ANNUAL REPORT 2016–2017

Mackay Hospital and Health Service

Queensland Government

Acknowledgement to Traditional Owners

The Mackay Hospital and Health Service acknowledges the Traditional Custodians of the land and waters of all areas within our geographical boundaries. We pay respect to the Aboriginal and Torres Strait Islander Elders past, present and those yet to come on whose land we provide health services as we make tracks towards closing the gap.

The Mackay Hospital and Health Service is committed to Closing the Gap Initiative targets:

- to close the gap in life expectancy within a generation (by 2031); and
- to halve the gap in mortality rates for Indigenous children under five by 2018.

Recognition of Australian South Sea Islanders

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

Attribution

Content from this annual report should be attributed as:
Mackay Hospital and Health Service Annual Report 2016–2017.

Public Availability Statement

Copies of this publication can be obtained from the Mackay Hospital and Health Service website:
http://www.mackay.health.qld.gov.au/

The direct download link is:
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Copies of the report can be sent by email by contacting the Media and Communications Managers on (07) 4885 5984 or by emailing **mhhs-comms@health.qld.gov.au**

Interpreter Service Statement

Mackay Hospital and Health Service Annual Report 2016–2017

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 (07) 4885 5984 and we will arrange an interpreter to effectively communicate the report to you.

Written and developed by the Mackay Hospital and Health Service 2017

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Letter of compliance

30 August 2017

The Honourable Cameron Dick MP
Minister for Health and Minister for Ambulance Services
GPO Box 48
BRISBANE QLD 4001

Dear Minister,

I am pleased to submit for presentation to the Parliament the Annual Report 2016–2017 and financial statements for Mackay Hospital and Health Service.

I certify that this Annual Report complies with:

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

A checklist outlining the annual reporting requirements can be found on pages 30–31 of this annual report.

Yours sincerely

The Honourable Timothy Mulherin
Board Chair
Mackay Hospital and Health Board

Cyclone Debbie

Mackay Hospital and Health Service (Mackay HHS) facilities were battered and tested when Cyclone Debbie made landfall near Airlie Beach on 28 March 2017.

Proserpine, Cannonvale, Bowen, Collinsville, Moranbah, Mackay and Sarina were all affected with the Whitsundays bearing the brunt of the Category 4 system.

Our capable staff sprung into action in the days leading up to Cyclone Debbie, working as a team to prepare for the storm and keep services available to our community.

The Mackay HHS response to Cyclone Debbie was managed around-the-clock in the Emergency Operations Centre with support from the State Health Emergency Coordination Centre.

Every hospital remained open during the cyclone and the following storm despite varying degrees of infrastructure damage. Many staff worked long hours, going above and beyond their normal roles.

Relief staff from other hospital and health services were welcomed with open arms by exhausted locals, many who had been bedded down at their facilities for more than 24 hours.

The 156 staff members from other hospital and health services included a mix of clinical, public health, mental health and building engineering and maintenance services support.

Operational impacts from the cyclone were significant, with record Emergency Department presentations to Bowen, Proserpine and Mackay hospitals.

All cancelled patient appointments and elective surgery as a direct result of Cyclone Debbie were rescheduled and completed before the end of the 2016–2017 year.

Support for staff personally affected by the cyclone continues to be provided through the Staff Employee Assistance Scheme. Community mental health services have also been expanded through additional funding of $2.37 million over two financial years to provide early intervention mental health support.

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Board Chair and Chief Executive Message

The 2016–17 financial year has once again positioned Mackay HHS as one of the top performing hospital and health services in Queensland. We have experienced the busiest year ever, caring for a record number of people in our hospitals, emergency and specialist outpatients departments, dental clinics and community-based services. Even more impressively this has been done within budget.

The opening of a new 12-bed ward in February 2017 is undoubtedly among the highlights, along with expanding mental health services and seeing major infrastructure projects at Bowen and Proserpine progress.

Waiting times to see a specialist doctor in the Outpatients Department significantly improved with most people waiting within the clinically recommended time. This is brilliant news for our community and we thank the hard working staff who made this happen. As a health service our vision is to deliver Queensland's best rural and regional healthcare and one way we can do this is by making sure, where possible, that people are treated on time.

We are particularly proud of providing more local care for our community because we know the burden and pressure of travelling for services is significant. In late 2016 Mackay Base Hospital started Ear, Nose and Throat specialist outpatient appointments thanks to a visiting service from The Townsville Hospital. This service expanded in early 2017 to include weekly theatre sessions, also reducing the need for people to travel away for care.

The Mackay Hospital and Health Board (MHHB) and the Executive Leadership Team have worked together to set us on a strong path to deliver our strategic direction. Through careful consideration the MHHB has been pleased to support retained earnings expenditure of $9.8 million to invest in the digital hospital, new ward opening, specialist outpatients department and research and innovation. We ended the year with a planned deficit of $6.08 million and are pleased to enter the new financial year with a 16% operating budget increase.

In 2016–17 we continued to embrace technology to offer more care to patients in a way that is smarter and safer. The use of telehealth grew by an impressive 48% and per capita we are now the number one provider of telehealth in Queensland. Mackay Base Hospital's transformation into a digital hospital continues and this year we rolled out more functionalities of the Integrated Electronic Medical Record (ieMR). In six months we have seen benefits across pathology, care delivery and emergency applications.

Collaboration with external partners and the community is improving the care of our patients. The launch of the Mackay Institute of Research and Innovation (MIRI) will lead to cutting edge medical research and clinical innovation. Partnering with other healthcare providers, researchers and companies will help translate the latest clinical knowledge into practice. The community is also playing a bigger role in advising how we deliver hospital and health services. Membership of the Mackay Consumer Advisory Partners expanded to better reflect the voice of our diverse communities and a new community group was formed in Bowen.

Our progress towards one health system moved forward with Mackay HHS chosen as a pilot site for the Clinical Prioritisation Criteria project improves information sharing processes with GPs to enhance triage categorisation processes for their patients needing to see a specialist doctor. The Clinical Prioritisation Criteria is accessed through the HealthPathways portal and this has correlated to a decrease in unnecessary referrals to the specialist outpatients department.

Looking ahead we start the new year with a strong focus on improving the health of our region in terms of obesity, smoking and alcohol consumption rates, and mental health. Through wide-ranging partnerships we will be tackling these issues on a community level.

A note from the Board Chair

Mackay HHS is delighted to have welcomed Jo Whitehead as Chief Executive in May 2017, bringing stability and expertise to the Executive Leadership Team. Jo came to us from Central Queensland Hospital and Health Service where she worked as both Acting Chief Executive and Deputy Chief Executive. Prior to this she had a varied career in the UK with more than 30 years of experience in healthcare.

During the year, the Mackay HHS also benefited from the extensive executive healthcare leadership experience and operational strength of former Acting Chief Executive Helen Chalmers. I would also like to personally thank Helen on behalf of the MHHB for her support and to wish Helen every success in her future endeavours.

I have thoroughly enjoyed my full first year as Board Chair and I thank the Executive Leadership Team and my fellow Board Members for their considerable service. I continue to be impressed with the thoroughness, diligence, experience and commitment of the Board Members and their passion for developing safe and sustainable services across the region and supporting our outstanding workforce.

On behalf of the MHHB I wish to express my gratitude to all staff for their pride and commitment in their work. The health service is also supported by the wonderful work of the Mackay Hospital Foundation and its volunteers who do so much to improve the comfort of our patients. Whether it is purchasing medical equipment, a friendly hello when you walk into the Mackay Base Hospital or visit the gift shop or craft activities with our smallest patients your work is noticed and valued.

The Honourable Timothy Mulherin
Board Chair
Mackay Hospital and Health Board

Jo Whitehead
Chief Executive
Mackay Hospital and Health Service

2016–2017

Snapshot and Highlights

9,944
*Operations performed**

207,098
*Outpatient appointments provided**

77,044
People presented to emergency departments

7,667
Number of breast screens

6,913
Telehealth consultations

1,615
Babies born

50,545
Patients cared for on our wards

40,348
Dental treatments

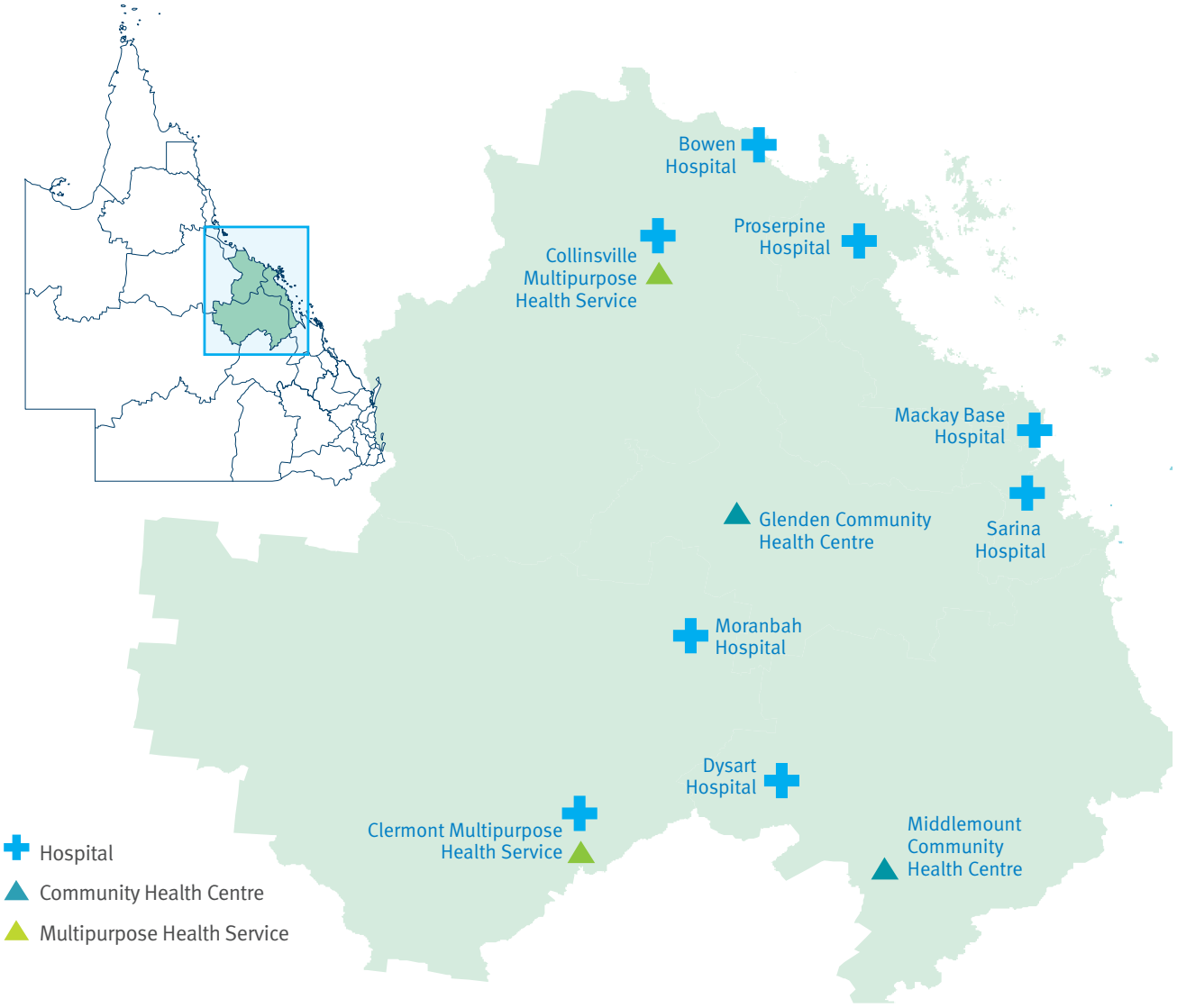
358
Number of staff recognised for 5 to 50 years' service

** Total numbers for Mackay Base Hospital and Proserpine Hospital*

Our organisation

Our role and function

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



About the Mackay Hospital and Health Service

The Mackay HHS is responsible for the delivery of public hospital and health services including medical, surgical, emergency, obstetrics, paediatrics, specialist outpatient clinics, mental health, critical care and clinical support services to an estimated resident population of 181,800 persons. The geographical catchment of the Mackay HHS spans 90,364 square kilometres, extending from Bowen in the north to St Lawrence in the south, west to Clermont and northwest to Collinsville and includes Proserpine and the Whitsundays.

The Aboriginal and Torres Strait Islander population in the Mackay HHS region is 4.9% of the overall population (Queensland Government Statistician's Office), higher than the 4.0% Queensland average. There is also a significant Australian South Sea Islander community in the region.

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

The health service has 354 approved beds and bed alternatives plus 29 aged care beds. Facilities include:

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

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

Strategic risks, challenges and opportunities

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

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

Looking ahead, we expect to see a continued increase in demand for public health services, within a constrained fiscal environment. This means we will focus on responding to the community's health priorities, such as mental health and chronic disease and continue our commitment to closing the gap for Aboriginal and Torres Strait Islander people through implementation of *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033*.

We will work with our public and private partners to ensure individuals receive care at the right place, at the right time and as close to home as possible. We will remain resolute in improving our patient flow, including theatre efficiency; working to achieve shorter stays in emergency departments and ensuring our patients are treated within the clinically recommended timeframes. To respond to the demand, attracting and retaining a skilled workforce and developing and implementing innovative service models will continue to be a strong focus for the health service.

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

Public Service Values

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

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

Customers first

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

Ideas into action

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

Unleash potential

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

Be courageous

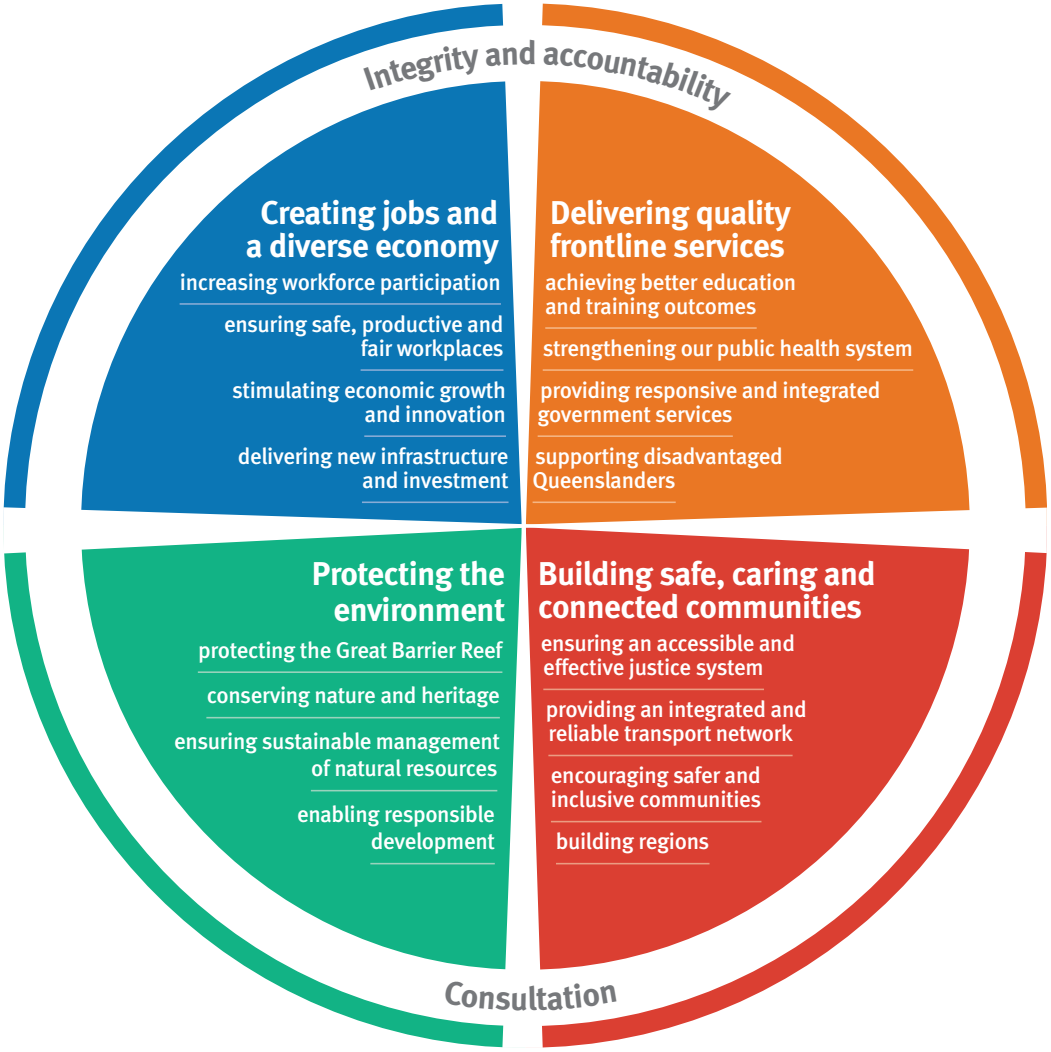
- Own your actions, successes and mistakes
- Take calculated risks
- Act with transparency

Empower people

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

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

Our performance



The Queensland Government's Objectives for the Community

Our strategic direction

Mackay HHS is committed to providing services that are efficient, diverse and flexible to changing community and government needs.

