Torres and Cape Hospital and Health Service

2018–2019 ANNUAL REPORT

ADVANCING Queensland

Queensland Government

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

An electronic copy of this report is available at https://www.health.qld.gov.au/torres-cape/html/publication-scheme. Hard copies of the annual report are available by contacting the Board Secretary (07) 4226 5945. Alternatively, you can request a copy by emailing TCHHS-Board-Chair@health.qld.gov.au.

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on telephone (07) 4226 5974 and we will arrange an interpreter to effectively communicate the report to you.

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

ACKNOWLEDGEMENT TO TRADITIONAL OWNERS

The Torres and Cape Hospital and Health Service respectfully acknowledges the Traditional Owners / Custodians, past and present, within the lands in which we work.

CAPE YORK

Ayabadhu, Alngith, Anathangayth, Anggamudi, Apalech, Binthi, Burunga, Dingaal, Girramay, Gulaal, Gugu Muminh, Guugu-Yimidhirr, Kaantju, Koko-bera, Kokomini, Kuku Thaypan, Kuku Yalanji, Kunjen/Olkol, Kuuku – Yani, Lama Lama, Mpalitjanh, Munghan, Ngaatha, Ngayimburr, Ngurrumungu, Nugal, Oolkoloo, Oompala, Peppan, Puutch, Sara, Teppathiggi, Thaayorre, Thanakwithi, Thiitharr, Thuubi, Tjungundji, Uutaalnganu, Wanam, Warrangku, Wathayn, Waya, Wik, Wik Mungkan, Wimarangga, Winchanam, Wuthathi and Yupungathi.

NORTHERN PENINSULA AREA

Atambaya, Gudang, Yadhaykenu, Angkamuthi, Wuthathi.

TORRES STRAIT ISLANDS

The five tribal nations of the Torres Strait Islands:
The Kaiwalagal
The Maluilgal
The Gudamaluilgal
The Meriam
The Kulkalgal Nations.

RECOGNITION OF AUSTRALIAN SOUTH SEA ISLANDERS

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

04 September 2019

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

Dear Minister

I am pleased to deliver for presentation to the Parliament the Annual Report 2018–2019 and financial statements for Torres and Cape Hospital and Health Service.

I certify that this Annual Report complies with:

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

A checklist outlining the annual reporting requirements can be found on page 56 of this annual report.

Yours sincerely

Elthies (Ella) Kris
Board Chair
Torres and Cape Hospital and Health Board

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STATEMENT ON GOVERNMENT OBJECTIVES FOR THE COMMUNITY

The Torres and Cape Hospital and Health Service is committed to the *Our Future State: Advancing Queensland's Priorities*. Our policies, strategies and services align with the outcomes of:

- Keep Queenslanders healthy
- Give all our children a great start
- Be a responsive government
- Keep Communities safe
- Create jobs in a strong economy

The *Torres and Cape Hospital and Health Service Strategic Plan 2019-2023* outlines our goal of strengthening the region through the development of a sustainable, supported local workforce, growing our ability and capability to respond to local needs by delivering innovative self-sufficient services closer to home.

The Torres and Cape HHS's vision aligns with the directions outlined in *My health, Queensland's future: Advancing health 2026*.

Torres and Cape Hospital and Health Service

Strategic Plan 2019-2023

Strengthening the region through the development of a sustainable, supported local workforce, growing our ability and capability to respond to local needs by delivering innovative self-sufficient services closer to home.

Leading connected health care to achieve longer, healthier lives.

About us

Torres and Cape Hospital and Health Service (TCHHS) is the largest provider of public health care services across the most northern remote areas of Queensland.

TCHHS provides health services to a resident population of 26,966 with 67% identifying as Aboriginal and/or Torres Strait Islander. The range and type of services provided are defined in a formal Service Agreement with the Department of Health. Services are provided across 35 facilities (4 hospitals and 31 primary and community health services) by more than 1000 staff.

Our purpose

Deliver high quality health services that maximise potential for wellness by:

- Ensuring seamless patient journeys.
- Embracing cultural diversity.
- Collaborating and connecting with communities and agencies.
- Enhancing the capacity and capability of the workforce.
- Maximising the use of technology.

Opportunities

We are committed to identifying and responding to opportunities in:

- Closing the Gap.
- Preventative health care.
- Providing care closer to home.
- Partnering with agencies and communities.
- Maximising self-sufficiency in each facility.
- Digital transformation with improved data analytics.
- Training and education.

Our risks

We will achieve our strategic objectives by recognising and managing risks which impact our ability to:

- Provide safe and high quality patient care.
- Deliver integrated and coordinated primary health care.
- Ensure adequate infrastructure, digital and other assets to deliver services.
- Attract and retain a skilled and competent workforce.
- Engage and communicate with community and staff to deliver changes required.

Our proactive opportunities to mitigate risk include:

- Continuous service improvements in alignment with safety and quality standards.
- Digital transformation including improved business intelligence and analytical capabilities.
- Growing our workforce through close links with our communities and education partners.

Linking with Queensland Government objectives for the community

Our strategic plan reflects our commitment to working with and advancing the Queensland Government's objectives for the community:

- Keep Queenslanders healthy.
- Give all our children a great start.
- Be a responsive government.
- Keep communities safe.
- Create jobs in a strong economy.

Our Strategic Plan aligns to the aims of My health, Queensland's future: Advancing health 2026.

