		
Lease liabilities (2019: Finance lease liabilities)	**316**	-
Non-current		
Lease liabilities (2019: Finance lease liabilities)	**1,710**	-
Total lease liabilities	**2,026**	-

Accounting policies – Leases as lessee

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

North West HHS has elected not to recognise right-of-use assets and lease liabilities arising from 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 $5,000 when new.

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

When measuring the lease liability, North West HHS 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 of North West HHS's leases. To determine the incremental borrowing rate, North West HHS uses loan rates provided by Queensland Treasury Corporation that correspond to the commencement date and term of the lease.

Disclosures – Leases as lessee

(i) Details of leasing arrangements as lessee

NWHHS applied AASB 16 Leases for the first time in 2019-20. NWHHS applied the modified retrospective transition method and has not restated comparative information for 2018-19, which continue to be reported under AASB 117 Leases and related interpretations.

(ii) Office accommodation, employee housing and motor vehicles

The Department of Housing and Public Works (DHPW) provides the department with access to office accommodation, employee housing and motor vehicles under government-wide frameworks. These arrangements are categorised as procurement of services rather than as leases because DHPW has substantive substitution rights over the assets. The related service expenses are included in Note A2-3.

(iii) Amounts recognised in profit or loss

	2020 $'000	2019 $'000
Interest expense on lease liabilities	**29**	
Breakdown of 'Lease expenses' included in Note A2-2		
- Expenses relating to short-term leases	**4,566**	4,590

(iv) Total cash outflow for leases

	2020 $'000	2019 $'000
Total cash outflow for leases under AASB 16	**334**	-

2018-19 disclosures under AASB 117

NWHHS has non-cancellable operating leases relating predominantly to residential accommodation. Lease payments are generally fixed, but with escalation clauses on which contingent rentals are determined. No lease arrangements contain restrictions on financing or other leasing activities. Commitments for minimum lease payments in relation to non-cancellable operating leases are payable as follows:

	2020 $'000	2019 $'000
No later than 1 year	**4,096**	3,231
Later than 1 year but no later than 5 years	**784**	66
Total Operating Leases	**4,880**	3,297

Operating lease commitments includes contracted amounts for various residential properties under non-cancellable operating leases expiring within 1 and 5 years with, in some cases, options to extend. The leases have various escalation clauses. On renewal, the terms of the leases are renegotiated.

B10 ASSET REVALUATION SURPLUS BY CLASS

	2020 $'000	2019 $'000
Land		
Balance at the beginning of the financial year	**1,440**	1,440
Revaluation increments/(decrements)	**(1,440)**	-
Impairment gain/(loss) through equity	**-**	-
	-	1,440
Buildings		
Balance at the beginning of the financial year	**21,832**	22,978
Revaluation increments/(decrements)	**12,885**	(725)
Impairment gain/(loss) through equity		(421)
	34,717	21,832
Balance at the end of the financial year	**34,717**	23,272

C NOTES ABOUT RISKS AND OTHER ACCOUNTING UNCERTAINTIES

C1 FINANCIAL RISK MANAGEMENT

NWHHS is exposed to a variety of financial risks – credit risk, liquidity risk and market risk. NWHHS holds the following financial instruments by category:

	Note	2020 $'000	2019 $'000
Financial assets			
Cash and cash equivalents	B1	591	4,139
Financial assets at amortised cost:			
Receivables	B2	2,078	1,326
Total Financial Assets		2,669	5,465
Financial liabilities			
Bank overdraft	B6	2,843	-
Financial liabilities at amortised cost:			
Payables	B7	13,680	5,976
Lease liabilities	B9	2,026	-
Total Financial Liabilities		18,549	5,976

(a) Credit Risk

Credit risk is the potential for financial loss arising from a counterparty defaulting on its obligations. The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any allowance for impairment. The carrying amount of financial assets, which are disclosed in more detail in notes B1 and B2, represent the maximum exposure to credit risk at the reporting date.

No financial assets have had their terms renegotiated to prevent them from being past due or impaired and are stated at the carrying amounts as indicated.

There are no significant concentrations of credit risk.

Overall credit risk is considered minimal.

(b) Liquidity risk

Liquidity risk is the risk that North West HHS will not have the resources required at a particular time to meet its obligations to settle its financial liabilities.

North West HHS is exposed to liquidity risk through its trading in the normal course of business. North West HHS aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times.

Under the whole-of-government banking arrangements, North West HHS has an approved working debt facility of $4 million (2019: $1.5 million) to manage any short-term cash shortfalls. This facility has $2.843 million drawn down as at 30 June 2020, (2019: nil)

Due to the short-term nature (less than 12 months) of the current payables, their carrying amount is assumed to approximate the total contractual cash flow.

As at 30 June2020, the NWHHS was in a net current liability position of $13.357m and had an accumulated deficit of $9.904m. For the year ended 30 June 2020, the HHS incurred a net operating cash outlay of $6.391m and a net operating deficit of $8.335m.

The current year operating deficit is due to increasing cost pressures across the workforce, supplies and services. Part of this increase is linked to the delivery of activity above contracted levels. Expenditure on external agency nursing increased by $2.7 million (35%) in 2019-20 over the prior year. Other areas of increased expenditure included computer services and repairs and maintenance.