Our strategic plan reflects the Queensland Government's priorities regarding frontline services; creating jobs and a diverse economy and building safe, caring and connected communities. More specifically, we have focussed on the following key areas specific to the health context – strengthening our public health system; supporting disadvantaged people; ensuring safe, productive and fair workplaces and achieving better health-related education and training outcomes.

The MHHB sets the organisation's strategic agenda and monitors performance against its delivery. The Mackay HHS Strategic Plan 2016–2020 sets out four inter-related objectives each with their own strategies, to achieve the Mackay HHS vision. These strategic objectives are – Inspired People; Exceptional Patient Experiences; Excellence in Integrated Care; and Sustainable Service Delivery. In 2016–2017 a range of services, programs and initiatives were implemented to deliver on our strategic objectives, including those highlighted on the following pages.

Inspired People

Valued and empowered staff

Mackay HHS values and empowers its staff through a comprehensive program of reward and recognition events, wellbeing and peer support initiatives and leadership development opportunities. Our workforce is diverse and highly skilled and in 2016–17 there was a strong focus on supporting managers and senior leaders to grow their leadership capability.

The Reward and Recognition Program acknowledges, celebrates and thanks staff in front of their peers for their contribution to healthcare. In April 2017 more than 200 staff at Mackay Base Hospital attended the *Let's Celebrate* event and throughout the month similar events were held at rural facilities. This year 358 employees were recognised for length of service from five to 55 years. A record 42 nominations were received for eight award categories that were strongly linked to achievements and behaviour that reflects the Mackay HHS values of Collaboration, Trust, Respect and Teamwork.

Safe and caring place to work

Mackay HHS is embedding a Peer Support Program to provide caring, supportive and confidential interventions for staff involved in occupational violence incidents and other potentially traumatic events. This reflects the health service's commitment to being a safe and caring place to work. The voluntary and confidential service is led by 31 volunteer peer coordinators who are trained in psychological first aid techniques and self-care principles and who are available to provide a 'caring ear' to offload everyday stressors and link colleagues with additional services if needed.

Bowen Hospital... winner of the Collaboration Award.

Exceptional Patient Experiences

Better access to services

Mackay HHS has made significant gains to improving the patient experiences of the health system both in terms of the range of clinical service provided and engagement with consumers, community and healthcare partners.

Almost every patient who needs to see a specialist doctor in the Outpatients Department is having their appointment within the clinically recommended time. At 30 June 2017 there were 84 long wait patients from Mackay and Proserpine, down from 1,248 in January 2017. An investment of more than $5.5 million from the Mackay HHS and Department of Health has allowed more appointments to be offered by locum and visiting specialists and increased use of telehealth. We have also partnered with private healthcare providers to outsource some services. The areas with the greatest improvements were cardiology, ophthalmology and neurosurgery.

Fewer patients are travelling for specialist care following a 48% increase in the use of telehealth with 6,912 services across 34 specialties in 2016–17. Mackay HHS is the fourth highest user of telehealth in Queensland and on a per capita basis is number one.

Telehealth connects patients in Mackay with specialist doctors in capital cities.

Listen to our community and consumers

Consumer and community input in to the development and review of health services increased significantly. Membership of the Consumer Advisory Partners group was expanded from 10 to 22 and comprises a diverse membership including representation from multicultural and indigenous group, aged care, chronic disease, disability support, mental health, maternity services, end-of-life care and primary health care. Community reference groups have been established in Bowen, with other rural facility groups to come on line in 2017–18. There has been an increase in consumer engagement in the evaluation of service delivery and service improvements, including focus groups to review communication in patient travel, way finding and discharge surveys.

Treat our patients as individuals

Improving the healthcare journey for people accessing mental health services is a high priority for the Mackay HHS. Community mental health services and patient supports have been strengthened through additional frontline staff. An additional 10 mental health positions were created to increase access to medical officers and to expand home-based acute care services. There is a particular focus on Child and Youth Mental Health Services to meet increased demand. Funding was also provided to open a new Step Up Step Down mental health facility to support consumer recovery. This facility is a safe place to 'step down' after a hospital stay before returning home or a place to 'step up' if their health is deteriorating with the aim of avoiding a hospital admission.

Excellence in Integrated Care

Seamless health care system

Patient care is becoming more seamless as Mackay HHS works with other healthcare providers to provide more integrated care. Nurse Navigators are helping patients find their way through an often complex health system by providing support to people who need a high degree of clinical care. The five nurse navigators work in palliative care, aged care, ambulatory care, stroke recovery and rural support to provide end-to-end care and service coordination along their entire healthcare journey. They work across system boundaries and in close partnerships with other service providers to ensure patients receive appropriate and timely care.

Mackay HHS's first five Nurse Navigators and Acting Nursing Director.

Collaborative and productive partnerships

People requiring specialist doctor review are benefitting from more appropriate referral categories as relationships between GPs and the Mackay HHS strengthen through implementation of the Clinical Prioritisation Criteria. The new guidelines support GPs to triage their patients into urgency and ensure there is more equitable allocation of categories – that the same categories are applied State-wide. The HealthPathways program now has 374 live localised referral pathways that healthcare workers can access to determine the treatment options for patients. GPs also have access to hospital medical records through The Viewer to allow better information sharing and care coordination between primary and acute care.

Smart use of technology

Smart use of technology through the Digital Hospital Project is delivering more coordinated care. Mackay Base Hospital successfully deployed Phase 1 of the Digital Release functionality in July 2016 resulting in improved pathology, care delivery and emergency applications. Integrated vital signs monitors are now used for all patients and the connected and automated upload of patient's vital signs into the clinical notes allows nursing staff to dedicate more time to patient communication and care rather than data collection. Patient safety is improved as transcription errors are eliminated.

Pathology samples are electronically scanned in the Emergency Department.

Sustainable Service Delivery

Work with our private and public sector partners

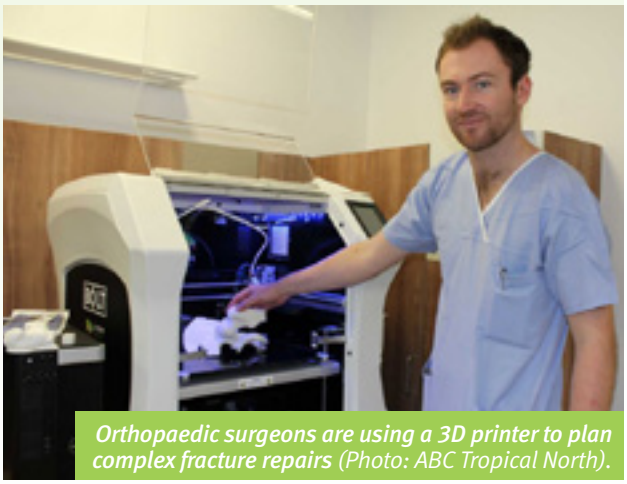
New partnerships and service models are providing more community mental health support in the Mackay HHS. People recovering from a severe mental illness are receiving more support in the community thanks to a partnership between the Mackay HHS and Ozcare. The Support Time and Rehabilitation Recovery Service brings together mental health clinicians and support workers to help people regain their independence and community connections. Ozcare workers provide a range of non-clinical services and allow health service staff to focus on clinical work. Mackay HHS also partners with the Mackay Mater Hospital and The Townsville Hospital to offer some surgical services to ensure services meet community health needs.

Leading teaching hospital

Mackay Base Hospital's position as a leading teaching hospital is being cemented with the launch of the MIRI. MIRI will collaborate with external partners to lead to cutting edge research and innovation. The aim is to improve patient care by implementing the latest clinical knowledge into practice. The emerging translational research and innovation centre also has a focus on improving patient care through productivity, safety and better ways of doing business. MIRI is a partnership between Mackay HHS, James Cook University (JCU) and the Tropical Australian Academic Heath Centre.

The right service, in the right place

Weekly Ear Nose and Throat specialist clinics and theatre sessions have started so patients no longer have to travel to Townsville or Brisbane for care. Patients are supported by medical and nursing staff in their own community which removes the stress of leaving home to receive care. Mackay Base Hospital has partnered with The Townsville Hospital to provide the visiting outpatient and surgical service.



Orthopaedic surgeons are using a 3D printer to plan complex fracture repairs (Photo: ABC Tropical North).

Mackay Base Hospital has welcomed new anaesthetic machines as part of the digital hospital project.

Service Delivery Statement: 2016–17 Performance Statement

Mackay HHS – Service Standards	Notes	2016–17 Target/Est.	2016–17 Actual
Effectiveness measures			
Percentage of patients attending emergency departments seen within recommended timeframes:			
• Category 1 (within 2 minutes)		100%	99.0%
• Category 2 (within 10 minutes)		80%	82.1%
• Category 3 (within 30 minutes)	1	75%	61.0%
• Category 4 (within 60 minutes)		70%	73.3%
• Category 5 (within 120 minutes)		70%	93.1%
• All categories	2	..	69.9%
Percentage of emergency department attendances who depart within four hours of their arrival in the department	3	›80%	74.4%
Percentage of elective surgery patients treated within clinically recommended times:			
• Category 1 (30 days)		›98%	98.3%
• Category 2 (90 days)		›95%	99.3%
• Category 3 (365 days)		›95%	99.7%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days		‹2	0.37
Rate of community follow-up within 1–7 days following discharge from an acute mental health inpatient unit		›65%	67%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	4	‹12%	16.8%
Percentage of specialist outpatients waiting within clinically recommended times:			
• Category 1 (30 days)		70%	95.8%
• Category 2 (90 days)		70%	96.0%
• Category 3 (365 days)		90%	98.7%
Percentage of specialist outpatients seen within clinically recommended times:			
• Category 1 (30 days)		New measure	76.1%
• Category 2 (90 days)		New measure	65.5%
• Category 3 (365 days)		New measure	91.4%
Median wait time for treatment in emergency departments (minutes)		20	18
Median wait time for elective surgery (days)	5	25	41

Mackay HHS – Service Standards	Notes	2016–17 Target/Est.	2016–17 Actual
Efficiency measure			
Average cost per weighted activity unit for Activity Based Funding facilities		$4,752	$4,774
Other measures			
Number of elective surgery patients treated within clinically recommended time:			
• Category 1 (30 days)		New measure	1081
• Category 2 (90 days)		New measure	1162
• Category 3 (365 days)		New measure	361
Number of Telehealth outpatient occasions of service events		New measure	6,875
Total weighted activity units:	6		
• Acute Inpatient		27,430	37,352
• Outpatients		9,509	10,090
• Sub-acute		1,972	1,902
• Emergency Department		8,480	9,240
• Mental Health		3,302	3,571
• Prevention and Primary Care		1,764	1,904
Ambulatory mental health service contact duration (hours)		›27,854	27,888

Notes:

1. In 2016–2017, the Mackay HHS delivered in excess of 57,300 emergency episodes of care, of which greater than 45% were category 3. This category has seen an 11% increase in presentations since 2015–2016.
2. A target for percentage of emergency department patients seen within clinically recommended timeframes is not included for the 'All Categories' as there is no national benchmark. The included triage category 2016–17 target/estimates are based on the Australasian Triage Scale.
3. The centrally collected dataset includes Emergency Departments of the Mackay Base Hospital and Proserpine Hospital. This measure relates to patients who arrived at and departed from the emergency department, inclusive of patients who departed by admission to hospital as an inpatient. In 2016–17, the Mackay HHS experienced overall growth of 7% in inpatient activity.
4. Final data for 2016–17 is not yet available. As such the measure only includes data available to May 2017 financial year to date.
5. The 2016–17 Actual is below target primarily due to the increased number of elective theatre cases of 8% for the Mackay HHS, with the Mackay Base Hospital increasing by 15% on the previous financial year.
6. The 2016–17 Actual is preliminary until final validation and data updates occur prior to the end of the calendar year. Actuals for procedures and interventions have been apportioned notionally to acute inpatient and outpatients categories, based on historical statewide trends.

Financial Performance

The Mackay HHS has incurred a planned financial deficit of $6.08 million for the year ending 30 June 2017.

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

The MHHB resolved in the 2016–2017 financial year that it would invest a significant amount of the retained earnings in initiatives to improve health services delivery to its community. These included the following initiatives:

- reduced waiting times for specialist outpatient appointments and elective surgery
- enhanced clinical information technology systems – the Digital Hospital
- increased inpatient acute bed capacity through the opening of 12 new beds at the Mackay Base Hospital
- supporting clinicians and General Practitioners by way of Health Pathways to better navigate the local health system for assessment, management and referral of patients.

If the reported deficit is adjusted for the MHHB approved spend from retained earnings the Mackay HHS has achieved a surplus of $4.9 million which exceeds the budgeted breakeven objective committed to in its Service Delivery Statement.

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

Income

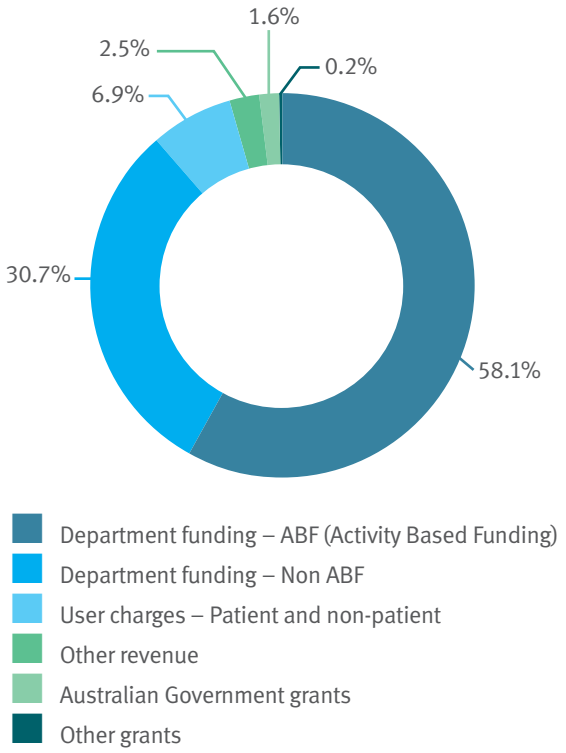
Mackay HHS's income is sourced from three major areas:

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

Figure 1 details the extent of these funding sources for 2016–2017. Mackay HHS total income was $400.1 million which includes:

- The **Activity Based Funding (ABF)** for hospital services was 58.1% or $232.3 million
- **Non ABF funding** was 30.7% or $123.0 million
- **User charges** comprising patient and non-patient funding was 6.9% or $27.7 million
- **Australian Government grant** funding was 1.6% or $6.3 million
- **Other revenue** was 2.5% or $9.9 million
- **Other grant** was 0.2% or $0.8 million.