Our values

TCHHS supports and upholds the Queensland Public Service values:

Customers first | Ideas into action | Unleash potential | Be courageous | Empower people

Torres and Cape Hospital and Health Service

Strategic Plan 2019-2023

Excellence in health care

Government objective: Delivering quality frontline services.

Health care delivered by the right people with the right skills at the right place and the right time.

Actions:

- Implement our new Clinical Services Plan.
- Coordinate clinical care closer to home.
- Deliver high value health care.
- Develop contextualised Models of Care.
- Coordinate seamless retrieval services.
- Build and optimise self-sufficiency at facilities.
- Deliver best practice and regionally based, relevant education and training.
- Optimise Telehealth.

Measures of success

- Services meet National Safety and Quality Standards including all safety and quality Key Performance Indicators.
- Improved Closing the Gap health target results.
- Increased self-sufficiency at facilities.
- Increased telehealth occasions of service.

Advance health through strong partnerships

Government objective: Building safe, strong and connected communities.

Partner to optimise health and wellbeing in our communities.

Actions:

- Improve and enhance community involvement in decision making.
- Seek increased membership of peak strategic bodies to influence health and social policy.
- Promote health career pathways for our community members.
- Nurture purposeful relationships with our regional, research, and education partners.

Measures of success

- Enhanced community engagement processes.
- Enhanced participation in health care design and delivery.
- Increased and consistent participation at peak strategic bodies.
- Increased number of clinical placements for medical, nursing and allied health students.

A safe, engaged, valued and skilled workforce

Government objective: Creating jobs and a diverse economy.

Inspire a culture that values collaboration, challenges the norm and promotes a welcoming workplace.

Actions:

- Develop a Workforce Strategy.
- Maintain contemporary learning and development platforms.
- Maintain staff security and safety.
- Promote positive organisational values.
- Work with secondary schools and training providers to provide employment pathway opportunities.
- Establish a scholarship program.
- Recognise staff and team successes.
- Improve staff feedback mechanisms.
- Improve workforce culture.

Measures of success

- Increased use of staff training and development programs.
- Increased proactive hazard reporting.
- Increased number of scholarships and training pathways.

A well-governed organisation

Government objective: Delivering quality frontline services.

Efficient, productive and responsive governance structures.

Actions:

- Maintain strong organisational structure.
- Maintain robust and comprehensive plans at all levels.
- Strengthen project management governance and support.
- Improve performance through better monitoring and analytics.
- Implement our Information and Cyber Security Governance Framework.

Measures of success

- Achievement of planned financial position.
- Successful project governance and delivery.
- Services achieve or exceed performance targets for Service Agreement and Performance Framework Key Performance Indicators.
- Implementation of business intelligence dashboards.

MESSAGE FROM THE BOARD CHAIR

As I put pen to paper for my comments in this, my first Annual Report, I firstly acknowledge all the Traditional Land Owners of where we operate our service from.

In May 2019, I was appointed Chair of Torres and Cape Hospital and Health Service. I would like to thank outgoing Board Chair Mr Bob McCarthy AM for his hard work and leadership. Mr McCarthy began in 2014 with the amalgamation of the Cape York HHS and Torres Strait-Northern Peninsula HHS and has been a passionate advocate for our region. Over the last five years, Mr McCarthy and continuing Board members Cr Karen Price, Dr Scott Davis, Dr Ruth Stewart, Tracey Jia, Cr Fraser Nai, Brian Woods and Horace Baira have helped in the transformation of our Health Service and have put Torres and Cape HHS in an excellent position. I look forward to building on the work done by the Board as we move into the future.

I would like to welcome our newest Board member, Rhonda Shibasaki. Rhonda is well known in the Northern Peninsula Area and Torres Strait and has worked extensively in the health sector throughout Queensland. Her energy and insight is a welcome addition to the Board.

I would also like to thank the State Government and the Minister for Health and Minister for Ambulance Services The Hon Steven Miles for our ongoing funding to maintain our services and infrastructure works and thank the Commonwealth and State Governments for their continued support.

The main function of hospital and health services is to deliver hospital services, primary and community health services, teaching, research and other services stated in the service agreement. As we continue our diverse and extensive range of services across Cape York, the Northern Peninsula Area and the Torres Strait, we continue to face challenges that affect our social, emotional, environmental, cultural and spiritual health and wellbeing.

If we are serious about Closing the Gap, then we must be serious about addressing the underlying structural factors that widen the gap. These include factors such as social determinants of health, institutional racism, addressing family, domestic and lateral violence and improving access not only to a culturally appropriate primary health care but a culturally safe hospital and health service for all people of Cape York, the Northern Peninsula Area and Torres Strait. Health is more than just a hospital service, it is the social and emotional wellbeing of an individual, of a family, a community and a nation.

To address the structural factors underlying the poor health outcomes of our region, we must first accept that health is everybody's responsibility, including each of us as individuals, and should be a topic for every government and non-government agency. If we are emotional unhealthy, so will be our level of self-esteem.

A lack of emotional health is often the cause of physical disease and mental illness. We need to slow down and deal with what is challenging us. This means you open your heart and feel your emotions and be respectful of other people.

Torres and Cape HHS has completed several important projects as part of a $85.85 million infrastructure plan, an example of the Board's commitment to meeting these challenges, providing health services and support services closer to home.