A Financial Recovery and Sustainability Plan has been developed to meet the current level of fiscal challenge faced by the HHS and ensure that health services can be delivered within the annual level of funding in the future. Key components of the plan include achieving and maintaining cost efficiencies and expenditure reductions across labour and non-labour areas, and an improvement in revenue. The HHS is negotiating a multi-year arrangement with the Department of Health to ensure there is minimal impact on the level of health services delivered and relies on the Department of Health to provide flexibility in cash advances to address short- and medium-term cash shortfalls as they arise.

(c) Interest rate risk

North West HHS is exposed to interest rate risk on its cash deposited in interest bearing accounts with Queensland Treasury Corporation.

North West 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 NWHHS.

(d) Fair value measurement

Cash and cash equivalents are measured at fair value. All other financial assets or liabilities are measured at cost less any allowance for impairment, which given the short-term nature of these assets, is assumed to represent fair value.

C2 CONTINGENCIES

Litigation

As at 30 June 2020, there is one case filed in the courts naming the State of Queensland acting through the North West Hospital and Health Service as defendant (2019: one case). North West HHS management believe it would be misleading to estimate the final amount payable (if any) in respect of the litigation before the courts at this time. Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). North West HHS liability in this area is limited to an excess per insurance event. As at 30 June 2020, North West HHS has 11 claims currently managed by QGIF (some of which may never be litigated or result in payments to claimants). At year end, the maximum exposure to North West HHS associated with these claims is $220,000 ($20,000 for each insurable event).

C3 COMMITMENTS

	2020	2019
	$'000	$'000
No later than 1 year	**4,371**	3,231
Later than 1 year but no later than 5 years	**784**	66
Total Commitments	**5,155**	3,297

As at 30 June 2020, NWHHS commitments for the 12 months predominantly included short term rental lease payment of $3.541million, QFleet vehicle lease payments $0.555million and $0.784million QFleet payments due later than one year but no more than 5 years

Capital Commitments

As at 30 June 2020, NWHHS capital commitments as at 30June 2020 was $0.275 million and this consisted of mainly CCTV installation ($0.113 million) Family room construction ($0.067 million) and the Mornington Island upgrades ($0.094 million)

D KEY MANAGEMENT PERSONNEL

D1 KEY MANAGEMENT PERSONNEL

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of North West HHS, directly or indirectly, including the Minister and Board members of North West HHS.

Minister for Health and Minister for Ambulance Services, Hon Steven Miles along with the following persons were considered key management personnel of North West HHS during the current financial year:

Position	Name	Current contract classification and appointment authority	Initial Appointment Date
Non-executive Director – Board Chair	Paul Woodhouse	*Hospital and Health Boards Act 2011*	18 May 2012
Non-executive Director – Board Member	Christopher Appleby	*Hospital and Health Boards Act 2011*	9 November 2012
	Karen Arbouin	*Hospital and Health Boards Act 2011*	17 May 2013
	Don Bowley OAM	*Hospital and Health Boards Act 2011*	29 June 2012
	Dr Kathryn Panaretto	*Hospital and Health Boards Act 2011*	18 May 2016
	Susan Sewter	*Hospital and Health Boards Act 2011*	18 May 2019
	Karen Read	*Hospital and Health Boards Act 2011*	18 May 2019
	Catrina Felton-Busch	*Hospital and Health Boards Act 2011*	18 May 2019
	Terry Mehan	*Hospital and Health Boards Act 2011*	18 May 2020
Chief Executive - Responsible for the overall management of North West Hospital and Health Service through functional areas to ensure the delivery of hospital and health service objectives.	Lisa Davies-Jones Dr Karen Murphy (Acting)	S24/S70 Hospital and Health Boards Act 2011 S24/S70 Hospital and Health Boards Act 2011	18 May 2016 to 31 December 2019 1 January 2020
Chief Finance Officer - Responsible for the overall financial management of North West Hospital and Health Service, including budgeting, activity-based funding measurement and departmental relationship management.	Peter Scott Rodney Margetts Jessie Henderson (Acting) Ken Bisset (Acting)	HES-2 *Hospital and Health Boards Act 2011* *Contractor Arrangement* HES-2 *Hospital and Health Boards Act 2011* *Contractor Arrangement*	18 September 2017 to 18 August 2019 19 August 2019 12 September 2019 To 25 September 2019 22 April 2020 To 29 May 2020
Executive Director Corporate Services - Responsible for the delivery of non-clinical support services, including building, engineering and maintenance services, capital infrastructure and contract management.	Barbara Davis	DSO2-1 *Hospital and Health Boards Act 2011*	1 July 2012

Position	Name	Current contract classification and appointment authority	Initial Appointment Date
Executive Director, People, Planning and Culture - Responsible for all strategic, tactical and operational strategy and service delivery, including Workforce and Organisational Planning, Recruitment, Talent Management, Organisational Development, Workforce Diversity, Employee Relations, Safety and Wellbeing and Human Resource operations and statutory compliance.	Peter Patmore	HES-2 *Hospital and Health Boards Act 2011*	19 February 2020
Executive Director Clinical and Medical Services - Responsible for the overall management and coordination of clinical operational and medical services for the health service.	Dr Karen Murphy Dr Simi Sachdev (Acting)	MMOI-3 *Medical Officers (Queensland Health) Award* MMO2-3 *Medical Officers (Queensland Health) Award*	7 January 2019 23 March 2020
Executive Director Nursing Midwifery and Clinical Governance - Responsible for the professional leadership of nursing services for the Mount Isa Hospital and clinical governance for the health service.	Michelle Garner	NRG11 *Queensland Health Nurses and Midwives Award 2012*	1 July 2012
Executive Director, Aboriginal and Torres Strait Islander Health – Responsible for transforming the HHS services to improve the health outcomes of Aboriginal people through building strong partnerships	Christine Mann	DSO1-2 *Hospital and Health Boards Act 2011*	1 July 2019