Figure 1. Revenue by funding type



Expenses

The total expenses were $406.2 million, an average of $1.1 million a day for providing health services.

Labour costs within Mackay HHS make up approximately 62% of expenditure with the remaining 38% being non-labour costs such as supplies, services, and depreciation charges.

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

Figure 2. Allocations to services within the Mackay HHS

Where the money goes	%
Admitted patient services in acute care institutions	45%
Non-admitted patient services in acute care institutions	15%
Mental health include community services	6%
Nursing homes for the aged	2%
Patient transport	3%
Public health services	3%
Other community health services	18%
Health administration	7%

Let's celebrate

Our people

Providing high quality health care in rural and regional Queensland is a unique and privileged challenge. Mackay HHS is one organisation across eight hospitals and five community health centres. The Mackay HHS's capacity to deliver excellent regional health care is supported by an exceptional workforce.

Enabling our workforce to provide the highest level of care to the community we serve requires a proactive approach to workforce planning, development and engagement to create the right capability mix to meet current and future demands.

Workforce

Mackay HHS employs health professionals and support service staff. Medical, nursing, clinical and non-clinical support staff and volunteers work together to deliver quality care and service to the community.

Full-Time Equivalents (FTE) as at 30 June 2017

Classification Stream	Permanent	Temporary	Casual
Managerial and Clerical	305.88	117.31	7.38
Medical (including Visiting Medical Officers)	79.81	186.72	–
Nursing	693.15	129.19	25.86
Operational	284.04	43.26	39.95
Trade and Artisans	4	–	–
Health Professional and Technical Officers	206.79	42.33	0.55
Total	**1,573.67**	**518.81**	**73.74**

The Mackay HHS turnover rate for 2016–2017 was 13.4% compared to a permanent separation rate for 2015–2016 of just over 13.6%. Sick leave (paid and unpaid) hours versus occupied FTE for the 2016–2017 year was 3.48%.

Interns

Mackay HHS welcomed 43 medical interns to start their careers in 2017. Six intern places were funded by the Commonwealth Medical Intern Program through our joint venture with Mercy Health and Mackay Mater Hospital. These interns complete core medical and surgical terms at Mackay Mater Hospital and the remainder of their terms at Mackay Base, Bowen or Proserpine Hospitals. Another 20 interns funded by the Medical Internship Program run through the Greenslopes Private Hospital visit Mackay HHS to complete a rotation at Mackay Base Hospital.

Graduate nurses

Mackay HHS welcomed 51 graduate nurses to Mackay Base Hospital and in rural facilities, an increase from 46 in 2016. Of the 51 new nurses 26 are working in rural facilities. The new nurses were mostly graduates from Central Queensland University (CQU) and JCU.

Workforce optimisation

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

Mackay HHS is improving its recruitment strategies with the start of a Talent Acquisition Project in October 2016 to review existing recruitment models and improve efficiencies. The use of LinkedIn recruiter to attract candidates has been embedded.

Workforce Development, Support and Engagement

The Mackay HHS developed and adopted the *Our People Plan 2016–2018*. This strategy provides a roadmap of workforce interventions to enable Mackay HHS to deliver the best regional healthcare and should place us in a strong position to meet further challenges. Staff learning was supported through improvements to the learning management system *My Learn*.

Mackay HHS is the first HHS to establish a Peer Support Program which will be deployed State-wide to other health services following evaluation of the pilot. The program is a recommendation from the Occupational Violence Prevention Task Force report established by the Minister for Health and Minister for Ambulance Services, The Honourable Cameron Dick MP. Since February 2017, 25 Peer Responders have provided 82 colleagues with psychological first aid and links to other supports.

Employee Health and Wellbeing Program

The Employee Health and Wellbeing Program supports staff to be healthy and active within the workplace and beyond. The program provides resources and facilitates activities and opportunities to encourage participation in healthy lifestyle programs that focus on physical, social, emotional and financial wellbeing.

Flexible working arrangements

Mackay HHS is committed to the provision of flexible work arrangements such as part time work. At 30 June 2017, 38% of staff had part-time working arrangements. Tools to support both line managers and employees to understand the options and processes around flexible working arrangements are available.

Performance development

The Performance and Development plan process assists employees to have meaningful and productive career discussions.

Work Health and Safety

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

- The Workplace Health and Safety Checklist Program was replaced with the WHS Internal Audit process for 2016–17 and evaluates compliance with legislative requirements and reviews identification and management requirements of workplace risks. As at 30 June 2017, 100% of work areas had completed the internal audit and provided evidence to substantiate legislative compliance.
- An OHS Audit against AS/NZS4801:2001 and Safer and Healthier Workplace Elements was conducted from 27–29 January 2016 by QRMC Risk Management Pty Ltd. The OHS Audit reported compliance with OHS Policy, Injury Treatment and Management and Claims Management; and the only outstanding recommendation is related to a non-conformance for the implementation of a contractor management system for Mackay HHS.
- Health and Safety Representatives have been appointed across the Mackay HHS with 95% attending the five day training with a Registered Training Organisation. With the appointment of Health and Safety Representatives it enhances the consultation process and revitalises the prominence and importance of health and safety across the Mackay HHS.

The Mackay HHS WorkCover premium rate continued to remain favourable as a result of the implementation of preventative strategies to manage workplace injuries and return to work programs. The Mackay HHS continues to achieve positive outcomes against key WorkCover Indicators including WorkCover hours lost compared with FTE which at 0.03% remains below this target of 0.35%.

Occupational Violence Prevention

Mackay HHS is committed to the reduction and impact of violence in the workplace. The Occupational Violence Prevention Sub-Committee continues to meet on a monthly basis focusing on reviewing data trends, researching current best practice, monitoring training and compliance rates and facilitating engagement with the working groups for the Occupational Violence Implementation Committee and implementing recommendations. In 2016–17, 520 staff were trained in occupational violence prevention.

Public Interest Disclosure

In accordance with section 160 of the HHBA, the Mackay HHS is required to include a statement in its Annual Report detailing the disclosure of confidential information in the public interest. There were four disclosures of alleged official misconduct made and investigated during 2016-2017.

Industrial and Employee Relations Framework

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

Early retirement, redundancy and retrenchment

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

Our Values

Collaboration

Through partnerships and co-operation we drive innovation

Trust

Having confidence, and belief in each other to be able to rely and depend on our actions

Respect

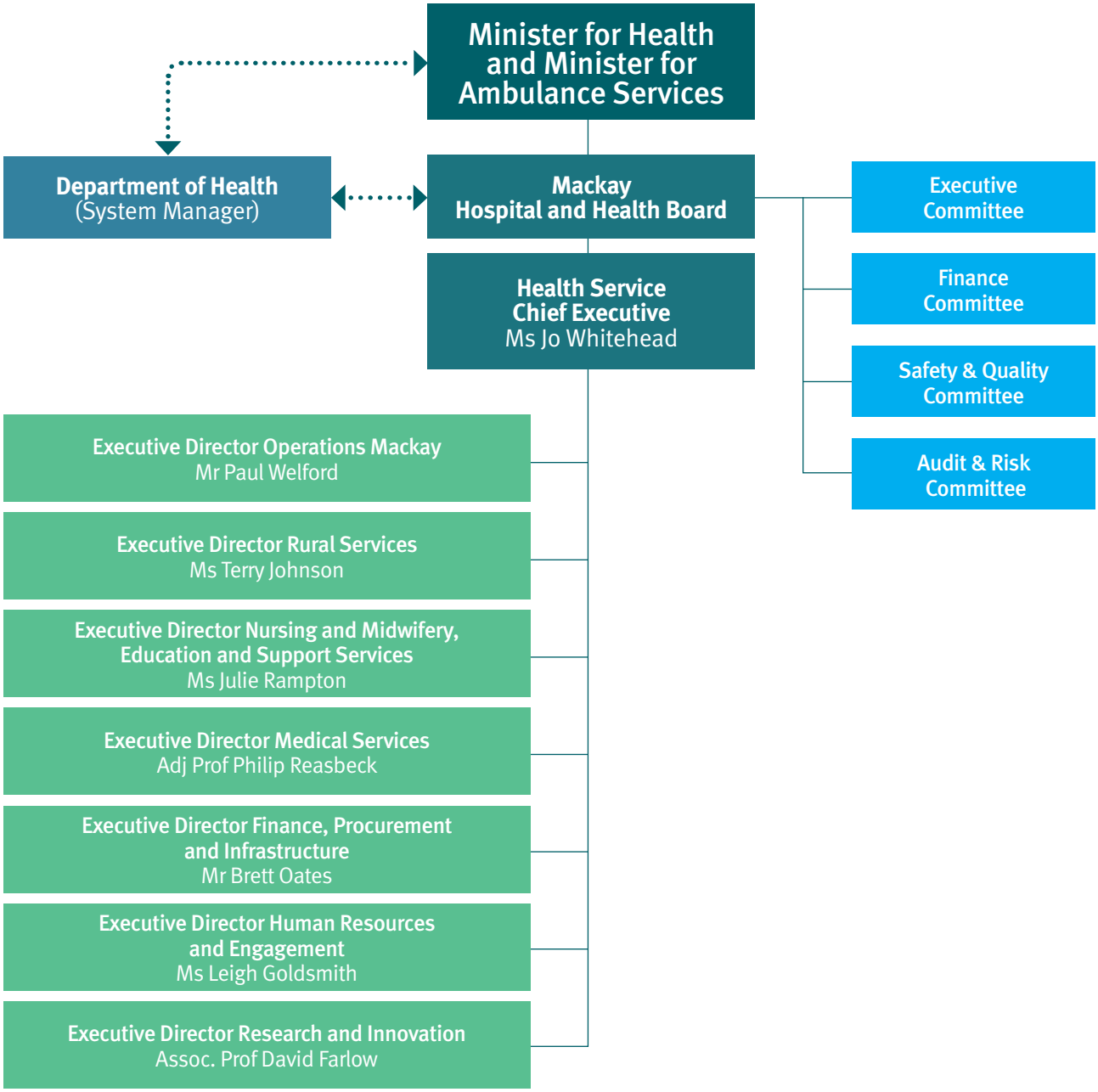
We show respect and compassion for the people we care for and work with

Teamwork

We depend on and support one another individually and as a team

Our governance

Organisation structure as at 30 June 2017



Mackay Hospital and Health Board

The MHHB is appointed by the Governor of the State of Queensland acting by and with the advice of the Executive Council on the recommendation of the Minister for Health and Minister for Ambulance Services. The MHHB derives its authority from the HHBA and the *Hospital and Health Boards Regulation 2012* (Qld) (HHBR). Board Members act in accordance with their duties and abide by the Code of Conduct and Values for the Queensland Public Service in accordance with the *Public Sector Ethics Act 1994* (Qld).

The MHHB's functions include:

- Develop strategic direction and priorities for the Mackay HHS. The MHHB uses local decision-making to develop plans, strategies and budgets to ensure accountable provision of health services to meet the needs of the community.
- Monitor compliance and performance of the Mackay HHS. It oversees the operation of systems for compliance and risk management, and audit reporting to meet legislative requirements and national standards.
- Focus on patient experience and quality outcomes. Meeting the challenges of distance and diversity is essential to providing patient care across the Mackay HHS.
- Ensure evidence-based practice education and research. The MHHB encourages partnering with universities and training providers to boost clinical capability.

MHHB achievements for 2016–2017:

- Approved the construction of a new aged care building at Clermont MPHS to accommodate patients relocating from Monash Lodge;
- Approved investment in the establishment of the MIRI;
- Developed the *Our People Plan 2016–2018* and *Employee Engagement Strategy 2017–2020*;
- Continued to invest in Mackay HHS's digital future through the Digital Hospital Program;
- Committed to improving access to car parking at Mackay Base Hospital through demand study;
- Continued to promote the Mackay HHS Strategic Plan objectives and values.

The MHHB meets monthly or as directed by the Board Chair. The 2016–2017 MHHB Committees structure was:

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

The Honourable Timothy Mulherin
Board Chair

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

Originally appointed on 18 May 2016, The Hon. Mulherin's current term of office is 18 May 2017 to 17 May 2021.

Mr Darryl Camilleri
Deputy Chair

Mr Camilleri is the former Deputy Mayor of the Mackay Regional Council and has served as Chair for a number of community organisations. He is also a Chartered Accountant and has extensive experience in tax planning, finance and audits.

Originally appointed on 29 June 2012, Mr Camilleri's current term of office is 18 May 2017 to 17 May 2020.

Mr David Aprile
Board Member

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

Originally appointed on 29 June 2012, Mr Aprile's current term of office is 18 May 2017 to 17 May 2020.

Our governance

Dr Helen Archibald
Board Member

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

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

Professor Richard Murray
Board Member

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

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

Mr John Nugent
Board Member

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

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

Mrs Suzanne Brown
Board Member

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

Originally appointed on 18 May 2016, Ms Brown's current term of office is 18 May 2017 to 17 May 2021.

Ms Karla Steen
Board Member

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

Originally appointed on 18 May 2016, Ms Steen's current term of office is 18 May 2017 to 17 May 2021.

Ms Leeanne Heaton
Board Member

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

Originally appointed on 18 May 2016, Ms Heaton's current term of office is 18 May 2017 to 17 May 2021.

Mackay Hospital and Health Board Committees

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

Executive Committee

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

a. working with the Health Service Chief Executive to progress strategic issues identified by the MHHB; and

b. strengthening the relationship between the MHHB and the Health Service Chief Executive to ensure accountability in the delivery of services by the Mackay HHS.

The Executive Committee functions under the authority of the MHHB in accordance with section 32B of the HHBA.

Committee membership

- Timothy Mulherin (Chair)
- Darryl Camilleri
- Helen Archibald
- Karla Steen

Meetings are held biannually or as directed by the Chair.

Audit and Risk Committee

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

Committee membership

- Darryl Camilleri (Chair)
- John Nugent
- Helen Archibald
- Suzanne Brown

Meetings are held quarterly or as directed by the Chair.

Finance Committee

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

Committee membership

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

Meetings are held monthly or as directed by the Chair.

Safety and Quality Committee

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

Committee membership

- Helen Archibald (Chair)
- Richard Murray
- Leeanne Heaton
- Karla Steen

Meetings are held quarterly or as directed by the Chair.

