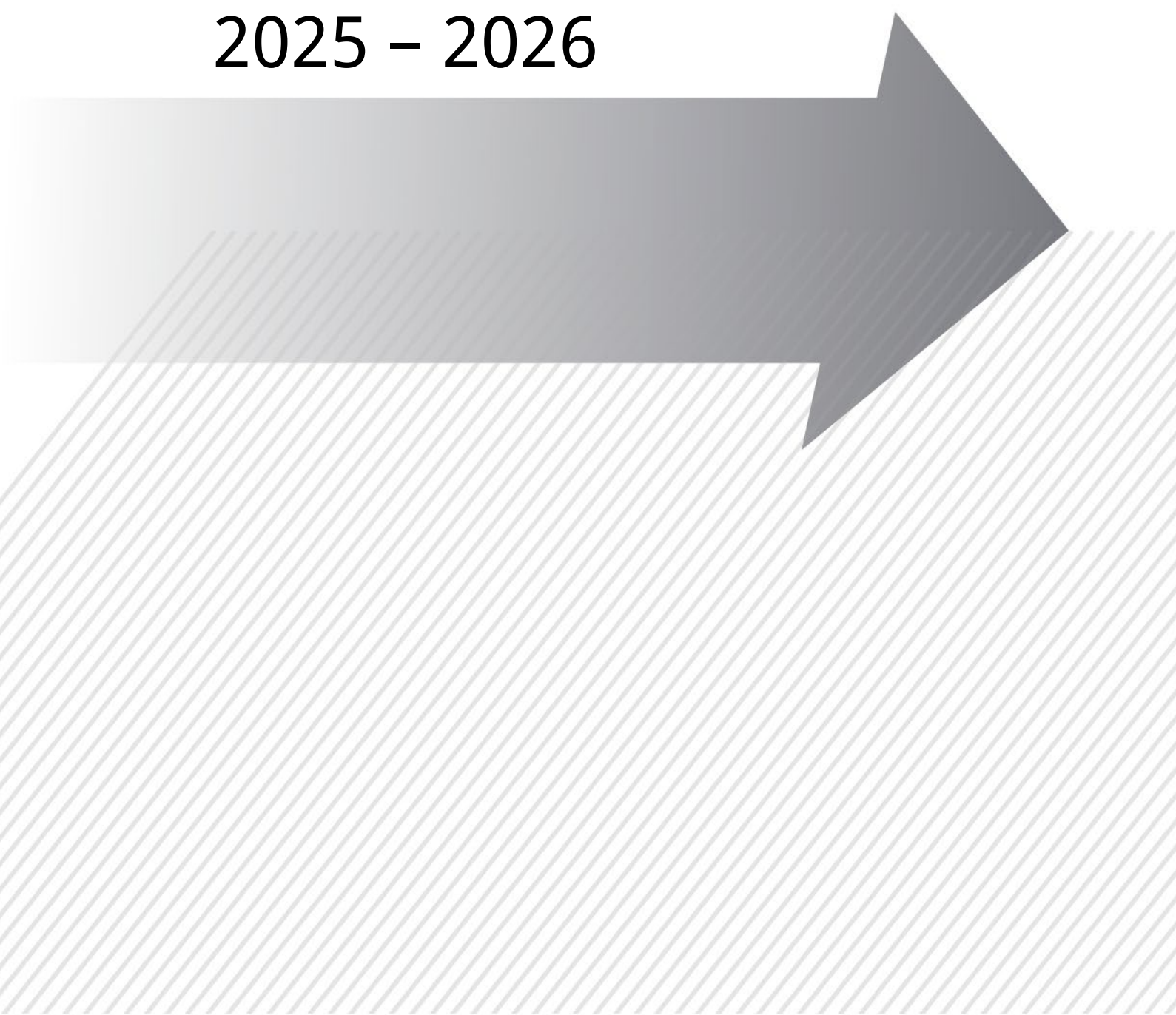


North West Hospital and Health Service

Annual Report

2025 – 2026



Purpose of the report

This annual report details the non-financial and financial performance of the North West Hospital and Health Service during the 2025-2026 financial year.

It highlights the achievements, performance, outlook and financial position of the North West Hospital and Health Service and satisfies the requirements of the *Financial Accountability Act 2009*, the *Financial and Performance Management Standard 2019* and detailed requirements set out in the *Annual Report Requirements for Queensland Government agencies*.

Open data

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

Public availability statement

An electronic copy of this report is available at <https://www.northwest.health.qld.gov.au/about-us/corporate-documents-and-publications/>.

Hard copies of the annual report are available by phoning the Office of the Chief Executive on (07) 4744 4469. Alternatively, you can request a copy by emailing NWHHS.HSCE@health.qld.gov.au.



Interpreter Service Statement

The Queensland Government is committed to providing accessible information and services to Queenslanders from all cultural and linguistic backgrounds. To talk to someone about this annual report in your preferred language call (07) 4744 4444 and ask to speak with the Human Resources Team.

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Acknowledgment of Traditional Custodians

North West Hospital and Health Service would like to acknowledge the Traditional Custodians of the land on which our services are located across the North West and Lower Gulf region.

We pay our respects to the Elders both past and present and acknowledge all Aboriginal and Torres Strait Islander people across the state. We also acknowledge the passion and commitment of the existing First Nations workforce across the whole health sector and thank them for their effort and commitment to working with us towards achieving health equity.

Recognition of Australian South Sea Islanders

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

North West Hospital and Health Service is committed to fulfilling the Queensland Government Recognition Statement: 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.

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

North West Hospital and Health Service is proud to recognise and celebrate the cultural diversity of our communities and workforce at the following locations:

Location	Traditional custodians
Burketown	Gangalidda and Garawa
Camooweal	Indjalandji - Dhidhanu
Cloncurry	Mitakoodi, Kalkadoon and Pitta Pitta
Dajarra	Yulluna
Doomadgee	Gangalidda, Waanyi and Garawa
Julia Creek	Kalkadoon, Yulluna, Mitakoodi and Mayi
Karumba	Gkuthaarn, Kukatj and Kurtijar
McKinlay	Kalkadoon, Yulluna, Mitakoodi and Mayi
Mornington Island	Lardil Yangkaal Gangalidda and Kaiadilt
Normanton	Gkuthaarn, Kukatj and Kurtijar
Mount Isa	Kalkadoon

Letter of compliance

31 August 2026

The Honourable Timothy Nicholls MP
Minister for Health, Mental Health and Ambulance Services
GPO Box 48
BRISBANE QLD 4001

Dear Minister,

I am pleased to submit for presentation to the Parliament the Annual Report 2025–2026 and financial statements for North West Hospital and Health Service.

I certify that this Annual Report complies with:

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

A checklist outlining the annual reporting requirements is provided at page 90 of this annual report.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Tanya Arnold', with a stylized, cursive script.

Tanya Arnold
Board Chair, North West Hospital and Health Service Board

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Queensland Government objectives for the community

North West Hospital and Health Service (HHS) supports the Queensland Government's objectives for the community, in particular:

- **Health services when you need them:** restoring health services when Queenslanders need them most through transparent and targeted investment with real-time data, boosting frontline health services, driving resources where they're needed most, improving our Emergency Departments, reopening regional maternity wards, fast-tracking access to elective surgeries, and helping patients to be seen faster.

This North West HHS Strategic Plan 2024-2028 outlines how the health service will contribute to this objective.

From the Board Chair and Chief Executive

From the Board Chair

It is my pleasure to present the North West Hospital and Health Service Annual Report for 2025–26.

This year has been one of significant transition for North West Hospital and Health Service, marked by changes to both Board and executive leadership. Throughout this period, our focus has remained steadfast: providing strong governance and strategic oversight to ensure our communities continue to receive safe, high-quality and sustainable healthcare.

On behalf of the Board, I extend my sincere gratitude to former Board Chair Cheryl Vardon AO and former Deputy Chair Professor Eleanor Milligan for their outstanding leadership, dedication and service. Through their vision, guidance and unwavering commitment, they helped strengthen our organisation, champion health equity and quality care, and position North West HHS to meet the evolving needs of our communities. Their contribution has left a lasting legacy, and I thank them for their years of service.

I also acknowledge former Health Service Chief Executive Sean Birgan for his leadership and contribution to North West Hospital and Health Service during his tenure.

I am pleased to welcome new Board members Professor John Prins, Dr Robin Williams and Janelle Stuart-Russell, who joined continuing members Deputy Board Chair Anne Pleash, Bill Armagnacq, Fiona Hill, Loretta Seamer, Tonya Murray and myself during the year. Together, we bring a breadth of skills and experience that will guide the strategic direction and governance of North West HHS.

As a Board, we remain committed to supporting our workforce, strengthening partnerships and improving health outcomes for the communities of North West Queensland

I thank Health Service Chief Executive Andrew Quabba and the Executive Leadership Team for their leadership throughout the year, and I acknowledge the remarkable dedication of our staff. Across every hospital, community and service, they continue to provide compassionate, high-quality care despite the unique challenges of delivering healthcare across our vast and diverse region.

On behalf of the Board, I thank our staff, consumers, healthcare partners and communities for your ongoing trust, collaboration and commitment. Together, we will continue to build a healthier future for North West Queensland.



Tanya Arnold
Board Chair

From the Chief Executive

Building on another year of strong performance, North West HHS improved access to care, strengthened partnerships and achieved better outcomes across our remote and diverse region. Guided by our commitment to safe, sustainable and equitable healthcare, we exceeded key targets and worked with communities to ensure care reflects local needs. Our achievements this year focus on expanding local services, advancing health equity, improving outcomes, and strengthening our health service for the future.

- **Enhancing community-focused services:** We improved access to timely care through reduced wait times, expanded outreach services and locally tailored models of care. Enhanced paediatric, antenatal and allied health services, along with a new paediatric electroencephalogram service, increased access to specialist care closer to home and reduced travel for families. We also boosted consumer engagement through improved patient feedback systems and community consultation.
- **Focusing on First Nations health equity:** Improving health equity for Aboriginal and Torres Strait Islander peoples remained a priority. Through the refreshed *North West Health Equity Strategy 2025–2028*, we strengthened culturally safe, community-led care and addressed institutional barriers to health equity. Initiatives such as the Doomadgee Truth Telling Day and community-led rheumatic heart disease prevention programs highlighted the value of local leadership, while workforce development initiatives strengthened pathways for future First Nations leadership.
- **Expanding services to improve health outcomes:** Innovative and collaborative models of care improved access to healthcare across the region. A new Chronic Disease Clinic in Dajarra supported earlier intervention and addressed local service gaps, while workforce innovations, including the Single Employer Model and an Australian-first Paramedic Remote Hospital role in Camooweal, enhanced sustainable healthcare delivery in remote communities.
- **Investing in infrastructure and technology:** Significant progress was made in building a sustainable health service. The opening of the new Normanton Hospital was a major milestone, delivering modern facilities for the community. Planning progressed for the new Yellagundgimarra Hospital Doomadgee and updated staff accommodation to support workforce attraction and retention. The release of our first Digital Strategy, *Footsteps to the Future*, and upgrades to clinical systems, patient monitoring technology, cyber security, connectivity and data analytics advanced our digital journey and maturity.
- **Strengthening partnerships:** Collaboration remained key to our success. We worked closely with healthcare partners to deliver integrated care and advance regional initiatives in chronic disease prevention, rheumatic heart disease and workforce development. National recognition of the *All In! Driving Down RHD Rates in Remote First Nations Communities* initiative demonstrated the impact of working together toward shared goals.

I sincerely thank our staff, consumers, volunteers, community members and healthcare partners for their dedication and collaboration throughout the year. Together, we are building a stronger, more connected and equitable health system for North West Queensland.



Andrew Quabba
Health Service Chief Executive

About us

North West HHS was established on 1 July 2012 under the *Hospital and Health Boards Act 2011*. Our vision is to be Queensland's premier provider of rural and remote health services, delivering exceptional care.

For a provider like us, this means ensuring access to clinical and support services in various locations throughout the region, delivering timely responses by our skilled staff. We operate under a service agreement with the Department of Health, outlining the services provided, funding arrangements, performance indicators, and targets to achieve the expected health outcomes for our communities. This agreement is negotiated annually and is publicly accessible on the Queensland Health website at <https://www.health.qld.gov.au/>.

Additionally, we are committed to our role as a vital part of the Queensland Health service landscape, continuing to develop integrated care models with other Hospital and Health Services and clinical networks.

Our strategic direction

The Strategic Plan ensures the continuation of delivering trusted, connected and quality healthcare for the period up until 30 June 2026. Our five key strategic objectives guide our annual priorities and contribute to achieving our vision to provide kind, inclusive and safe health services across our region in partnership with the communities we serve.

Each of the strategic objectives is further defined through several key strategies for actioning operational plans and health service planning to achieve our measures of success.

Focusing on health

Ensuring the right care, right place, right time; talking about and managing your healthcare.

Focusing on First Nations

Increase health equity and parity of life expectancy by 2031; strengthen relationships with communities; support First Nations workforce.

Focusing on improvement

Deliver our services efficiently; innovation; technology; financial integrity and sustainability.

Focusing on working together

Work with our communities; improve the patient experience across our health services; implement better ways to share data and to communicate across boundaries.

Focusing on valuing and growing our people

Support, develop and value our workplace culture; grow our workforce; increase our First Nations workforce.

Vision, purpose and values

Our vision

Trusted, connected, quality healthcare for all.

Our purpose

To provide kind, inclusive and safe health services across our region in partnership with the communities we serve.

Our values

We will respect, protect and promote human rights in our decision-making and actions through these processes:

- **Innovation** – we strive for continuous improvement
- **Respect** – we listen and learn from each other
- **Engagement** – we work with our communities and partners
- **Accountability** – we own our actions and behaviors
- **Caring** – we treat people with kindness and dignity
- **Honesty** – we are always truthful.

Our priorities

Our priority deliverables for 2025-2026 were shaped around the following key strategic priorities:

- focus on preventative health and health promotion in our region to improve health outcomes
- action the Health Equity reform agenda specifically with First Nations peoples
- expand the use of technology and harness innovation to enable easy and safe access to healthcare in our settings or closer to home
- prioritise staff retention and development while optimising approaches to attract the right people with the right skills to the right roles
- mentor and grow our First Nations workforce to strengthen, support and promote career and development opportunities
- partner with our diverse communities to understand and overcome social, economic and geographical barriers to healthcare
- invest in how we focus on growing our leadership culture and core structure.

Aboriginal and Torres Strait Islander health

We wish to thank all who have partnered with us during the inaugural Health Equity Strategy 2022-2025 and look forward to continuing to work together during the next three-year period. The *North West Health Equity Strategy and Implementation Plan 2025-2028* describes our commitment to drive health equity, eliminate institutional racism across the public health system and continue targeted efforts to achieve life expectancy parity for Aboriginal and Torres Strait Islander people by 2031.

Actively eliminate racial discrimination and institutional racism within the service

Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services was a review commissioned by the Anti-Discrimination Commission Queensland (now known as Human Rights Commission) and Queensland Aboriginal and Islander Health Council. Using a matrix developed by Professor Henrietta Marrie and Adrian Marrie, all Hospital and Health Services across Queensland were evaluated on their performance in addressing institutional racism. The audit provides a framework for measuring transparency and accountability, while monitoring progress towards the national goal of a public health system free of racism and inequality.

The 2017 audit, based on the 2014-2015 reporting period enabled a comparison against earlier assessments and highlighted significant opportunities for improvement. North West HHS recorded a score of 31 points out of a possible 140, placing it in the "Very High" level for institutional racism. In contrast, the 2025 audit, based on the 2024-2025 reporting period, recorded a score of 105.5 out of 140. This places North West HHS within the "Low" category for institutional racism, representing a 240% improvement over the 10-year period.

This result reflects an increased level of transparency and accountability in providing information to the community and highlights North West HHS' commitment to actively identifying and eliminating systemic barriers to equitable healthcare for Aboriginal and Torres Strait Islander peoples.

Influencing the social, cultural and economic determinants of health

North West HHS marked a deeply special day by hosting the Welcome Baby to Community and Birth Registration event, officially welcoming the region's newest community members. Supported by Gidgee Healing, Ngukuthati Children and Family Centre and MOB FM, the event provided a culturally safe environment where babies and their families were celebrated and grounded in culture. Elders played a central role in the event, welcoming babies with warmth and wisdom and sharing cultural knowledge. The day provided free birth registration services for families, Welcome Baby to Community certificates and baby care packs.

Work with First Nations peoples, communities and organisations to design, deliver, monitor and review health services

An annual investment of \$3.1 million through the Queensland Government's *Making Tracks* initiative supports efforts to address the health needs of Aboriginal and Torres Strait Islander people across the North West region. This investment aims to enhance healthcare outcomes by aligning with the Aboriginal and Torres Strait Islander Health Equity framework. Specific programs include chronic disease management, targeting renal health, cardiac and rheumatic heart disease (RHD), and diabetes care. Making Tracks funding also supports maternity outreach to remote communities.

Supported by \$1.73 million in funding, the *Growing Deadly Families Strategy* is helping to improve the health and wellbeing of Aboriginal and Torres Strait Islander mothers, babies, children and families. The strategy aims to ensure every woman in Queensland giving birth to an Aboriginal and/or Torres Strait Islander baby has access to high-quality, clinically safe and culturally capable maternity services.

Delivering sustainable, culturally safe and responsive health services and strengthening Aboriginal and Torres Strait Islander workforce

Through the continued delivery and expansion of Aboriginal and Torres Strait Islander workforce programs, increased participation in workforce initiatives and strong completion rates of the mandatory First Nations Cultural Safety and Equity in Healthcare training, North West HHS is strengthening cultural capability across the organisation and building a sustainable local Aboriginal and Torres Strait Islander workforce pipeline for the future.

Partnerships in health

Partnerships are fundamental to North West HHS's ability to deliver trusted, connected and high-quality healthcare across one of Queensland's most geographically dispersed regions. Recognising the importance of early intervention, prevention-focused models of care, improved health equity and better access to services, North West HHS has built strong relationships with a diverse range of agencies and organisations. Through these partnerships, we are improving healthcare outcomes and enhancing the experience of care for our communities.

North West HHS works closely with healthcare providers, First Nations organisations, universities, researchers and community services to deliver more connected, equitable and sustainable healthcare. These collaborations improve access to care closer to home, advance health equity, strengthen workforce capability and drive innovation, helping to ensure the people of North West Queensland receive the right care, in the right place, at the right time.

Our services

North West HHS is the primary provider of public hospital and health services in North West Queensland, spanning over 300,000 square kilometres. Serving a population of around 27,000 people, our health service includes several remote and discrete Aboriginal communities. We collaborate closely with healthcare partners to ensure timely and appropriate care in this challenging environment. North West Queensland is rich in Aboriginal and Torres Strait Islander culture, with these communities comprising around 30 per cent of the population, making North West HHS one of Australia's largest providers of health services to Aboriginal and Torres Strait Islander peoples.

In 2025-2026, North West HHS delivered health services through one regional hospital, two multi-purpose health services, three remote hospitals and five primary health clinics including:

- Mount Isa Hospital
- Cloncurry Multi-Purpose Health Service and Community Health Centre
- Julia Creek Multi-Purpose Health Service
- Yellagundgimarra Hospital Doomadgee and Community Health Centre
- Mornington Island Hospital and Community Health Centre

- Normanton Hospital and Community Health Centre
- Burketown Primary Health Clinic
- Camooweal Primary Health Care Centre
- Dajarra Primary Health Clinic
- Karumba Primary Health Clinic
- McKinlay Primary Health Clinic.