Ministerial remuneration entitlements are outlined in the Legislative Assembly of Queensland's Members' Remuneration Handbook. The HHS does not bear any cost of remuneration of the Minister. 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.

The Governor in Council approves the remuneration arrangements for Hospital and Health Board Chair, Deputy Chair and Members. The Chair, Deputy Chair and Members are paid an annual salary consistent with the Government policy titled: *Remuneration of Part-time Chairs and Members of Government Boards, Committees and Statutory Authorities.*

Remuneration of other Key Management Personnel comprises the following components:

- Short-term employee benefits which include:
  - ***Base*** – consisting of base salary, allowances and leave entitlements paid and provided for the entire year or for that part of the year during which the employee occupied the specified position. Amounts disclosed equal the amount expensed in the statement of comprehensive income
  - ***Non-monetary benefits*** – consisting of provision of housing and vehicle together with fringe benefits tax applicable to the benefit
- Long-term employee benefits include long service leave accrued
- Post-employment benefits include superannuation contributions
- Termination payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu on termination, regardless of the reason for termination.
- There were nil performance bonuses paid in the 2019-20 financial year (2018-19: $nil).

North West Hospital and Health Service

For the year ended 30 June 2020

2020

Name	Short-term benefits					
	Base	Non-monetary benefits	Long term benefits	Post employee benefits	Termination benefits	Total remuneration
	$'000	$'000	$'000	$'000	$'000	$'000
Paul Woodhouse	70	13	-	7	-	**90**
Dr Christopher Appleby	41	-	-	4	-	**45**
Karen Read	42	-	-	4	-	**46**
Catrina Felton-Busch	37	-	-	4	-	**41**
Karen (Kari) Arbouin	41	-	-	4	-	**45**
Dr Kathryn Panaretto	39	-	-	4	-	**43**
Dr Don Bowley OAM	41	-	-	4	-	**45**
Terry Mehan	4	-	-	-	-	**4**
Susan Sewter	37	-	-	4	-	**41**
Lisa Davies-Jones	158	11	3	13	-	**185**
Dr Karen Murphy	445	34	6	19	-	**504**
Michelle Garner	239	44	5	22	-	**310**
Christine Mann	136	-	3	10	-	**149**
Dr Simi Sachdev	154	3	3	10	-	**170**
Jessie Henderson	31	-	1	4	-	**36**
Peter Patmore	70	-	2	8	-	**80**
Peter Scott	81	2	-	1	-	**84**
Barbara Davis	114	31	2	16	-	**163**
Ken Bisset	33	-	-	-	-	**33**
Rod Margetts	173	16	-	-	-	**189**

2019

Name	Short-term benefits					
	Base	Non-monetary benefits	Long term benefits	Post employee benefits	Termination benefits	Total remuneration
	$'000	$'000	$'000	$'000	$'000	$'000
Paul Woodhouse	65	13	-	6	-	**84**
Annie Clarke	18	-	-	2	-	**20**
Rowena McNally	20	-	-	2	-	**22**
Richard Stevens OAM	2	-	-	-	-	**2**
Christopher Appleby	36	-	-	3	-	**39**
Karen Arbouin	38	-	-	4	-	**42**
Dr Kathryn Panaretto	38	-	-	4	-	**42**
Dallas Leon	21	-	-	2	-	**23**
Don Bowley OAM	37	-	-	4	-	**41**
Lisa Davies-Jones	303	39	6	26	-	**374**
Barbara Davis	149	31	3	20	-	**203**
Assoc. Prof Alan Sandford OAM	473	23	9	39	148	**692**
Dr Marjad Page	113	11	2	6	-	**132**
Dr John Currie	154	5	3	10	-	**172**
Dr Karen Murphy	156	-	-	-	-	**156**
Michelle Garner	222	44	4	20	-	**290**
Ruth Heather	120	10	2	12	-	**144**
Rosemarie Newitt	60	8	1	6		**75**
Peter Scott	180	12	3	14	-	**209**

D2 RELATED PARTY TRANSACTIONS

Transactions with Queensland Government controlled entities

North West HHS 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.

Department of Health

North West HHS receives funding in accordance with a service agreement with the Department of Health.

The funding from Department of Health is provided predominantly for specific public health services purchased by the Department from North West HHS in accordance with a service agreement between the Department and North West HHS. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by HHS.

The signed service agreements are published on the Queensland Government website and publicly available. The 2019-20 service agreement was for $197.958 million.

In addition to the provision of corporate services support (refer Note A2-2), the Department of Health provides a number 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 2019-20, these services totalled $22.749 million (2019: $20.204 million).