Board Members	MHHB	Finance Committee	Audit and Risk Committee	Safety and Quality Committee	Executive Committee
Total Meetings	**11**	**12**	**4**	**4**	**4**
Timothy Mulherin	11	11			3
Darryl Camilleri	10	11	4		4
Helen Archibald*	11		2	4	4
David Aprile*	8	10			
Richard Murray*	8			3	
John Nugent	11	10	4		
Suzanne Brown	11		4		
Karla Steen	10			4	4
Leeanne Heaton	11			4	

1. ** Members of the MHHB who satisfy the Clinical expertise requirement under section 23(4) of the HHB.*
2. *Total out of pocket expenses claimed during the reporting period totalled $1,187.89.*

Mackay HHS Executive Leadership Team

Ms Jo Whitehead
Health Service Chief Executive

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

Mr Brett Oates
Executive Director Finance, Procurement and Infrastructure

Mr Oates commenced with Mackay HHS in August 2016 following three and a half years as CFO for the North West Hospital and Health Service, where he oversaw the development of financial and reporting systems in the formative years of the HHS. Demonstrating his commitment to integration of hospital and primary health, Brett undertook the role as Interim Chief Executive of the Western Queensland Primary Health Network for a period of 6 months supporting this valuable initiative for Western Queensland.

Ms Julie Rampton
Executive Director Nursing and Midwifery, Education and Support Services

Ms Rampton has worked for Queensland Health for over 38 years, over 25 of those in senior nursing roles. She was the Director of Nursing at the Maryborough Base Hospital before moving to Mackay. She trained in Midwifery at the Royal Women's Hospital in Brisbane. Ms Rampton is a member of the Queensland Nursing and Midwifery Executive Council, and the Nursing and Midwifery Implementation Group for EB9. She is an adjunct professor at CQU.

Adj Prof Philip Reasbeck
Executive Director Medical Services

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

Mr Paul Welford
Executive Director Operations Mackay

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

Ms Terry Johnson
Executive Director Rural Services

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

Ms Leigh Goldsmith
Executive Director Human Resources and Engagement; and Digital Hospital Program

Ms Goldsmith is a skilled strategic leader with more than 30 years HR, organisational development, strategic and business planning, and change management experience. She has significant Queensland Government experience; as well as private sector and consultancy experience. Ms Goldsmith has lead organisational transformation across various sectors, including ICT, shared services, health and education. She is passionate about creating strategic and tactical HR services that add value to the business and enable an innovative culture able to respond to an ever changing operating environment.

Assoc. Prof David Farlow
Executive Director Research and Innovation

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

Ms Helen Chalmers
Acting Health Service Chief Executive (from 6 June 2016 to 3 March 2017)

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

Health Service Committees

The Mackay HHS committee structure compromises of a number of tiers, partnerships and forums to ensure good governance, including:

Executive Leadership Team

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

Clinical Governance Committee

The Committee is responsible for the implementation of the clinical governance framework and Mackay HHS Safety and Quality Plan in order to ensure the efficient, safe and effective delivery of clinical services by:

- Minimising preventable harm to patients and clients.
- Working to achieve best practice health outcomes.
- Providing the governance structure to ensure the 10 National Standards from the Australian Commission on Safety and Quality in Health Care are met together with the additional mandatory requirements of the accrediting agency.

Meetings are held on a monthly basis.

Credentialing and Scope of Clinical Practice (SOCP) Committee

The Committee is responsible for considering an applicant's credentials and requested SOCP and providing recommendations for defining a SOCP to the Mackay HHS's delegated decision. The Committee reviews the credentials and granted defined SOCP for Nurse Practitioners providing services with the Mackay HHS facilities. The Committee evaluates application for new clinical interventions and procedures and considers the SOCP for relevant medical practitioners who will be performing the new clinical intervention or procedure. Meeting are held on a monthly basis.

Clinical Council

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

Education and Research Advisory Council

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

Emergency and Business Continuity Planning Committee

The Committee governs emergency planning and business continuity systems and processes for the Mackay HHS to ensure facilities are prepared to respond to events in line with relevant legislation and Health Service Directives. Meetings are held on a quarterly basis.

Safe Practice and Environment Committee

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

Clinical Information and ABF Group

The Group's primary roles are to:

- To embrace and educate on the concepts, both administrative and clinical, of clinical data management and ABF across the HHS, ensuring optimum compliance in terms of data integrity, patient safety and funding.
- To create an open forum for attendees to discuss clinical data management issues affecting departmental activities, focussing on queries raised via Divisional Management meetings, ABF developments and organisational implementation strategies.
- Divisions to identify a representative who is responsible for promoting/raising clinical data management and ABF issues at Divisional Management meetings.
- Members to disseminate clinical data management and ABF related information in a timely manner to all staff within their Division, ensuring compliance with ABF rules and reporting.
- ABF plans to be developed for all Divisions each financial year with outcome reporting to be discussed within the meeting.
- Ensure the impact of business decisions are considered in the ABF framework through utilisation, discussion, dissemination and analysis of Casemix information.
- Members to follow up on identified issues that may prevent the Mackay HHS in meeting the ABF target and adversely affecting Healthcare Purchasing strategies, and advise the Mackay HHS Executive of potential risks.
- Clinical data management and ABF issues identified by this committee to be escalated via the Executive representative for appropriate and timely resolution by Executive Leadership Team.
- Drive consistent implementation of the funding model across the Mackay HHS.
- Provide leadership and decision support encouraging system and process improvements.
- Ensure standardisation in activity identification, counting, coding, costing and cost modelling.

Meetings are held on a monthly basis.

Ethics and code of conduct

The *Public Sector Ethics Regulation 2010* defines the Mackay HHS as a public service agency. Therefore the Code of Conduct for the Queensland Public Service is applicable to employees.

Mackay HHS is committed to upholding the values and standards of conduct outlined in the Code of Conduct for the Queensland Public Service, which came into effect on 1 January 2011. The code of conduct consists of four core aspirational principles:

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

Each principle is strengthened by a set of values and standards of conduct describing the behaviour that will demonstrate that principle. All Mackay HHS employees are required to undertake training in the Code of Conduct for the Queensland Public Service during their induction and in orientation sessions. Staff are required to refresh their understanding of the Code of Conduct annually and following any change to the document through intranet based modules.

Risk management and accountability

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

Mackay HHS has a risk management policy and integrated Risk Management Framework (RMF) based on the Australian/New Zealand ISO Standard 31000:2009 for risk management. The policy and framework outline Mackay HHS's intent, roles, responsibilities and implementation requirements. The Mackay HHS's RMF defines the processes for risk identification, recording, rating, key controls identification, determination of risk treatment required and regular monitoring and reporting of risks.

Risks are controlled within the financial and management accountabilities of each position. Significant risks are reported to the MHHB and the Audit and Risk Committee on a regular basis. Activities for 2016–2017 include:

- Continued development of in-house capability and knowledge to identify and mitigate risk, and development of the internal audit function;
- Internal review of the RMF and associated documentation; and
- Risk workshops with MHHB.

Proserpine Hospital staff and community pulled together to survive Tropical Cyclone Debbie.

External scrutiny

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

Patient feedback

Mackay HHS received 2,203 pieces of feedback from consumers with 1,573 compliments and 630 complaints. The top issues were access, treatment, and communication. Of these 630 complaints, 544 required further responses and 86 were resolved at frontline at the health service level. Feedback from consumers helped shape service delivery and changed the hospital environment and equipment used.

QH Patient Experience Surveys

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

Maternity

A total of 194 telephone interviews were completed of mothers who gave birth at Mackay Base Hospital, and 34 telephone interviews were completed of mothers who gave birth at Proserpine Hospital between September and November 2016. The Mackay HHS has reviewed all of the results and developed action plans to implement recommendations from these surveys.

Small Hospitals

A total of approximately 850 telephone interviews were completed by patients who were discharged from small public hospitals or MPHSs in Mackay HHS between October 2016 and January 2017. These interviews were undertaken from February 2017 to March 2017 and therefore, at the time of publication of this Annual Report, the results were not available. The Mackay HHS will review all of the results and, if necessary, develop an action plan to implement recommendations from this survey.

QAO Report – 2015–16 Results of Financial Audits

As a public sector entity, Mackay HHS is subject to an annual audit by the QAO. The QAO Final Management Report provided to the Mackay HHS for 2015–2016 financial year contained no high risks. Lower risk items are being managed through appropriate action plans or additional investigation.

QAO Report – Efficient and effective use of high value medical equipment

This audit was to assess whether Queensland public hospitals are using high value medical equipment cost-efficiently and realising expected benefits. It examined the process for procuring the equipment, including whether purchasing decisions addressed value-for-money considerations. There were no significant findings for the Mackay HHS with minor findings being managed through appropriate processes.

Internal audit

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

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

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

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

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

Internal audits conducted during 2016–2017 include reviews of:

- Recruitment Processes Review
- Contract Management and Procurement Review
- Financial Management Assurance Audit
- Pharmacy Audit
- Credentialing Audit.

Information systems and recordkeeping

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

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

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

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

Business Classification Scheme

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

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

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

Open Data

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

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

- Consultancies
- Overseas Travel
- Queensland Language Services Policy.

Health Information Service

Health information statistics	
Clinical Information Access – Requests for patient information (releasing patient information through multiple legislative mechanism)	1,511
Clinical Information Access – Secure Web Transfer System (STS) – Patient information release with encryption	41,572
Clinical Information Access – GP Requests	5,907
Right to Information/Information Privacy (RTI/IP) Applications received (annual)	233
RTI/IP Applications released in full	104
RTI/IP Applications partially released	6
RTI/IP denied in full	13
RTI/IP Applications withdrawn	25
Number of charts coded (Mackay and Sarina) (annual)	43,905
Number of chart/current encounter chart movements (annual)	166,896
Daily Average chart/current encounter chart movements	457
Number of batches processed onto ieMR	33,225
Number of documents scanned into ieMR	611,276
Number of letters transcribed	23,066
Number answered incoming operator calls	393,934

Glossary of terms

Activity based funding A management tool with the potential to enhance public accountability and drive technical efficiency in the delivery of health services by:

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

Acute care Care in which the clinical intent or treatment goal is to:

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of an illness or injury
- protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function.

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

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

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

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

Chronic a long-term or persistent condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Glossary of acronyms

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

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

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

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

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

Sub-Acute Somewhat acute; between acute and chronic.

Telehealth Delivery of health-related services and information via telecommunication technologies, including:

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

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

ABF	Activity based funding
BCS	Business Classification Scheme
CQU	Central Queensland University
FTE	Full-Time Equivalent
GP	General Practitioner
HHS	Hospital and Health Service
HHBA	*Hospital and Health Boards Act 2011* (Qld)
HHBR	*Hospital and Health Boards Regulation 2012* (Qld)
ieMR	Integrated Electronic Medical Record
JCU	James Cook University
Mackay HHS	Mackay Hospital and Health Service
MHHB	Mackay Hospital and Health Board
MPHS	Multi-Purpose Health Service
QAO	Queensland Audit Office
QH	Queensland Health
RMF	Risk Management Framework
RTI/IP	Right to Information/Information Privacy
SOCP	Scope of Clinical Practice

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	page 1
Accessibility		
Table of contents	ARRs – section 9.1	page 3
Glossary		page 28–29
Public availability	ARRs – section 9.2	page i
Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 9.3	page i
Copyright notice	*Copyright Act 1968* ARRs – section 9.4	page i
Information Licensing	*QGEA – Information Licensing* ARRs – section 9.5	page i
General information		
Introductory Information	ARRs – section 10.1	page 4–5
Agency role and main functions	ARRs – section 10.2	page 6
Operating environment	ARRs – section 10.3	page 7
Non-financial performance		
Government's objectives for the community	ARRs – section 11.1	page 8
Other whole-of-government plans/specific initiatives	ARRs – section 11.2	page 7
Agency objectives and performance indicators	ARRs – section 11.3	page 9–11
Agency service areas and service standards	ARRs – section 11.4	page 12–13
Financial performance		
Summary of financial performance	ARRs – section 12.1	page 14
Governance – management and structure		
Organisational structure	ARRs – section 13.1	page 18
Executive management	ARRs – section 13.2	page 22
Government bodies (statutory bodies and other entities)	ARRs – section 13.3	N/A
Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* ARRs – section 13.4	page 24
Queensland public service values	ARRs – section 13.5	page 7

Summary of requirement	Basis for requirement	Annual Report reference
Governance – risk management and accountability		
Risk management	ARRs – section 14.1	page 24
Audit committee	ARRs – section 14.2	page 21
Internal audit	ARRs – section 14.3	page 26
External scrutiny	ARRs – section 14.4	page 25
Information systems and recordkeeping	ARRs – section 14.5	page 26–27
Governance – human resources		
Workforce planning and performance	ARRs – section 15.1	page 16–17
Early retirement, redundancy and retrenchment	*Directive No. 11/12 Early Retirement, Redundancy and Retrenchment* *Directive No. 16/16 Early Retirement, Redundancy and Retrenchment (from 20 May 2016)* ARRs – section 15.2	page 17
Open Data		
Statement advising public of information	ARRs – section 16	page 27
Consultancies	ARRs – section 33.1	
Overseas travel	ARRs – section 33.2	
Queensland Language Services Policy	ARRs – section 33.3	
Financial Statements		
Certification of Financial Statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 17.1	page 71
Independent Auditor's Report	FAA – section 62 FPMS – sections 50 ARRs – section 17.2	page 72–73

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2009*

ARRs Annual report requirements for Queensland Government agencies

Mackay Hospital and Health Service

ABN 8742 789 6923

Annual Financial Statements

For the year ended 30 June 2017

Mackay Hospital and Health Service

Statement of Comprehensive Income

For the year ended 30 June 2017

OPERATING RESULT	Notes	2017 $'000	2016 $'000
Income from Continuing Operations			
User charges and fees	B1-1	27,732	28,495
Funding public health services	B1-2	355,329	325,518
Grants and other contributions	B1-3	7,147	7,853
Other revenue	B1-4	9,860	5,044
Total Income from Continuing Operations		**400,068**	**366,910**
Expenses from Continuing Operations			
Employee expenses	B2-1	36,242	34,766
Health service employee expenses	B2-2	216,123	196,878
Supplies and services	B2-3	116,812	107,222
Depreciation and amortisation	C4-2	29,917	26,780
Revaluation decrement	B2-4	1,397	1,983
Other expenses	B2-5	5,660	6,331
Total Expenses from Continuing Operations		**406,151**	**373,960**
Operating Surplus/(Deficit) from Continuing Operations		**(6,083)**	**(7,050)**
Other Comprehensive Income			
Items Not Reclassified to Operating Result			
Increase/(decrease) in Asset Revaluation Surplus		**5,745**	(7,073)
Total Items Not Reclassified to Operating Result		5,745	(7,073)
Other Comprehensive Income		**5,745**	**(7,073)**
Total Comprehensive Income		**(338)**	**(14,123)**

The accompanying notes form part of these statements

Mackay Hospital and Health Service

Statement of Financial Position

As at 30 June 2017

	Note	2017 $'000	2016 $'000
Current Assets			
Cash and cash equivalents	C1	54,497	60,785
Receivables	C2	15,642	12,647
Inventories	C3	3,953	3,855
Total Current Assets		**74,092**	**77,287**
Non-Current Assets			
Property, plant and equipment	C4-2	399,305	410,135
Total Non-Current Assets		**399,305**	**410,135**
Total Assets		**473,397**	**487,422**
Current Liabilities			
Payables	C5	22,440	18,673
Total Current Liabilities		**22,440**	**18,673**
Total Liabilities		**22,440**	**18,673**
Net Assets		**450,957**	**468,749**
Equity			
Contributed equity	C6-1	380,352	397,806
Accumulated surplus		50,495	56,578
Asset revaluation surplus	C6-2	20,110	14,365
Total Equity		**450,957**	**468,749**