The Board continued to connect with and engage to our communities and stakeholders throughout 2018-19, with site visits to Thursday Island, Bamaga, Weipa, Cooktown.

Looking ahead, the 2019–20 State Budget saw an increase in our annual budget of more than four times the current inflation rate – a recognition of the unique challenges in delivering services to a diverse region with numerous small and remote communities.

Over the next few years, we will see the implementation of the state-wide Advancing Kidney Care 2026 Plan. Supported by this plan, we are introducing our Western Cape Chronic Kidney Disease Service and establishing a two-chair nurse-assisted unit at Weipa, which will join our existing nurse-assisted dialysis units at Cooktown and Thursday Island. This expansion in renal services is in line with Torres and Cape HHS' decision last year to create a new, dedicated Renal Service to oversee current and future services throughout our region.

We know Aboriginal and Torres Strait Islander Queenslanders are four times more likely to die from chronic kidney disease than non-Indigenous Queenslanders, so, it's important that we have extra capacity to deliver services, including education and prevention, right here in the Torres and Cape HHS region.

We have also commenced planning for the return of a birthing service to Weipa.

We will also see the establishment of a cardiac outreach service for Cape York, Northern Peninsula Area and Torres Strait communities from the hub sites of Weipa, Cooktown and Thursday Island.

These new services are in addition to our existing wide-ranging services, which we will continue to grow and expand as required.

I would like to thank the Board for their ongoing commitment to the region and our staff and Executive for the excellent work they do to improve the health advancement of the people of Cape York, the Northern Peninsula Area and Torres Strait.

Eso,
Elthies (Ella) Kris
Board Chair

MESSAGE FROM THE CHIEF EXECUTIVE

It has been a challenging but successful year for the Torres and Cape Hospital and Health Service. In my first full year as Chief Executive, I am proud to say that we have improved in our performance, and we have built new infrastructure and services that will allow us to treat more of our patients closer to home.

The Torres and Cape HHS has launched its Strategic Plan (2019-2023), which gives us a clear vision for the next four years.

The plan focuses on:

- excellence in healthcare
- advancing health through strong partnerships
- a safe, engaged, valued and skilled workforce and
- a well-governed organisation

The introduction of the roles of Executive Director of Aboriginal and Torres Strait Islander Health and Executive Director of Allied Health in January and February 2019, has led to a strengthening of our workforce structure from entry to executive level.

In February 2019, our Clinical Services Plan was endorsed by the Executive and the Board. This important document gives Torres and Cape HHS a clinical roadmap for the next 10 years, identifying the key issues and health needs in our community, and how to best respond to them.

In 2018-19, we have delivered a greater volume of planned and unplanned care services, there are improvements in the times and lengths of stay in our Emergency Departments, and more patients were treated, and treated in time, in both gastro-intestinal endoscopy and elective surgery procedures.

We have continued to deliver health care by the right people, with the right skills, at the right place and the right time. A great example of this is the expansion of telehealth services that are now available to our patients. In partnership with Cairns and Hinterland HHS, we completed an Orthopaedic Telehealth trial from Cooktown Hospital, a first for the region, and the Torres Strait Dental telehealth project has seen the introduction of the first online oral health training program for remote primary health personnel.

This year saw an improvement in renal services in Torres and Cape HHS. Nearly one third of our adult population is identified as having some form of kidney disease, a reminder of the challenge we face and the reason for our commitment to improving renal services at every level. In December 2018, the self-care renal haemodialysis unit was opened at Thursday Island Hospital, allowing patients to dialyse themselves at times that better suited them. Looking to the future, Torres and Cape HHS will introduce a full-time, nurse-assisted dialysis unit in Weipa, which will be a major benefit to the residents of Western Cape York.

I am very proud of the way that our staff worked together to prepare for and recover from the extreme weather events we faced this year.

Three tropical cyclones – Owen, Penny and Trevor – crossed the coast, causing widespread damage to our communities. I congratulate and thank all of our staff that were involved; your resilience and continued focus on patient care is a strength and credit to our Health Service.

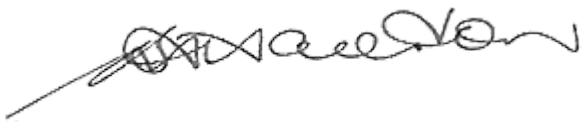
Despite the challenges of natural disasters, we have completed a range of capital works throughout the region as part of a $85.85 million infrastructure plan, including the redevelopment of the Aurukun Primary Health Care Centre (PHCC). Local community members were employed as part of the redevelopment and the waiting room was redesigned to meet the community's cultural requirements. Since completion, the number of permanent staff at Aurukun has increased from three to nine, improving continuity of care for our patients and keeping jobs in the local community. Planning and design is also underway for the $46 million redevelopment of Thursday Island Hospital and Primary Health Centre, along with the refurbishments of PHCCs on Poruma, Dauan, Ugar, Masig, Moa and Mer Islands.

Off the back of our investment in infrastructure and services, Torres and Cape HHS spent $228.55 million for the year, recording a small, planned deficit of $400,000. We have achieved considerable growth in overall revenue, which we will continue to invest in our communities.

Finally, and most importantly, thank you to all of our staff for their tireless efforts to maintain the highest standards of service to our communities. It is important for me to highlight that many of the initiatives and projects that are being implemented in Torres and Cape HHS have been put forward by our own staff and are the foundations of a positive culture. These projects are being internally driven, and the enthusiasm of our staff is exceptional in circumstances that are made more challenging by the geographical elements of our region.