Queensland Treasury Corporation

Under the whole-of-government banking arrangements, North West HHS has an approved working debt facility with Queensland Treasury Corporation of $4 million. North West HHS have accounts with the Queensland Treasury Corporation for general trust monies.

Department of Housing and Public Works

North West HHS pays rent to the Department of Housing and Public Works for a number of properties. In addition, North West HHS provides property maintenance for Department of Housing and Public works on a fee for service arrangement.

Inter HHS

Payments to and receipts from other HHSs occur to facilitate the transfer of patients, drugs, staff and other incidentals.

Western Queensland Primary Care Collaborative

North West HHS received $0.50 million for the Emergency Department Primary Care Transition project. $0.38 million of the contract amount was unspent at 30 June 2019 and recognised as unearned grant funding. All funding was spent by 30 June 2020.

Transactions with other related parties

The following entities have been disclosed as relevant interests for key management personnel:

Western QLD PHN;

North and West Remote Health;

Gidgee Healing;

Royal Flying Doctor Service;

James Cook University;

University of Queensland;

Central Queensland University;

All transactions in the year ended 30 June 2020 between North West HHS and key management personnel, including their related parties were on normal commercial terms and conditions and were immaterial in nature.

E OTHER INFORMATION

E1 PATIENT TRUST FUNDS

North West HHS acts in a fiduciary trust capacity in relation to patient trust accounts. Consequently, these transactions and balances are not recognised in the financial statements but are disclosed below for information purposes. Although patient funds are not controlled by North West HHS, trust activities are included in the audit performed annually by the Auditor-General of Queensland.

	2020 $'000	2019 $'000
Patient trust funds		
Opening balance	**6**	11
Patient fund receipts	**8**	8
Patient fund related payments	**(8)**	(13)
Closing balance (represented by cash)	**6**	6

E2 TAXATION

NWHHS is a State body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). FBT and GST are the only Commonwealth taxes recognised by NWHHS.

Both NWHHS and the Department of Health satisfy section 149-25(e) of the *A New Tax System (Goods and Services) Act 1999 (Cth)* (the GST Act) and were able, with other hospital and health services, to form a "group" for GST purposes under Division 149 of the GST Act. This means that any transactions between the members of the "group" do not attract GST.

E3 CLIMATE RISK ASSESSMENT

Climate Risk Assessment

North West HHS 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.

North West HHS 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.

Current Year Impacts

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.

Future Year Impacts

On 1 June 2020, the Queensland Government announced a new round of climate change mitigation measures as part of the Queensland Government's Queensland Climate Transition Strategy. As a result of these measures being announced, NWHHS will be required, as directed by the Government, to generate or acquire Australian Carbon Credit Units. No liabilities, contingent liabilities or contractual commitments exist at the reporting date in respect of this announcement.

E4 FIRST YEAR APPLICATION OF NEW ACCOUNTING STANDARDS OR CHANGE IN ACCOUNTING POLICY

Changes in accounting policy

North West HHS did not voluntarily change any of its accounting policies during 2019-20.

Accounting Standards early adopted for 2019-20

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

Accounting Standards Applied for the first time in 2019-20

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

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

The effect of adopting these new standards are detailed in notes E4-1 to E4-3. No other accounting standards or interpretations that apply to North West HHS for the first time in 2019-20 have any material impact on the financial statements

Note E4-1: AASB 15 Revenue from contracts with customers

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

New revenue recognition model

AASB 15 establishes a new five-step model for determining how much and when revenue from contracts with customers is recognised. The five-step model and significant judgments at each step are detailed below.

	Measurement basis
Step 1 – Identify the contract with the customer	Grant funding that North West HHS receives may contain a contract with a customer and thus fall within the scope of AASB 15. This is the case where the funding agreement requires North West HHS to transfer goods or services to third parties on behalf of the grantor, it is enforceable, and it contains sufficiently specific performance obligations.
Step 2 – Identify the performance obligations in the contract	This step involves firstly identifying all the activities North West HHS is required to perform under the contract, and determining which activities transfer goods or services to the customer. Where there are multiple goods or services transferred, North West HHS must assess whether each good or service is a distinct performance obligation or should be combined with other goods or services to form a single performance obligation. To be within the scope of AASB 15, the performance obligations must be 'sufficiently specific', such that North West HHS is able to measure how far along it is in meeting the performance obligations.
Step 3 – Determine the transaction price	When the consideration in the contract includes a variable amount, North West HHS needs to estimate the variable consideration to which it is entitled and only recognise revenue to the extent that it is highly probably a significant reversal of the revenue will not occur. This includes sales with a right of return, where the amount expected to be refunded is estimated and recognised as a refund liability instead of revenue.
Step 4 – Allocate the transaction price to the performance obligations	When there is more than one performance obligation in a contract, the transaction price must be allocated to each performance obligation, generally this needs to be done on a relative stand-alone selling price basis.
Step 5 – Recognise revenue when or as the department satisfies performance obligations	Revenue is recognised when North West HHS transfers control of the goods or services to the customer. A key judgement is whether a performance obligation is satisfied over time or at a point in time. And where it is satisfied over time, North West HHS must also develop a method for measuring progress towards satisfying the obligation.

Other changes arising from AASB 15

AASB 15 also specifies the accounting for incremental costs of obtaining a contract and costs directly related to fulfilling a contract.