The accompanying notes form part of these statements

Mackay Hospital and Health Service

Statement of Changes in Equity

For the year ended 30 June 2017

	Contributed equity Note C6-1 $'000	Accumulated surplus $'000	Asset revaluation surplus Note C6-2 $'000	Total equity $'000
Balance as at 1 July 2015	417,823	63,628	21,438	502,889
Operating Result from Continuing Operations	-	(7,050)	-	(7,050)
Other Comprehensive Income				
Increase/(decrease) in asset revaluation surplus	-	-	(7,073)	(7,073)
Total Comprehensive Income for the Year	-	(7,050)	(7,073)	(14,123)
Transactions with Owners as Owners:				
Net assets transferred	911	-	-	911
Equity injections - minor capital works	5,852		-	5,852
Equity withdrawals - Depreciation funding	(26,780)	-	-	(26,780)
Net Transactions with Owners as Owners	(20,017)	-	-	(20,017)
Balance at 30 June 2016	**397,806**	**56,578**	**14,365**	**468,749**
Balance as at 1 July 2016	397,806	56,578	14,365	468,749
Operating Result from Continuing Operations	-	(6,083)	-	(6,083)
Other Comprehensive Income				
Increase/(decrease) in asset revaluation surplus	-	-	5,745	5,745
Total Comprehensive Income for the Year	-	(6,083)	5,745	(338)
Transactions with Owners as Owners:				
Net assets transferred	2,926			2,926
Equity injections - minor capital works	9,537			9,537
Equity withdrawals - Depreciation funding	(29,917)			(29,917)
Net Transactions with Owners as Owners	(17,454)	-	-	(17,454)
Balance at 30 June 2017	**380,352**	**50,495**	**20,110**	**450,957**

The accompanying notes form part of these statements

Mackay Hospital and Health Service

Statement of Cash Flows

For the year ended 30 June 2017

	Note	2017 $'000	2016 $'000
Cash flows from operating activities			
Inflows			
User charges and fees		27,266	26,496
Funding public health services		323,887	301,139
Grants and other contributions		6,480	7,024
GST input tax credits from ATO		7,758	6,901
GST collected from customers		439	485
Other receipts		8,695	5,247
		374,525	**347,292**
Outflows			
Employee expenses		(36,045)	(34,402)
Health service employee expenses		(214,920)	(197,899)
Supplies and services		(114,887)	(111,082)
GST paid to suppliers		(7,743)	(7,044)
GST remitted to ATO		(413)	(452)
Other payments		(4,461)	(5,470)
		(378,469)	**(356,349)**
Net cash from/(used by) operating activities	CF-1	**(3,944)**	**(9,057)**
Cash flows from investing activities	CF-2		
Inflows			
Sales of property, plant and equipment		128	8
Outflows			
Payments for property, plant and equipment		(12,009)	(8,817)
Net cash from/(used by) investing activities		**(11,881)**	**(8,809)**
Cash flows from financing activities			
Inflows			
Equity injections		9,537	5,852
Net cash from/(used by) financing activities		**9,537**	**5,852**
Net increase/(decrease) in cash and cash equivalents		**(6,288)**	**(12,014)**
Cash and cash equivalents at the beginning of the financial year		60,785	72,799
Cash and cash equivalents at the end of the financial year	C1	**54,497**	**60,785**

The accompanying notes form part of these statements

NOTES TO THE STATEMENT OF CASH FLOWS

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

	2017	*2016*
	$'000	*$'000*
Operating Result	(6,083)	(7,050)
Non-cash movements:		
Depreciation and amortisation	29,917	26,780
Depreciation funding	(29,917)	(26,780)
Revaluation decrement	1,397	1,983
Net (gain)/loss on disposal/revaluation of non-current assets	767	349
Reversal impairment loss on plant and equipment	(32)	-
Impairment losses	107	176
Donated assets	(667)	(829)
Changes in assets and liabilities:		
(Increase)/decrease in receivables	(1,455)	(2,370)
(Increase)/decrease in funding receivables	(1,761)	2,401
(Increase)/decrease in GST receivables	15	(143)
(Increase)/decrease in inventories	51	(1,524)
(Increase)/decrease in other receivables	(76)	(481)
Increase/(decrease) in accounts payable	2,564	(581)
Increase/(decrease) in accrued contract labour	1,203	(1,021)
Increase/(decrease) in GST payable	26	33
Net cash from/(used by) operating activities	**(3,944)**	**(9,057)**

CF-2 NON-CASH INVESTING AND FINANCING ACTIVITIES

Assets received from or liabilities donated/transferred by the Hospital and Health Service to agencies outside of the State Health portfolio agencies are recognised as revenues (refer Note B1-3) or expenses (refer Note B2-5) as applicable.

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

PREPARATION INFORMATION

GENERAL INFORMATION

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

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

For information in relation to the Hospital and Health Service's financial statements, please visit the website www.health.qld.gov.au/mackay.

COMPLIANCE WITH PRESCRIBED REQUIREMENTS

The Hospital and Health Service has prepared these financial statements in compliance with section 62 (1) of the *Financial Accountability Act 2009* and section 43 of the *Financial and Performance Management Standard 2009*. The financial statements comply with Queensland Treasury's Minimum Reporting Requirements for reporting periods beginning on or after 1 July 2016.

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

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

PRESENTATION

Currency and Rounding

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

Comparatives

Comparative information reflects the audited 2015-16 financial statements.

Current/Non-Current Classification

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

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

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

AUTHORISATION OF FINANCIAL STATEMENTS FOR ISSUE

The financial statements are authorised for issue by the Chairman of the Hospital and Health Service, the Chief Executive and the Chief Financial Officer at the date of signing the Management Certificate.

BASIS OF MEASUREMENT

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

- Land and buildings which are measured at fair value; and
- Inventories which are measured at the lower of cost and net realisable value.

Historical Cost

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

Fair Value

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

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

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

Present Value

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

Net Realisable Value

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

THE REPORTING ENTITY

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

SECTION A
HOW WE OPERATE – OUR OBJECTIVES AND ACTIVITIES

A1 OBJECTIVES OF MHHS

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

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

A2 CONTROLLED ENTITIES

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

A2-1 DISCLOSURES ABOUT NON WHOLLY-OWNED CONTROLLED ENTITIES

North Queensland Primary Health Network Limited (NQPHNL) was established as a public company limited by guarantee on 21 May 2015. Mackay Hospital and Health Service is one of six members along with Cairns and Hinterland Hospital and Health Service, Townsville Hospital and Health Service, Torres and Cape Hospital and Health Service, the Pharmacy Guild of Australia (Queensland Branch) and the Australian College of Rural and Remote Medicine with each member holding one voting right in the company.

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

As each member has the same voting entitlement (16.6%), it is considered that none of the individual members has power or significant influence over NQPHNL (as defined by AASB 10 *Consolidated Financial Statements and AASB 128 Investments in Associates and Joint Ventures*). Each member's liability to NQPHNL is limited to $10. NQPHNL is legally prevented from paying dividends to its members and its constitution also prevents any income or property of the Company being transferred directly or indirectly to or amongst the Members.

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

SECTION B
NOTES ABOUT OUR FINANCIAL PERFORMANCE

B1 REVENUE

B1-1 USER CHARGES AND FEES

	2017 $'000	2016 $'000
Pharmaceutical Benefit Scheme	7,746	7,878
Sales of goods and services	1,974	2,050
Hospital fees	18,012	18,567
	27,732	**28,495**

Accounting Policy – User charges and fees

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

B1-2 FUNDING PUBLIC HEALTH SERVICES

	2017 $'000	2016 $'000
Activity based funding*	232,331	236,276
Block funding	43,380	41,757
Teacher training funding	8,289	7,808
Depreciation funding	29,917	26,780
General purpose funding*	41,412	12,897
	355,329	**325,518**

* The Department of Health reviewed the funding of activity based hospitals under the HHS Service Agreement in 2017. As MHHS is able to utilise revenues collected from private health insurance, medicare benefits, pharmaceutical benefits and other self-funded patient contributions, to assist in the provision of public services; activity based funding was reduced by this amount $30.040 million. As the overall contract funding amount has not changed during the year, an equivalent amount of general funding has been provided by the department to offset the decline in activity based funding.

Disclosure about funding received to deliver public health services

Funding is provided predominantly by the Department of Health in accordance with a service agreement. The Department of Health receives its funding from the Queensland Government and the Australian Government. The Department purchases delivery of health services based on nationally set funding and efficient pricing models determined by the Independent Hospital Pricing Authority (IHPA). The majority of services are funded on an activity unit basis. Block and other funding are not based on levels of public health care activity. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by MHHS. Funding is received fortnightly in advance. Revenue is recognised when earned and can be measured reliably with sufficient degree of certainty.

At the end of the financial year, a financial adjustment may be required where the level of services provided is above or below the agreed level. State funding is also provided for depreciation and minor capital works. Funding for depreciation charges is via a non-cash revenue. The Department retains the cash to fund future major capital replacements. This is achieved through a withdrawal of funds from equity refer Note C6-1.

B1-3 GRANTS AND OTHER CONTRIBUTIONS

	2017 $'000	2016 $'000
Australian Government grants		
Home and community care grants	3,626	3,559
Specific purpose payments	2,684	2,989
Total Australian Government grants	6,310	6,548
Other grants		
Other grants	837	1,305
	7,147	**7,853**

Accounting Policy – Grants, contributions, donations and gifts

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

Contributed assets are recognised at their fair value.

B1-4 OTHER REVENUE

	2017 $'000	2016 $'000
Sales proceeds for assets	59	56
Recoveries	8,649	4,520
Other	1,152	468
	9,860	**5,044**

Accounting Policy – Other revenue

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

B2 EXPENSES

B2-1 EMPLOYEE BENEFIT EXPENSE

	2017 $'000	2016 $'000
Employee benefits		
Wages and salaries	30,959	29,802
Annual leave levy	1,989	1,943
Employer superannuation contributions	2,212	2,028
Long service leave levy	638	597
Employee related expenses		
Workers compensation premium	59	67
Other employee related expenses	385	329
	36,242	**34,766**
	No.	No.
Full-Time Equivalent Employees*	88	81

*reflecting Minimum Obligatory Human Resource Information (MOHRI)

Accounting Policy – Superannuation

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

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

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

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

B2-2 HEALTH SERVICE EMPLOYEE EXPENSES

	2017 $'000	2016 $'000
Department of Health	216,123	196,878
	216,123	**196,878**

The Hospital and Health Service through service arrangements with the Department of Health has engaged 2,078 (2016: 1,960) full time equivalent persons. As well as direct payments to the department, premium payments made to WorkCover Queensland representing compensation obligations are included in this category 2017: $1.828 million (2016: $1.849 million).

Accounting Policy – Employee benefits

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

Accounting Policy – Workers' Compensation Premiums

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

Accounting Policy – Sick leave

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

Accounting Policy – Annual leave and long service leave

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

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

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

Accounting Policy – Health service employee expense

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

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

B2-3 SUPPLIES AND SERVICES

	2017 $'000	2016 $'000
Consultants and contractors	13,113	14,975
Electricity and other energy	4,993	4,316
Patient travel	10,991	10,465
Other travel	1,773	1,587
Building services	1,950	2,236
Computer services	2,399	2,114
Communications	3,563	3,538
Repairs and maintenance	14,431	11,305
Operating lease rentals	1,102	1,314
Outsourced supplies and services	13,532	11,320
Inventories consumed		
Drugs	12,120	11,221
Clinical supplies and services	16,403	13,023
Catering and domestic supplies	1,876	1,841
Pathology, blood and parts	10,416	9,123
Other	8,150	8,844
	116,812	**107,222**

Accounting Policy – Inventories consumed

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

MHHS receives corporate services support from the Department at no cost. Corporate services received include payroll services, financial transactions services (including accounts payable and banking services), administrative services and information technology services. Since the fair value of these services is unable to be estimated reliably, no associated revenue or expense is recognised in the Statement of Comprehensive Income.

B2-4 REVALUATION DECREMENTS

	2017 $'000	2016 $'000
Revaluation decrement*	**1,397**	1,983
	1,397	**1,983**

Accounting Policy - Revaluations

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

* Accumulated decrements, recognised as an expense in the current and previous years, totalled $6.325 million at 30 June 2017 (2016: $4.928 million).

B2-5 OTHER EXPENSES

	2017 $'000	2016 $'000
Insurance premiums - QGIF	3,519	3,625
Insurance premiums - Other	25	38
Losses from the disposal of non-current assets	826	418
Special payments		
Ex-gratia payments	4	15
Other legal costs	64	758
Other	1,222	1,477
	5,660	**6,331**

Accounting Policy – Insurance

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

The Insurance Arrangements for Public Health Entities Health Service enables Hospital and Health Services to be named insured parties under the department's policy. For the 2016-17 policy year, the premium was allocated to each HHS according to the underlying risk of an individual insured party.

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

B2-6 AUDITOR REMUNERATION

	2017 $	2016 $
Audit services - Queensland Audit Office		
Audit of financial statements	**160,000**	**160,000**

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

SECTION C
NOTES ABOUT OUR FINANCIAL POSITION

C1 CASH AND CASH EQUIVALENTS

	2017 $'000	2016 $'000
Imprest accounts	6	7
Cash at bank*	53,138	59,458
QTC cash funds*	1,353	1,320
	54,497	**60,785**

Cash deposited with Queensland Treasury Corporation earns interest, calculated on a daily basis reflecting market movements in cash funds. The annual effective interest rate was 2.49% (2016: 2.85%).

Accounting Policy – Cash and Cash Equivalents

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

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

*MHHS receives cash contributions primarily from private practice clinicians and external entities to provide for education, study and research in clinical areas. Contributions are also received from benefactors in the form of gifts, donations and bequests for stipulated purposes. At 30 June 2017, amounts of $1.526 million (2016:$1.591million) in General Trust, $873 thousand (2016:$873 thousand) for excess earnings under Granted Private Practice, were set aside for the specified purposes underlying the contribution.

C2 RECEIVABLES

	2017 $'000	2016 $'000
Trade debtors	6,763	5,571
Payroll receivables	2	2
Less: Allowance for impairment	(383)	(390)
	6,382	5,183
GST receivable	1,104	1,119
GST payable	(84)	(58)
	1,020	1,061
Funding public health services	7,533	5,772
Other	707	631
	15,642	**12,647**

Trade debtors includes receivables of $3.047 million (2016: $4.150 million) from health funds (reimbursement of patient fees), $1.305 million (2016: $515 thousand) from Department of Health (recovery of costs), $711 thousand from Universities (2016: $364 thousand), $88 thousand from NQPHN (2016: $190 thousand) and $1.612 million (2016: $352 thousand) external debtors.

All known bad debts were written-off as at 30 June 2017. In 2017, $263 thousand (2016: $184 thousand) was written-off. All receivables within terms and expected to be fully collectible are considered of good credit quality based on recent collection history. Credit risk management strategies are detailed in Note D2.