It is with great pleasure that I present to you Torres and Cape Hospital and Health Service's 2018-19 Annual Report.

Yours Sincerely,



Beverley Hamerton
Chief Executive

HIGHLIGHTS OF THE YEAR

JULY

Torres and Cape HHS Consumer Advisory Group expanded

16 patients flown to Weipa for life changing hearing health surgery under new ENT program

AUGUST

500 pairs of thongs donated for remote patients to wear when travelling

SEPTEMBER

Torres and Cape HHS wins four out of six awards at CRANAplus national conference

Aurukun redevelopment completed

New nursing and midwife graduates start with the Health Service

July 2018 | August 2018 | September 2018

JULY – 16 Aboriginal and Torres Strait Islander patients from Cape York had life-changing hearing health surgery

The program is a partnership between CheckUP, the Torres and Cape HHS, the Clinical Excellence Division of Queensland Health and ENT surgeon Dr Tuan Pham from the John James Foundation. The 16 patients were referred for surgery out of a cohort of 90 patients who underwent audiology assessments at specialist outpatient clinics in Cooktown, Weipa and Lockhart River in May and early June. The surgery means they will be better able to listen, learn, and engage with their family, teachers and peers. The 30-minute procedure gives them the opportunity to have a more productive, healthier, happier future than they may have had otherwise.

SEPTEMBER – $6.7 million Aurukun Primary Health Care Centre Redevelopment

Beginning in September 2017, the redevelopment of the Aurukun PHCC addressed an acute shortage of clinical space, while creating a more welcoming environment in the waiting area that met the cultural requirements of the local community. Eight self-contained accommodation units were also constructed for staff, while five of the existing accommodation spaces were refurbished. Local community members were employed as part of the redevelopment, contributing to the local economy. Permanent staff numbers at Aurukun has increased from three to nine since the redevelopment was completed.

OCTOBER

Thursday Island Hospital receives network upgrades

Health Minister visits Torres and Cape region

Rheumatic Heart Disease becomes a notifiable condition

DECEMBER

Thursday Island self-care renal service opens

Severe TC Owen crosses over Kowanyama

287 MMR vaccinations in response to a mumps outbreak

Torres and Cape HHS nominated for QH Excellence award

NOVEMBER

Severe Tropical Cyclone Owen crossed the east coast

First Torres and Cape HHS Renal Summit held

First ever Spinal Rehab telehealth appointment in Torres Strait

October 2018 | November 2018 | December 2018

NOVEMBER – First Renal Summit Held by Torres and Cape HHS

An initial draft plan that will set the direction into the future of renal services within the Torres and Cape HHS will be distributed to stakeholders in January. The development of a draft renal services plan was a major outcome of the Torres and Cape HHS's first renal summit held in Cairns on 27 November 2018 and attended by more than 30 participants. In tandem with the development of a renal plan, Torres and Cape HHS also has created a new, dedicated Renal Service to oversee current and future services in the region.

HIGHLIGHTS OF THE YEAR

JANUARY

TC Penny crosses just south of Weipa

Successful Polio program achieves 75% coverage in Northern Torres Strait

IVMS system installed in all Torres and Cape HHS vehicles

Executive Director of Aboriginal and Torres Strait Islander Health recruited

FEBRUARY

Kowanyama nurses quarters completed

First tele-urology appointment for TCHHS

Development of Clinical Services Plan completed

Executive Director of Allied Health recruited

MARCH

Severe TC Trevor crosses at Lockhart River

Cellulitis study led by TCHHS

January 2019 | February 2019 | March 2019

March – Severe Tropical Cyclone Trevor

Severe Tropical Cyclone Trevor crossed the Queensland coast on 19 March 2019.

Luckily, there were no fatalities, injuries, and no significant damage to our health centres from Tropical Cyclone Trevor.

Staff from Aurukun, Lockhart River and Coen all put in an extraordinary effort to help keep our patients and communities safe.

APRIL

Lockhart River PHCC recognised for excellent healthcare testing

MAY

New Torres and Cape HHS Board Chair Elthies (Ella) Kris appointed

JUNE

myHR goes live in Torres and Cape HHS

10th edition of the *Primary Clinical Care Manual* launched

Cooktown doctor Ebonney van der Meer wins RDAQ award for outstanding registrar

Executive Director of Workforce and Engagement appointed

Health Practitioner project - 13 Aboriginal and Torres Strait Islander participants complete training

April 2019 | May 2019 | June 2019

MAY – New Board Chair Appointed

Ella brings more than 20 years of experience within the health industry and through volunteering within her community to lead, support and empower health changes within community.

Ella is a proud Torres Strait Islander woman, with cultural connection to the land and sea from her father from Mabuiag, Saibai and St Pauls and her mother from Mer and Erub. She carries and lives by her mother's totem Serar (tern bird). "I am passionate about serving the people of Cape York, the Northern Peninsula Area and Torres Strait and am humble that I will be able to do so," Ella said.