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

Transitional impact
Transitional policies adopted are as follows:

- North West HHS applied a practical expedient to reflect, on transition, the aggregate effect of all contract modification that occurred before 1 July 2019.

User charges and fees
To align with new terminology in AASB 15, accrued revenue and unearned revenue arising from contracts with customers have been renamed as contract assets and contract liabilities respectively. They are separately disclosed in Note B4 and Note B7.

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

Note E4-1: AASB 15 Revenue From Contracts With Customers

	Under AASB 118 & AASB 1004	AASB 15/1058 adjustment	Under AASB 15/1058
	2019		2019
	$'000	$'000	$'000
Receivables	3,149	(1,823)	1,326
Other current assets – Contract asset	-	1,823	1,823
Payables – Trade payables	(5,976)	87	(5,889)
Payables - Contract liabilities	-	(87)	(87)

Note E4-2: AASB 1058 Income of Not-For-Profit Entities

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

Scope and revenue recognition under AASB 1058

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

General revenue recognition framework

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

1. Recognise the asset – e.g. cash, receivables, PP&E, a right-of-use asset or an intangible asset
2. Recognise related amounts – e.g. contributed equity, a financial liability, a lease liability, a contract liability or a provision;(grants and donations in many cases can have nil related amounts)
3. Recognise the difference as income upfront

The initial recognition and measurement of receivables arising from statutory requirements (such as taxes and stamp duty) falls under AASB 9 Financial Instruments, therefore AASB 9 governs the timing and amount of revenue recognised under AASB 1058 for such statutory income.

Specific-purpose capital grants

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

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

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

Volunteer services

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

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

Transitional impact

Transitional policies adopted are as follows:

- North West HHS applied a practical expedient to not remeasure at fair value assets previously acquired for significantly less than fair value and originally recorded at cost.

Revenue recognition for North West HHS's appropriations, taxes, royalties and most grants and contributions will not change under AASB 1058, as compared to AASB 1004. Revenue will continue to be recognised when North West HHS gains control of the asset (e.g. cash or receivable) in most instances.

The following table summarises the transitional adjustments on 1 July 2019 relating to the adoption of AASB 1058.

	2019 $'000
Payables - Contract liability	-

Note E4-3: Impact of Adoption of AASB 15 And AASB 1058 In the Current Period
The following table shows the impacts of adopting AASB 15 and AASB 1058 on North West HHS's 2019-20 financial statements. It compares the actual amounts reported to amounts that would have been reported if the previous revenue standards (AASB 1004, AASB 118, AASB 111 and related interpretations) had been applied in the current financial year.

	As reported $'000	AASB 15 changes $'000	AASB 1058 changes $'000	Previous Standards $'000
Operating result for 2019-20				
User charges and fees	6,624	-	-	6,624
Funding for public health service	190,580	-	-	190,580
Grants and other contributions	2,635	-	-	2,635
Other revenue	1,301	-	-	1,301
Balances as at 30 June 2020				
Assets				
Receivables	2,078	144	-	2,222
Other current assets - Contract Assets	144	(144)	-	-
Liabilities				
Payables	9,379	690	-	10,069
Payables - Contract liabilities	690	(690)	-	-

Note E4-4: AASB 16 Leases
North West HHS applied AASB 16 Leases for the first time in 2019-20. North West HHS applied the modified retrospective transition method and has not restated comparative information for 2018-19, which continue to be reported under AASB 117 Leases and related interpretations.

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

Definition of a lease
AASB 16 introduced new guidance on the definition of a lease.
For leases and lease-like arrangements existing at 30 June 2019, North West HHS elected to apply the practical expedient to grandfather the previous assessments made under AASB 117 and Interpretation 4 Determining whether an Arrangement contains a Lease about whether those contracts contained leases. However, arrangements were reassessed under AASB 16 where no formal assessment had been done in the past or where lease agreements were modified on 1 July 2019.

Amendments to former operating leases for office accommodation and employee housing
In 2018-19, North West HHS held operating leases under AASB 117 from North West HHS of Housing and Public Works (DHPW) for non-specialised commercial office accommodation through the Queensland Government Accommodation Office (QGAO) and residential accommodation through the Government Employee Housing (GEH) program.

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

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

Lease liabilities
Lease liabilities are initially recognised at the present value of lease payments over the lease term that are not yet paid. The lease term includes any extension or renewal options that North West HHS 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 rate, initially measured using the index or rate as at the commencement date
- amounts expected to be payable by North West HHS under residual value guarantees
- the exercise price of a purchase option that North West HHS is reasonably certain to exercise
- payments for termination penalties, if the lease term reflects the early termination

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

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

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

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

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

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

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

	$'000
Right-of-use assets – Land	-
Right-of-use assets – Buildings	2,076
Right-of-use assets – Plant and equipment	-
Lease liabilities	(2,076)

Leases as lessor - No transitional adjustments were required for leases as NWHHS is not a lessor.