Our comprehensive range of services includes specialist inpatient and outpatient care, including but not limited to:

- | | |
|---|---|
| • Allied health | • General medicine |
| • Mental health, alcohol and other drugs services | • Aboriginal and Torres Strait Islander health services |
| • Cancer care | • Surgical services |
| • Palliative care | • Maternal, child and youth health services |
| • Oral health | • Aged care |
| • Outpatients | • Chronic disease |
| • Advanced care planning | • Sexual health |
| • Pharmacy services | • Outreach services |
| • Telehealth | • Paediatrics |
| • Medical imaging | • Women's health |
| • Emergency medicine | • Infectious diseases |
| • Intensive care | • Rehabilitation |
| • Obstetrics and gynaecology | • Community health |

Targets and challenges

North West HHS continues to provide healthcare to our remote communities, acknowledging the unique challenges of our region, while still supporting the health service to be an agile and connected health system to better meet the diverse needs of our communities. In 2025-2026, we focused on achieving our strategic objectives.

Targets and measures of success

Actions	Measures of success
Focusing on Health • <i>Ensuring the right care, right place, right time</i> • <i>Talking about and managing your healthcare</i>	• Exceeded or met targets for emergency and planned care • Increased patient reported outcome measures • Achievement of <i>North West HHS Clinical Services Plan</i> directives • Increased engagement and consumer/ community voice representation
Focusing on First Nations • <i>Increase health equity and parity of life expectancy by 2031</i> • <i>Strengthen relationships with communities</i> • <i>Support First Nations workforce</i>	• Implemented <i>North West HHS Health Equity Strategy</i> • Strengthened relationships with community and local leaders • Reduced rates of preventable hospitalisations
Focusing on Improvement • <i>Deliver our services efficiently</i> • <i>Innovation</i> • <i>Technology</i> • <i>Financial integrity and sustainability</i>	• Improved and maintained patient safety and quality measures • Increased equity in access to digital healthcare and health technologies • Achievement of a balanced budget with maximised own source revenue • Increased embedding of data analytics and data insights • Improved health outcomes in our communities • Achieved capital expenditure KPIs
Focusing on Working Together • <i>Work with our communities</i> • <i>Improve the patient experience across our health services</i> • <i>Implement better ways to share data and to communicate across boundaries</i>	• Embedded feedback from community consultation into service planning • Increased community voice represented in service planning • Strengthened relationships, collaborations and data sharing with regional partners • Improved functionality of our Consumer Advisory Groups (CAG) • Improved consumer experience, navigation and delivery pathways
Focusing on Valuing and Growing our People • <i>Support, develop and value our workplace culture</i> • <i>Grow our workforce</i> • <i>Increase our First Nations workforce</i>	• Continued to improve our employee engagement score and staff wellbeing indicators • Aligned workforce rates to community requirements • Increased Aboriginal and Torres Strait Islander people's workforce engagement • Improved staff retention rates and employment/development pathways • Increased clinician-led healthcare improvement initiatives

Challenges

The Strategic Plan outlines key priorities and highlights ongoing challenges that must be addressed to ensure high-quality healthcare for our communities:

- **Fit-for-purpose business systems:** Ensuring our systems, data and infrastructure enable ongoing improvements/innovation in care delivery.
- **Disrupted finance and funding models:** The complexities of state and federal funding models may disrupt our strategic goals of delivering committed, connected care close to home.
- **Health equity amongst our First Nations peoples:** The rural and remote nature of our work, and the access challenges our geography brings puts achieving genuine health equity at risk. Failure to walk this path with our First Nations people could undermine achieving our shared goal of health equity across our region.
- **Sustainable health workforce:** Our remote location, employment competition and high workforce turnover could reduce our capacity to maintain safe, high quality, culturally respectful services. Partnering will be essential; while acknowledging we cannot control the delivery capacity of our partners.
- **Security of technology:** Cyber threats, access vulnerabilities and connectivity risks pose potential harm to patient data and operational integrity. Robust safeguards are essential for a resilient healthcare system.
- **Investment in mental health services:** The growing need for mental healthcare across the state and our region requires additional investment in these services.

Governance

Our people

Board membership

The North West Hospital and Health Board (the Board) is appointed by the Governor-in-Council on the recommendation of the Minister for Health, Mental Health and Ambulance Services in accordance with section 23 of the *Hospital and Health Boards Act 2011 (Qld)*. The Board is responsible for the governance activities of the organisation, deriving its authority from the *Hospital and Health Boards Act 2011 (Qld)* and the *Hospital and Health Boards Regulation 2023 (Qld)*.

Tanya Arnold, Board Chair	
Appointed Member: 1 July 2024 Appointed Board Chair: 1 April 2026	Current Term: 1 April 2026 - 31 March 2028
Tanya Arnold brings over 30 years of experience living and working in remote Queensland and the Northern Territory, offering deep insight into the healthcare challenges of rural regions. She manages a large pastoral property near Normanton, giving her practical experience navigating rural health systems to support staff care. With a background in human resource management, strategic planning, and communication, Ms Arnold is a strong advocate for collaboration and consumer-focused solutions. From 1 April 2026, Ms Arnold was appointed Board Chair. On 15 April 2026, she was appointed Chair of the Board Executive Committee. She served as a member of the Board Audit and Risk Committee from 1 September 2025 to 15 April 2026, continued as a member of the Board Finance and Performance Committee, and was appointed to the Board Stakeholder Engagement Committee on 1 September 2025. From 1 June 2026, she also served as Interim Chair of the Board Finance and Performance Committee.	

Cheryl Vardon AO, Board Chair (Former)	
Appointed: 1 April 2022	Term: 1 April 2022 – 31 March 2026
Ms Cheryl Vardon AO has more than 25 years' experience in senior leadership roles across the public and private sectors, including as the inaugural Chief Executive and Principal Commissioner of the Queensland Family and Child Commission. Appointed an Officer of the Order of Australia (AO) for distinguished service to child welfare, public administration, social policy and the community, Ms Vardon is a recognised expert in public policy, governance and service reform. She is a Fellow of the Australian Institute of Management and the Australian College of Education, a member of the Australian Institute of Company Directors, and an Adjunct Professor and Honorary Doctor at Griffith University. Ms Vardon AO served as Board Chair and Chair of the Board Executive Committee throughout her term from 1 April 2022 to 31 March 2026. From 1 September 2025, she also served as a member of the Board Safety and Quality Committee. During her tenure, she provided strong strategic leadership and governance in support of improved health outcomes for communities across the North West.	

Anne Pleash, Deputy Board Chair	
Appointed: 1 April 2024 Appointed Deputy Board Chair: 1 April 2026	Current Term: 1 April 2026 - 31 March 2030
Anne Pleash is an experienced executive and non-executive director with expertise in stakeholder and government relations, media, health, and advocacy across both private and public sectors. She holds degrees in Arts and Business, runs her own consulting business, and serves on several boards including Cancer Council Australia. Deeply committed to the North West health district, Ms Pleash has strong ties to the region, having grown up in Normanton and the Mid-West and returned there to live and work after university. From 1 April 2026, Ms Pleash was appointed Deputy Board Chair. Having served as a member of the Board Finance and Performance Committee from 2024, she transitioned to the Board Audit and Risk Committee on 15 April 2026. Ms Pleash continues as Chair of the Board Stakeholder Engagement Committee and as a member of the Board Executive Committee.	

Professor Eleanor Milligan, Deputy Board Chair (Former)	
Appointed: 1 April 2022	Term: 1 April 2022 – 31 March 2026
Professor Milligan is a respected leader with extensive experience across health practitioner regulation, governance, ethics, accreditation and education. She has held a number of senior statutory appointments, including with the Medical Board of Australia, the Australian Medical Council, the National Health and Medical Research Council, and Metro South Hospital and Health Board. Professor Milligan holds a PhD and is a Fellow of the Australasian College of Health Service Management and a Graduate of the Australian Institute of Company Directors. Professor Milligan served as the Deputy Board Chair and Chair of the Board Safety and Quality Committee from April 2022 to March 2026 and during this period brought deep governance expertise and an unwavering commitment to patient safety and quality improvement.	

Thomas (Bill) Armagnacq, Board Member	
Appointed: 1 April 2022	Current Term: 1 April 2026 - 31 March 2030
Bill Armagnacq is an experienced non-executive director, senior executive, and chartered accountant with expertise across governance, risk management, compliance, internal audit, lending, and corporate regulation. He currently serves as a director of Energy Queensland Limited, MoveBank Ltd, and CEnet Limited. He's also chair of the People First Bank Foundation and the Inner Darling Downs Community Consultative Committee for Inland Rail. Mr Armagnacq was reappointed to the Board on 1 April 2026. From 1 September 2025, he transitioned from Chair to member of the Board Finance and Performance Committee and from member to Chair of the Board Audit and Risk Committee. He continues as a member of the Board Executive Committee.	

Dr Marco Giuseppin, Board Member (Former)	
Appointed: 1 April 2022	Resigned: 31 August 2025
Dr Marco Giuseppin is a Rural Generalist with extensive experience across general practice, emergency medicine, retrieval medicine and anaesthesia in regional Queensland. A Fellow of the Australian College of Rural and Remote Medicine and a Graduate of the Australian Institute of Company Directors, he is a recognised leader in rural health and clinical governance. Until his resignation from the Board on 31 August 2025, Dr Giuseppin served as Chair of the Board Audit and Risk Committee and as a member of the Board Safety and Quality Committee and Board Executive Committee.	

Fiona Hill, Board Member	
Appointed: 1 December 2022	Current Term: 1 April 2024 – 31 March 2028
Fiona Hill, a proud First Nations woman of the Waluwarra, Alyawarra, Yirendali, and Ngawun peoples, has over 30 years' experience in government and the social and community services sector. She has led and delivered social programs across the community-controlled, not-for-profit, and government sectors in Mount Isa and the Gulf communities of Doomadgee, Mornington Island, and Normanton. Ms Hill is a member of the Board Stakeholder Engagement Committee.	

Tonya Murray, Board Member	
Appointed: 1 July 2024	Current Term: 1 July 2024 - 31 March 2028
Tonya Murray, a Gangalidda woman from Burketown and Mount Isa, brings over 20 years of community leadership, including 16 years on Burke Shire Council with four as Deputy Mayor. Experienced in business management, education administration, and team supervision, she excels in strategic planning, budgeting, and communication. Ms Murray has deep knowledge of the Gulf and North West's health challenges and strong connections with Aboriginal health workers and Indigenous service providers, supporting sustainable health delivery in remote communities. From 1 September 2025, Ms Murray was appointed as a member of the Board Safety and Quality Committee and has remained a member of the Board Stakeholder Engagement Committee.	

Dr Mellissa Naidoo, Board Member (Former)	
Appointed: 1 April 2022	Resigned: 16 February 2026
Dr Mellissa Naidoo is a specialist medical administrator with over 20 years of experience in clinical, leadership, and executive roles across the public and private health sectors. She holds a Master's in Health Management, dual fellowships with the Royal Australasian College of Medical Administrators and the Australian College of Health Service Management, and certification in health informatics. Until her resignation from the Board on 16 February 2026, Dr Naidoo was a member of the Board Safety and Quality Committee and the Board Audit and Risk Committee.	

Professor John Prins, Board Member	
Appointed: 1 April 2026	Current Term: 1 April 2026 - 31 March 2030
Professor John Prins is a respected endocrinologist and senior health leader with extensive experience across clinical care, medical research and higher education. He has held executive leadership roles including Head of Melbourne Medical School, Director and Chief Executive Officer of the Mater Research Institute, Chief Executive Officer of Health Translation Queensland, and Chair of the Australian Health Research Alliance. Professor Prins is a Fellow of the Royal Australasian College of Physicians and the Australian Academy of Health and Medical Sciences, with a strong track record in health research translation and commercialisation. Professor Prins is a member of the Board Safety and Quality Committee and Board Finance and Performance Committee.	

Steven Renouf, Board Member (Former)	
Appointed: 1 April 2024	Resigned: 7 July 2025
Steven Renouf, a proud Gunggarri and Gubbi Gubbi man, is a former international rugby league player, Australian Sports Medallist and inductee into both the Australian Indigenous Team of the Century and the Brisbane Broncos Hall of Fame. Following his sporting career, he has championed Aboriginal and Torres Strait Islander health through leadership and ambassador roles, including with the Institute for Urban Indigenous Health. Until his resignation from the Board on 7 July 2026, Mr Renouf was a member of the Board Safety and Quality Committee and the Board Stakeholder Engagement Committee.	

Loretta Seamer, Board Member	
Appointed: 1 April 2024	Current Term: 1 April 2024 - 31 March 2028
Loretta Seamer is a highly experienced health executive and board director with a strong background in both Australian and international health systems. She has held executive CFO roles at Children's Health Queensland, Sunshine Coast Hospital and Health Services, and the Mater Hospital Group, as well as CFO positions at Great Ormond Street Hospital in London and Sidra Medicine in Qatar. Her expertise includes healthcare performance, financial operations, strategic and health service planning, governance, and infrastructure. Ms Seamer holds a Business Degree, MBA, and Graduate Certificate in Applied Finance, and is a Fellow of CPA Australia and a Graduate of the Australian Institute of Company Directors. From 1 September 2025, Ms Seamer transitioned from member to Chair of the Board Finance and Performance Committee and has remained a member of the Board Audit and Risk Committee and Board Executive Committee. From 1 June 2026, Ms Seamer was appointed Interim Chief Finance Officer for North West Hospital and Health Service pending the permanent appointment of a Chief Finance Officer. During this period, she temporarily stepped down from her Board committee roles to maintain appropriate governance arrangements and manage conflicts of interest. She will resume these roles following the completion of her interim appointment.	

Janelle Stuart-Russell, Board Member	
Appointed: 1 April 2026	Current Term: 1 April 2026 - 31 March 2030
Janelle Stuart-Russell is an experienced Registered Nurse with more than 30 years' experience across emergency, surgical, paediatric, community health and clinical education settings. She is currently a Clinical Facilitator at Mount Isa Hospital, supporting workforce development through education, mentorship and training. Janelle has held a range of clinical and leadership roles across regional and rural health services and brings extensive experience in patient care, workforce development and clinical governance. She holds a Bachelor of Nursing and a Bachelor of Education from Queensland University of Technology and is registered with the Australian Health Practitioner Regulation Agency. Ms Stuart- Russell is a member of the Board Safety and Quality Committee.	

Dr Robin Williams, Board Member	
Appointed: 1 April 2026	Current Term: 1 April 2026 - 31 March 2030
Dr Robin Williams trained in medicine at Charing Cross Hospital Medical School, University of London, before practising as a rural general practitioner in North Wales and regional New South Wales. He has more than 25 years' experience in health governance, including as Chair of the Western NSW Local Health District and Western NSW Primary Health Network. Throughout his career, Dr Williams has been committed to improving equitable access to healthcare for rural and remote communities through innovation, workforce development and integrated models of care. Dr Robin is the Chair of the Board Safety and Quality Committee and a member of the Board Audit and Risk Committee and Board Executive Committee.	

North West Hospital and Health Board overview

North West Hospital and Health Board					
Act or instrument		Hospital and Health Boards Act 2011			
Functions		Refer to section ‘About Us’			
Achievements		Reported throughout the Annual Report			
Financial reporting		Refer to Annual Financial Statements			
Remuneration					
Position	Name	Meetings/Sessions Attendance	Approved annual fee	Approved sub-committee fees	Actual fees received
Current Chair	Tanya Arnold	13/13 - Board 01/01 - Executive* 05/05 - Finance and Performance* 02/02 - Audit and Risk 01/02 - Stakeholder Engagement	\$68,243	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$55,944
Former Chair	Cheryl Vardon AO <i>Tenure concluded 31 March 2026</i>	07/09 – Board 02/04 - Executive* 01/02 - Safety and Quality	\$68,243	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$61,766

Current Deputy Chair	Anne Pleash	13/13 - Board 04/04 - Executive 03/03 - Finance and Performance 01/01 - Audit and Risk 03/03 - Stakeholder Engagement*	\$35,055	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$46,872
Former Deputy Chair	Prof Eleanor Milligan <i>Tenure concluded 31 March 2026</i>	09/09 - Board 03/04 - Executive 03/03 - Safety and Quality*	\$35,055	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$34,018
Member	Thomas (Bill) Armagnacq	12/13 - Board 03/04 - Executive 05/05 - Finance and Performance* 04/04 - Audit and Risk*	\$35,055	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$46,652
Member	Dr Marco Giuseppin <i>Resignation effective 31 August 2025</i>	02/02 - Board 0/0 - Executive 01/01 - Safety and Quality 01/01 - Audit and Risk*	\$35,055	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$9,963
Member	Fiona Hill	04/13 - Board 02/03 - Stakeholder Engagement	\$35,055	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$41,797
Member	Tonya Murray	12/13 - Board 03/03 - Safety and Quality 03/03 - Stakeholder Engagement	\$35,055	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$44,990
Member	Dr Melissa Naidoo <i>Resignation effective 16 February 2026</i>	04/07 - Board 01/02 - Safety and Quality 01/02 - Audit and Risk	\$35,055	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$26,703
Member	Prof John Prins <i>Tenure commenced 1 April 2026</i>	04/04 - Board 02/02 - Finance and Performance 01/01 - Safety and Quality	\$35,055	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$11,309
Member	Steven Renouf <i>Resignation effective 7 July 2025</i>	0/0 - Board 0/0 - Safety and Quality 0/0 - Stakeholder Engagement	\$35,055	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$1,519
Member	Loretta Seamer	12/13 - Board 03/03 - Executive 04/04 - Finance and Performance* 04/04 - Audit and Risk	\$35,055	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$42,681
Member	Janelle Stuart-Russell <i>Tenure commenced 1 April 2026</i>	04/04 - Board 01/01 - Safety and Quality	\$35,055	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$9,929

Member	Dr Robin Williams <i>Tenure commenced 1 April 2026</i>	04/04 - Board 01/01 - Executive 01/01 - Safety and Quality* 01/01 - Audit and Risk	\$35,055	\$2,500 pa (as Chair) \$2,000 pa (as Member)	\$12,032
* Indicates Chair roles					
No. scheduled meetings –	Board				13
	Board Finance and Performance Committee (BFPC)				5
	Board Audit and Risk Committee (BARC)				4
	Board Safety and Quality Committee (BSQC)				4
	Board Executive Committee (BEC)				4
	Board Stakeholder Engagement Committee (BSEC)				3
Total out of pocket expenses		\$13,710			

Board committees

Five of the Board committees are prescribed, while the Board Stakeholder Engagement Committee is a nonprescribed committee. Each Committee operates with terms of reference describing the purpose, role, responsibilities, composition, structure, and membership.

Executive Committee

The Executive Committee supports the Board by working with the Health Service Chief Executive to progress strategic issues and ensure accountability in the delivery of services within North West HHS.