ABOUT US

The Torres and Cape Hospital and Health Service covers an area of 129,770 square kilometres. We serve communities that are widely spread across Cape York, the Northern Peninsula Area and the Torres Strait Islands. Torres and Cape HHS is comprised of 31 primary health care centres, two hospitals, a multi-purpose health service and an integrated health service. Sixty-four percent of the population in the region identify as Aboriginal and/or Torres Strait Islander. Torres and Cape HHS is one of Australia's largest providers of health services to Aboriginal and Torres Strait Islander peoples.

STRATEGIC DIRECTION

The *Torres and Cape Hospital and Health Service Strategic Plan 2019-2023* was developed based on extensive collaboration with our staff and community. It sets the future directions and actions for Torres and Cape HHS to meet the healthcare challenges and opportunities of our region.

OUR VISION

Leading connected healthcare to achieve longer, healthier lives.

OUR PURPOSE

Deliver health services that maximise potential for wellness by:

- Ensuring seamless patient journeys
- Embracing cultural diversity
- Collaborating and connecting with communities and agencies
- Enhancing the capacity and capability of the workforce
- Maximising the use of technology

OUR VALUES

TCHHS supports and upholds the Queensland Public Service values:

- Customers first
- Ideas into action
- Unleash potential
- Be courageous
- Empower people

OUR PRIORITIES

- Excellence in Healthcare: Health care delivered by the right people with the right skills at the right place and the right time.
- Advance health through strong partnerships: Partner to optimise health and wellbeing in our communities.

- A safe, engaged, valued and skilled workforce: Inspire a culture that values collaboration, challenges the norm and promotes a welcoming workplace.
- A well governed organisation: Efficient, productive and responsive governance structures.

Outer Islands: Community Clinics

Badu	Mer (Murray Island)
Boigu	Moa (St Pauls & Kubin)
Dauan	Ngurupai (Horn Island)
Erub (Darnley Island)	Poruma (Coconut Island)
Iama (Yam Island)	Saibai
Mabuiag	Ugar (Stephen Island)
Masig (Yorke Island)	Warraber

Island Medical Service
Umagico
Injinoo

Northern Sector
Northern leadership team

Mapoon
Community Clinic

Weipa
Multipurpose Health Service

Napranum
Community Clinic

Southern Sector
Western leadership team

Arukun
Community Clinic

Pormpuraaw
Community Clinic

Kowanyama
Community Clinic

Thursday Island
Hospital
Community Clinic

Bamaga
Community Hospital

Lockhart River
Community Clinic

Coen
Community Clinic

Southern Sector
Eastern leadership team

Hope Vale
Community Clinic

Cooktown
Multipurpose Health Service

Laura
Community Clinic

Wujul Wujul
Multipurpose Health Service

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

The Torres and Cape Hospital and Health Service has the largest percentage (64%) of people in Queensland identifying as Aboriginal and Torres Strait Islander as well as the greatest diversity of Traditional Owner Groups.

There are approximately 18,000 Aboriginal and Torres Strait Islander residents in our communities from over 60 different Traditional Owner Groups. Across these Traditional Owner Groups are different languages and cultural practices which are both strong protective factors for reducing the risks of poor health.

However, there is also a broad health inequity across these Aboriginal and Torres Strait Islander populations. More than two-thirds of disease burden come from six leading broad cause contributors:

- cardiovascular disease
- diabetes
- mental health
- chronic respiratory disease
- cancer
- intentional injuries

NEW EXECUTIVE DIRECTOR OF ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Venessa Curnow began in the role on 28 January 2019. She is an Ait Koedal and Sumu woman with links to Saibai Island, as well as to Keith in South Australia. She is the professional lead for all Aboriginal and Torres Strait Islander Health Practitioners and Health Workers within Torres and Cape HHS, advocates for ways to increase the number of Indigenous peoples working in the Health Service and improve the skills and career opportunities for those already working with us.

Venessa is also a board member of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives and the National Congress of Australia's First Peoples.

STRONGER MOB, LIVING LONGER

Torres and Cape HHS is part of a joint planning initiative for a health plan for Aboriginal and Torres Strait Islander people across the Far North, involving five Aboriginal community controlled health organisations, Cairns and Hinterland Hospital and Health Service, Check-Up Australia, Royal Flying Doctor Service, Northern Queensland Primary Health Network, Queensland Aboriginal and Islander Health Council and the Northern Aboriginal and Torres Strait Islander Health Alliance.

The plan identifies six priorities where action is needed from all partners to improve the health and wellbeing of Aboriginal people and Torres Strait Islanders in Far North Queensland:

- Improved integration of services;
- More efficient patient transport;
- Recognising the importance of the social determinants of health;
- Better access to, and sharing of, data and information across providers;
- More coordinated, collaborative approach to Aboriginal and Torres Strait Islander workforce development, attraction and retention
- Renewed focus on promotion, prevention and public health.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONER PROJECT

A partnership between the Rural and Remote Clinical Support Unit (RRCSU) and the Workforce Strategy Branch supported the implementation of the Aboriginal and Torres Strait Islander Health Practitioner role with Torres and Cape HHS. A Manager and a Clinical Nurse Consultant were engaged to draft a robust clinical governance framework including assessment and monitoring frameworks to support the implementation of the Aboriginal and Torres Strait Islander Health Practitioner role within Hospital and Health Services. The project has achieved the following outcomes:

- Clinical competency assessments conducted on all 13 Aboriginal and Torres Strait Islander Health Practitioner candidates
- A draft practice plan was completed with each candidate
- Two medication units of competency were delivered – 'Work with Medicines" and 'Safe Use of Medicines" delivered by TAFE Queensland
- A three-day medication upskilling workshop was conducted
- CPR training was delivered to nine candidates as an essential component of the annual required training for Health Workers

PROGRAMS FUNDED FOR ABORIGINAL AND TORRES STRAIT ISLANDER RESIDENTS

In 2018-19 $3.6 million in funding was provided to the Torres and Cape HHS under the *Making Tracks Investment Strategy 2018-2021*, and the *North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan 2016-2021*. The funding is administered by the Aboriginal and Torres Strait Islander Health Branch.