Reconciliation of operating lease commitments at 30 June 2019 to the lease liabilities at 1 July 2019

	$'000
Total undiscounted operating lease commitments at 30 June 2019	3,297
- discounted using the incremental borrowing rate at 1 July 2019 (1.143%)	
Present value of operating lease commitments	3,250
- less internal-to-government arrangements that are not AASB 16 leases	(1,715)
- less leases with remaining lease term of less than 12 months	(1,535)
- less leases of low value assets	
- add/less adjustments due to reassessments of lease terms	2,076
- add/less other adjustments	
Finance lease liabilities at 30 June 2019	-
Lease liabilities at 1 July 2019	**2,076**

E5 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE

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

E6 SUBSEQUENT EVENTS

Up to the date of signing there are no matters or circumstances that have arisen since 30 June 2020 that have significantly affected, or may significantly affect NWHHS's operations, the results of those operations, or the HHS's state of affairs in future financial years.

E7 IMPACT OF COVID 19 ON FINANCIAL REPORTING

E7-1 SPECIFIC AREAS OF ACCOUNTING FOCUS

As mentioned in Note B5, the Fair Value of Assets were measured using the current replacement cost method and a significant change in the value as a result of Covid-19 is not currently expected to occur for 30 June 2020 financial statement reporting.

Own Source Revenue was significantly impacted by the Covid-19 restrictions that were in place during the financial year, there was restricted access to patient wards, and this affected the revenue generated from converting Medicare patients to private patients. The travel restrictions also affected outreach programs that included an element of travel and this affected the cash inflows for the year.

E7-2 COVID-19 Financial Statement Disclosures

Significant items of Revenue and Expense

The following significant transactions were recognised by North West Hospital and Health Services during the 2019-20 financial year in response to the COVID-19 pandemic.

Operating Statement	***$'000***
Significant expense arising from COVID-19	
Additional cost incurred in relation to COVID-19	3,458
Significant revenue arising from COVID-19	
Additional revenue received to fund COVID-19	1,891

Balance Sheet

There were no significant impairment and revaluations that were recognised by North West Hospital and Health Services.

E8 S4/HANA IMPLEMENTATION

On 1 August 2019, North West HHS implemented S4/HANA, a new state-wide enterprise resource planning (ERP) system, which replaced FAMMIS ERP. The system is used to prepare the general-purpose financial statements, and it interfaces with other software that manages revenue, payroll and certain expenditure streams. Its modules are used for inventory and accounts payable management.

IT and application level controls were required to be redesigned and new workflows implemented. Extensive reconciliations were completed on implementation to ensure the accuracy of the data migrated.

F BUDGETARY REPORTING DISCLOSURES

NB: A budget versus actual comparison and explanation of major variances has not been included for the statement of changes in equity, as major variances relating to that statement have been addressed in explanation of major variances in the other statements.

a) Statement of comprehensive income

	Note	Actual 2020 $'000	Budget 2020 $'000	Variance $'000	Variance %
Income					
User charges and fees	a	**6,624**	**5,373**	1,251	19%
Funding for public health services	b	**190,580**	**187,141**	3,439	2%
Grants and other contributions	c	**2,635**	**4,387**	(1,752)	(66%)
Other revenue	d	**1,301**	**1,694**	(393)	(30%)
Total income		**201,140**	**198,595**	2,545	
Expenses					
Employee expenses	e	**109,617**	**128,490**	(18,873)	(17%)
Health service employee expenses	f	**3,611**		3,611	100%
Other supplies and services	g	**82,632**	**60,221**	22,411	27%
Grants and subsidies		**1,015**	**1,004**	11	1%
Depreciation and amortisation	h	**9,970**	**9,134**	836	8%
Interest on lease liabilities		**29**	**-**	29	100%
Revaluation decrement		**78**	**-**	78	100%
Other expenses	i	**2,543**	**1,869**	674	27%
Total expenses		**209,495**	**200,718**	8,777	
Operating result		**(8,355)**	**(2,123)**	(6,232)	
Other comprehensive income					
Items that will not be subsequently reclassified to operating result					
Increase/(decrease) in asset revaluation surplus	j	**11,445**	**-**	11,445	100%
Total other comprehensive income		**11,445**	**-**	11,445	
Total comprehensive income		**3,090**	**(2,123)**	5,213	

b) Statement of financial position

	Note	Actual 2020 $'000	Budget 2020 $'000	Variance $'000	Variance %
Current assets					
Cash and cash equivalents	k	**591**	**-**	591	100%
Receivables	**l**	**2,078**	**3,313**	(1,235)	(59%)
Inventories	**m**	**1,358**	**1,124**	234	17%
Other	n	**405**	**65**	340	84%
Total current assets		**4,432**	**4,502**	(70)	
Non-current assets					
Property, plant and equipment	o	**125,951**	**114,144**	11,807	9%
Right-of-use assets		**2,060**	**1,595**	465	23%
Total non-current assets		**128,011**	**115,739**	12,272	
Total assets		**132,443**	**120,241**	12,202	
Current Liabilities					
Bank overdraft	p	**2,843**	**3,041**	(198)	(7%)
Payables	q	**13,680**	**5,011**	8,669	63%
Lease liabilities		**316**	**279**	37	12%
Accrued employee benefits	r	**950**	**4,795**	(3,845)	(405%)
Other	**s**	**-**	**378**	(378)	0%
Total current liabilities		**17,789**	**13,504**	4,285	
Non-Current Liabilities					
Lease liabilities		**1,710**	**1,316**	394	23%
Total non-current liabilities		**1,710**	**1,316**	394	
Total liabilities		**19,499**	**14,820**	**4,679**	
Net assets		**112,944**	**105,421**	7,523	
Equity					
Contributed equity		**88,131**	**89,931**	(1,800)	(2%)
Accumulated deficit		**(9,904)**	**(7,782)**	(2,122)	21%
Asset revaluation surplus		**34,717**	**23,272**	11,445	33%
Total equity	**t**	**112,944**	**105,421**	7,523	