Finance and Performance Committee

The Finance and Performance Committee makes recommendations to the Board by overseeing the financial position, performance and resource planning strategies of the Hospital and Health Service in accordance with the *Financial Accountability Act 2009*.

Safety and Quality Committee

The Safety and Quality Committee makes recommendations to the Board by overseeing quality and safety, including compliance with state and national standards, provision of person-centred care, service accreditation preparedness, periodic industry review outcomes and critical incidents of concern.

Audit and Risk Committee

The Audit and Risk Committee provides independent oversight of the internal and external audit function, providing the Board with advice and recommendations on matters relating to risk and compliance for financial, accounting, and legislative requirements.

Stakeholder Engagement Committee

The Stakeholder Engagement Committee is a non-prescribed Committee established to monitor and promote the service's reputation by ensuring clear and meaningful communication and engagement with staff, the community, and other stakeholders. The committee also acts as the pathway committee for the Partnering with Consumers Committee to the Board.

Executive management

As at 30 June 2026, the Health Service Chief Executive was supported by an executive team including the following members:

Health Service Chief Executive	
Sean Birgan	Term during reporting period: 1 July 2025 – 12 October 2025 Resigned position 1 February 2026.
Andrew Quabba	Term during reporting period: 13 October 2025 – 30 June 2026 (acting)
• The Health Service Chief Executive is responsible and accountable for the day-to-day management of the HHS and for operationalising the Board's strategic vision and direction. • The Health Service Chief Executive is appointed by, and reports to, the Board.	

Chief Operating Officer	
Andrew Quabba	Term during reporting period: 1 July 2025 – 12 October 2025
Wesley Shann	Term during reporting period: 13 October 2025 – 30 June 2026 (acting)
Clare Newton	Term during reporting period: 22 December 2025 – 11 January 2026 (acting)
• Works collaboratively with the Health Service Chief Executive and Executive Leadership Team to manage and coordinate all commissioning, planning and positioning of services to ensure optimal levels of health service delivery and patient safety are achieved. • Ensures effective, efficient and safe delivery of clinical services, non-clinical services and resources required for the North West HHS to achieve and sustain its responsibilities to its stakeholders. • Strategically leads the development of strategies to address key service gaps, high level risks and performance issues. • Provides advice to the Health Service Chief Executive and Board as required.	

Executive Director People, Culture and Planning	
Sylvie Brdjanovic	Term during reporting period: 1 July 2025 – 30 June 2026
• Provides strategic oversight and executive leadership of human resources, workplace health and safety and corporate and support services. • Provides oversight of key service planning activities. • Strategic leadership and oversight of corporate governance, strategy development and innovation. • Ensures compliance with all necessary legislation and statutory obligations through management systems, governance, policies and procedures. • Provides leadership of recruitment and retention to ensure North West HHS is an employer of choice.	

Executive Director Nursing and Midwifery	
Dr Karen Slater	Term during reporting period: 1 July 2025 – 13 March 2026
Wesley Shann	Term during reporting period: 18 September – 26 October 2025 (acting)
Jacqueline Smith	Term during reporting period: 2 March 2026 – 13 March 2026 (acting)
Sari Holland	Term during reporting period: 16 March to 30 June 2026 (acting)
• Provides strategic oversight and executive leadership for nursing and midwifery workforce for the North West HHS. • Works collaboratively with all members of the executive and clinical leadership team members across North West HHS, to fulfil the accountabilities in accordance with values, vision and strategic direction and engages with other internal and external partners to build relationships. • Provides leadership in nursing and midwifery education. • Monitors and reports on compliance and performance functions of the North West HHS, including clinical benchmarks, clinical performance, risk and credentialing. • Provides high-level expert advice and input relating to clinical governance and patient safety.	

Chief Finance Officer	
Sinfree Chirunga	Term during reporting period: 1 July 2025 – 8 May 2026
Manoj Manoj-Margison	Term during reporting period: 23 April 2026 – 31 May 2026 (acting)
Loretta Seamer	Term during reporting period: 01 June 2026 – 30 June 2026 (acting)
• Provides strategic oversight and leadership of finance, accommodation, building, engineering and maintenance and ICT. • Provides oversight of the financial direction of the North West HHS budget across a diverse portfolio of clinical and corporate streams. • Provides expert and authoritative financial and commercial analysis and reporting. • Ensures fidelity and reliability of funding and costing information and modelling as a key part of service planning and performance governance. • Leads the annual financial audit process and audited financial accounts.	

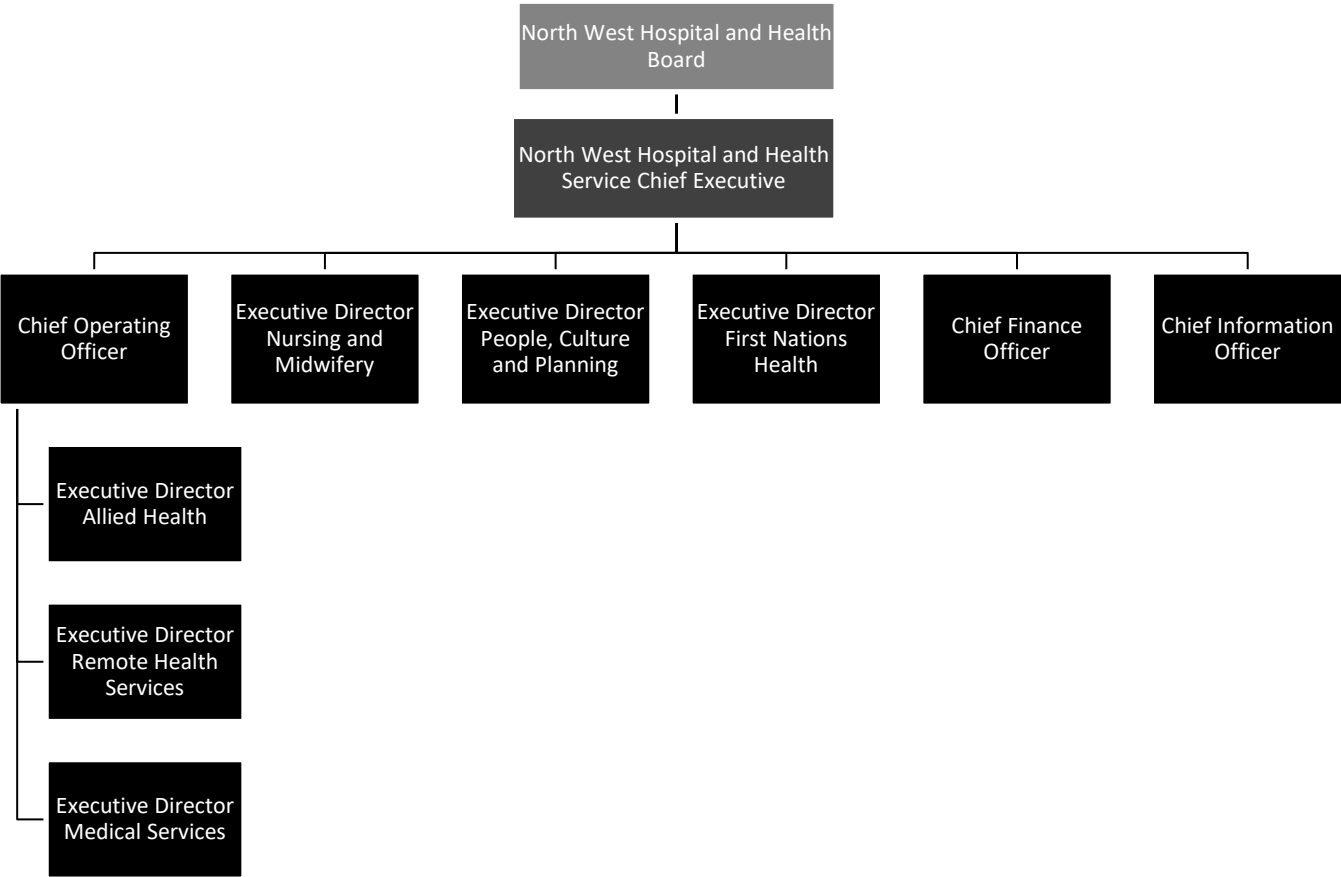
Executive Director Medical Services	
Dr Anthony Bell	Term during reporting period: 1 July 2025 – 30 June 2026
• Provides strategic oversight and executive leadership for medical and clinical workforce and clinical governance for the North West HHS. • Provides clinical leadership in the education of the medical and clinical workforce. • Monitors and reports on compliance and performance functions of the North West HHS, including clinical benchmarks, clinical performance, risk and credentialing. • Provides high-level expert advice and input relating to clinical governance, patient safety and medico-legal.	

Executive Director First Nations Health	
Christine Mann	Term during reporting period: 1 July 2025 – 30 June 2026
Shannon Ah Sam	Term during reporting period: 23 June 2025 – 13 July 2025 (acting) 06 October 2025 – 17 October 2025 (acting)
• Provides strategic oversight and executive leadership for Indigenous Hospital Liaison Office, First Nations Health workforce management, cultural practices, consumer engagement and consumer liaison. • Executive Lead for the First Nations Health Equity reform agenda collaboratively with the health sector to ensure local needs are met with a more regionally coherent system of healthcare. • Provides high-level expert advice and input relating to partnering with consumers and consumer engagement. • Workforce strategic lead for Aboriginal and Torres Strait Islander health programs and services	

Executive Director Allied Health	
Lynette Stenhouse	Term during reporting period: 1 July 2025 – 13 July 2025 (acting) 14 July 2025 – 30 June 2026 (permanent appointment)
Hannah Russell	Term during reporting period: 13 October 2025 – 7 November 2025 (acting)
• Provides strategic oversight and executive leadership of allied health and pharmacy. • Provides oversight of key service planning activities. • Strategic leadership and oversight of allied health and pharmacy credentialing, workforce planning, education, and research. • Ensures compliance with all necessary legislation and statutory obligations through management systems, governance, policies and procedures. • Provides high-level expert advice and input relation to clinical governance and patient safety. • Deliver on the agreed financial, activity and outcomes performance targets and reporting requirements.	

Executive Director Remote Health Services	
Clare Newton	Term during reporting period: 1 July 2025 – 30 June 2026
Dianne Phillips	Term during reporting period: 2 October 2025 – 21 October 2025 (acting)
• Provides strategic oversight and executive leadership to remote health service facilities within North West HHS to ensure that teams deliver services and achieve high levels of service quality, safety, efficiency and effectiveness. • Strategically and collegiately work with the Executive Director First Nations Health, Community Elders and senior staff to achieve service improvements for First Nations people through a contemporary understanding of Aboriginal and Torres Strait Islander health, cultural issues and the social determinants of health • Provides oversight of key service planning activities. • Provide strategic leadership and innovation in the management of all available resources within the portfolio with an emphasis on focussed recruitment. • Deliver on the agreed financial, activity and outcomes performance targets and reporting requirements.	

Organisational structure



Strategic workforce planning and performance

Total staffing

Total Staffing	Number
Headcount	1,018
Paid FTE	925.59

Occupation types by FTE for North West HHS*

Occupation types by FTE	Percentage
Corporate	7.84%
Frontline and Frontline Support	92.16%

Appointment type by FTE for North West HHS*

Appointment type by FTE	Percentage
Permanent	80.49%
Temporary	17.31%
Casual	1.55%
Contract	0.65%

Employment status by headcount for North West HHS*

Employment status by headcount	Percentage
Full-time	79.86%
Part-time	16.90%
Casual	3.24%

Source: *Minimum Obligatory Human Resource Information (MOHRI) as at the last full fortnight of the June quarter, provided by the Public Sector Commission

Figure 1: Gender*

Gender	Number (Headcount)	Percentage of total workforce (Calculated on headcount)
Woman	812	79.76%
Man	204	20.04%
Non-binary	2	0.20%
Another term	0	0.00%
Not disclosed	0	0.00%

* Where data available

Figure 2: Diversity target group data*

Diversity Groups	Number (Headcount)	Percentage of total workforce (Calculated on headcount)
Women	812	79.76%
Aboriginal peoples and Torres Strait Islander peoples	112	11.00%
People with disability	13	1.28%
Culturally and Linguistically Diverse – speak a language at home other than English [^]	184	18.07%

* To ensure privacy, in tables where there are less than 5 respondents in a category, specific numbers must be replaced by <5.

[^]This includes Aboriginal and Torres Strait Islander languages or Australian South Sea Islander languages spoken at home.

Figure 3: Target group data for women in leadership roles*

	Women (Headcount)	Women as percentage of total leadership cohort (Calculated on headcount)
Senior Officers (Classified, s122 and s155 combined)	4	100.00%
Senior Executive Service, High-level senior executives and Chief Executives (Classified, s122 and s155 combined)	3	50.00%

* Women in leadership are defined as those in classified roles or on s122 or s155 contracts. This data must not include salary equivalency.

Strategic workforce planning remained a priority for North West HHS, as did the focus on strengthening workforce pipelines and overall improvement of attraction, development and retention through:

- Increased access to culture and leadership programs.
- Enhanced career progression and development opportunities.
- Access to flexible workforce models.
- Growth and development of graduates and school-based traineeships.
- Housing incentives for skills professionals.
- Local and global recruitment campaigns.
- Recognising and celebrating staff achievements.

Work health, safety and wellbeing

North West HHS strengthened its work health, safety and wellbeing governance through the establishment of a Work Health and Safety Committee, providing a collaborative forum to identify workplace risks, monitor safety performance and support informed decision-making across the organisation.

To further strengthen workplace safety culture, North West HHS encouraged staff to become elected Health and Safety Representatives or Safety Champions, increasing local leadership and staff participation in promoting safe and healthy workplaces across the health service.

Early retirement, redundancy and retrenchment

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

Open data

North West HHS has Open Data to report on expenditure on consultancy and implementation of the Queensland Language Services Policy, and that data can be found on the Queensland Government Open Data website (www.data.qld.gov.au).

North West HHS has no open data to report for overseas travel in the 2025-2026 reporting period.

Our risk management

North West HHS has an established risk management system, underpinned by our Risk Management Framework that applies a standardised and structured approach to risk management aligned to international standards. The framework reinforces that all staff have role to play in being risk aware and managing risk. Our Risk Appetite Statement sets out the Board's expectations in managing risk. The Statement outlines key activities, behaviours and risk exposures, linked to our strategic objectives and priorities. Strategic risks are identified and managed by the health service Executive and monitored by the Board Audit and Risk Committee and the Board.

Internal audit

The *Financial Accountability Act 2009* requires each accountable officer and statutory body to establish and maintain appropriate systems of internal control and risk management. The internal audit function provides independent and objective assurance and advisory services to the Board and Executive management through a systematic approach to evaluating internal controls, governance and risk management processes.

The function has executed the strategic annual internal audit plan prepared based on reviewing the strategic objectives, high-level operational risks, contractual and statutory obligations and prior audit assurance in consultation with the Audit and Risk Committee and executive management. During this reporting period, the Board approved audit plan was executed by an independent audit firm Ernst & Young.

External scrutiny, information systems and record keeping

The Queensland Auditor-General holds statutory appointment as auditor of all public sector entities and is responsible for reporting independently to Parliament on a range of matters including conducting financial audits and undertaking performance audits of important aspects of public services—examining efficiency and effectiveness and sharing opportunities to apply best practice. The 2025-2026 financial statements are provided from page 46 of this annual report.

North West HHS complies with the *Public Records Act 2002* in the ongoing management of both clinical and corporate records. Procedures for managing these records align with Queensland Health policies and standards. The health service adheres to the general retention and disposal schedule for corporate records and the Health Sector (Clinical Records) Retention and Disposal Schedule for clinical records.

Information security and privacy are high priorities, with a focus on implementing an Information Security Management System (ISMS). North West HHS monitors appropriate use and access to ensure compliance with recommendations from the Crime and Corruption Commission's (CCC) Operation Impala. Any inappropriate access is referred to CCC for investigation and appropriate action.

HSCE Attestation of IS18 (ISMS) information security risk

During the 2025-2026 financial year, North West HHS has an informed opinion that information security risks were actively managed and assessed against the North West HHS's risk appetite with appropriate assurance activities undertaken in line with the requirements of the Queensland Government Enterprise Architecture Information and cyber security policy (IS18).

Queensland Public Service ethics and values

North West HHS continues to uphold the principles of the *Public Sector Ethics Act 1994: Integrity and impartiality; Promoting the public good; Commitment to the system of government; and Accountability and transparency*.

The Code of Conduct for the Queensland Public Service applies to all employees of North West HHS, with training provided to staff as part of their mandatory induction training and subsequently at regular intervals. The Code is also reflected in the values of North West HHS.

Employees are required to undertake awareness training regarding inappropriate workplace behaviours such as bullying, harassment, and discrimination, as well as training in relation to ethics, fraud, and conflicts of interest.

Such training is made available to staff through orientation sessions and online learning modules via Learning-on-Line. Significant work was undertaken this year to update and improve the North West HHS Learning-on-Line platform.

During the year, the health service contributed to the development of the statewide Conflict of Interest Policy as well as developing its own Conflict of Interests procedure.

Human rights

North West HHS is committed to respecting, protecting, and promoting human rights in our decision-making and actions. All governing policies and procedures, when being developed or reviewed, undergo a compliance check to ensure our delivery of care is compatible with the *Human Rights Act 2019*.

North West HHS engages professional interpreters to facilitate communication between the service and consumers who speak languages other than English, ensuring they can provide feedback and receive a response in their first language, supported by interpreter services.

In the financial year 2025-2026, the health service received no human rights complaints.

Confidential information

The *Hospital and Health Boards Act 2011* requires annual reports to state the nature and purpose of any confidential information disclosed in the public interest during the financial year.

The Health Service Chief Executive did not authorise the disclosure of confidential information on public interest grounds during the reporting period.

Our performance

Non-financial performance

The Strategic Plan states the strategic objectives and key performance measures to be achieved over a four-year period. Progress for the 2025-2026 period is outlined below.

Focusing on health

Exceed or meet targets for emergency and planned care

- **Continued to exceed Emergency Department performance targets** with patient of stretcher time (POST) 98.6% FYTD and emergency length of stay (ELOS) 86.5% FYTD; based on data captured May 2026.
- **Exceeded the elective surgical waitlist target** with an additional 137 cases treated and 109 people treated in time; based of FYTD data comparing May 2026 to May 2025.
- **Continued to show improvement against specialist outpatient department targets**, with an additional 409 referrals seen, 718 patients seen in time and a reduction in long waits of 64; based on FYTD data comparing May 2026 to May 2025.

Achievement of North West HHS clinical services plan directives

- **Drove healthcare system improvements across North West Queensland** in response to the 2023 Office of the Health Ombudsman (OHO) and Coroners Court of Queensland inquiries into RHD deaths in Doomadgee. All 12 North West HHS recommendations were closed by the OHO, while ongoing partnership with Gidgee Healing continues to strengthen coordinated and integrated care across the region.
- **Strengthened rural workforce pathways and improved long-term workforce sustainability** by successfully implementing the Single Employer Model in Cloncurry and Julia Creek. This integrates hospital and primary care service coordination to better meet community needs and creates greater continuity for General Practitioner and Rural Generalist Registrar trainees.

Increased patient reported outcome measures

- **Improved consumer engagement** through collaboration with staff and consumers by providing secure, accessible and visible feedback mechanisms, enabling actionable insights to improve delivery of high-quality healthcare.