With this funding, the Health Service is undertaking a number of initiatives and projects.

These include:

- Torres Strait Hostel - Meriba Mudh
- *Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033— Torres Strait and Cape York*
- Health Practitioner Workforce Leadership Project
- Northern Peninsula Area Maternal and Infant Service
- Outreach Maternal Health Service
- Child and Youth Mental Health Service - Aurukun

- Transition to Community Control Project
- Women's Health Program
- Aboriginal and Torres Strait Islander Sexual Health Men's program
- Improving Sexual Health – Supporting Syphilis Outbreaks in Remote Indigenous Communities
- Enhanced Sexual Health services in Torres Strait and Northern Peninsula Area

KEY INDICATORS

PROPORTION OF WOMEN WHO ATTENDED FIVE OR MORE ANTENATAL VISITS

Our health service achieved a high level of performance (as at March 2019 FYTD) with 97.1 per cent of Torres and Cape Indigenous women attending five or more antenatal visits in 2018-19.

IMMUNISATION

Immunisation is highly effective in reducing morbidity and mortality. In 2018-19 the health service achieved excellent levels of immunisation for Aboriginal and Torres Strait Islander children and met or exceeded state-wide targets with 99.3 per cent of the region's Aboriginal and Torres Strait Islander children under five years of age fully immunised.

DISCHARGE AGAINST MEDICAL ADVICE

In 2018-19, 2.2 per cent of all our region's Aboriginal and Torres Strait Islander resident hospitalisations resulted in discharge against medical advice. Trend data shows that while we are not currently meeting the target of one percent, we are below the state average.

COMPLETED GENERAL COURSES OF ORAL HEALTH CARE

In 2018-19, 1743 Aboriginal and Torres Strait Islander people had a completed general course of oral health care, 715 less than the previous period.

OUR COMMUNITY BASED AND HOSPITAL-BASED SERVICES

The Torres and Cape HHS is responsible for the delivery of local public hospital and health services in the geographical area stretching from Boigu Island in the north of the Torres Strait to Wujal Wujal to the south on the east coast and Kowanyama in western Cape York.

Torres and Cape HHS is responsible for the direct management of the facilities within its geographical boundaries including:

- Aurukun Health Service
- Badu Island Primary Health Care Centre
- Bamaga Hospital
- Bamaga Primary Health Care Centre
- Boigu Primary Health Care Centre
- Coen Primary Health Care Centre
- Cooktown Multi-Purpose Health Service
- Dauan Primary Health Care Centre
- Erub (Darnley Island) Primary Health Care Centre
- Iama (Yam Island) Primary Health Care Centre
- Hope Vale Primary Health Care Centre
- Kowanyama Primary Health Care Centre
- Kubin Primary Health Care Centre
- Laura Primary Health Care Centre
- Lockhart River Primary Health Care Centre
- Mabuiag Island Primary Health Care Centre
- Mapoon Primary Health Care Centre
- Masig (Yorke Island) Primary Health Care Centre
- Mer (Murray Island) Primary Health Care Centre
- Napranum Primary Health Care Centre
- New Mapoon Primary Health Care Centre
- Ngurapai (Horn Island) Primary Health Care Centre
- Pormpuraaw Primary Health Care Centre
- Poruma (Coconut Island) Primary Health Care Centre
- Saibai Primary Health Care Centre
- Seisia Primary Health Care Centre
- St Pauls Primary Health Care Centre
- Thursday Island Hospital
- Thursday Island Community Wellness Centre
- Thursday Island Primary Health Care Centre
- Ugar (Stephen Island) Primary Health Care Centre
- Umagico Primary Health Care Centre
- Warraber (Sue Island) Primary Health Care Centre
- Weipa Integrated Health Service
- Wujal Wujal Primary Health Centre

ABOUT US

Thursday Island Hospital is a Level 3 facility providing moderate-risk inpatient and ambulatory care clinical services. Weipa Integrated Health Service and Cooktown Multi-Purpose Health Service (MPHS) are Level 3 facilities providing low to moderate-risk inpatient and ambulatory care. Bamaga Hospital provides low risk inpatient and ambulatory clinical care services. Torres and Cape HHS residents access highly complex care at Townsville or Brisbane; while the majority of all but the most highly complex patients and procedures are managed at Cairns Hospital.

The office in Cairns hosts Torres and Cape HHS' business, finance, human resources, patient safety, quality, performance and planning, and some clinical outreach services. The significant regional hubs are located in Cooktown, Weipa, Bamaga and Thursday Island.

SERVICES

Our services include emergency, primary health and acute care, medical imaging, oral health, maternity, aged care, allied health, palliative and respite services, and visiting specialist services. Torres and Cape HHS provides a number of services through a mixed model of locally located services and visiting teams including mental health, oral health and BreastScreen.