Accounting Policy – Receivables

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

Disclosure – Credit Risk Exposure of Receivables

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

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

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

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

C2-1 IMPAIRMENT OF RECEIVABLES

Throughout the year, MHHS assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. Objective evidence includes financial difficulties of the debtor, changes in debtor credit ratings and current outstanding accounts over 120 days. The allowance for impairment reflects MHHS's assessment of the credit risk associated with receivable balances and is determined based on historical rates of bad debts (by category) over the past three years and management judgement. The allowance for impairment reflects the occurrence of loss events. If no loss events have arisen in respect of a particular debtor or group of debtors, no allowance for impairment is made in respect of that debt/group of debtors. If MHHS determines that an amount owing by such a debtor does become uncollectible (after appropriate range of debt recovery actions), that amount is recognised as a bad debt expense and written-off directly against receivables. In other cases where a debt becomes uncollectible but the uncollectible amount exceeds the amount already allowed for impairment of that debt, the excess is recognised directly as a bad debt expense and written-off directly against receivables. Impairment loss expense for the current year regarding receivables is $383 thousand (2016: $390 thousand).

C2 RECEIVABLES (continued)

Disclosure - Movement in allowance for impairment for receivables

	2017	*2016*
	$'000	*$'000*
Balance at beginning of the year	390	258
Amounts written off during the year	(263)	(184)
Increase/(decrease) in allowance recognised in operating result	256	316
Balance at the end of the year	**383**	**390**

Disclosure - Ageing of past due but not impaired trade receivables

	2017	*2016*
	$'000	*$'000*
Not overdue	10,482	7,509
Overdue		
Less than 30 days	3,255	2,597
30 to 60 days	902	1,187
60 to 90 days	371	515
Greater than 90 days	632	839
Total	**15,642**	**12,647**

C3 INVENTORIES

	2017	*2016*
	$'000	*$'000*
Inventories held for distribution - at cost		
Pharmaceutical drugs	1,824	2,062
Clinical supplies	2,123	1,787
Catering and domestic	6	6
	3,953	**3,855**

Accounting Policy – Inventories

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

C4 PROPERTY, PLANT AND EQUIPMENT AND RELATED DEPRECIATION

C4-1 ACCOUNTING POLICIES

Property, Plant and Equipment

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

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

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

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

Componentisation of Complex Assets

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

Acquisition of Assets

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

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

Measurement using historical cost

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

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

Measurement using fair value

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

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

Revaluation of property measured at fair value

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

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

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

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

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

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

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

Depreciation

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

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

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

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

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

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

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

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

Class	Depreciation rates
Buildings and Improvements	
- Structural fabric of building	0.9 to 6.3%
- External fabric	0.9 to 7.7%
- Internal fabric	1.5 to 11.1%
- Internal finishes	2.6 to 12.5%
- Fittings	2.8 to 12.5%
- Building services	2.4 to 16.7%
- Land improvements	1.5 to 3.1%
- Other buildings including residential	0.9 to 12.5%
Plant and equipment including artworks	1.0 - 20.0%

Impairment of non-current assets

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

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

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

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

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

2017	Land (Level 2) $'000	Buildings (Level 3) $'000	Plant and equipment (at cost) $'000	Capital works in progress (at cost) $'000	Total $'000
Gross	13,159	525,550	50,687	3,849	593,245
Less: Accumulated depreciation	-	(167,261)	(26,679)	-	(193,940)
Carrying amount at 30 June 2017	**13,159**	**358,289**	**24,008**	**3,849**	**399,305**
Represented by movements in carrying amount:					
Carrying amount at 1 July 2016	14,105	371,597	23,478	955	410,135
Transfers in - practical completion projects from the Department	451	2,480	-	-	2,931
Transfers in from other Queensland Government entities	-	-	4	-	4
Acquisitions	-	992	4,770	6,247	12,009
Donated assets	-	419	248	-	667
Disposals	-	(393)	(502)	-	(895)
Transfers out to other Queensland Government entities	-	-	(9)	-	(9)
Transfers between classes	-	3,254	99	(3,353)	-
Reversal impairment losses recognised in operating surplus/(deficit)	-	-	32	-	32
Net revaluation increments/(decrements)	(1,397)	5,745	-	-	4,348
Depreciation expense	-	(25,805)	(4,112)	-	(29,917)
Carrying amount at 30 June 2017	**13,159**	**358,289**	**24,008**	**3,849**	**399,305**

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

2016	Land (Level 2) $'000	Buildings (Level 3) $'000	Plant and equipment (at cost) $'000	Capital works in progress (at cost) $'000	Total $'000
Gross	14,105	529,215	48,902	955	593,177
Less: Accumulated depreciation	-	(157,618)	(25,424)	-	(183,042)
Carrying amount at 30 June 2016	**14,105**	**371,597**	**23,478**	**955**	**410,135**
Represented by movements in carrying amount:					
Carrying amount at 1 July 2015	16,173	395,541	23,318	739	435,771
Transfers in - practical completion projects from the Department	-	1,198	-	-	1,198
Transfers in from other Queensland Government entities	-	-	1	-	1
Acquisitions	-	2,980	5,085	752	8,817
Donated assets	-	829	-	-	829
Disposals	-	(212)	(145)	-	(357)
Transfers out to other Queensland Government entities	(85)	(161)	(42)	-	(288)
Transfers between classes	-	536	-	(536)	-
Net revaluation increments/(decrements)	(1,983)	(7,073)	-	-	(9,056)
Depreciation expense	-	(22,041)	(4,739)	-	(26,780)
Carrying amount at 30 June 2016	**14,105**	**371,597**	**23,478**	**955**	**410,135**

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

C4-3 VALUATION OF PROPERTY, PLANT AND EQUIPMENT INCLUDING KEY ESTIMATES AND JUDGEMENTS

Land

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

In 2017, MHHS engaged State Valuation Service to undertake a comprehensive revaluation program over three years (with indices applied in the intervening periods) for all land holdings at 30 June 2017. 2017 is the first year in the current rolling valuation cycle. To date, SVS has comprehensively revalued ten parcels of land (68% by value).

SVS was also engaged to provide indices for land. Where a comprehensive revaluation has not been undertaken, indices have been applied to approximate market movement. The State Valuation Service provided appropriate indices derived from data on land sales in the respective areas during the previous year.

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

The revaluation program resulted in a decrement of $1.397 million (2016: decrement $1.983 million) to the carrying amount of land.

Buildings

MHHS engaged independent quantity surveyors, AECOM Pty Ltd in 2016 to comprehensively revalue all buildings with a replacement cost exceeding $3 million, and calculate relevant indices for all other assets. A four year, rolling valuation program commenced in 2017. To date AECOM has comprehensively revalued 11.6 % of buildings (by value) as at 30 June 2017.

The balance of assets has had indices applied, approximating movement in market prices for labour and other key resource inputs, as well as changes in design standards as at reporting date. Refer to Note D1-3 for further details on the revaluation methodology applied.

The revaluation program resulted in an increment of $5.745 million (2016: decrement $7.073 million) to the carrying amount of buildings.

C5 PAYABLES

	2017 *$'000*	*2016* *$'000*
Trade creditors	13,588	11,151
Accrued labour - Department of Health	7,273	6,070
Other	1,579	1,452
	22,440	**18,673**

Payables of $11.217 million (2016: $9.715 million) were owing to the Department of Health at 30 June including trade creditors $3.709 million (2016: $3.645 million), accrued labour $7.273 million (2016: $6.070 million) and $235 thousand (2016: Nil) in repayable or unearned funding.

Accounting Policy – Payables

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

C6 EQUITY

C6-1 CONTRIBUTED EQUITY

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

- Cash equity contributions fund purchases of equipment, furniture and fittings associated with capital work projects managed by MHHS. In 2017 MHHS received $9.5 million (2016 $5.8 million) funding from the State as equity injections throughout the year. These outlays are paid by the Department of Health on behalf of the State;
- Non-reciprocal transfers of assets between Hospital and Health Services. In 2014, the Minister for Health signed an enduring designation of transfer for property, plant and equipment between Hospital & Health Services (HHS) and the Department of Health. This transfer is recognised through equity when the Chief Finance Officers of both entities agree in writing to the transfer:

During this year a number of assets have been transferred under this arrangement.	*2017* *$'000*	*2016* *$'000*
Transfer in - practical completion of projects from the Department*	2,931	1,198
Net transfer of property, plant and equipment "from/to" the Department	4	(85)
Net transfers equipment between HHS	(9)	(202)
	2,926	**911**

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

- Equity withdrawal of funds by the Department of Health on behalf of the State, MHHS received $29.9 million funding in 2017 (2016 $26.8 million) from the Department of Health to account for the cost of depreciation. However, as depreciation is a non-cash expenditure item, the Health Minister has approved a withdrawal of equity by the State for the same amount, resulting in a non-cash revenue and non-cash equity withdrawal.

C6-2 ASSET REVALUATION SURPLUS BY ASSET CLASS

	2017 *$'000*	*2016* *$'000*
Land		
Balance at the beginning of the financial year	-	-
Revaluation increments/(decrements)	**-**	-
Balance at the end of the financial year	**-**	**-**
Buildings		
Balance at the beginning of the financial year	14,365	21,438
Revaluation increments/(decrements)	5,745	(7,073)
Balance at the end of the financial year	**20,110**	**14,365**
Total	**20,110**	**14,365**

Accounting Policy - Asset revaluation surplus

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

SECTION D
NOTES ABOUT RISKS AND OTHER ACCOUNTING UNCERTAINTIES

D1 FAIR VALUE MEASUREMENT

D1-1 ACCOUNTING POLICIES AND BASIS FOR FAIR VALUE MEASUREMENT

What is fair value?

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

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

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

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

Fair value measurement hierarchy

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

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

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

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

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

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

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

	Level 2		Level 3		Total	
	$'000		*$'000*		*$'000*	
	2017	*2016*	*2017*	*2016*	*2017*	*2016*
Land	13,159	14,105		-	13,159	14,105
Buildings	-	-	358,289	371,597	358,289	371,597

D1 FAIR VALUE MEASUREMENT (continued)

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

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

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

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

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

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

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

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

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

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

D2 FINANCIAL RISK DISCLOSURES

D2-1 FINANCIAL INSTRUMENT CATEGORIES

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

Category	Note	*2017* *$'000*	*2016* *$'000*
Financial assets			
Cash and cash equivalents	C1	54,497	60,785
Receivables at amortised cost	C2	15,642	12,647
Total		**70,139**	**73,432**
Financial liabilities			
Financial liabilities at amortised cost - comprising:			
Payables	C5	22,440	18,673
Total		**22,440**	**18,673**

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

D2-2 FINANCIAL RISK MANAGEMENT

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

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

Risk exposure	*Measurement method*
Credit risk	Ageing analysis, cash inflows at risk
Liquidity risk	Monitoring of cash flows by active management of accrual accounts
Interest risk	Interest rate sensitivity analysis

Credit risk is further discussed in Note C2 Receivables.

Liquidity risk

Liquidity risk is the risk that MHHS will not have the resources required at a particular time to meet its obligations to settle its financial liabilities. MHHS is exposed to liquidity risk through its trading in the normal course of business and aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times. An approved debt facility of $3 million (2016: $3 million) under whole-of-Government banking arrangements to manage any short term cash shortfalls has been established. No funds have been withdrawn against this debt facility as at 30 June 2017 (2016: Nil).

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

Interest risk

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

Fair value

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

D3 CONTINGENCIES

(a) Litigation in progress

As at 30 June 2017, the following cases were filed in the courts naming the State of Queensland acting through the Mackay Hospital and Health Service as defendant:

	2017 Number of cases	2016 Number of cases
Supreme Court	1	1
District Court	2	-
Magistrates Court	-	-
Tribunals, commissions and boards	1	1
	4	**2**

Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). MHHS's liability in this area is limited to an excess per insurance event of $20,000 - refer Note B2-5. As at 30 June 2017, MHHS has 33 claims currently managed by QGIF, some of which may never be litigated or result in payments to claims (excluding initial notices under Personal Injuries Proceedings Act).

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

(b) Investigations into non-conforming building products

The Queensland Government has established a dedicated taskforce to determine the existence of, and develop a response strategy regarding non-conforming building products (particularly around aluminium composite panelling) on Queensland Government owned buildings and non-government owned buildings. At the time of certification of the financial statements, the taskforce has not been able to confirm the extent of this risk for MHHS's buildings, let alone a quantification of the financial impact. This work will conclude during 2017-18.

D4 COMMITMENTS

(a) Non-cancellable operating lease commitments

	2017 $'000	*2016 $'000*
Commitments under operating leases at reporting date (inclusive of non-recoverable GST input tax credits) are payable:		
No later than 1 year	99	108
Later than 1 year but no later than 5 years	57	-
Total	**156**	**108**

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

(b) Capital expenditure commitments

	2017 $'000	*2016 $'000*
Commitments for capital expenditure at reporting date (inclusive of non-recoverable GST input tax credits) are payable:		
Building		
No later than 1 year	2,697	5,608
Total	**2,697**	**5,608**
Plant and Equipment		
No later than 1 year	-	53
Total	**-**	**53**

D5 EVENTS AFTER THE BALANCE DATE

No matters or circumstances has arisen since 30 June 2017 that has significantly affected, or may significantly affect MHHS's operations, the results of those operations, or MHHS's state of affairs in future financial years.

D6 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE

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

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

These standards will first apply to MHHS's financial statements in 2019-20.

MHHS has commenced analysing the new revenue recognition requirements under these standards and is yet to form conclusions about significant impacts. Potential future impacts identifiable at the date of this report are as follows:

- Under the new standards, grants presently recognised as revenue upfront may be eligible to be recognised as revenue progressively as the associated performance obligations are satisfied, but only if the associated performance obligations are enforceable and sufficiently specific. The MHHS is yet to evaluate the existing arrangements with the Australian Government as to whether revenue from those grants could be deferred under the new requirements.
- Grants that are not enforceable and/or not sufficiently specific will not qualify for deferral, and continue to be recognised as revenue as soon as they are controlled. MHHS receives several grants for which there are no sufficiently specific performance obligations, so these grants will continue to be recognised as revenue upfront.
- Depending on the specific contractual terms, the new requirements may potentially result in a change to the timing of revenue from sales of MHHS's goods and services, such that some revenue may need to be deferred to a later reporting period to the extent that MHHS has received cash but has not met its associated obligations (such amounts would be reported as a liability in the meantime). MHHS is yet to complete its analysis of current arrangements for sale of its goods and services, but at this stage does not expect a significant impact on its present accounting practices.
- A range of new disclosures will also be required by the new standards in respect of MHHS's revenue.

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

These standards will first apply to MHHS's financial statements for 2018-19. The main impacts of these standards on MHHS are that they will change the requirements for the classification, measurement, impairment and disclosures associated with MHHS's financial assets. AASB 9 will introduce different criteria for whether financial assets can be measured at amortised cost or fair value.

MHHS has commenced reviewing the measurement of its financial assets against the new AASB 9 classification and measurement requirements. However, as the classification of financial assets at the date of initial application of AASB 9 will depend on the facts and circumstances existing at that date, MHHS's conclusions will not be confirmed until closer to that time. At this stage, and assuming no change in the types of transactions entered into, the carrying value of MHHS's current receivables is not expected to change. Another impact of AASB 9 relates to calculating impairment losses for MHHS's receivables. Assuming no substantial change in the nature of MHHS's receivables, as they don't include a significant financing component, impairment losses will be determined according to the amount of lifetime expected credit losses. On initial adoption of AASB 9, MHHS will need to determine the expected credit losses for its receivables by comparing the credit risk at that time to the credit risk that existed when those receivables were initially recognised.

A number of one-off disclosures will be required in the 2018-19 financial statements to explain the impact of adopting AASB 9. Assuming no change in the types of financial instruments that MHHS enters into, the most likely ongoing disclosure impacts are expected to relate to the credit risk of financial assets subject to impairment.