Financial Year	All Compliments	First Nations Compliments	All Complaints	First Nations Complaints
2023-2024	1447	371 (25.6%)	179	47 (26.2%)
2024-2025	689	150 (21.7%)	134	36 (26.9%)
2025-2026	1083	185 (17.1%)	237	88 (37.1%)

- **Enhanced accessibility for patients** by providing them with a convenient electronic channel to share their experience through the reintroduction of QR code-based feedback.
- **Supported flexible and inclusive engagement** through the development of improved paper-based tools to align with QR code surveys.
- **Strengthened the organisation's ability to capture structured, real-time insights into patient experience** by reinstating the Patient Reported Experience Measures (PREMs) program under a new system administrator.

Increased engagement and consumer / community voice representation

- **Supported community-informed healthcare planning in Doomadgee** during National Reconciliation Week by participating in a Truth Telling Day, which marked the release of the Doomadgee Health Vision and enabled families affected by RHD to share their lived experiences and expectations for the local health system directly with healthcare providers.

Focusing on First Nations

Implemented North West HHS Health Equity Strategy

- **Enabled greater access to First Nations leadership development** by expanding the First Nations Leadership Program to healthcare workers from partner agencies, supporting First Nations participants to strengthen their leadership capability and navigate the unique opportunities and challenges within the health sector and their communities.
- **Improved the cultural safety of oral health services** through the First Nations Dental Assistant Traineeship Program, designed to achieve positive workforce outcomes for Aboriginal and Torres Strait Islander staff and their patients.
- **Expanded access to culturally safe care and better health outcomes for First Nations communities** through state-leading growth of the Aboriginal and Torres Strait Islander Health Practitioner role, enabling more First Nations healthcare workers to become credentialed practitioners.
- **Strengthened workforce sustainability and enhanced access to healthcare in remote communities** by supporting the inaugural General Practice trainee position in partnership with the RFDS, showcasing the effectiveness of locally based training pathways

Strengthened relationships with community and local leaders

- **Advanced partnerships to improve health outcomes in remote First Nations communities**, with the *All In! Driving Down RHD Rates in Remote First Nations Communities* initiative receiving the *National Rural and Remote Health Award for Rural/Remote Multidisciplinary Collaboration of the Year*, recognising the collective efforts of healthcare, community and local government partners.
- **Provided more equitable access to care for vulnerable groups** by broadening Hospital in the Home services through increased engagement with watchhouse populations.

- **Further strengthened collaborative approaches to addressing regional health priorities** through engagement with local governments, community leaders and collaboration with the North West Queensland Regional Organisation of Councils.

Reduced rates of preventable hospitalisations

- **Delivered flexible, hospital-based options for monthly bicillin injections** at Yellagundgimarra Hospital Doomadgee, continuing a proactive care approach for patients with ARF and RHD to support Doomadgee to maintain one of the highest bicillin adherence rates in Queensland over the past three years.
- **Strengthened community-led primary healthcare on Mornington Island** by supporting the transition of services to Ngarnal Community Controlled Health Organisation, which commenced as the local primary healthcare provider on 1 July 2026 under the governance of a community-led Board, with clinical support provided by the RFDS.
- **Enhanced chronic disease outcomes** by implementing a Chronic Disease Clinic in Dajarra, delivered in collaboration with the RFDS and co-designed and funded by Western Queensland Primary Health Network, the clinic provides a proactive model of care to address service gaps, strengthen early intervention, and support value-based healthcare.

Focusing on improvement

Improved and maintained patient safety and quality measures

- **Enhanced the delivery of patient-focused, evidence-based care** by introducing the updated North West HHS Research Strategy, which provides a clear framework for innovation and research governance across the health service.
- **Contributed to the National Safety and Quality Health Service Standards** by providing insight to accreditation readiness, quality improvement initiatives, risk management and governance reforms. These activities supported continued compliance with national standards while fostering a culture of accountability, learning and continuous improvement.
- **Strengthened organisational capability to proactively manage risk and drive improved patient outcomes through enhanced clinical governance processes**, including expanded morbidity and mortality reviews, improved clinical incidents and mortality audit management, and the finalisation of credentialing reviews.
- **Improved patient safety and oversight of diagnostic investigations** by advancing the *Closing the Diagnostic Loop to Prevent Missed or Delayed Diagnosis* Action Plan, strengthening North West HHS' governance and approaches to managing the return of diagnostic reports.
- **Fostered integration between hospital and primary care** through the establishment of a permanent General Practice Liaison Officer role, reducing risks related to patient safety, clinical governance, and organisational reputation, while improving care coordination and a smoother transition for patients between hospital and community settings.

Improved health outcomes in our communities

- **Increased access to healthcare services closer to home** by expanding specialist paediatric and antenatal outreach services across remote communities.

- **Expanded access to essential frontline healthcare in remote communities** through the introduction of a Paramedic Remote Hospital role in Camooweal, an Australian-first initiative that strengthens multidisciplinary care and helps to address remote workforce shortages.

Increased embedding of data analytics and data insights

- **Strengthened integrated corporate governance and planning** by establishing a permanent Senior Director of Strategy and Planning role to lead the strategic functions required to deliver safe, sustainable and equitable health services.
- **Embedded more robust governance** through the establishment of the Corporate Governance Working Group, formalising Corporate Governance activities to improve accountability and ensure consistent monitoring of priorities and deliverables.
- **Advanced data-driven decision making across the health service** by expanding the use of contemporary data platforms and reporting tools, improving the availability, quality and timeliness of data, and building staff capability in data literacy and analytics to support informed operational and strategic decisions.
- **Enhanced organisational performance monitoring and quality improvement** through the implementation of the *Performance at a Glance* dashboard and the use of multiple analytics platforms, providing leaders with timely, integrated insights from across the health service to support operational oversight and performance management.

Achievement of a balanced budget with maximised own source revenue

- **Improved own source revenue** through better Rural and Remote Medical Benefits Scheme billing at remote sites.
- **Achieved a Surplus budget** for 2025-26 through increase in total revenue of 6.7 per cent and increase in total expenses of 4.5 per cent.

Improved capital maintenance and delivery

- **Improved access to care** through the delivery of the new Normanton Hospital under the Building Rural and Remote Health Program, officially opened on 29 October 2025 by the Governor of Queensland, Her Excellency the Honourable Dr Jeannette Young AC PSM. The facility provides modern healthcare infrastructure and essential support services, enabling more services to be delivered closer to home.
- **Strengthened the health service's ability to attract and retain staff in remote locations** by delivering new staff accommodation in Camooweal, Dajarra and Mount Isa, providing contemporary housing to support a sustainable workforce.
- **Progressed the new Yellagundgimarra Hospital at Doomadgee** by completing the concept design and detailed design phases of the new build. The new hospital is planned as part of the investment by the Queensland Government in the Building Rural and Remote Health Program, and will have six inpatient beds, three Emergency Department spaces and six renal chairs.

Increased equity in access to digital healthcare and health technologies

- **Refreshed and re-platformed our public facing website**, providing a more secure and contemporaneous web site with improved user experience the key focus of the change.

- **Published Digital Strategy *Footsteps to the Future***, setting the scene for the ongoing digital transformation, the health service's first digital strategy was published. The strategy outlines a three horizon plan with an embedded digital maturity model.
- **Enhanced clinical systems**, reducing the fragmentation of the clinical record. The General Practice system at Julia Creek now has an active feed of data to The Viewer enabling improved visibility of clinicians Queensland-wide who care for our patients wherever they go, subject to consent. Other enhancements are planned for our Primary Care System with improving cyber security, secure messaging and electronic prescribing.
- **Advanced the upgrade to the patient monitoring system**, ensuring critical clinical technology is refreshed and meets information security requirements. The patient monitoring system is in the process of being replaced with Special Care Nursery first to see the upgrade, soon to be followed by Intensive Care Unit, Operating Theatre, Emergency Department and Medical ward.
- **Collaborated with eHealth Queensland** to ensure that every facility within the health service has an operational backup link that leverages either a fibre optic connection or a satellite connection, new staff accommodation at Dajarra and Camooweal have a Wi-Fi capability, Mount Isa Intensive Care Unit has a new electronic medical record, and a new data analytics dashboard called 'Performance at a Glance' has been delivered.

Focusing on working together

Embedded feedback from community consultation into service planning

- **Informed future service planning and investment decisions** through the Western Queensland Joint Regional Health Needs Assessment 2025-2028, building on the 2024 Local Area Needs Assessment to ensure that regional health priorities and service gaps are clearly identified and reflected in strategic planning.

Increased community voice represented in service planning

- **Enabled a community-led approach to the planning and design of new infrastructure projects** through continued collaboration with the community and local partners. Community consultation in Doomadgee, facilitated by an external provider, has informed all phases of the new Yellagundgimarra Hospital build. Similarly, community feedback through the Consumer Advisory Network informed the implementation of renal services at the new Normanton Hospital, ensuring local input shaped service planning and delivery.
- **Provided a framework for building local mental health services that are easy to access** through the publication of the North West HHS Mental Health, Alcohol and Other Drugs Strategic Plan 2025-2031. Informed by community consultation and data analysis, the plan defines the long-term direction for delivering culturally supported services tailored for remote and First Nations communities.

Strengthened relationships, collaboration and data sharing with regional partners

- **Improved access to specialist renal care closer to home and strengthened local workforce capability** through a collaborative training partnership with Townsville HHS and

Metro South HHS, supporting advanced haemodialysis training and ongoing professional development for Mount Isa renal nurses.

- **Supported more coordinated and integrated healthcare delivery across North West Queensland communities** through the release of expanded healthcare service mapping, helping providers and community stakeholders better understand local services, identify opportunities for collaboration and improve care navigation.
- **Expanded access to specialist services and more integrated models of care** through Service Level Agreements with tertiary health services, supported by ongoing collaboration with universities, primary care providers, the RFDS and community stakeholders to strengthen workforce development, education and service innovation.

Improved consumer experience, navigation and delivery pathways

- **Improved timely diagnosis and treatment for children in rural and remote communities** through the establishment of a new electroencephalogram (EEG) pilot in partnership with Townsville University Hospital. The initiative enables local testing with remote interpretation by tertiary neurologists via telehealth, improving attendance rates and reducing barriers to accessing specialist paediatric neurology services closer to home.
- **Strengthened coordinated, integrated and community-based care for people living with ARF and RHD** in Doomadgee through the finalisation of a shared care model in partnership with Gidgee Healing, enabling patient choice and supporting flexible access to monthly bicillin treatment.

Focusing on valuing and growing our people

Improved cultural and staff wellbeing indicators

- **Boosted organisational insight into employee engagement and workforce experience** through the launch of *Vibe Check*, North West HHS's new employee engagement survey, achieving a 27.9% increase in participation and informing future improvements in culture, leadership and wellbeing.
- **Enhanced medical workforce wellbeing and engagement**, achieving among the highest professional fulfilment scores and lowest burnout risk across Queensland health services in the Medical Workforce Wellbeing Survey, reflecting ongoing investment in staff development, engagement and wellbeing.
- **Advanced workforce management transformation across the health service** through the implementation of the Integrated Workforce Management (IWFM) system, with strong staff engagement supporting the transition to a more efficient, accurate and integrated roster-to-pay solution that will improve payroll accuracy, reduce administrative burden and enhance the staff experience.

Increased clinician-led healthcare improvement initiatives

- **Strengthened outcomes for children and families** through the launch of the LEAP-CP early intervention program, a culturally adapted research initiative that enabled Allied Health

professionals in the Special Care Nursery to identify developmental risks early and provide targeted support during a child's first 1,000 days.

Improved staff retention rates and employment/development pathways

- **Built workforce capability, supported career development and contributed to workforce growth** across the North West through continued investment in workforce attraction, development and retention initiatives, including leadership development, rural generalist training, graduate programs and innovative workforce models.
- **Secured successful re-accreditation** of the Prevocational Medical Accreditation Queensland program for prevocational doctors, the Australian College of Rural and Remote Medicine Rural Generalist advanced skills training posts, the Australasian College for Emergency Medicine and the Royal Australian College of Physicians, further reinforcing North West HHS' reputation as a high-quality rural and remote training provider.
- **Enhanced clinical oversight, local leadership and operational accountability** by establishing a regional medical leadership structure through the implementation of three dedicated Director of Medical Services roles, providing expanded medical leadership in Mount Isa Hospital, the Gulf communities and the Cloncurry and Julia Creek region.

Increased Aboriginal and Torres Strait Islander peoples' workforce engagement

- **Expanded future First Nations health workforce development** through increased participation and completion of the Deadly Start Traineeship Program, strengthening pathways for First Nations Year 11 students to progress from a Certificate II in Health Support Services into traineeships and Certificate III qualifications in Health Service Assistance or Allied Health Assistance.
- **Created a local training pathway for future First Nations health professionals** through a partnership with Central Queensland University and the Murtupuni Centre for Rural and Remote Health (James Cook University) to deliver Certificate IV Aboriginal and Torres Strait Islander Primary Health Care (Practice) training blocks in Mount Isa, supporting long-term access to culturally safe care.
- **Strengthened the future health workforce pipeline** through increased participation in the Aboriginal and Torres Strait Islander Cadetship Program, supporting eligible tertiary students to gain practical experience at North West HHS while completing Bachelor-level qualifications in Queensland.

Aligned workforce rates to community requirements

- **Strengthened team cohesion, continuity of care and service stability** through the successful recruitment and onboarding of permanent Senior Medical Officers, reducing reliance on locum staff and supporting more consistent healthcare delivery.
- **Supported sustainable healthcare delivery and improved access to services** across the North West through workforce planning initiatives that aligned workforce capacity and capability with community needs, supported by targeted recruitment, workforce innovation and expanded training pathways.

Service standards

North West HHS delivers services in line with its obligations outlined in the Service Agreement with the Department of Health to deliver public hospital and health services for the North West Queensland community. The Service Agreement specifies the health services provided by North West HHS, the funding for these services, and performance measures to ensure the achievement of outcomes.

Our performance against 2025-2026 Service Delivery Statement targets is summarised in the following table:

Service standards – performance 2025-2026

North West Hospital and Health Service	2025–2026 Target	2025–2026 Actual
Effectiveness measures		
Percentage of emergency department patients seen within recommended timeframes		
• Category 1 (within 2 minutes)	100%	100%
• Category 2 (within 10 minutes)	80%	88%
• Category 3 (within 30 minutes)	75%	83%
• Category 4 (within 60 minutes)	70%	84%
• Category 5 (within 120 minutes)	70%	98%
Percentage of emergency department attendances who depart within 4 hours of their arrival in the department	>80%	86%
Percentage of elective surgery patients treated within the clinically recommended times		
• Category 1 (30 days)	>98%	94%
• Category 2 (90 days)	>95%	93%
• Category 3 (365 days)	>95%	90%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days ¹	≤1.0	0.4
Percentage of specialist outpatients waiting within clinically recommended times ²		
• Category 1 (30 days)	98%	55%
• Category 2 (90 days) ³	..	67%
• Category 3 (365 days) ³	..	85%
Percentage of specialist outpatients seen within clinically recommended times		
• Category 1 (30 days)	98%	77%
• Category 2 (90 days) ³	..	77%
• Category 3 (365 days) ³	..	93%
Median wait time for treatment in emergency departments (minutes) ⁴	..	11
Median wait time for elective surgery treatment (days) ⁵	..	27
Efficiency measure		
Average cost per weighted activity unit for Activity Based Funding facilities ⁶	\$7,102	\$7,367

North West Hospital and Health Service	2025–2026 Target	2025–2026 Actual
Other measures		
Number of elective surgery patients treated within clinically recommended times ⁷		
• Category 1 (30 days)	203	236
• Category 2 (90 days)	189	199
• Category 3 (365 days)	146	238
Number of Telehealth outpatients service events ⁸	6,000	6,822
Total weighted activity units (WAU) ⁹		
• Acute Inpatients	10,794	11,423
• Outpatients	4,332	4,483
• Sub-acute	1,494	1,310
• Emergency Department	10,550	9,993
• Mental Health	1,359	1,643
• Prevention and Primary Care	284	371
Ambulatory mental health service contact duration (hours) ¹⁰	>7,591	5,968
Staffing ¹¹	926	926

Notes:

1. Staphylococcus aureus (including MRSA) bloodstream (SAB) infections Actual rate is based on data reported between 1 July 2025 and 31 December 2025 as at 25 March 2026.
2. Waiting within clinically recommended time is a point in time performance measure. 2025-2026 Actual is as at 1 July 2026.
3. Given the System's focus on reducing the volume of patients waiting longer than clinically recommended for specialist outpatients, it is expected that higher proportions of patients seen from the waitlist will be long wait patients and the seen within clinically recommended time percentage will be lower. To maintain the focus on long wait reduction, the 2025-2026 Targets for category 2 and 3 patients are not applicable.
4. There is no nationally agreed target for this measure, and the median wait time varies depending on the proportion of patients in each urgency category.
5. There are no targets for median wait times as performance is determined through the percentage of elective surgery patients treated within the clinically recommended time for their respective category.
6. All measures are reported in QWAW Phase Q28. 2025-2026 Actual is based on data for the period 1 July 2025 to 31 March 2026. The 2025-2026 Target does not include funding adjustments made during the year, including those for Enterprise Bargaining or reproductive leave, which impact the actual results.
7. Elective surgery performed in public hospitals.
8. The Telehealth 2025-2026 Actual is as at 20 July 2026.
9. All measures are reported in Queensland WAU Phase Q28. The 2025-2026 Actual is a 12-month projection based on data for the period 1 July 2025 to 31 May 2026. As the Hospital and Health Services have operational discretion to respond to service demands and deliver activity across services streams to meet the needs of the community, variation to the Target can occur. Variances in the Mental Health stream are the result of ongoing refinement and maturing of the new national Mental Health classification.
10. Ambulatory Mental Health service contact duration 2025-2026 Actual is a 12-month projection based on data for the period 1 July 2025 to 31 May 2026 as at 21 July 2026.
11. In alignment with PSC reporting guidelines, only one employment record per employee is reported. For employees with concurrent employment, the arrangement with the highest percentage of work is reported. This may result in a minor variance where staff work across multiple Hospital and Health Services.

Financial summary

North West HHS exceeded its activity against the Activity Based Funding health services target in 2025-2026. North West HHS reported an operating surplus of \$4.29 million for the year ended 30 June 2026.

Source of revenue

North West HHS income for 2025–2026 was \$323.35 million, which is an increase of \$21.76 million (7.2 per cent) from the prior year. Of this, the Queensland Government’s contribution was \$229.53 and the Commonwealth contribution was \$73.62. Specific-purpose grants and other contributions worth \$3.82 million were received and user charges, fees and other revenue was \$16.37 million.

Costs of health services

North West HHS expenses for 2025-26 were \$319.06 million, which is an increase of \$14.40 million (4.7 per cent) from the prior year. The largest portion of expenditure relates to employee expenses, including clinicians and support staff of (55.8 per cent). Supplies and services expenses such as clinical supplies, drugs, prosthetics, pathology, catering, repairs and maintenance, energy, communication and computers account for 36.1 per cent of expenditure; 5.9 per cent of expenditure was related to depreciation and amortisation; and 2.2 per cent of expenditure relates to grants, interest and other expenses.