We support a wide range of healthcare providers including outreach teams and visiting specialist services from other health services and non-government providers.

PARTNERSHIPS

Torres and Cape HHS maintain agreements and close working partnerships with local health care organisations:

- Northern Queensland Primary Healthcare Network (NQPHN)
- Apunipima Cape York Health Council
- Northern Peninsula Area Family and Community Services Aboriginal and Torres Strait Islander Corporation
- Royal Flying Doctor Service
- Cairns and Hinterland HHS
- Centre for Chronic Disease, Australian Institute of Tropical Health and Medicine – James Cook University.

We support a wide range of healthcare providers including outreach teams and visiting specialist services from other health services and non-government providers. Torres and Cape HHS works in collaboration with visiting specialists including paediatricians, ophthalmologists, renal specialists and surgeons who use the HHS facilities and typically travel from Cairns.

RURAL AND REMOTE CLINICAL SUPPORT UNIT

The RRCSU provides support services for Queensland's rural hospitals and health services (HHSs), primarily Torres and Cape, Central West, North West and South West. The unit supports these services to provide quality rural and remote healthcare through the provision of clinical resources, training, credentialing, medical advisory and medical employment support. On request, support is available for all HHSs with rural and remote facilities. The RRCSU was developed in response to the need to provide governance and support services to the smaller rural and remote HHSs. The Unit has been hosted by Torres and Cape Hospital and Health Service since 2012.

COMMUNITY ENGAGEMENT

The Torres and Cape HHS Consumer Advisory Committee (CAC) was formed in August 2017 and meets quarterly to provide consumer advice on improving health services.

The Committee is an integral part of the organisation and is involved in co-designing key services and programs with Torres and Cape HHS staff and leaders to ensure that care is person-centred and culturally appropriate and meets the person's holistic needs (physical, emotional, spiritual, cultural, financial, family, community) and work as partners in planning, design, delivery, measurement and evaluation of systems and services within the Hospital and Health Service.

To date, the Consumer Advisory Committee has been involved and provided consumer input into the Clinical Services Plan, Strategic Plan, infrastructure projects and many other aspects of service delivery including how to talk about end of life care with patients.

In early June, Mr Robert Tamwoy (Chair) and Isobel Moase, the Health Service's Quality Coordinator, presented an important body of work at the 2019 Health Consumers Queensland forum. The CAC and Isobel worked with the Office of Advance Care Planning to change the Statement of Choices outer cover sheet to be more user-friendly and explain Advance Care Planning in a more consumer-centred way.

The Weipa Community Consultative Network meets quarterly and comprises a range of community representatives. It is chaired by the Weipa Town Authority Chair and secretariat functions are provided by the Manager of Community Services at Weipa Integrated Health Service. Senior staff from the Weipa IHS attend and provide reports to the committee on health service performance.

The Cooktown Community Advisory Network meets every month and has representation from other government agencies and the community. The Chair is a community representative and senior staff from Cooktown Multi-purpose Health Service attend, report to the committee and provide secretariat functions.

Torres and Cape HHS is proudly setting new levels of community engagement for new health infrastructure in the region. By talking with communities about their ideas and needs, Torres and Cape HHS is able to add 'cultural character' to future building designs. We have teamed up with councillors, prescribed body corporates, community representatives, Elders, youth groups, women's groups and Traditional Owners to progress these vital works.

Torres and Cape HHS manages its operations in consideration of a variety of strategic risks and opportunities.

TARGETS AND CHALLENGES

OUR TARGETS:

- Delivering care closer to home.
- Building, nurturing and sustaining relationships based on trust and purposeful partnerships.
- Implementing a robust performance and accountability framework to demonstrate important improvements.
- Establishing foundations for optimal digital health delivery and business solutions.

OUR CHALLENGES:

- Our community experiences a range of chronic and complex conditions, including higher than average rates of smoking during pregnancy, adult obesity, daily smoking, and alcohol consumption.
- Our average age at death is 61 years, which 19 years below the state average.
- Each of our communities has its own identity, its own history and its own needs.
- We service the unique health needs of our diverse population and have the highest proportion of Aboriginal and Torres Strait Islander population of any HHS in the State.
- Our physical environment provides challenges to accessibility and the delivery of services.

BOARD MEMBERSHIP

MR ROBERT (BOB) MCCARTHY AM

Board Chair

(Appointed 1/7/2014) (Term ended 17 May 2019)

Mr McCarthy has more than 30 years' experience in high-level positions in the private sector, as well as Federal and Queensland governments. He has a wealth of experience as a member and chairman of a number of statutory boards and corporations.

Mr McCarthy holds a Bachelor of Economics degree (honours) has been a Fellow of the Australian Institute of Management and a member of the Australian Institute of Company Directors. Mr McCarthy was Chair of the Board, Chair of the Executive Committee, and a member of the Finance and Performance Committee up until 17 May 2019.

MS ELTHIES (ELLA) KRIS

Board Chair

(Appointed 18/5/2019) (Current term 18/5/2019 to 17/5/2022)

Ms Kris is a proud Torres Strait Islander woman, with cultural connection to the land and sea from her father from the Mabuiag, Saibai and St Pauls and her mother from Mer and Erub. She carries and lives by her mother's totem Serar (tern bird). Ms Kris brings more than 20 years of experience within the health industry, including corporate, primary health care and public health and through volunteering with Torres Shire Council to lead, support and empower health changes within her community of Thursday Island. In addition to chairing the Board, her current role includes developing,planning and implementing sustainable health related activities within Torres Strait Island Regional Council communities.