AASB 16 Leases

This standard will first apply to MHHS's financial statements for 2019-20. When applied, the standard supersedes AASB 117 *Leases*, AASB Interpretation 4 *Determining whether an Arrangement contains a Lease,* AASB Interpretation 115 *Operating Leases – Incentives* and AASB Interpretation 127 *Evaluating the Substance of Transactions Involving the Legal Form of a Lease.*

Impact for Lessees

Unlike AASB 117 Leases, AASB 16 introduces a single lease accounting model for lessees. Lessees will be required to recognise a right-of-use asset (representing rights to use the underlying leased asset) and a liability (representing the obligation to make lease payments) for all leases with a term of more than 12 months, unless the underlying assets are of low value.

In effect, the majority of operating leases (as defined by the current AASB 117) will be reported on the Statement of Financial Position under AASB 16. There will be significant increase in assets and liabilities for agencies that lease assets. The impact on the reported assets and liabilities would be largely in proportion to the scale of the agency's leasing activities. The right-of-use asset will be initially recognised at cost, consisting of the initial amount of the associated lease liability, plus any lease payments made to the lessor at or before the effective date, less any lease incentive received, the initial estimate of restoration costs and any initial direct costs incurred by the lessee. The right-of-use asset will give rise to a depreciation expense. The lease liability will be initially recognised at an amount equal to the present value of the lease payments during the lease term that are not yet paid. Current operating lease rental payments will no longer be expensed in the Statement of Comprehensive Income. They will be apportioned between a reduction in the recognised lease liability and the implicit finance charge (the effect rate of interest) in the lease. The finance cost will also be recognised as an expense.

D6 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE (continued)

AASB 16 allows a 'cumulative approach' rather than full retrospective application to recognising existing operating leases. If a lessee chooses to apply the 'cumulative approach', it does not need to restate comparative information. Instead, the cumulative effect of applying the standard is recognised as an adjustment to the opening balance of accumulated surplus (or other component of equity, as appropriate) at the date of initial application. MHHS will await further guidance from Queensland Treasury on the transitional accounting method to be applied

Presently MHHS has minimal non-cancellable operating leases with a term exceeding 12 months and as such it is not anticipated that the impact of changes to the accounting standards for leases will have a material impact.

Impact for Lessors

Lessor accounting under AASB 16 remains largely unchanged from AASB 117. For finance leases, the lessor recognises a receivable equal to the net investment in the lease. Lease receipts from operating leases are recognised as income either on a straight-line basis or another systematic basis where appropriate.

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

SECTION E
NOTES ON OUR PERFORMANCE COMPARED TO BUDGET

E1 BUDGETARY REPORTING DISCLOSURES

This section discloses MHHS's original published budgeted figures for 2016-17 compared to actual results, with explanations of major variances, in respect of MHHS's Statement of Comprehensive Income, Statement of Financial Position and Statement of Cash Flows. Note original published budget from the Service Delivery Statement (SDS) has been reclassified to improve transparency and analysis by remapping particular budgeted transactions on the same basis as reported in actual financial statements.

A budget to actual comparison, and explanations of major variances, has not been included for the Statement of Changes in Equity, as major variances relating to that statement have been addressed in explanations of major variances for other statements.

E2 BUDGET TO ACTUAL COMPARISON – STATEMENT OF COMPREHENSIVE INCOME

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

	Variance Notes	Original SDS Budget 2017 $'000	Actual 2017 $'000	SDS Budget V Actual Variance $'000
OPERATING RESULT				
Income from Continuing Operations				
User charges and fees	V1.	30,762	**27,732**	(3,030)
Funding public health services	V2.	311,264	**355,329**	44,065
Grants and other contributions		7,174	**7,147**	(27)
Other revenue		4,544	**9,860**	5,316
Total Revenue		**353,744**	**400,068**	**46,324**
Total Income from Continuing Operations		**353,744**	**400,068**	**46,324**
Expenses from Continuing Operations				
Employee expenses*		34,538	**36,242**	1,704
Health service employee expenses**		210,520	**216,123**	5,603
Supplies and services	V3.	87,660	**116,812**	29,152
Depreciation and amortisation	V4.	20,521	**29,917**	9,396
Revaluation decrement			**1,397**	1,397
Other expenses		4,705	**5,660**	955
Total Expenses from Continuing Operations		**357,944**	**406,151**	**48,207**
Operating Results from Continuing Operations		**(4,200)**	**(6,083)**	**(1,883)**
Other Comprehensive Income				
Items Not Reclassified to Operating Result				
Increase/(decrease) in Asset Revaluation Surplus			**5,745**	
Total Items Not Reclassified to Operating Result		**-**	**5,745**	**-**
Total Comprehensive Income		**(4,200)**	**(338)**	**(1,883)**

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

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

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

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

V1. User charges and fees

User charges are lower than budget by $3.03 million primarily reflecting lower hospital revenues than forecast at the time of the original published budget. Whilst overall patient activity exceeded budget targets, persons electing to be treated as a private patient declined in 2016-17. The combination of lower private patient activity and reductions in rebates available to public hospitals (from health funds) resulted in lower private patient revenues $1.435 million. Fees generated from the treatment of WorkCover patients $759 thousand, and recoveries generated under the Private Practice arrangement with doctors $399 thousand, were also lower than forecast in the Budget, contributing to the overall decline in hospital revenues.

V2. Funding public health services

The increase relates to additional funding provided through amendments to the Service Agreement between Mackay Hospital and Health Service and the Department of Health. Additional funding was provided for higher patient activity $16.000 million, enterprise bargaining agreements $1.446 million, new initiatives $17.223million to expand service delivery and reduce patient waiting lists, and depreciation expense $9.396 million.

V3. Supplies and services

Supplies and services expenditure exceeded SDS original budget by $29.152 million at 30 June 2017. The increase is primarily attributable to higher than anticipated demand for hospital services. In addition, 2017 included a number of initiatives, approved by the Board after the finalisation of the Budget, to enhance health service delivery to the community such as reduction of waiting times for specialist, endoscopy and ophthalmology appointments, improving elective surgery within clinically recommended timeframes and expansion of cardiac services.

The original NWAU target for the financial year was 41,151, this compares against achieved activity of 48,624 in 2017, an improvement of 18%. The provision of additional services resulted in overall higher costs, with increased external labour and outsourcing of services adding $21.082 million to supplies and services.

Repairs and maintenance also increased as further works were undertaken on behalf of the Department, mainly to rural hospital facilities $5.045 million. These costs were reimbursed by the Department and are matched by higher revenues.

A further $1.066 million was spent on outsourcing patient services and repairing damage sustained as a result of cyclone Debbie in March 2017.

V4. Depreciation and amortisation

Depreciation expense has exceeded SDS Budget by $9.396 million. Useful lives are reassessed annually by MHHS management to reflect current physical asset condition, future service potential and planned asset replacement strategies. A comprehensive review of hospital buildings was undertaken as part of AECOM valuation process with significant declines in remaining useful life (RUL) noted. Adjustments were also made to RUL for current replacement strategies. Original forecast depreciation was calculated prior to the impact of revisions to useful life.

E3 BUDGET TO ACTUAL COMPARISON – STATEMENT OF FINANCIAL POSITION

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

	Variance Notes	Original SDS Budget 2017 $'000	Actual 2017 $'000	SDS Budget V Actual Variance $'000
Current Assets				
Cash and cash equivalents		54,125	**54,497**	372
Receivables	V5.	12,639	**15,642**	3,003
Inventories		2,231	**3,953**	1,722
Total Current Assets		**68,995**	**74,092**	**5,097**
Non-Current Assets				
Property, plant and equipment	V6.	476,010	**399,305**	(76,705)
Total Non-Current Assets		**476,010**	**399,305**	**(76,705)**
Total Assets		**545,005**	**473,397**	**(71,608)**
Current Liabilities				
Payables	V7.	13,223	**22,440**	9,217
Total Current Liabilities		**13,223**	**22,440**	**9,217**
Total Liabilities		**13,223**	**22,440**	**9,217**
Net Assets		**531,782**	**450,957**	**(80,825)**
Equity		**531,782**	**450,957**	**(80,825)**

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

V5. Receivables

Receivables increased $3.003 million from $12.639 million per the SDS budget to $15.642 million for the year ended 30 June 2017. This increase was primarily as a result of increased amounts owing by the Department of Health $2.563 million for funding of patient activity, and reimbursement of works undertaken on behalf of the department. MHHS has also sought reimbursement of costs incurred in repairing damage sustained as a result of cyclone Debbie in March 2017 under Natural Disaster Relief and Recovery Arrangements (NDRRA) $607 thousand.

V6. Property, plant and equipment

Property plant and equipment was $76.705 million lower than $476.010 million forecast at the time of the budget. This is due to a number of contributing factors.

At the time of the budget, property plant and equipment was forecast to be $51.255 million higher, at the beginning of the year, than realised (budget estimated actuals 2016: $461.391 million compared to actuals $410.136 million). This has impacted the balance at 30 June 2017.

Original SDS budget assumed market growth in land values of 4% and escalation in replacements costs for buildings of 7%. The primary reason for the decline in property plant and equipment during 2017 was lower fair values for property, with values $21.107 million lower than forecast. AECOM in their 2017 building valuation report noted no effective growth in tender price construction contracts due to continuing slow demand in the region. In addition, land values within the Mackay region continue to be impacted, with market appraisals by the State Valuation Service resulting in a decline in land values of $1.397 million or 9.9% in 2017. Downward revisions to remaining useful life for hospital buildings, reflecting current physical asset condition, future service potential and planned asset replacement strategies, further contributed to lower property values $9.396 million. This was not forecast at the time of the budget.

Partially offsetting these declines were additional building construction and purchases of equipment, up $5.359 million on budget estimates. This was funded jointly, by Department of Health and from retained cash surpluses. These purchases were approved post the original budget and included additional medical equipment and redevelopment projects in rural hospital sites.

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

E3-2 EXPLANATION OF MAJOR VARIANCES - STATEMENT OF FINANCIAL POSITION (continued)

V7. Payables

Payables increased $9.217 million from $13.223 million at the time of the budget to $22.440 million.

At the time of the budget, payables were forecast to be $6.377 million lower, at the beginning of the year, than realised (budget estimated actuals 2016: $12.296 million compared to actuals $18.673 million). This has impacted the balance at 30 June 2017.

During 2017 payables increased a further $2.840 million over budget, reflecting increased accrued labour expenses and outsourcing of services in line with higher than anticipated FTEs and demand for hospital services. Retained cash surpluses were used to fund capital costs associated with the implementation of improved clinical information systems and additional costs of refurbishment for the Bowen and Proserpine hospitals. The use of retained cash surpluses was not included at the time of the budget.

E4 BUDGET TO ACTUAL COMPARISON – STATEMENT OF CASH FLOWS

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

	Variance Notes	Original SDS Budget 2017 $'000	Actual 2017 $'000	SDS Budget V Actual Variance $'000
Cash flows from operating activities				
Inflows				
User charges and fees	V8.	30,596	**27,266**	(3,330)
Funding public health services	V9.	290,743	**323,887**	33,144
Grants and other contributions		7,174	**6,480**	(694)
GST input tax credits from ATO		5,328	**7,758**	2,430
GST collected from customers		-	**439**	439
Other receipts		4,544	**8,695**	4,151
		338,385	**374,525**	**36,140**
Outflows				
Employee expenses		**(34,538)**	**(36,045)**	(1,507)
Health service employee expenses		**(210,520)**	**(214,920)**	(4,400)
Supplies and services	V10.	**(86,923)**	**(114,887)**	(27,964)
GST paid to suppliers		**(5,332)**	**(7,743)**	(2,411)
GST remitted to ATO		**-**	**(413)**	(413)
Other payments		**(4,487)**	**(4,461)**	26
		(341,800)	**(378,469)**	**(36,669)**
Net cash from/(used by) operating activities		**(3,415)**	**(3,944)**	**(529)**
Cash flows from investing activities				
Inflows				
Sales of property, plant and equipment		-	**128**	128
Outflows				
Payments for property, plant and equipment	V11.	(2,773)	**(12,009)**	(9,236)
Net cash from/(used by) investing activities		**(2,773)**	**(11,881)**	**(9,108)**
Cash flows from financing activities				
Inflows				
Equity injections	V12.	2,773	**9,537**	6,764
Net cash from/(used by) financing activities		**2,773**	**9,537**	**6,764**
Net increase/(decrease) in cash and cash equivalents		**(3,415)**	**(6,288)**	**(2,873)**
Cash and cash equivalents at the beginning of the financial year		57,540	**60,785**	3,245
Cash and cash equivalents at the end of the financial year		**54,125**	**54,497**	**372**

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

V8. User charges and fees

Cash flows from user charges and fees declined from SDS budget by $3.330 million. The key contributors to this are largely consistent with the reasons set out in V1 adjusted for variances above that budgeted in 2017 for receivables, revenue received in advance and debts written off during the year. In 2017 a number of invoices were issued later in the year, resulting in higher receivables at 30 June 2017 $141 thousand while revenue received in advance declined $139 thousand in 2017 as the number of student medical placements fell during the year. Neither of these events were anticipated at budget time.

V9. Funding public health services

Funding public health service cash flows exceeded SDS budget by $33.144 million. The increase relates to additional funding provided through amendments to the Service Agreement between Mackay Hospital and Health Service and the department. Additional funding was provided for increases in service activity, enterprise bargaining agreements and new initiatives.

V10. Supplies and services

Actual cash flows exceeded budget by $27.964 million. The key contributors to this are largely consistent with the reasons set out in V3 adjusted for differences in movements between forecasts in the SDS budget and actuals for trade payables of $1.345 million and to a lesser extent, inventories and prepayments.

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

E4-1 BUDGET TO ACTUAL COMPARISON - STATEMENT OF CASH FLOWS (continued)

V11. Cash flows - Payments for property, plant and equipment

Payments for property, plant and equipment in 2017 were higher by $9.236 million than budgeted. This was a result of additional infrastructure construction and medical equipment purchases approved post budget. A change in the funding arrangements for Priority Capital Projects (PCP) by the Department of Health during 2017 also increased cash outflows.

In 2017 $4.301 million of additional infrastructure construction was approved, with joint funding from the Department of Health and retained cash surpluses. This includes completed redevelopment projects (Moranbah) and capitalisation of works undertaken in facilities at Moranbah, Bowen, Clermont, Dysart and Proserpine. In addition, purchases of health technology equipment in 2017 were higher than forecast in the Budget.

Original Budget included $6.812 million of infrastructure projects to be managed by the Department and transferred to MHHS on project completion. During 2017, management of projects totalling $3.876 million were transferred to MHHS, along with associated cash funding from the department. MHHS paid for these construction works during the year, increasing payments for property, plant and equipment.

V12. Cash flows – Equity injections

Cash flows from equity injections increased $6.764 million, from $2.773 million per the SDS budget, to $9.537 million for the year ended 30 June 2017. Post budget estimates, the Department approved in additional cash funding for infrastructure projects $2.175 million, purchases of medical equipment $1.653 million and changes in the funding arrangements for PCP projects $2.936 million refer V11. This was not included at the time of budget estimates.

SECTION F
WHAT WE LOOK AFTER ON BEHALF OF THIRD PARTIES

F1 TRUST TRANSACTIONS AND BALANCES

The Hospital and Health Service acts in a fiduciary trust capacity in relation to patient trust accounts. Consequently, these transactions are not recognised in the financial statements. Trust activities are included in the audit performed annually by the Auditor-General of Queensland.