Financial outlook

North West HHS is committed to a sustainable financial position to meet the healthcare needs of our remote community. Financial year 2026-27 plan forecasts to deliver service needs and achieve a balanced financial position.

Asset Maintenance and Renewal

All Queensland Health entities comply with the *Queensland Government Building Policy Framework* which requires the reporting of overdue asset maintenance liabilities. Delaying maintenance is a commonly used asset management strategy which can optimise value while managing resources and asset risks.

Queensland Health entities report overdue maintenance using the terms “*deferred maintenance*” and “*postponed capital renewal*”.

Deferred maintenance refers to maintenance of an operational nature (OPEX) that has been identified as required but has been delayed.

Postponed capital renewal refers to capital works required to restore an asset’s service potential (CAPEX) that have been delayed.

Neither deferred maintenance nor postponed capital renewal include forecast maintenance – work that was planned but found to be not required during the reporting period (e.g. planned repainting where no deterioration occurred).

All overdue asset expenditure is risk assessed to identify any potential impact on users and services and is closely managed to ensure all facilities remain safe.

Both operational and capital quantities are reported.

As of 30 June 2026, the North West HHS reported:

- \$7,809,715 in deferred maintenance, and
- \$52,797,943 in postponed capital renewal.

The North West HHS has the following strategies in place to mitigate any risks associated with these items:

- risk-based prioritisation within the Timely Investment Infrastructure Maintenance (TIIM) program allocation
- increasing operational maintenance budgets
- seeking additional funding through whole-of-government processes
- improving planning and procurement strategies to reduce costs in remote locations.

North West Hospital and Health Service

Financial Statements - 30 June 2026

North West Hospital and Health Service

For the year ended 30 June 2026

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North West Hospital and Health Service

For the year ended 30 June 2026

STATEMENT OF COMPREHENSIVE INCOME

	Notes	2026 \$'000	2025 \$'000
Income			
Funding for public health services	B1-1	303,155	280,478
User charges and fees	B1-2	11,267	10,745
Grants and other contributions	B1-3	3,819	3,086
Other revenue	B1-4	5,105	7,279
Total income		323,346	301,588
Expenses			
Employee expenses	B2-1	38,757	31,560
Health service employee expenses	B2-2	139,435	135,723
Supplies and services	B2-3	115,122	111,210
Grants and other contributions	B2-4	549	210
Depreciation	C5-1, C7-1	18,926	19,907
Interest on lease liabilities	C7-2	314	251
Other expenses	B2-5	5,952	5,792
Total expense		319,055	304,653
Operating result for the year		4,291	(3,065)
Other comprehensive income			
<i>Items that will not be subsequently reclassified to operating result:</i>			
Increase in asset revaluation surplus	C8	11,452	(11,848)
Total other comprehensive income		11,452	(11,848)
Total comprehensive income		15,743	(14,913)

The accompanying notes form part of these financial statements.

North West Hospital and Health Service

For the year ended 30 June 2026

STATEMENT OF FINANCIAL POSITION

	Notes	2026 \$'000	2025 \$'000
Current assets			
Cash and cash equivalents	C1	9,789	5,040
Receivables	C2-1	3,103	3,224
Inventories	C3	1,833	1,820
Other assets	C4	4,107	3,089
Total current assets		18,832	13,173
Non-current assets			
Property, plant and equipment	C5-1	208,502	171,067
Right-of-use assets	C7-1	7,088	5,614
Other assets	C4	-	62
Total non-current assets		215,590	176,743
Total assets		234,422	189,916
Current liabilities			
Payables	C6	24,566	24,598
Lease liabilities	C7-2	1,840	1,326
Accrued employee benefits		1,047	683
Other		1,403	176
Total current liabilities		28,856	26,783
Non-current liabilities			
Lease liabilities	C7-2	5,356	4,178
Total non-current liabilities		5,356	4,178
Total liabilities		34,212	30,961
Net assets		200,210	158,955
Equity			
Contributed equity	C9	151,372	125,860
Accumulated deficit		(8,036)	(12,331)
Asset revaluation surplus	C8	56,878	45,426
Total equity		200,210	158,955

The accompanying notes form part of these financial statements.

North West Hospital and Health Service

For the year ended 30 June 2026

STATEMENT OF CHANGES IN EQUITY

	Contributed equity \$'000	Accumulated deficit \$'000	Asset revaluation surplus \$'000	Total equity \$'000
Balance as at 1 July 2024	91,182	(9,266)	57,274	139,190
Operating Result	-	(3,065)	-	(3,065)
<i>Total other comprehensive income</i>				
- Decrease in asset revaluation surplus (Note C8)	-	-	(11,848)	(11,848)
<i>Transactions with owners</i>				
- Non-appropriated equity injections (Note C9)	34,654	-	-	34,654
- Non-appropriated equity withdrawals (Note C9)	(19,907)	-	-	(19,907)
- Non-appropriated equity asset transfers (Note C9)	19,931	-	-	19,931
Balance at 30 June 2025	125,860	(12,331)	45,426	158,955
Balance as at 1 July 2025	125,860	(12,331)	45,426	158,955
Operating Result	-	4,291	-	4,291
Net effect of prior year adjustments	-	-	-	-
<i>Total other comprehensive income</i>				
- Increase in asset revaluation surplus (Note C8)	-	-	11,452	11,452
<i>Transactions with owners</i>				
- Non-appropriated equity injections (Note C9)	5,309	-	-	5,309
- Non-appropriated equity withdrawals (Note C9)	(18,926)	-	-	(18,926)
- Non-appropriated equity asset transfers (Note C9)	39,129	-	-	39,129
Balance at 30 June 2026	151,372	(8,036)	56,878	200,210

The accompanying notes form part of these financial statements.

North West Hospital and Health Service

For the year ended 30 June 2026

STATEMENT OF CASH FLOWS

	Notes	2026 \$'000	2025 \$'000
Cash flows from operating activities			
<i>Inflows:</i>			
User charges, fees and funding for public health		295,076	271,026
Grants and other contributions		2,175	1,490
GST collected from customers		390	402
GST input tax credits from ATO		8,414	7,751
Donated Assets		70	15
Other		5,015	7,167
<i>Outflows:</i>			
Employee expenses		(38,672)	(31,578)
Health service employee expenses		(138,083)	(135,331)
Supplies and services		(113,923)	(109,390)
Grants and subsidies		(549)	(210)
GST paid to suppliers		(8,527)	(7,546)
GST remitted to ATO		(456)	(329)
Other		(5,787)	(5,597)
Net cash generated by/ (used in) operating activities	CF-1	5,143	(2,130)
Cash flows from investing activities			
<i>Inflows:</i>			
Sales of property, plant and equipment		14	60
<i>Outflows:</i>			
Payments for property, plant and equipment	C5-1	(3,654)	(27,241)
Net cash used in investing activities		(3,640)	(27,181)
Cash flows from financing activities			
<i>Inflows:</i>			
Equity injections	C9	5,309	34,654
<i>Outflows:</i>			
Lease payments	CF-2	(2,063)	(2,475)
Net cash provided by financing activities		3,246	32,179
Net increase in cash and cash equivalents		4,749	2,868
Cash and cash equivalents at the beginning of the financial year		5,040	2,172
Cash and cash equivalents at the end of the financial year	C1	9,789	5,040

The accompanying notes form part of these financial statements.

North West Hospital and Health Service

For the year ended 30 June 2026

STATEMENT OF CASH FLOWS

NOTES TO THE STATEMENT OF CASH FLOWS

CF-1 Reconciliation of gain/ (deficit) to net cash from operating activities

	2026 \$'000	2025 \$'000
Operating result	4,291	(3,065)
<i>Adjustments for:</i>		
Depreciation and amortisation	18,926	19,907
Depreciation and amortisation funding	(18,926)	(19,907)
Net loss on disposal of property, plant and equipment	69	61
Donated Assets	70	15
Provision for Doubtful Debts	363	260
Doubtful Debts Written Off	(169)	(83)
Inventory Write Off	71	91
<i>Changes in assets and liabilities:</i>		
(Increase)/decrease in receivables	(71)	2,608
(Decrease) in inventories	(84)	(336)
(Increase)/decrease in contract assets	(838)	(1,097)
(Increase)/decrease in prepayments	(118)	(70)
Increase/(decrease) in contract liabilities	(1,129)	(1,130)
Increase/(decrease) in accrued health services labour (DOH)	1,352	392
Increase/(decrease) in accrued employee benefits	364	166
Increase/(decrease) in unearned revenue	1,199	(582)
Increase in payable	(227)	640
Net cash generated by/ (used in) operating activities	5,143	(2,130)

CF-2 Changes in liabilities arising from financing activities

2026

	Non-cash changes				Cash flows		
	Opening balance	Transfers to/(from) other Queensland Government entities	New leases acquired	Other	Cash received	Cash repayments	Closing balance
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Lease liabilities	5,505		3,754	-		(2,063)	7,196
Total	5,505	-	3,754	-	-	(2,063)	7,196

2025

	Non-cash changes				Cash flows		
	Opening balance	Transfers to/(from) other Queensland Government entities	New leases acquired	Other	Cash received	Cash repayments	Closing balance
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Lease liabilities	7,141		839	-		(2,475)	5,505
Total	7,141	-	839	-	-	(2,475)	5,505

Non-Cash investing and financing activities

Assets received or liabilities donated/transferred by the Hospital and Health Service to agencies outside of State Health portfolio agencies are recognised as revenues (refer Note B1-3) or expenses (refer Note B2-5) as applicable. Assets received or liabilities transferred by the Hospital and Health Service as a result of administrative arrangements are set out in the Statement of Changes in Equity.

North West Hospital and Health Service

For the year ended 30 June 2026

SECTION A ABOUT THE ENTITY AND THIS FINANCIAL REPORT

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

A1 GENERAL INFORMATION

The North West Hospital and Health Service (North West HHS) is a not-for-profit statutory body under the *Hospital and Health Boards Act 2011* and is domiciled in Australia. The North West HHS is responsible for providing public sector health services to communities within the area assigned under the Hospital and Health Boards Regulation 2023. Its principal place of business is:

30 Camooweal Street,
Mount Isa QLD 4825

A2 OBJECTIVES AND PRINCIPAL ACTIVITIES

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

The ultimate parent entity is the State of Queensland.

A3 OTHER ENTITIES NOT CONTROLLED

Investment in Western Queensland Primary Care Collaborative Limited

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

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

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

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

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

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

Investment in Tropical Australian Academic Health Centre Limited

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

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

As each member has the same voting entitlement (14.3%), it is considered that none of the individual members has power or significant influence over TAAHCL (as defined by AASB 10 Consolidated Financial Statements and AASB 128 Investments in Associates and Joint Ventures). **Each member's liability to TAAHCL is limited to \$10. TAAHCL's constitution prevents any income or property of the company being transferred** directly or indirectly to or amongst the members. Each member must pay annual membership fees as determined by the board of TAAHCL.

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

Collaboration in Better Health North Queensland Alliance

Better Health NQ Alliance (BHNQA) is a collaboration between Cairns and Hinterland Hospital and Health Service, Mackay Hospital and Health Service, North West Hospital and Health Service, Torres and Cape Hospital and Health Service, Townsville Hospital and Health Service, North Queensland Primary Health Network, Western Queensland Primary Health Network, Queensland Aboriginal and Island Health Council and the Department of Health.

The principal function of the BHNQA is to improve the health outcomes of North Queensland residents by undertaking a collective approach to planning, designing, alliancing and commissioning of health services.

BHNQA is not controlled by North West HHS and is not considered a joint operation or an associate of North West HHS.

North West Hospital and Health Service

For the year ended 30 June 2026

A4 PRESENTATION

Statement of Compliance

The financial statements:

- have been prepared in compliance with section 62(1) of the *Financial Accountability Act 2009* and section 39 of the *Financial and Performance Management Standard 2019*;
- are general purpose financial statements prepared on a historical cost basis, except where stated otherwise;
- are presented in Australian dollars;
- have been rounded to the nearest \$1,000 or, where the amount is \$500 or less, to zero unless the disclosure of the full amount is specifically required;
- **present reclassified comparative information where required for consistency with the current year's presentation;**
- have been prepared in accordance with all applicable new and amended Australian Accounting Standards and Interpretation as well as the **Queensland Treasury's Financial Reporting Requirements for Queensland Government Agencies for reporting periods beginning on or after 1 July 2024**, and other authoritative pronouncements.

A5 BASIS OF MEASUREMENT

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

- **Land and buildings, which are measured at fair value;**
- **Inventories which are measured at weighted average cost.**

Historical cost

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

Fair value

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

- **The market approach uses prices and other relevant information generated by market transactions involving identical or comparable (i.e. similar) assets, liabilities or a group of assets and liabilities, such as a business.**
- **The cost approach reflects the amount that would be required currently to replace the service capacity of an asset. This method includes the current replacement cost methodology.**
- **The income approach converts multiple future cash flow amounts to a single current (i.e. discounted) amount. When the income approach is used, the fair value measurement reflects current market expectations about those future amounts.**

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

Present value

Present value represents the present discounted value of the future net cash inflows that the item is expected to generate (in respect of assets), or the present discounted value of the future net cash outflows expected to settle (in respect of liabilities) in the normal course of business. Net realisable value represents the amount of cash or cash equivalents that could currently be obtained by selling an asset in an orderly disposal.

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' when the 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 North West HHS does not have a right to defer settlement to beyond 12 months after the reporting date.

A6 THE REPORTING ENTITY

The financial statements include the value of all revenues, expenses, assets, liabilities and equity of North West Hospital and Health Service. The North West Hospital and Health Service does not have any controlled entities.

North West Hospital and Health Service

For the year ended 30 June 2026

A7 ECONOMIC DEPENDENCY

North West HHS has prepared these financial statements on a going concern basis which assumes it will be able to meet its financial obligations as and when they fall due. North West HHS is economically dependent on funding received from its Service Agreement with the Department of Health (the Department).

The Service Agreement provides performance targets and terms and conditions in relation to provision of funding commitments and agreed purchased activity for this period. Accordingly, the Board and management of North West HHS believe that the terms and conditions of its funding arrangements under the Service Agreement Framework, will provide North West HHS with sufficient cash resources to meet its financial obligations for at least the next financial year. The Department provided an equity injection to support North West HHS cash flow in 2025-26.

North West HHS has no intention to liquidate or to cease operations. Under section 18 of the Hospital and Health Boards Act 2011, North West HHS represents the State of Queensland and thus has all the privileges and immunities of the State in this respect.

A8 AUTHORISATION OF FINANCIAL STATEMENTS FOR ISSUE

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

Further information

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

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

North West Hospital and Health Service

For the year ended 30 June 2026

SECTION B NOTES ABOUT FINANCIAL PERFORMANCE

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

B1 INCOME

Note B1-1: Funding for public health services

	2026 \$'000	2025 \$'000
Revenue from contracts with government agencies		
Activity based funding	144,182	141,493
Block funding	65,178	53,747
General Purpose Funding	74,869	65,331
Depreciation funding	18,926	19,907
Total funding for public health services	303,155	280,478

Funding is provided predominantly from the Department of Health (DOH) for specific public health services purchased by the Department in accordance with a service agreement. The Australian Government pays its share of National Health funding directly to the Department of Health, for on forwarding to the Hospital and Health Service. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by North West HHS. Cash funding from the Department of Health is received fortnightly for State payments and monthly for Australian Government payments and is recognised as revenue as the performance obligations under the service level agreement are discharged. Commonwealth funding to North West HHS in 2026 was \$73.62 million (2025: \$61.08 million).

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

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

Activity-based funding is recognised as public health services delivered under the National Health Reform Agreement, with any estimated penalties accrued in the applicable month. Following the end of the Minimum Funding Guarantee by the Department of Health in the 2021-22 financial year, North West HHS incurred no penalties for 2025-26 (nil for 2024-25) related to the under delivery of in-scope activity at Mount Isa Hospital, and there was no clawback of funding for 2025-26 (clawback for 2024-25 \$0.129 million) related to the under delivery of activity for Oral Health.

Block funding is received for all facilities within North West HHS, with the exception of Mount Isa, and is receipted based on the applicable days in the month. There are no specific reporting requirements against the recognition of block funding. General purpose funding includes all other funding arrangements such as community state wide services, third party funded health services, commonwealth grant programs and other revenue received by North West HHS.

The HHS received funding from the First Nations Health Branch of the Department of Health in 2025-26 for the Making Tracks Investment Strategy of \$3.1 million. The First Nations Health Branch advised funding is reinvested recurrently to North West HHS under the Making Tracks Investment strategy from 2024-25.

Note B1-2: User charges and fees

	2026 \$'000	2025 \$'000
Revenue from contracts with customers		
Sales of goods and services	4,743	4,315
Pharmaceutical benefits scheme	4,386	4,062
Hospital fees	2,138	2,368
Total user charges and fees	11,267	10,745

Revenue in this category primarily consists of payment for claims made under the rural and remote Medicare Benefits Scheme, hospital fees (patients who elect to utilise their private health cover or are not covered by Medicare) and sale of goods and services which includes retail sales and reimbursement of pharmaceutical benefits.

Revenue from the sale of goods is recognised at the time of transfer of the goods to the customer, which is the sole performance obligation. Revenue from the sale of services is recognised progressively as the services are provided, in line with the agreement, and a contract **asset is recognised representing the HHS's right to consideration for services delivered but not yet billed**.

North West Hospital and Health Service

For the year ended 30 June 2026

B1 INCOME (Continued)

Note B1-3: Grants and other contributions

	2026 \$'000	2025 \$'000
Other grants and contributions		
Services received below fair value	1,644	1,596
Grants from other bodies	1,723	1,344
Other donations and contributions	52	35
State Government grants	400	111
Total grants and contributions	3,819	3,086

Grants and contributions are transactions where North West HHS receives funds to further its objectives. Where an agreement is enforceable and contains sufficiently specific performance obligations for North West HHS to transfer goods or services to a third-party on the grantor's behalf, the transaction is accounted for under AASB 15 Revenue from Contracts with Customers. In this case, revenue is initially deferred (as a contract liability) and recognised as or when the performance obligations are satisfied.

Otherwise, the grant is accounted for under AASB 1058 Income of Not-for-Profit Entities, whereby revenue is recognised upon receipt of the grant funding. **A contract asset representing North West HHS's right to consideration for services delivered but not yet billed will be raised** where applicable.

North West HHS receives corporate services support from the Department of Health for no direct cost. Corporate services received would have been purchased if they were not provided by the Department of Health and include payroll services, accounts payable and banking services. The fair value of corporate services received in 2025-26 are estimated by the Department of Health as \$1.362 million (2025: \$1.312 million) for payroll services and \$0.282 million (2025: \$0.284 million) for accounts payable and banking services. An equal amount of expense is recognised as services below fair value, under supplies and services, refer Note B2-3.

Note B1-4: Other revenue

	2026 \$'000	2025 \$'000
Interest	33	34
Capital Recoveries	2,229	4,942
Other ¹	2,843	2,303
Total other revenue	5,105	7,279

¹Other predominantly relates to lease revenue, salary recoveries and other ad-hoc reimbursements.