North West Hospital and Health Service

For the year ended 30 June 2020

c) Statement of cash flows

	Note	Actual 2020 $'000	Budget 2020 $'000	Variance $'000	Variance %
Cash flows from operating activities					
Inflows:					
User charges, fees and funding for public health	u	**188,386**	**191,001**	(2,615)	(1%)
Grants and other contributions	v	**2,297**	**1,901**	396	17%
GST collected from customers		**344**		344	100%
GST input tax credits from ATO		**5,244**	**4,231**	1,013	19%
Insurance Recoveries		**-**		-	0%
Other	w	**342**	**983**	(641)	(187%)
Outflows:					
Employee expenses	x	**(114,080)**	**(110,228)**	(3,852)	3%
Supplies and services	y	**(77,604)**	**(80,226)**	2,622	(3%)
Grants and subsidies	z	**(1,015)**	**(865)**	(150)	15%
GST paid to suppliers		**(5,336)**		(5,336)	100%
GST remitted to ATO		**(362)**	**(4,233)**	3,871	(1069%)
Other	aa	**(2,051)**	**(794)**	(1,257)	61%
Net cash from/(provided by) operating activities		**(3,835)**	**1,770**	(5,605)	
Cash flows from investing activities					
Inflows:					
Sales of property, plant and equipment		**5**		5	100%
Outflows:					
Payments for property, plant and equipment	ab	**(5,061)**	**(1,842)**	(3,219)	64%
Net cash from/(used by) investing activities		**(5,056)**	**(1,842)**	(3,214)	
Cash flows from financing activities					
Inflows:					
Equity injections	ac	**2,835**	**(6,828)**	9,663	341%
Outflows:					
Lease payments	ad	**(334)**	**(280)**	(54)	16%
Net cash from/(used by) financing activities		**2,501**	**(7,108)**	9,609	
Net increase/(decrease) in cash and cash equivalents		**(6,391)**	**(7,180)**	790	
Cash and cash equivalents at the beginning of the financial year		**4,139**	**4,139**	-	0%
Cash and cash equivalents at the end of the financial year		**(2,252)**	**(3,041)**	790	

Explanation of major variances:

Major variances are variances that are material within the 'Total' line item that the item falls within.

a. The movement in user charges and fees relates to a decrease in predominantly own source revenue and other revenue due to COVID-19.
b. The movement in Funding for public health services relates to COVID-19 reimbursements by the state and commonwealth governments which were not budgeted for.
c. Grants and Contributions relates to corporate services received from the Department of Health below fair value. A corresponding expense is recorded in other supplies and services. Contributions reduced due to the COVID-19 restrictions that were in place in the second half of the year.
d. The movement in Other Revenue relates to a decrease in other revenue sources due to COVID-19 restrictions that were in place in the second half of the year.
e. The movement in employee expenses relates to lower actual employee expenses than had been budgeted for.
f. The movement in health services employee expenses relate to outsourced labour from the department of health by North West HHS as a result of not being a prescribed employer from the 14th of June 2020
g. The movement in Other Supplies and Services predominately relates to increases in clinical supplies, travel, drugs expense, consultancies, and external labour costs reflective of the increased activity and growth in demand for healthcare services due to both organic demand and activity related to COVID-19.

h. The movement in Depreciation expense primarily relates to the delay in commissioning of the McKinlay Shire Multipurpose Health Centre.
i. The movement in Other Expenses relates primarily to unbudgeted expense. Other expenses are made up of audit fees, asset write downs and legal expenses. Legal fees increased significantly in the financial year due to unexpected human resource issues.
j. The movement in the Asset Revaluation Surplus relates to the revaluation land and buildings as at 30 June 2020.
k. The increase in Cash and Cash Equivalents predominantly relates to the reclassification of the bank overdraft.
l. The variance in receivables is a result of a combination of reduced own source revenue and the reclassification of trade receivable into contract assets due to implementation of new revenue standard.
m. The variance in inventory is a result of increase in the volumes procured in anticipation of supply chain disruptions due to the impact of COVID-19.
n. The variance relates to an increase in prepayments and recognition of other contract assets.
o. The variance in property, plant and equipment relates to the revaluation surplus that resulted in an increment in buildings and site improvements, the material change is a result of the comprehensive valuations performed.
p. The variance relates to a lower than expected closing bank overdraft.
q. The increase in payables relates to the delay in settling our obligations to suppliers.
r. The variance is a result of an increase in the number of FTE
s. The variance relates to new right of use assets that were recognised in the financial year.
t. The movement in equity relates to an increase in the valuation reserve and equity injections made by the department of health.
u. The movement in user charges and fees relates to the transfer of primary health services to Gidgee Healing resulting in a decrease in Remote Medicare Benefit Scheme payments and a drop in own service revenue.
v. The movement is due to an increase in the number of grants and subsidies received than had been budgeted for.
w. The movement in other revenue relates to a decrease in own-source revenue due to COVID-19.
x. The movement in employee expenses relate to an increase in FTE and one-off payments that were made to employees.
y. The movement relates to delay in NWHHS to settle its obligation as evidenced by the increase in payables.
z. The movement in grants and subsidies expenses is related to an increase in grant and subsidies funding received by NWHHS.
aa. Other outflows relate to insurance payments and other expenses paid by the HHS.
bb. The movement in payments for property, plant and equipment relates to higher than budgeted locally managed projects paid by the HHS and reimbursed by department of health
cc. The increase in Equity Injections related to higher than budgeted depreciation funding, non-capitalised reimbursements and equity injections relating to right of use assets.
dd. The variance in lease payments relate to an increase in the number of leases that were converted into right of use as per AASB 16 requirements.