	2017 $'000	2016 $'000
Patient Trust receipts and payments		
Receipts		
Patient trust receipts	-	2
Total receipts	-	2
Payments		
Patient trust payments	-	2
Total payments	-	2
Increase/decrease in net patient trust assets	-	-
Patient trust assets opening balance	-	-
Patient trust assets closing balance	-	-
Patient trust assets		
Current assets		
Cash at bank and on hand	-	-
Patient trust and refundable deposits	-	-
Total	-	-

F2 GRANTED PRIVATE PRACTICE

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

	2017 $'000	2016 $'000
Receipts		
Billings - (Doctors and Visiting Medical Officers)	7,496	7,161
Interest	11	14
Total receipts	**7,507**	**7,175**
Payments		
Payments	6,874	6,672
Hospital and Health Service recoverable administrative costs	647	414
Hospital and Health Service - Education/travel/research fund	15	26
Total payments	**7,536**	**7,112**
Closing balance of bank account under a trust fund arrangement not yet disbursed and not restricted cash	**728**	**757**

SECTION G
OTHER INFORMATION

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES

Details of Key Management Personnel

As from 2016-17, MHHS's responsible Minister is identified as part of MHHS's key remuneration personnel (KMP), consistent with additional guidance included in the revised version of *AASB 124 Related Party Disclosures*. That Minister is the Minister of Health and Minister for Ambulance Services. The following details for non-Ministerial KMP, include those positions that had authority and responsibility for planning, directing and controlling the activities of MHHS during 2016-17 including Board members of MHHS. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management and the Board.

Position	Responsibilities
Health Service Chief Executive	Responsible for the overall leadership and management of the Mackay Hospital and Health Service to ensure that MHHS meets its strategic and operational objectives. This position is the single point of accountability for ensuring patient safety through the effective executive leadership and management of all hospital and health services. This position is accountable to the Hospital and Health Board for ensuring that the HHS achieves a balance between efficient service delivery and high quality health outcomes
Executive Director, Operations Mackay	Responsible to the Chief Executive for the strategic and operational management of the service divisions within Mackay, and corporate services functions of the MHHS
Executive Officer, Finance, Procurement & Infrastructure	Responsible to the Chief Executive to ensure the financial and fiscal responsibilities of the HHS are met. Provides governance arrangements to meet financial performance targets and imperatives. Provides strategic and financial advice in all aspects of finance management and activity performance.
Executive Director, Rural Services	Responsible to the Chief Executive for the leadership and operational management of the rural facilitates within the MHHS.
Executive Director, HR & Engagement	Responsible to the Chief Executive for the management of people and cultural issues within the MHHS. Provides strategic development and strategies to achieve maximum employee engagement, safety and productivity and to ensure the HHS's capacity to attract and retain the skilled resources required.
Executive Director, Medical Services & Chief Medical Officer	Responsible to the Chief Executive for clinical governance and leadership and direction of clinical services across the HHS. Provides executive leadership, strategic focus, authoritative counsel and expert advice on a wide range of professional and policy issues that meet safe clinical practice standards.
Executive Director, Research & Innovation & Clinical Dean	Responsible to the Chief Executive for leadership of a sustainable medical workforce, including staff optimisation, expertise and service delivery. Provides postgraduate medical specialty training and research, and executive leadership, strategic focus, authoritative counsel in relation to research and innovation.
Executive Director, Nursing & Midwifery, Education & Support Services.	Responsible to the Chief Executive for strategic and professional leadership of nursing workforce across MHHS.

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration Policies

Ministerial remuneration entitlements are outlined in the Legislative Assembly of Queensland's Members' Remuneration Handbook. MHHS does not bear any cost of remuneration of Ministers. The majority of 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 from 2016-17, which are published as part of Queensland Treasury's Report on State Finances.

Section 74 of the *Hospital and Health Board Act 2011* provides the contract of employment for health executive staff must state the term of employment, the person's functions and any performance criteria as well as the person's classification level and remuneration package. Section 76 of the Act provides the Chief Executive authority to fix the remuneration packages for health executives, classification levels and terms and conditions having regard to remuneration packages for public sector employees in Queensland or other States and remuneration arrangements for employees employed privately in Queensland.

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

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

Short-term employee expenses which include:

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

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

Performance bonuses are not paid under the contracts in place.

Board remuneration

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

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

Board Position	Date of appointment
Deputy Chair	29 June 2012
Board member	29 June 2012
Board member	29 June 2012
Board member	10 September 2012
Board member	23 August 2013
Chairperson	18 May 2016
Board member	18 May 2016
Board member	18 May 2016
Board member	18 May 2016

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

KMP Remuneration Expense

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

2017

Position (date resigned if applicable)	*Short Term Employee Expenses*		*Long term Employee Expenses*	*Post Employment Expenses*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*			
	$'000	*$'000*	*$'000*	*$'000*	*$'000*
Health Service Chief Executive (27 February to 30 June 2017)	97	12	2	9	120
A/Health Service Chief Executive (1 July 2016 to 26 February 2017)	213	12	4	18	247
Executive Director Operations Mackay	201	2	4	20	227
Executive Officer, Finance, Procurement & Infrastructure (8 August 2016 to 30 June 2017)	165	-	3	17	185
Executive Director, Rural Services	194	-	4	18	216
Executive Director, HR & Engagement	197	-	4	21	222
Executive Director, Medical Services & Chief Medical Officer	450	-	9	35	494
Executive Director, Research & Innovation & Clinical Dean	477	-	10	36	523
Executive Director Nursing & Midwifery, Education & Support Services	201	-	4	19	224

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

2016

Position (date resigned if applicable)	*Short Term Employee Expenses*		*Long term Employee Expenses*	*Post Employment Expenses*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*			
	$'000	*$'000*	*$'000*	*$'000*	*$'000*
Health Service Chief Executive (1 July to 5 June 2016)	292	12	6	27	337
A/Health Service Chief Executive (6 June to 30 June 2016)	13	-	-	1	14
Executive Director, Operations Mackay (1 July to 4 December 2015)	76	-	1	5	82
Executive Director, Operations Mackay (14 January to 5 June 2016)	71	-	1	7	79
Executive Director, Finance, Procurement & Infrastructure (resigned 1 July 2016)	188	-	4	19	211
Executive Director, Rural Services	173	1	3	16	193
Executive Director, People and Culture (1 July to 7 August 2015)	74	-	-	-	74
Executive Director, HR & Communications (27 July to 30 June 2016)	199	13	2	11	225
Executive Director, Clinical Governance & Chief Medical Officer (1 March to 30 June 2016)	153	11	3	12	179
A/Executive Director, Clinical Governance & Chief Medical Officer (1 July to 12 February 2016)*	345	-	7	26	378
Executive Director, Medical Workforce & Clinical Dean (25 January to 30 June 2016)*	220	3	4	17	244
Executive Director Teaching, Training and Research	181	-	3	20	204

* The substantive occupant was on extended leave from January 2015 to January 2016. During this period, the position of Executive Director, Clinical Governance & Chief Medical Officer was filled temporarily. On return to active duties, the substantive occupant was appointed as the Executive Director, Medical Workforce & Clinical Dean.

G1 KEY MANAGEMENT PERSONNEL DISCLOSURES (continued)

Remuneration paid or owing to board members during 2016-17 was as follows:

Board Member	*Short Term Employee Expenses*		*Post Employment Expenses*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*		
	$'000	*$'000*	*$'000*	*$'000*
Chairperson	80	-	8	88
Deputy Chair	53	-	5	58
Board Member	46	-	5	51
Board Member	43	-	4	47
Board Member*	51	-	5	56
Board Member	47	-	4	51
Board Member	42	-	5	47
Board Member	46	-	5	51
Board Member	42	-	5	47

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

Board Member	*Short Term Employee Expenses*		*Post Employment Expenses*	*Total Expenses*
	Monetary Expenses	*Non-monetary Benefits*		
	$'000	*$'000*	*$'000*	*$'000*
Chairperson (1 July to 17 May 2016)	70	-	7	77
Chairperson (18 May to 30 June 2016)	13	-	-	13
Deputy Chair	48	-	5	53
Board Member	45	-	4	49
Board Member	42	-	4	46
Board Member*	43	-	4	47
Board Member	44	-	5	49
Board Member (1 July to 17 May 2016)	39	-	4	43
Board Member (1 July to 17 May 2016)	41	-	4	45
Board Member (18 May to 30 June 2016)	7	-	-	7
Board Member (18 May to 30 June 2016)	7	-	-	7
Board Member (18 May to 30 June 2016)	7	-	-	7

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

G2 RELATED PARTY TRANSACTIONS

Transactions with other Queensland Government-controlled entities

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

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

Entity	For the year ending 30 June 2017		As at 30 June 2017	
	Revenue	Expenditure	Asset	Liability
	$'000	$'000	$'000	$'000
Department of Health	360,699	247,576	8,838	11,217

Department of Health

MHHS's primary source of funding is provided by the Department of Health, with payments made in accordance with a service agreement. The signed service agreements are published on the Queensland Government website and are publicly available. Revenue under the service arrangement was $355.3 million for the year ended 30 June 2017. For further details on the purchase of health services by the Department refer to Note B1-2. Also during the year, MHHS incurred expenditure on behalf of the Department of Health for a number of capital projects, including the redevelopment of the Bowen and Proserpine Hospitals. These costs were reimbursed by the Department totalling $5.3 million in 2017.

The Hospital and Health Service, through service arrangements with the Department of Health, has engaged 2,078 (2016: 1,960) full time equivalent persons. In accordance with the Hospital and Health Boards Act 2011, the employees of the Department of Health are referred to as health service employees. In 2017, $214.3 million was paid to the department for health service employees. The terms of this arrangement are fully explained in Note B2-2.

The Department of Health centrally manages, on behalf of Hospital and Health Services, a range of services including pathology testing, pharmaceutical drugs, clinical supplies, patient transport, telecommunications and technology services. These services are provided on a cost recovery basis. In 2017, these services totalled $33.3 million.

Any associated receivables or payables owing to the Department of Health at 30 June 2017 are separately disclosed in Note C2 and Note C5. No impairment has been applied to these balances.

The Department of Health also provides funding from the State as equity injections to purchase property, plant and equipment. All construction of major health infrastructure is managed and funded by the Department of Health. Upon practical completion of a project, assets are transferred from the Department to MHHS. Throughout the year, funding received to cover the cost of depreciation is offset by a withdrawal of equity by the State for the same amount. For further details on equity transactions with the Department refer to Note C6-1.

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

Transactions with other related parties

All transactions in the year ended 30 June 2017 between Mackay Hospital and Health Service and key management personnel, including their related parties were on normal commercial terms and conditions and were immaterial in nature and dollar.

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

Changes in Accounting Policy

Mackay Hospital and Health Service did not voluntarily change any of its accounting policies during 2016-17.

Accounting standards early adopted

No Australian Accounting Standards have been early adopted for 2016-17.

Accounting Standards Applied for the First Time in 2016-17

The only Australian Accounting Standard that became effective for the first time in 2016-17, and materially impacted on this financial report, is AASB 124 *Related Party Disclosures*. This standard requires note disclosures about relationships between a parent entity and its controlled entities, key management personnel (KMP) remuneration expenses and other related party transactions, and does not impact on financial statement line items. As Queensland Treasury already required disclosure of KMP remuneration expenses, AASB 124 itself had minimal impact for the MHHS's disclosures compared to 2015-16 (refer to Note G1). However, the standard has resulted in MHHS's responsible Minister being identified as part of MHHS's KMP from 2016-17. Material related party transactions for 2016-17 are disclosed in Note G2. No comparative information about related party transactions is required in respect of 2015-16.

G4 TAXATION

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

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

Mackay Hospital and Health Service

Management Certificate

For the year ended 30 June 2017

These general purpose financial statements have been prepared pursuant to section 62(1) of the *Financial Accountability Act 2009* (the Act), section 43 of the *Financial and Performance Management Standard 2009* and other prescribed requirements. In accordance with section 62(1)(b) of the Act we certify that in our opinion:

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

b) the financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Mackay Hospital and Health Service for the financial year ended 30 June 2017 and of the financial position of the Hospital and Health Service at the end of that year; and

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

Mr Darryl Camilleri	Miss Jo Whitehead	Mr Brett Oates
Bachelor of Commerce	Bachelor of Arts	Bachelor of Commerce
Fellow Chartered Accountant (FCA)	Member of the Institute of Health Service Management	Associate CPA (ASA)
Deputy Chair, MHH Board	Chief Executive Officer	Chief Finance Officer
28 /8/2017	28 /8/2017	28 /8/2017

Mackay Hospital and Health Service

Independent Auditor's Report

To the Board of Mackay Hospital and Health Service

Report on the audit of the financial report

Opinion

I have audited the accompanying financial report of Mackay Hospital and Health Service. The financial report comprises the statement of financial position as at 30 June 2017, 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.

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2017, 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 2009* and Australian Accounting Standards.

Basis for opinion

I conducted my audit in accordance with the *Auditor-General of Queensland 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 of Queensland Auditing Standards.*

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

Key audit matters

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

Specialised buildings valuation ($358.3M)

Key audit matter	How my audit addressed the key audit matter
Buildings were material to Mackay Hospital and Health Service at balance date, and were measured at fair value using the current replacement cost method. Mackay Hospital and Health Service performed a comprehensive revaluation of approximately 11.6% of its buildings this year with remaining assets being revalued using indexation. The current replacement cost method comprises: • Gross replacement cost, less • Accumulated depreciation Mackay Hospital and Health Service derived the gross replacement cost of its buildings at balance date using unit prices that required significant judgements for: • identifying the components of buildings with separately identifiable replacement costs • developing a unit rate for each of these components, including: o estimating the current cost for a modern substitute (including locality factors and oncosts), expressed as a rate per unit (e.g. $/square metre) o identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference. • indexing unit rates for subsequent increases in input costs. The measurement of accumulated depreciation involved significant judgements for forecasting the remaining useful lives of building components. The significant judgements required for gross replacement cost and useful lives are also significant for calculating annual depreciation expense.	My procedures included, but were not limited to: • Assessing the adequacy of management's review of the valuation process. • Assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices • For unit rates associated with buildings that were comprehensively revalued this year: o Assessing the competence, capabilities and objectivity of the experts used to develop the models o Reviewing the scope and instructions provided to the valuer, and obtaining an understanding of the methodology used and assessing its appropriateness with reference to common industry practices. o Meeting with the expert to discuss the methodologies and assumptions applied in the valuation, and the results thereof o 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) ▪ adjustment for excess quality or obsolescence. • For unit rates associated with the remaining buildings: o Evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices o Recalculate the application of the indices to asset balances. • Evaluating useful life estimates for reasonableness by: o Reviewing management's annual assessment of useful lives. o For specific assets, we analysed the asset management plans for consistency between renewal budgets and the gross replacement cost of those assets. o Tested that no asset still in use has reached or exceeded its useful life. o Enquiring of management about their plans for assets that are nearing the end of their useful life. o Reviewing assets with an inconsistent relationship between condition and remaining useful life. • Where changes in useful lives were identified, evaluating whether they were supported by appropriate evidence.

Refer to Note 16 in the financial report.

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 2009* 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, but not for expressing an opinion on the effectiveness of the entity's internal control.
- 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

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2017:

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

b) In my opinion, the prescribed requirements in relation to the establishment and keeping of accounts were complied with in all material respects.

D J OLIVE
as delegate of the Auditor-General

Queensland Audit Office
Brisbane