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

B2 EXPENSES

Note B2-1: Employee expenses

	2026 \$'000	2025 \$'000
Employee expenses		
Wages and salaries	31,538	25,871
Annual leave levy	3,097	2,485
Employer superannuation contributions	2,884	2,385
Long service leave levy	762	651
Termination Benefits	273	1
Workers' compensation premium	203	167
Total employee expenses	38,757	31,560

Effective 15 June 2020, a legislative change to the employer arrangements within Queensland Health was implemented. From this date, all non-executive employees of the North West Hospital and Health Service (i.e. other than senior executives, senior medical officers and visiting medical officers) became the employees of the Director-General, Queensland Health. Direct labour postings, in addition to related assets and liabilities including accrued employee benefits, for these employees will be classified from employee expense to Health Service Employee Expenses.

The amounts paid are separately classified and disclosed on the face of the Statement of Comprehensive Income.

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

Workers' compensation insurance is an employee expense but is not part of an employee's total remuneration package. They are not employee benefits and are recognised separately as employee related expenses.

North West Hospital and Health Service

For the year ended 30 June 2026

B2 EXPENSES (Continued)

Annual leave, long service leave and sick leave

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

Superannuation

Superannuation schemes comprise defined benefit and defined contribution categories. Employer superannuation contributions are paid to employee nominated superannuation funds, however payments to the defined benefit superannuation scheme for Queensland Government employees are at rates determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are paid, or payable and North West HHS's obligation is limited to the rate determined by the Treasurer on the advice of the State Actuary. The liability for defined benefits is held on a Whole-of-Government basis and reported in those financial statements pursuant to AASB 1049 Whole of Government and General Government Sector Financial Reporting.

Key management personnel and remuneration disclosures are detailed in Note F1.

Number of full time equivalent employees (FTE)*	2026	2025
	No.	No.
Number of Employees	51	47
Number of Health Service Employees	875	868
Total FTE as at 30 June	926	915

*restated to accurately reflect Minimum Obligatory Human Resource Information (MOHRI) at the reporting date.

Note B2-2: Health service employee expenses

	2026	2025
	\$'000	\$'000
Department of Health	139,435	135,723
Total health service employee expenses	139,435	135,723

Health Service Employee Expense

As at 30 June 2026, North West HHS through service agreements with the Department of Health engaged 875 full time equivalent persons (2025: 868 Full time equivalent).

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

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

Recoveries of salaries and wages costs for North West HHS employees working for other agencies are recorded as revenue. Refer Note B1-4 Other Revenue.

North West Hospital and Health Service

For the year ended 30 June 2026

B2 EXPENSES (Continued)

Note B2-3: Supplies and services

	2026 \$'000	2025 \$'000
Patient travel and aeromedical retrieval services	20,845	22,256
Other consultancies and contract labour ¹	16,876	12,180
Medical consultancies and contract labour ²	7,674	9,691
Repairs and maintenance	8,533	8,458
Drugs	6,285	6,016
Pathology and blood supplies and services	7,290	7,507
Outsourced service delivery ³	9,892	9,018
Clinical supplies and services	4,244	4,239
Lease expenses	6,601	5,040
Other travel	4,663	5,161
Building services	4,704	4,635
Communications	2,423	2,542
Electricity and other energy	3,365	2,980
Other	2,755	2,602
Catering and domestic supplies	2,004	1,943
Computer services	3,217	2,803
Services received below fair value ⁴	1,644	1,596
Minor plant and equipment	1,139	1,647
Water	700	655
Motor vehicles	268	241
Total supplies and services	115,122	111,210

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

Lease expenses: Lease expenses include lease rentals for short-term leases, leases of low value assets and variable lease payments. Refer to Note C8 for breakdown of lease expenses and other lease disclosures.

¹ Other consultancies and contract labour includes temporary employment services (non-clinicians and clinicians, except for medical) amounting to \$13.31 million (2025: \$9.27 million) and \$3.566 million (2025: \$2.91 million) of other employee related expenses

² Medical consultancies and contract labour includes medical locums and contracted visiting medical officers

³ Outsourced service delivery consists of \$8.1 million externally provided radiology services, \$1.5 million other outsourced clinical services contracts and \$0.25 million outsourced clinical supplies.

⁴ Services received below fair value relates to corporate services support from the Department of Health. An equal amount of revenue is recognised as donations under grants and contributions, refer Note B1-3

Note B2-4: Grants and other contributions

	2026 \$'000	2025 \$'000
Public hospital support services	549	210
Total grants and subsidies	549	210

Public hospital support services include grants provided to The Lead Alliance for community health and risk prevention including blood lead testing and other community programs, and contributions for laundry services in Mornington Island and Doomadgee relating to the healthy skin program.

North West Hospital and Health Service

For the year ended 30 June 2026

B2 EXPENSES (Continued)

Note B2-5: Other expenses

	2026 \$'000	2025 \$'000
Insurance	1,942	1,822
Professional Services	2,219	2,439
Other	645	490
Legal costs	445	276
External audit fees	203	298
Net loss from disposal of property, plant and equipment	143	136
Advertising - recruitment	166	117
Other audit fees	126	123
Inventory written off	63	91
Total other expenses	5,952	5,792

Total audit fees paid or payable to the Queensland Audit Office in the 2025-26 financial year was \$0.231 million (2025: \$0.229 million). There are no non-audit services included in these amounts.

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

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

North West Hospital and Health Service

For the year ended 30 June 2026

SECTION C NOTES ABOUT OUR FINANCIAL POSITION

This section provides information on the assets used in the operation of North West Hospital and Health Service and the liabilities incurred as a result.

C1 CASH AND CASH EQUIVALENTS

	2026 \$'000	2025 \$'000
Cash at bank and on hand	9,486	4,749
Queensland Treasury Corporation cash fund	303	291
Total cash and cash equivalents in the statement of cash flows	9,789	5,040

For the purposes of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques received but not banked at 30 June as well as deposits at call with financial institutions.

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

Overdraft Facility

North West HHS has approval from Queensland Treasury to operate bank accounts in overdraft up to a limit of \$2.5 million in 2025-2026 (2024-2025: \$2.5 million). The overdraft facility was not utilised at 30 June 2026 (2025: nil).

C2 RECEIVABLES

Note C2-1: Receivables

	2026 \$'000	2025 \$'000
Trade receivables	1,049	752
Payroll receivables	12	5
Accrued revenue	1,786	2,235
Contract assets - funding for public health services	472	433
Less: Loss allowance	(887)	(693)
	2,432	2,732
GST input tax credits receivable	706	593
GST payable	(35)	(101)
	671	492
Total receivables	3,103	3,224

Receivables are measured at amortised cost, which approximates their fair value at reporting date. Trade receivables are initially recognised at the amount invoiced to customers for services provided with settlement being 30 days from invoice date. Other receivables generally arise from transactions outside the usual operating activities of the HHS and are recognised at their assessed values. Receivables include end of year funding accrual of \$1.110 million (2025: \$1.159 million).

Disclosure – Credit Risk Exposure of Receivables

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

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

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

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

Disclosure – Receivables

The closing balance of receivables arising from contracts with customers at 30 June 2026 is \$2.258 million (2025: \$2.266 million).

North West Hospital and Health Service

For the year ended 30 June 2026

C2 RECEIVABLES (Continued)

Note C2-2: Expected Credit Loss

	2026			2025		
	Trade receivables	Loss rate	Allowance for credit losses	Trade receivables	Loss rate	Allowance for credit losses
Aging	\$'000	%	\$'000	\$'000	%	\$'000
Current	143	2.79%	4	71	2.67%	2
1 - 30 days overdue	124	93.54%	116	213	78.57%	187
31 - 60 days overdue	103	91.26%	94	60	98.51%	66
61 - 90 days overdue	116	99.01%	115	99	88.51%	98
More than 90 days overdue	563	98.93%	557	310	97.98%	340
Total	1,049		887	752		693

Note C2-3: Impairment of Receivables

	2026	2025
	\$'000	\$'000
Balance at beginning of the financial year	693	516
Amounts written-off during the year	(164)	(83)
Increase in allowance recognised in operating result	358	260
Balance at the end of the financial year	887	693

C3 INVENTORIES

	2026	2025
	\$'000	\$'000
Clinical supplies and equipment	1,799	1,794
Other	34	26
Total inventories	1,833	1,820

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

C4 OTHER ASSETS

	2026	2025
	\$'000	\$'000
Current		
Other prepayments	660	480
Contract assets	3,447	2,609
	4,107	3,089
Non-Current		
Other prepayments	-	62
	-	62
Total other assets	4,107	3,151

Disclosure – Contract Assets

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

North West Hospital and Health Service

For the year ended 30 June 2026

C5 PROPERTY, PLANT AND EQUIPMENT

Note C5-1: Balances and reconciliation of carrying amounts

	Land (at fair value) \$'000	Buildings (at fair value) \$'000	Plant and equipment (at cost) \$'000	Capital works in progress (at cost) \$'000	Total \$'000
Year ended 30 June 2025					
Opening net book value	2,744	117,628	11,417	21,597	153,386
Acquisitions	-	-	2,297	24,944	27,241
Disposals	-	-	(136)	-	(136)
Revaluation decrements	-	(11,848)	-	-	(11,848)
Transfer of assets from Department of Health	-	19,579	352	-	19,931
Transfer of assets between asset classes	-	23,575	-	(23,575)	-
Donated Assets	-	-	-	-	-
Depreciation expense	-	(15,401)	(2,106)	-	(17,507)
Carrying amount at 30 June 2025	2,744	133,533	11,824	22,966	171,067
At 30 June 2025					
At cost/fair value	2,744	436,788	24,044	22,966	486,542
Accumulated depreciation	-	(303,255)	(12,220)	-	(315,475)
	2,744	133,533	11,824	22,966	171,067
Year ended 30 June 2026					
Opening net book value	2,744	133,533	11,824	22,966	171,067
Acquisitions	-	-	2,457	1,197	3,654
Disposals	-	-	(153)	-	(153)
Revaluation increments/(decrements)	58	11,394	-	-	11,452
Transfer of assets from Department of Health	-	39,129	-	-	39,129
Transfer of assets between asset classes	-	11,990	75	(12,065)	-
Depreciation expense	-	(14,416)	(2,230)	-	(16,646)
Carrying amount at 30 June 2026	2,802	181,630	11,972	12,098	208,502
At 30 June 2026					
At cost/fair value	2,802	513,222	25,171	12,098	553,293
Accumulated depreciation	-	(331,592)	(13,199)	-	(344,791)
	2,802	181,630	11,972	12,098	208,502

Note C5-2: Accounting Policies

Property, Plant and Equipment

Recognition threshold

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

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

Key Judgement:

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

Acquisition

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

Where assets are received free of charge from another Queensland Government entity (whether as a result of a machinery-of-Government change or other involuntary transfer), the acquisition cost is recognised at the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation.

North West Hospital and Health Service

For the year ended 30 June 2026

C5 PROPERTY, PLANT AND EQUIPMENT (Continued)

Componentisation of complex assets

Complex assets comprise separately identifiable components (or groups of components) of significant value, that require replacement at regular intervals and at different times to other components comprising the complex asset.

On initial recognition, the asset recognition thresholds outlined above apply to the complex asset as a single item. Where the complex asset qualifies for recognition, components are then separately recorded when their value is significant relative to the total cost of the complex asset.

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

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

North West HHS's complex assets are its special purpose buildings.

Subsequent measurement

Land and buildings are subsequently measured at fair value as required by *AASB 116 Property, Plant and Equipment*, *AASB 13 Fair Value Measurement* and **Queensland Treasury's Non-Current Asset Policies** for the Queensland Public Sector. These assets are reported at their revalued amounts, being the fair value at the date of valuation, less any subsequent accumulated depreciation and accumulated impairment losses where applicable. The cost of items acquired during the financial year has been judged by management to materially represent their fair value at the end of the reporting period.

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

Depreciation

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

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

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

<u>Class</u>	<u>Useful Life</u>
Buildings	26 – 88 years
Plant and Equipment	5 – 30 years

Impairment

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

- As a not-for-profit entity, certain property, plant and equipment of the HHS is held for the continuing use of its service capacity and not for the generation of cash flows. Such assets are typically specialised in nature. In accordance with *AASB 136*, where such assets measured at fair value under *AASB 13*, that fair value (with no adjustment for disposal costs) is effectively deemed to be the recoverable amount. Therefore, *AASB 136* does not apply to such assets unless they are measured at cost.
- For other non-specialised property, plant and equipment measured at fair value, where indicators of impairment exist, the only **difference between the asset's fair value and its fair value less costs of disposal is the incremental costs attributable** to the disposal of the asset. Consequently, the fair value of the asset determined under *AASB 13* will materially approximate its recoverable amount where the disposal costs attributable to the asset are negligible. After the revaluation requirements of *AASB 13* are first applied to these assets, applicable disposal costs are assessed and, in the circumstances where such costs are not negligible, further adjustments to the recoverable amount are made in accordance with *AASB 136*.

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

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

North West Hospital and Health Service

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C5 PROPERTY, PLANT AND EQUIPMENT (Continued)

Impairment (Continued)

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

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

Note C5-3: Valuation

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

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

On revaluation, for assets revalued using a cost valuation approach (e.g. current replacement cost) - accumulated depreciation is adjusted to equal the difference between the gross amount and carrying amount, after taking into account accumulated impairment losses. This is generally referred to as the 'gross method'. For assets revalued using a market or income-based valuation approach - accumulated depreciation and accumulated impairment losses are eliminated against the gross amount of the asset prior to restating for the revaluation. This is generally referred to as the 'net method'.

In determining the values reported in the accounts for North West HHS land and buildings we have relied on the information provided by the independent valuers.

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

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

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

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

Land Component

Colliers (outsourced by Ripple Group) performed a comprehensive revaluation for movements in fair value, as at 30 June 2026. Colliers performed valuation of land assets controlled by North West HHS. A 2% indexation was assessed for the revaluation of land assets.

Level 2 input evidence is available for 12 North West HHS properties and therefore the market comparison approach has been utilised to assess the value of freehold land owned by North West HHS. Four of the assessments were considered Level 3 however Level 2 market input is considered appropriate methodology in active markets for similar assets or liabilities, with the value adjusted to reflect the assumption of risk, rarely traded restrictive zoning and non-freehold tenure characteristics that market participants would use when pricing the asset or liability.

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

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

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

North West Hospital and Health Service

For the year ended 30 June 2026

C5 PROPERTY, PLANT AND EQUIPMENT (Continued)

Building and Property and Equipment Component

North West HHS engaged Ripple Group to provide a comprehensive revaluation for movements in building and PPE values in 2025-26 financial year.

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

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

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

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

	Level 2 \$'000	Level 3 \$'000	Total \$'000
2025			
Land	2,744	-	2,744
Buildings	-	133,533	133,533
Fair value at 30 June 2025	2,744	133,533	136,277
2026			
Land	2,802	-	2,802
Buildings	-	181,630	181,630
Fair value at 30 June 2026	2,802	181,630	184,432

The following table details the reconciliation of above levels:

	Buildings \$'000
Fair value at 30 June 2024	117,628
Transfers in (Department of Health)	19,579
Transfers in (work-in-progress)	23,575
Depreciation	(15,401)
<i>Losses recognised in other comprehensive income:</i>	
Decrease in asset revaluation reserve	(11,848)
Fair value at 30 June 2025	133,533
Fair value at 30 June 2025	133,533
Transfers in (Department of Health)	39,129
Transfers in (work-in-progress)	11,990
Depreciation	(14,416)
<i>Gains/Losses recognised in other comprehensive income:</i>	
Increase in asset revaluation reserve	11,394
Fair value at 30 June 2026	181,630

North West Hospital and Health Service

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C6 PAYABLES

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

	2026 \$'000	2025 \$'000
Trade payables	19,914	20,141
Contract Liabilities	903	2,032
Accrued labour - Department of Health	3,749	2,397
Other	-	28
Total payables	24,566	24,598

C7 RIGHT OF USE ASSETS AND LEASE LIABILITIES

Note C7-1: Leases as a lessee - Right-of-use assets

	Buildings \$'000	Total \$'000
Year ended 30 June 2025		
Opening balance 1 July	7,176	7,176
Additions	1,893	1,893
Depreciation expense	(2,400)	(2,400)
Other changes	(1,055)	(1,055)
Carrying amount at 30 June 2025	5,614	5,614
Year ended 30 June 2026		
Opening balance 1 July	5,614	5,614
Additions	3,754	3,753
Depreciation expense	(2,280)	(2,280)
Other changes	-	1
Carrying amount at 30 June 2026	7,088	7,088

Note C7-2: Lease liabilities

	2026 \$'000	2025 \$'000
Current		
Lease liabilities	1,840	1,326
Non-current		
Lease liabilities	5,356	4,178
Total lease liabilities	7,196	5,504

Lease Liability Maturity

	2026 \$'000	2025 \$'000
Not later than one year	2,115	1,609
Later than one year and no later than five years	4,246	2,691
Later than five years	1,886	2,283
Total lease liabilities	8,247	6,583

North West Hospital and Health Service

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C7 RIGHT OF USE ASSETS AND LEASE LIABILITIES (Continued)

Accounting policies – Leases as lessee

Right-of-use assets

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

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

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

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

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

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

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

Lease liabilities

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

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

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

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

Disclosures – Leases as lessee

(i) Office accommodation, employee housing and motor vehicles

The Department of Housing and Public Works (DHPW) provides the department with access to office accommodation, employee housing and motor vehicles under government-wide frameworks. These arrangements are categorised as procurement of services rather than as leases because DHPW has substantive substitution rights over the assets. The related service expenses are included in Note B2-3.

Buildings – North West Hospital and Health Service (North West HHS) enters into residential lease contracts with real estate agents or individual house owners to provide rural and remote housing assistance to attract employees in isolated areas.

North West Hospital and Health Service

For the year ended 30 June 2026

C7 RIGHT OF USE ASSETS AND LEASE LIABILITIES (Continued)

(ii) Amounts recognised in profit or loss

	2026 \$'000	2025 \$'000
Interest expense on lease liabilities	314	251
Expenses relating to short-term and low value leases	6,267	5,040

C8 ASSET REVALUATION SURPLUS BY CLASS

	2026 \$'000	2025 \$'000
Land		
Balance at the beginning of the financial year	75	75
Revaluation increments	58	-
	133	75
Buildings		
Balance at the beginning of the financial year	45,351	57,199
Revaluation (decrements)/increments	11,394	(11,848)
	56,745	45,351
Balance at the end of the financial year	56,878	45,426

C9 EQUITY INJECTIONS AND EQUITY WITHDRAWALS

	2026 \$'000	2025 \$'000
Balance at beginning of financial year	125,860	91,182
<i>Non-appropriated equity injections</i>		
Cash injection for capital works and asset acquisitions	5,309	34,654
<i>Non-appropriated equity withdrawals</i>		
Non-cash withdrawal for depreciation and amortisation	(18,926)	(19,907)
<i>Non-appropriated equity asset transfers</i>		
Non-cash injection for assets transferred from DOH or other QH entities	39,129	19,931
Balance at the end of the financial year	151,372	125,860

North West Hospital and Health Service

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SECTION D NOTES ABOUT RISKS AND OTHER ACCOUNTING UNCERTAINTIES

D1 FINANCIAL RISK MANAGEMENT

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

	Note	2026 \$'000	2025 \$'000
Financial assets			
Cash and cash equivalents	C1-1	9,789	5,040
Financial assets at amortised cost:			
Receivables	C2-1	3,103	3,224
Total		12,892	8,264
Financial liabilities at amortised cost:			
Payables	C6-1	24,566	24,598
Lease liabilities	C7-1	7,196	5,504
Total		31,762	30,102

(a) Credit Risk

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

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

There are no significant concentrations of credit risk.