MANAGEMENT CERTIFICATE

These general-purpose financial statements have been prepared pursuant to Section 62(1) of the *Financial Accountability Act 2009* (the Act), Section 38 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;

(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 North West Hospital and Health Service for the financial year ended 30 June 2020 and of the financial position of the Service at the end of the year; and

We acknowledge responsibility under s.7 and s.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 the reporting period.

Mr Paul Woodhouse
Chair
27 August 2020

Dr Karen Murphy
Acting Chief Executive
27 August 2020

Queensland Audit Office
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INDEPENDENT AUDITOR'S REPORT

To the Board of North West Hospital and Health Service

Report on the audit of the financial report

Opinion

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

In my opinion, the financial report:

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

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

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

Basis for opinion

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

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

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

Key audit matters

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

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Valuation of specialised buildings $113.9 million

Refer Note B5 in the financial report.

Description	How my audit addressed the key audit matter
As at 30 June 2020 Buildings are measured at fair value using the current replacement cost method. North West Hospital and Health Service performed a comprehensive revaluation over its buildings portfolio this financial year as part of the rolling revaluation program. The current replacement cost method comprises: • gross replacement cost, less • accumulated depreciation. North West 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 on-costs), – 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 determining condition and 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 the annual depreciation expense.	My procedures included, but were not limited to: • Assessing the appropriateness 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 and objectivity of the experts used to develop the models. • For unit rates associated with buildings that were comprehensively revaluated this financial year: – on a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the: ▪ modern substitute (including locality factors and oncosts), and ▪ adjustments for excess quality or obsolescence. • 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; – assessing the reasonableness of the process undertaken by management to determine whether any building asset still in use had reached or exceeded its useful life; – inquiring of management about their plans for assets that are nearing the end of their useful life; and – reviewing assets with an inconsistent relationship between condition and remaining useful life. • Where changes in useful lives were identified, evaluating whether the effective dates of the changes applied for depreciation expense were supported by appropriate evidence. • I also assessed the appropriateness of the disclosures in the Notes to the financial statements.

Implementation of new finance system [S/4HANA]

Refer to Note E8 in the financial report

Description	How my audit addressed the key audit matter

The Department of Health (the "Department") is the shared service provider to the North West Hospital and Health Service for the management of the financial management information system, and processing of accounts payable transactions in the system. The Department replaced its primary financial management information system on 1 August 2019.
 	
The financial management system is the general ledger and it interfaces with other software that manages revenue, payroll and certain expenditure streams. Its modules are used for inventory and accounts payable management.
 	
The replacement of the financial management system increased the risk of error in the control environment of North West Hospital and Health Service.
 	
The implementation of the financial management system was a significant business and IT project for the Queensland Health entities. It included:
• ensuring accuracy and completeness of closing balances transferred between the old and new systems;
• establishing system interfaces with other key software programs;
• developing and documenting IT general controls and application controls;
• establishing and implementing new workflow processes;
• cleansing and migrating of vendor and open purchase order master data; and
• training of employees.
	My procedures included, but were not limited to:
	• Assessing the appropriateness of the IT general and application level controls including system configuration of the financial management system by:
	  − reviewing the access profiles of users with system wide access;
	  − reviewing the delegations and segregation of duties; and
	  − reviewing the design, implementation and effectiveness of the key general information technology controls.
	• Validating account balances from the old system to the new system to verify the accuracy and completeness of data migrated.
	• Documenting and understanding the change in process and controls for how material transactions are processed, and balances are recorded.
	• Assessing and reviewing controls temporarily put in place due to changing system and procedural updates.
	• I increased the level of sample testing to obtain sufficient appropriate audit evidence, including:
	  − verifying the validity of journals processed pre and post go-live;
	  − verifying the accuracy and occurrence of changes to bank account details; and
	  − verifying the completeness and accuracy of vendor payments, including testing for potential duplicate payments.
	• Undertaking test counts of a sample of inventory items to assess the accuracy of inventory quantities recorded in the accounting records
	• Verifying the mapping of the general ledger to the financial statement line items.
	  − I also assessed the appropriateness of the disclosures in the Notes to the financial statements.

Responsibilities of the entity for the financial report

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

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

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

Report on other legal and regulatory requirements

Statement

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

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

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

Prescribed requirements scope

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

28 August 2020

C G Strickland
as delegate of the Auditor-General

Queensland Audit Office
Brisbane