Overall credit risk is considered minimal.

(b) Liquidity risk

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

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

Under the whole-of-government banking arrangements, North West HHS has an approved working debt facility of \$2.5 million (2025: \$2.5 million) to manage any short-term cash shortfalls. This facility was not drawn down as at 30 June 2026 (2025: \$nil).

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

As at 30 June 2026, the North West HHS was in a net current liability position of \$10.0 million (2025: \$13.610 million) and had an accumulated deficit of \$8.0 million (2025: \$12.331 million). For the year ended 30 June 2026, the HHS recorded a net operating cash surplus of \$9.418 million (2025: cash deficit \$2.130 million) and a net operating surplus of \$4.3 million (2025: net operating deficit \$3.1 million).

The current year operating surplus was mainly driven by workforce underspends and higher-than-anticipated revenue. The financial performance included one-off GST correction of \$1.5 million relating to travel expenses from the prior financial year. NWHHS continued to experience increasing cost pressures across workforce expenses, supplies and services, as well as higher expenditure on locum and agency staff resulting from workforce model changes and challenges in recruitment. Expenditure on patient travel including aeromedical retrievals decreased by \$1.41 million (6.3%) in 2025-26 over the prior year. Other areas of increased expenditure included pathology services, radiology services and other outsourced clinical and non-clinical service delivery contracts.

North West HHS are committed to a focus on delivering and meeting clinical service demand in order to meet associated targets. The HHS has arrangements in place with the Department of Health to ensure there is minimal impact on the level of health services delivered and relies on the Department of Health to provide flexibility in cash advances to address short and medium-term cash shortfalls as they arise. North West HHS is economically dependent on funding received from its Service Agreement with the Department of Health (the Department).

(c) Interest rate risk

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

North West HHS does not undertake any hedging in relation to interest rate risk.

Changes in interest rate have a minimal effect on the operating result of North West HHS.

North West Hospital and Health Service

For the year ended 30 June 2026

D1 FINANCIAL RISK MANAGEMENT (Continued)

(d) Fair value measurement

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

D2 CONTINGENCIES

Litigation

As at 30 June 2026, there are two cases filed in the courts naming the State of Queensland acting through the North West Hospital and Health Service as defendant (2025: one). North West HHS management believe it would be misleading to estimate the final amount payable (if any) in respect of the litigation before the courts at this time. Health litigation is underwritten by the Queensland Government Insurance Fund (QGIF). North West HHS liability in this area is limited to an excess per insurance event. As at 30 June 2026, North West HHS has 12 claims (2025: 9 claims) currently managed by QGIF (some of which may never be litigated or result in payments to claimants). At year end, the maximum exposure to North West HHS associated with these claims is \$130,000 (\$10,000 for all other policy sections and \$20,000 for each medical indemnity insurable event).

D3 COMMITMENTS

	2026 \$'000	2025 \$'000
No later than 1 year	2,620	1,884
Later than 1 year but no later than 5 years	598	833
Total	3,218	2,717

As at 30 June 2026, North West HHS commitments for the 12 months predominantly included short term rental lease payment of \$1.894 million (2025: \$1.077 million), QFleet vehicle lease payments \$0.726 million (2025: \$0.807 million) and payments of \$0.598 million (2025: \$0.833 million) due later than one year but no more than 5 years

Capital Commitments

As at 30 June 2026, North West HHS capital commitment is \$7.8 million (2025: 11.5 million).

D4 SUBSEQUENT EVENTS

Up to the date of signing there are no matters or circumstances that have arisen since 30 June 2026 that have significantly affected or may significantly affect North West HHS's operations, the results of those operations, or the HHS's state of affairs in future financial years.

North West Hospital and Health Service

For the year ended 30 June 2026

SECTION E NOTES ON OUR PERFORMANCE COMPARED TO BUDGET

E1 BUDGET TO ACTUAL COMPARISON - STATEMENT OF COMPREHENSIVE INCOME

	Note	Actual 2026 \$'000	Budget 2026 \$'000	Variance \$'000	Variance %
Income					
User charges and fees	a	11,267	8,342	2,925	35%
Funding for public health services		303,155	290,619	12,536	4%
Grants and other contributions		3,819	6,320	(2,501)	(40%)
Other revenue	b	5,105	2,022	3,083	152%
Total income		323,346	307,303	16,043	
Expenses					
Employee expenses	c	38,757	34,309	4,448	13%
Health service employee expenses	d	139,435	135,998	3,437	3%
Other supplies and services	e	115,122	112,113	3,009	3%
Grants and subsidies		549	768	(219)	(29%)
Depreciation and amortisation		18,926	19,079	(153)	(1%)
Interest on lease liabilities		314	-	314	100%
Other expenses		5,952	5,036	916	18%
Total expenses		319,055	307,303	11,752	
Operating result		4,291	-	4,291	
Other comprehensive income					
<i>Items that will not be subsequently reclassified to operating result</i>					
Increase in asset revaluation surplus	f	11,452	-	11,452	100%
Total other comprehensive income		11,452	-	11,452	
Total comprehensive income		15,743	-	15,743	

North West Hospital and Health Service

For the year ended 30 June 2026

E2 BUDGET TO ACTUAL COMPARISON - STATEMENT OF FINANCIAL POSITION

	Note	Actual 2026 \$'000	Budget 2026 \$'000	Variance \$'000	Variance %
Current assets					
Cash and cash equivalents	g	9,789	1,200	8,589	716%
Receivables		3,103	7,107	(4,004)	(56%)
Inventories		1,833	1,574	259	16%
Other		4,107	353	3,754	1063%
Total current assets		18,832	10,234	8,598	
Non-current assets					
Property, plant and equipment		208,502	219,469	(10,967)	(5%)
Right-of-use assets	h	7,088	-	7,088	100%
Other		-	28	(28)	(100%)
Total non-current assets		215,590	219,497	(3,907)	
Total assets		234,422	229,731	4,691	
Current Liabilities					
Payables	i	24,566	27,092	(2,526)	(9%)
Lease liabilities	j	1,840	991	849	86%
Accrued employee benefits		1,047	517	530	103%
Other	k	1,403	14	1,389	9921%
Total current liabilities		28,856	28,614	242	
Non-Current Liabilities					
Lease liabilities	l	5,356	2,986	2,370	79%
Total non-current liabilities		5,356	2,986	2,370	
Total liabilities		34,212	31,600	2,612	
Net assets		200,210	198,131	2,079	
Equity					
Total Equity		200,210	198,131	2,079	1%
Total equity		200,210	198,131	2,079	

North West Hospital and Health Service

For the year ended 30 June 2026

E3 BUDGET TO ACTUAL COMPARISON - STATEMENT OF CASH FLOWS

	Note	Actual 2026 \$'000	Budget 2026 \$'000	Variance \$'000	Variance %
Cash flows from operating activities					
Inflows:					
User charges, fees and funding for public health	m	295,076	298,961	(3,885)	(1%)
Grants and other contributions		2,175	4,785	(2,610)	(55%)
GST collected from customers		390	-	390	100%
GST input tax credits from ATO		8,414	-	8,414	100%
Donated Assets		70	-	70	100%
Other		5,015	5,731	(716)	(12%)
Outflows:					
Employee expenses	n	(38,672)	(34,309)	(4,363)	13%
Health service employee expenses		(138,083)	(135,998)	(2,085)	2%
Supplies and services	o	(113,923)	(115,087)	1,164	(1%)
Grants and subsidies		(549)	(768)	219	(29%)
GST paid to suppliers		(8,527)	-	(8,527)	100%
GST remitted to ATO		(456)	-	(456)	100%
Other		(5,787)	(3,501)	(2,286)	65%
Net cash from/(provided by) operating activities		5,143	19,814	(14,671)	
Cash flows from investing activities					
Inflows:					
Sales of property, plant and equipment		14	-	14	100%
Outflows:					
Payments for property, plant and equipment	p	(3,654)	-	(3,654)	100%
Net cash from/(used by) investing activities		(3,640)	-	(3,640)	
Cash flows from financing activities					
Inflows:					
Equity injections	q	5,309	1,083	4,226	390%
Outflows:					
Lease payments		(2,063)	(1,083)	(980)	90%
Equity Withdrawals		-	(19,079)	19,079	(100%)
Net cash from/(used by) financing activities		3,246	(19,079)	22,325	
Net increase in cash and cash equivalents		4,749	735	4,014	
Cash and cash equivalents at the beginning of the financial year		5,040	465	4,575	984%
Cash and cash equivalents at the end of the financial year		9,789	1,200	8,589	

North West Hospital and Health Service

For the year ended 30 June 2026

E4 EXPLANATION OF MAJOR VARIANCES

This section contains explanations of major variances between the department's actual 2025-26 financial results and the original budget presented to Parliament.

E4-1 EXPLANATION OF MAJOR VARIANCES – STATEMENT OF COMPREHENSIVE INCOME

- a. The variance in user charges and fees is attributable to an increase in Rural and Remote Medical Benefits Scheme revenue related to an increase in renal services provided in remote facilities, and an increase in inter agency reimbursements for services provided to other health services.
- b. The increase in other revenue is predominantly due to an increase in reimbursements from the Department of Health for expense related payments under the capital funding programs.
- c. The variance in employee expenses is due to the increase in utilisation of locum and overtime to fill internal medical officers.
- d. The increase in health service employee expenses is attributable to an increase in full time equivalent employees linked to new funding arrangements, as well as increases resulting from enterprise bargaining related payments and the government workforce attraction incentive scheme program for rural and remote hospital and health services and use of agency staff to fill vacant nursing and midwifery positions.
- e. The variance in other supplies and services is due to an increase in aeromedical services, short term operating leases, non-capitalised asset related expenses, and other outsourced clinical and non-clinical service contracts, unbudgeted in 2025-26.
- f. Increase in asset revaluation reserve upon revaluation and adjustment of asset values.

E4-2 EXPLANATION OF MAJOR VARIANCES – STATEMENT OF FINANCIAL POSITION

- g. Cash and cash equivalent variance to budget is caused by the surplus position recorded in 2025-26.
- h. Right-of-use assets increased as a result of increased demand for staff housing leases due to a significant increase in employee full time equivalent staff in 2025-26 following increased funding received by North West HHS for specific programs. A proportion of this variance is attributable to misalignment of budget allocations. The budget in Right of use assets was incorporated in the Property, plant and equipment.
- i. The variance in payables is due to the misalignment of budget allocation for the end of year funding adjustments between other current liabilities and payables.
- j. The variance in current lease liability is due to increase in short term property leases, which was higher than expected this year.
- k. The variance in other current liabilities is due to the misalignment of budget allocation for the end of year funding adjustments between other current liabilities and payables.
- l. The variance in non-current lease liability is due to increase in right of use asset contracts related to property leases.

E4-3 EXPLANATION OF MAJOR VARIANCES – STATEMENT OF CASH FLOWS

- m. User Charges, fees and funding for public health is primarily attributable to the cash reimbursement from the Department of Health for expense related payments under the capital funding programs and increase in Medicare billing.
- n. The variance Health service employee expenses is due to the increased in utilisation of locums, overtime and casual employment.
- o. The variance in supplies and services is due to an increase in aeromedical services, short term operating leases, non-capitalised asset related expenses, and other outsourced clinical and non-clinical service contracts, unbudgeted in 2025-26.
- p. The variance is associated with the allocation of capital funding to the Department of Health. The payments for property, plant and equipment relate to capital works programs completed by the HHS and is funded by the Department of Health. This budget is controlled by the Department of Health and was not included in North West HHS budget.
- q. The variance is associated with the allocation of capital funding to the Department of Health who account for this in their budget. Equity cash injections are provided to repay the HHS which has completed the capital program or incurs costs associated with the capital works.

North West Hospital and Health Service

For the year ended 30 June 2026

SECTION F OTHER INFORMATION

F1 KEY MANAGEMENT PERSONNEL

Key management personnel are those persons having authority and responsibility for planning, directing, and controlling the activities of North West HHS, directly or indirectly, including the Minister for Health and Ambulance Services, Board members and Executive management of North West HHS. **North West HHS's responsible Minister is the Minister for Health and Ambulance Services, Timothy (Tim) Nicholls MP.**

The following details for non-Ministerial key management personnel include those positions that had authority and responsibility for planning, directing, and controlling the activities of North West HHS during the financial year. Further information about these positions can be found in the body of the Annual report under the section relating to Executive Management.

Position	Position Responsibility
Non-executive Director – Board Chair	The North West HHS board is accountable to the local community and the Minister for Health and Ambulance Services for the services provided by the North West HHS. The Board serves to strengthen local decision making and accountability by promoting local consumer, community and clinician engagement and setting the local health system planning and coordination agenda, including financial management and oversight.
Non-executive Director – Board Member	The North West HHS board is accountable to the local community and the Minister for Health and Ambulance Services for the services provided by the North West HHS. The Board serves to strengthen local decision making and accountability by promoting local consumer, community and clinician engagement and setting the local health system planning and coordination agenda, including financial management and oversight.
Health Service Chief Executive	Responsible for the overall management of North West HHS through functional areas to ensure the delivery of hospital and health service objectives.
Chief Finance Officer	Responsible for the overall financial management of North West HHS, including budgeting, activity-based funding measurement and departmental relationship management. Also responsible for the delivery of non-clinical support services, include building, engineering and maintenance services, capital infrastructure and contract management.
Chief Operating Officer	Responsible for the overall management of the day-to-day administration and operational functions of North West HHS.
Executive Director, People, Culture and Planning	Responsible for all strategic, tactical, and operational strategy and service delivery, including Workforce and Organisational Planning, Recruitment, Talent Management, Organisational Development, Workforce Diversity, Employee Relations, Safety and Wellbeing and Human Resource operations and statutory compliance.
Executive Director Medical Services	Responsible for the overall management and coordination of clinical operational and medical services for the health service.
Executive Director Nursing, Midwifery and Clinical Governance	Responsible for the professional leadership of nursing services for the Mount Isa and remote Hospitals and clinical governance for the health service.
Executive Director, First Nations Health	Responsible for transforming the HHS services to improve the health outcomes of Aboriginal people through building strong partnerships.
Chief Information Officer, Rural and Remote	Responsible for the operational and strategic leadership of the eHealth and Communication Technology portfolio within rural and remote hospital and health services. The role is hosted by eHealth Queensland and proportionally on-charged to each of the rural and remote hospital and health services.
Executive Director Allied Health	Responsible for clinical governance and professional leadership, direction and education of allied health services.
Executive Director Remote Health Services	Responsible for delivering effective and efficient services of all clinical and non-clinical services and resources within the portfolio.

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

North West Hospital and Health Service

For the year ended 30 June 2026

F1 KEY MANAGEMENT PERSONNEL (Continued)

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

Remuneration of other Key Management Personnel comprises the following components:

- Short-term employee benefits which include:
 - **Base** – consisting of base salary, allowances and leave entitlements paid and provided for the entire year or for that part of the year during which the employee occupied the specified position. Amounts disclosed equal the amount expensed in the statement of comprehensive income
 - **Non-monetary benefits** – consisting of provision of housing and vehicle together with fringe benefits tax applicable to the benefit
- Long-term employee benefits include long service leave accrued
- Post-employment benefits include superannuation contributions
- Termination payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu on termination, regardless of the reason for termination.
- No performance bonuses were paid in the 2025-26 financial year (2024-25: nil).

2026						
Name	Short-term benefits		Long term benefits	Post employee benefits	Termination benefits	Total remuneration
	Base	Non-monetary benefits				
	\$'000	\$'000				
BOARD MEMBERS						
Cheryl Vardon (Jul-25 to Apr-26)	55	0	0	7	0	62
Tanya Arnold	50	0	0	6	0	56
Loretta Seamer	36	3	0	7	0	46
Thomas Armagnacq	42	0	0	5	0	47
Janelle Stuart-Russell (Apr-26 to Jun-26)	9	0	0	1	0	10
Marco Giuseppin (Jul-25 to Aug-25)	9	0	0	1	0	10
Eleanor Milligan (Jul-25 to Apr-26)	30	0	0	4	0	34
Mellissa Naidoo (Jul-25 to Feb-26)	24	0	0	3	0	27
Fiona Hill	37	0	0	5	0	42
Anne Pleash	42	0	0	5	0	47
Steven Renouf (Jul-25)	1	0	0	1	0	2
Tonya Murray	40	0	0	5	0	45
Johannes Prins (Apr-26 to Jun-26)	10	0	0	1	0	11
Robin Williams (Apr-26 to Jun-26)	11	0	0	1	0	12
EXECUTIVE MEMBERS						
Sean Birgan (Jul-25 to Oct-25)	129	9	2	15	0	155
Andrew Quabba	311	0	9	36	0	356
Christine Mann	203	1	2	27	0	233
Loretta Seamer (Jun-26)	37	4	1	3	0	45
Sylvie Brdjanovic	232	54	9	29	0	324
Anthony Bell	882	11	6	85	0	984
Wendy Richards (Jul-25)	2	2	0	1	0	5
Wesley Shann (Aug-25 to Jun-26)	284	1	8	25	0	318
Damien Searle (Jun-26)	12	2	1	2	0	17
Shannon Ah Sam (Sep-25)	11	0	0	1	0	12
Clare Newton	229	2	3	29	0	263
Lynette Stenhouse	230	0	1	25	0	256
Jose Amel Polong (Jan-26 to Jun-26)	161	0	5	11	0	177
Manoj Manoj-Margison (Apr-26 to Jun-26)	45	7	2	5	0	59
Kristine Sketcher-Baker (Aug-25 to Sep-25)	19	0	0	2	0	21
Sinfree Chirunga (Jul-25 to May-26)	224	1	8	28	273	534

North West Hospital and Health Service

For the year ended 30 June 2026

F1 KEY MANAGEMENT PERSONNEL (Continued)

2025

2025

Name	Short-term benefits		Long term benefits	Post employee benefits	Termination benefits	Total remuneration
		Non-monetary benefits				
	Base					
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
BOARD MEMBERS						
Cheryl Vardon	71	-	-	8	-	79
Thomas Armagnacq	41	-	-	6	-	47
Cath Brokenborough (to 31 July 2025)	5	-	-	1	-	6
Marco Giuseppin	41	-	-	6	-	47
Eleanor Milligan	27	-	-	3	-	30
Melissa Naidoo	7	-	-	1	-	8
Fiona Hill	37	-	-	5	-	42
Anne Pleash	41	-	-	5	-	46
Steven Renouf	39	-	-	5	-	44
Loretta Seamer	8	-	-	1	-	9
Tonya Murray (from 1 July 2024)	37	-	-	5	-	42
Tanya Arnold (from 1 July 2024)	36	-	-	5	-	41
EXECUTIVE MEMBERS						
Sean Birgan	271	52	6	32	-	361
Christine Mann	222	-	5	25	-	252
Karen Slater	276	28	6	34	-	344
Sylvie Brdjanovic	214	59	5	25	-	303
Anthony Bell	889	35	21	80	-	1,025
Helen Murray	31	-	-	-	-	31
Andrew Quabba	264	30	6	26	-	326
Clare Newton	214	26	5	25	-	270
Lynette Stenhouse (from 24 March 2025)	107	2	2	12	-	123
Loretta Seamer (from 9 September to 29 June 2025)	298	14	7	34	-	353
Elyse Mugridge (8 July to 8 December 2024)	117	7	2	10	-	136
Hannah Russell (9 December 2024 to 28 February 2025)	58	-	1	6	-	65
Theodore Chamberlain (to 12 July 2024)	26	2	1	3	-	32
Tanya Mason (to 21 August 2024)	62	5	1	5	-	73
Sinfree Chirunga (from 16 June 2025)	6	2	1	1	-	10

F2 RELATED PARTY TRANSACTIONS

Transactions with Queensland Government controlled entities

North West HHS is controlled by its ultimate parent entity, the State of Queensland. All State of Queensland controlled entities meet the definition of a related party in AASB 124 Related Party Disclosures.

Department of Health

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

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

North West Hospital and Health Service

For the year ended 30 June 2026

F2 RELATED PARTY TRANSACTIONS (Continued)

The signed service agreements are published on the Queensland Government website and publicly available. The 2025-26 service agreement was for \$317.4 million (2025: \$274.3 million).

In addition to the provision of corporate services support (refer Note A2-2 and A2-3), the Department of Health provides a number of services including, pathology testing, pharmaceutical drugs, clinical supplies, patient transport, telecommunications and technology services. These services are provided on a cost recovery basis. In 2025-26, these services totalled \$24.82 million (2025: \$26.87 million).

Queensland Treasury Corporation

Under the whole-of-government banking arrangements, North West HHS has an approved working debt facility with Queensland Treasury Corporation of \$2.5 million. The facility was not drawn down at 30 June 2026. North West HHS have accounts with the Queensland Treasury Corporation for general trust monies.

Department of Housing and Public Works

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

Payment to and Receipts from other HHS's

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

Transactions with other related parties

All transactions in the year ended 30 June 2026 between North West HHS and their key management personnel and their related parties were examined. Related party transactions relating to remuneration for two clinicians during their tenure as Board members totalled \$0.065mil.

There are no other individually or collectively significant transactions with related parties.

F3 PATIENT TRUST FUNDS

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

	2026	2025
	\$'000	\$'000
Patient trust funds		
Opening balance	8	7
Patient fund receipts	3	1
Closing balance (represented by cash)	11	8

F4 TAXATION

North West HHS is a State body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation except for Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). FBT and GST are the only Commonwealth taxes recognised by North West HHS.

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

North West Hospital and Health Service

For the year ended 30 June 2026

F5 ENTITY ACCOUNTING ESTIMATES AND JUDGEMENTS – CLIMATE-RELATED RISKS

The State of Queensland, as the ultimate parent of North West HHS has published a wide range of information and resources on climate related risks, strategies and actions accessible at <https://www.treasury.qld.gov.au/policies-and-programs/climate/>.

The Queensland Sustainability Report (QSR) outlines the Queensland Government's approach to managing key Environmental, Social and Governance (ESG) risks and opportunities, including governance structures, major commitments and policies, and how these risks and opportunities are measured, monitored and managed across government. The QSR is supported by comprehensive datasets and data dictionaries. The QSR is available via Queensland Treasury's website at <https://www.treasury.qld.gov.au/programs-and-policies/queensland-sustainability-report>

No adjustments to the carrying value of assets were recognised during the financial year as a result of climate-related risks impacting current accounting estimates and judgements. No other transactions have been recognised during the financial year specifically due to climate-related risks impacting the HHS.

F6 FIRST YEAR APPLICATION OF NEW ACCOUNTING STANDARDS OR CHANGE IN ACCOUNTING POLICY

Changes in accounting policy

North West HHS did not voluntarily change any of its accounting policies during 2025-26. No accounting standards have been implemented during 2025-26 Financial year that has had a material impact on the financial statements.

Accounting Standards early adopted for 2025-26

There have been no Australian Accounting Standards early adopted for 2025-26.

F7 FUTURE IMPACT OF ACCOUNTING STANDARDS NOT YET EFFECTIVE

AASB18 Presentation and Disclosure of Financial Statements

AASB 18 Presentation and Disclosure in Financial Statements is effective for not-for-profit entities from 1 January 2028 (2028-29 financial year) and for for-profit entities from 1 January 2027 (2027- 28 financial year). **AASB 18's changes will only affect** presentation and disclosure - predominantly through revisions to the layout of the income statement - it will not affect the recognition or measurement of any reported amounts.

North West Hospital and Health Service

For the year ended 30 June 2026

MANAGEMENT CERTIFICATE

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

- (a) the prescribed requirements for establishing and keeping the accounts have been complied with in all material respects;
- (b) the financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of North West Hospital and Health Service for the financial year ended 30 June 2026 and of the financial position of the Service at the end of the year.

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



Tanya Arnold

Board Chair

26 August 2026



Andrew Quabba

Health Service Chief Executive

26 August 2026

INDEPENDENT AUDITOR'S REPORT

To the Board of North West Hospital and Health Service

Report on the audit of the financial report

Opinion

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

The financial report comprises the statement of financial position as at 30 June 2026, 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 material accounting policy information, and the management certificate.

In accordance with s. 40 of the *Auditor-General Act 2009*, for the year ended 30 June 2026:

- a) I received all the information and explanations I required.
- b) I consider that, the prescribed requirements in relation to the establishment and keeping of accounts were complied with in all material respects.
- c) In my opinion, the financial report:
 - i. gives a true and fair view of the entity's financial position as at 30 June 2026, and its financial performance and cash flows for the year then ended
 - ii. complies with the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2019 and Australian Accounting Standards.

Basis for opinion

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

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

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

Key audit matters

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

Valuation of specialised buildings \$181.6 million

Refer to Note C5 in the financial report

Key audit matter	How my audit addressed the key audit matter
Buildings were material to North West Hospital and Health Service at balance date and were measured at fair value using the current replacement cost method. North West Hospital and Health Service performed a comprehensive revaluation over a portion of its portfolio. All other buildings were assessed using relevant indices. The current replacement cost method comprises: - gross replacement cost, less - accumulated depreciation. North West Hospital and Health Service derived the gross replacement cost of its buildings at balance date using unit prices that required significant judgements for: - identifying the components of buildings with separately identifiable replacement costs - developing a unit rate for each of these components, including: - estimating the current cost for a modern substitute (including locality factors and oncosts), expressed as a rate per unit (e.g. \$/square metre) - identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference. The measurement of accumulated depreciation involved significant judgements for determining condition and forecasting the remaining useful lives of building components. The significant judgements required for gross replacement cost and useful lives are also significant judgements for calculating annual depreciation expense. Using indexation required: - significant judgement in determining changes in cost and design factors for each asset type since the previous revaluation - reviewing previous assumptions and judgements used in the last comprehensive valuation to ensure ongoing validity of assumptions and judgements used.	My procedures included, but were not limited to: - assessing the adequacy of management's review of the valuation process and results - reviewing the scope and instructions provided to the valuer as management's specialist - assessing the appropriateness of the valuation methodology and the underlying assumptions with reference to common industry practices. - assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices - assessing the competence, capabilities and objectivity of the experts used to develop the models - for unit rates, 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) - adjustments for excess quality or obsolescence. - evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices - evaluating useful life estimates for reasonableness by: - reviewing management's annual assessment of useful lives - at an aggregated level, reviewing asset management plans for consistency between renewal budgets and the gross replacement cost of assets - testing that no material building asset still in use has reached or exceeded its useful life - enquiring of management about their plans for assets that are nearing the end of their useful life - reviewing assets with an inconsistent relationship between condition and remaining useful life. - where changes in useful lives were identified, evaluating whether the effective dates of the changes applied for depreciation expenses were supported by appropriate evidence.

Other Information

The other information comprises the information included in the entity's annual report for the year ended 30 June 2026, but does not include the financial report and our auditor's report thereon.

My opinion on the financial report does not cover the other information and accordingly I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial report, my responsibility is to read the other information identified above and, in doing so, consider whether the other information is materially inconsistent with the financial report or my knowledge obtained in the audit or otherwise appears to be materially misstated.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Responsibilities of the Board for the financial report

The Board is responsible for:

- the preparation of the financial report that gives a true and fair view in accordance with the *Financial Accountability Act 2009*, the Financial and Performance Management Standard 2019 and Australian Accounting Standards, and such internal control as they determine is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error
- the establishment and keeping of accounts in accordance with prescribed requirements
- 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

A further description of my responsibilities for the audit of the financial report is located at the Auditing and Assurance Standards Board website at:
www.auasb.gov.au/auditors_responsibilities/ar6.pdf

A further description of my responsibilities under the *Auditor-General Act 2009* and *Auditor-General Auditing Standards* is located at the Queensland Audit Office website at:
www.qao.qld.gov.au/audit-program/audit-standards

These descriptions form part of my auditor's report.



D Ryan
as delegate of the Auditor-General

31 August 2026
Queensland Audit Office
Brisbane

Glossary

Term	Description
Accessible	Accessible healthcare is characterised by the ability for people to obtain appropriate healthcare at the right place and right time, irrespective of income, geography or cultural background.
Accreditation	Accreditation is independent recognition that an organisation, service, program, or activity.
Activity Based Funding (ABF)	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 accuracy • measuring the costs of delivery • creating an explicit relationship between funds allocated and services provided • strengthening management's focus on outputs, outcomes and quality • encouraging clinicians and managers to identify variations in costs and practices so they can be managed at a local level in the context of improving efficiency and effectiveness • providing mechanisms to reward good practice and support quality initiatives
Acute	Having a short and relatively severe course of care.
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.
Allied Health staff (Health Practitioners)	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; medical imaging; nuclear medicine technology; occupational therapy; orthoptics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work.
Ambulatory care	Care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics.
Antenatal	Antenatal care constitutes screening for health, psychosocial and socioeconomic conditions likely to increase the possibility of specific adverse pregnancy outcomes, providing therapeutic interventions known to be effective; and educating pregnant women about planning for safe birth, emergencies during pregnancy and how to deal with them (WHO, 2011).
Block Funding	Block funding is typically applied for small public hospitals where there is an absence of economies of scale that mean some hospitals would not be financially viable under Activity Based Funding (ABF), and for community-based services not within the scope of Activity Based Funding.
Consumer Advisory Group (CAG) and Consumer Advisory Network (CAN)	A Consumer Advisory Group and Consumer Advisory Network is made up of community representatives who work with the health service to improve our local health system.
Chronic disease	Chronic disease: Diseases which have one or more of the following characteristics: (1) is permanent, leaves residual disability (2) is caused by non-reversible pathological alteration. (3) requires special training of the individual for rehabilitation, and/or may be expected to require a long period of supervision, observation or care.

Term	Description
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.
Closing the Gap	A government strategy that aims to reduce disadvantage among Aboriginal and Torres Strait Islander peoples with respect to life expectancy, child mortality, access to early childhood education, educational achievement, and employment outcomes.
Deadly Ears	Queensland Health's statewide Aboriginal and Torres Strait Islander Ear Health Program for children. Middle ear disease, medically known as otitis media, affects up to 8 out of 10 Aboriginal and Torres Strait Islander children living in remote communities and is conducive to hearing loss, which impacts upon health, child development and educational outcomes of children, their families and communities
Deadly Start Program	The Deadly Start Program gives school students a head start in healthcare through completion of a relevant traineeship
Emergency department	Dedicated area of a hospital organised and administered to provide emergency care to those in the community who perceive the need for, or are in need of, acute or urgent care.
Full-time equivalent (FTE)	Refers to full-time equivalent staff currently working in a position.
GP (general practitioner)	A general practitioner is a registered medical practitioner who is qualified and competent for general practice in Australia. General practitioners operate predominantly through private medical practices.
General Retention and Disposal Schedule (GRDS)	Authorises the disposal of common and administrative public records created by all Queensland Government agencies
Governance	Governance focuses on achieving organisational goals through responsibilities, practices, policies, and procedures that provide strategic direction, manage risks, and ensure efficient resource use. It supports accountability, transparency, and ethical decision-making.
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 Board	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to managing a complex healthcare organisation.
Hospital and Health Service (HHS)	Hospital and Health Service (HHS) is a separate legal entity established by Queensland Government to deliver public hospital service.
Human rights	Human rights are moral principles or norms that describe certain standards of human behaviour and are regularly protected as natural and legal rights in municipal and international law.
Local Assessment Needs Analysis (LANA)	A systematic method of identifying unmet health and healthcare needs of a population and determining if changes are required to meet those unmet needs.
Inpatient	A patient who is admitted to a hospital or health service for treatment that requires at least one overnight stay.
Intern	A medical practitioner in the first postgraduate year, learning further medical practice under supervision.
Internal Audit	Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

Term	Description
Key Performance Indicators	Key performance indicators are metrics used to help a business define and measure progress towards achieving its objectives or critical success factors.
Minimum Obligatory Human Resource Information (MOHRI)	MOHRI is a whole of government methodology for producing an Occupied Full Time Equivalent (FTE) and headcount value sourced from the Queensland Health payroll system data for reporting and monitoring.
Multipurpose Health Service (MPHS)	Provide a flexible and integrated approach to health and aged care service delivery for small rural communities. They are funded through pooling of funds from Hospital and Health Services (HHS) and the Australian Government Department of Health and Ageing.
National Safety and Quality Health Service Standards (NSQHS)	The NSQHS Standards provide a nationally consistent statement of the level of care consumers can expect from health service organisations.
Nurse practitioner	A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role.
Outpatient	A non-admitted, non-emergency patient provided with a service such as an examination, consultation, treatment or other service.
Outreach	Services delivered to sites outside of the service's base to meet or complement local service needs.
Palliative care	Palliative care is an approach that improves quality of life of patients and their families facing the problems associated with life threatening illness, through the prevention of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychological and spiritual.
Patient Reported Experience Measures (PREMs)	PREMs –a patient reported experience survey asks patients and parents/carers about their recent experience with the care they/their child received at the hospital. Queensland Health Patient Reported Experience Measures provide the ability to capture real-time patient experience to support clinicians in partnering with patients to achieve safe, high-quality care.
Performance indicator	Measures the extent to which agencies are achieving their objectives.
Primary care	First level healthcare, including health promotion, advocacy and community development, provided by general practitioners (GPs) and a range of other healthcare professionals.
Primary Health Network	Established by Federal Government with the key objectives of increasing the efficiency and effectiveness of medical services for patients – particularly those at risk of poor health outcomes – and improving coordination of care to ensure patients receive the right care in the right place at the right time.
Public Health Unit	Public Health Unit (PHU) focus on protecting health; preventing disease, illness and injury; and promoting health and wellbeing at a population or whole of community level. This is distinct from the role of the rest of the health system which is primarily focused on providing healthcare services to individuals and families.
Renal dialysis	Renal dialysis is a medical process of filtering the blood with a machine outside of the body.
Rheumatic Heart Disease (RHD)	A notifiable chronic condition caused by damage to the heart valves, which occurs after single or repeated episodes of acute rheumatic fever (ARF).
Royal Flying Doctor Service (RFDS)	A not-for-profit organisation, supported by the Commonwealth, State and Territory Governments but also relying heavily on fundraising and donations from the community to purchase and medically-equip its aircraft, and to finance other major capital initiatives. Today, the RFDS has a fleet of 63 aircraft operating from 21 bases located across the nation and provides medical assistance to over 290,000 people every year.

Term	Description
Rural Generalist Pathway	A dedicated medical training pathway to attract, retain and support rural generalist doctors.
Strategic plan	A short, forward-looking document to set direction and provide local objectives and strategies to ensure alignment with the government's objectives for the community.
Telehealth	Delivery of health-related services through telecommunication technology, including: Live interactive video and audio links for clinical consultations and education purposes Store and forward systems to enable the capture of digital images, video, audio and clinical data stored on a computer and forwarded to another location to be studied and reported on by specialists. Remote reporting and provision of clinical advice associated with diagnostic images. Other services and equipment for home monitoring of health.
Visiting Medical Officer	A medical practitioner who is employed as an independent contractor or an employee to provide services on a part time, sessional basis.
Working for Queensland (WfQ)	Queensland Health Working for Queensland employee opinion survey. WfQ is an annual survey which measures Queensland public sector employee perceptions of their work, manager, team and organisation.

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	<u>4</u>
Accessibility	- Table of contents - Glossary	ARRs – section 9.1	<u>5</u> <u>85</u>
	Public availability	ARRs – section 9.2	<u>2</u>
	Interpreter service statement	Queensland Government Language Services Policy ARRs – section 9.3	<u>2</u>
	Copyright notice	Copyright Act 1968 ARRs – section 9.4	<u>2</u>
	Information Licensing	QGEA – Information Licensing ARRs – section 9.5	<u>2</u>
General information	Introductory Information	ARRs – section 10	<u>10</u>
Non-financial performance	Government’s objectives for the community and whole-of-government plans/specific initiatives	ARRs – section 11.1	<u>7</u>
	Agency objectives and performance indicators	ARRs – section 11.2	<u>11</u> & <u>34</u>
	Agency service areas and service standards	ARRs – section 11.3	<u>41</u>
Financial performance	Summary of financial performance	ARRs – section 12.1	<u>43</u>
Governance – management and structure	Organisational structure	ARRs – section 13.1	<u>28</u>
	Executive management	ARRs – section 13.2	<u>24</u>
	Government bodies (statutory bodies and other entities)	ARRs – section 13.3	<u>17</u>
	Public Sector Ethics	Public Sector Ethics Act 1994 ARRs – section 13.4	<u>32</u>
	Human Rights	Human Rights Act 2019 ARRs – section 13.5	<u>33</u>

Summary of requirement		Basis for requirement	Annual report reference
	Queensland public service values	ARRs – section 13.6	<u>32</u>
Governance – risk management and accountability	Risk management	ARRs – section 14.1	<u>31</u>
	Audit committee	ARRs – section 14.2	<u>23</u>
	Internal audit	ARRs – section 14.3	<u>31</u>
	External scrutiny	ARRs – section 14.4	<u>32</u>
	Information systems and recordkeeping	ARRs – section 14.5	<u>32</u>
	Information Security attestation	ARRs – section 14.6	<u>32</u>
Governance – human resources	Strategic workforce planning and performance	ARRs – section 15.1	<u>29</u>
	Early retirement, redundancy and retrenchment	Directive No.04/18 <i>Early Retirement, Redundancy and Retrenchment</i> ARRs – section 15.2	<u>31</u>
Open Data	Statement advising publication of information	ARRs – section 16	<u>31</u>
	Consultancies	ARRs – section 31.1	https://data.qld.gov.au
	Overseas travel	ARRs – section 31.2	https://data.qld.gov.au
	Queensland Language Services Policy	ARRs – section 31.3	https://data.qld.gov.au
	Charter of Victims' Rights	<i>VCSVRB Act 2024</i> ARRs – section 31.4	https://data.qld.gov.au
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	<u>84</u>
	Independent Auditor's Report	FAA – section 62 FPMS – section 46 ARRs – section 17.2	<u>81</u>

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