Ms Kris has a Graduate Diploma in Indigenous Health Promotion and a Master of Public Health. Ms Kris is Chair of the Board, Chair of the Executive Committee, and a member of the Finance and Performance Committee.

ASSOCIATE PROFESSOR, DR RUTH STEWART

Board Member

(Appointed 12/12/2014) (Current term 18/05/2018 to 17/05/2020)

Dr Stewart is Associate Professor of Rural Medicine and Director, Rural Clinical Training and Support at James Cook University.

She also has been a member of the Cape York HHS board since 2012 and the Torres and Cape HHS board. Dr Stewart is a member of the Executive, Audit and Risk, and Safety and Quality Committees.

MRS TRACEY JIA

Board Member

(Appointed 01/07/2014) (Current term 18/05/2018 to 17/05/2020)

From 2012-2014, Mrs Jia was a member of the Cape York HHS Board and has been a member of the Torres and Cape HHS Board since 2014. She is well regarded for her recent work with the Department of Communities, Child Safety and Disability Services where she assisted people with a disability and their families in Weipa and the West Cape communities of Aurukun, Napranum and Mapoon.

Mrs Jia is a member of the Executive Committee and the Audit and Risk Committee.

COUNCILLOR TED (FRASER) NAI

Board Member

(Appointed 01/07/2014) (Current term 18/05/2018 to 17/05/2020)

As a member of the Torres Strait Island Regional Council and respected councillor for Masig (Yorke) Island, Mr Nai brings leadership and local government experience, as well as a wealth of local knowledge to the role.

Mr Nai is a member of the Executive Committee and the Safety and Quality Committee.

MR HORACE BAIRA

Board Member

(Appointed 19/01/2015) (Current term 18/05/2019 to 17/05/2021)

Mr Baira is a member of the Torres Strait Regional Authority and was previously a member of the Torres Strait Island Regional Council as the Councillor for Badu.

He is committed to delivering better services to his community and to preserving the environment. He will provide strong local input to the board. Mr Baira is a member of the Finance and Performance Committee and the Safety and Quality Committee.

MR BRIAN WOODS

Board Member

(Appointed 19/01/2015) (Current term 18/05/2019 to 17/05/2021)

Mr Woods has a 35-year career in business and financial management, with over 10 years recent executive-level experience in enabling and applying high standards of corporate governance, statutory compliance, policy, strategy and business performance across the region. He is the director/owner of DFK Kidsons, a public accountancy practice based in Cairns and is head of DFK Kidsons Indigenous practice. Mr Woods believes in future-focused business partnership and relishes the opportunity to contribute to client success. Mr Woods is a Certified Practicing Accountant, Fellow of CPA Australia and Graduate Member of the Australian Institute of Company Directors. Mr Woods is Chair of the Finance and Performance Committee and is a member of the Audit and Risk Committee. He brings extensive financial, business and management expertise to the Torres and Cape HHS Board.

COUNCILLOR KAREN (KAZ) PRICE

Board Member

(Appointed 11/12/2015) (Current term 18/05/2017 to 17/05/2020)

Ms Price lives in Cooktown and has been involved in community and regional-based roles including management of regional projects in that town for the past 12 years. She is currently Director of the Cooktown District Community Centre and is a Councillor with Cook Shire Council with portfolios across community, arts and education. Ms Price previously worked for Cape York Hospital and Health Service as manager of the Learning and Development Unit. Ms Price is Chair of the Audit and Risk Committee, and a member of the Executive Committee.

DR SCOTT DAVIS

Board Member

(Appointed 18/05/2016) (Current term 18/05/2017 to 17/05/2020)

Dr Davis has worked in regional development and Indigenous health and is committed to addressing the social determinants of health for rural and remote Indigenous committees. He has more than 25 years experience in senior leadership roles within the health, education and research sectors and more than 20 years of board experience. Dr Davis is currently co-leading an international development project in PNG, is a committee member of the Regional Development Australia's FNQ&TS sector, and is actively involved with the local communities. He holds a doctorate in Indigenous Community Capacity Development and a Masters in International Public Health. Dr Davis is Chair of the Safety and Quality Committee and a member of the Finance and Performance Committee.

MS RHONDA SHIBASAKI

Board Member

(Appointed 18/05/2019) (Current term 18/05/2019 to 31/03/2022)

Ms Shibasaki has worked extensively in the health sector throughout Queensland in urban, regional and remote communities since 2008. She has undertaken various executive roles and is experienced in leading change management processes at board, corporate, clinical and service provision levels. Ms Shibasaki is recognised for introducing management and system reforms in several community health organisations. As the operator of two businesses in the surrounding areas of Thursday Island, Ms Shibasaki brings proven leadership and local knowledge. She is committed to being involved in addressing health issues within community. Ms Shibasaki is a member of the Audit and Risk Committee and the Finance and Performance Committee.

MS TINA CHINERY

(Appointed 18/05/2018) (term ended 17 May 2019)

Ms Chinery is the Executive Director of Cairns Services at Cairns and Hinterland Hospital and Health Service. Tina is an experienced chief operating officer with a demonstrated history of working in the hospital and health care industry. Ms Chinery is skilled in government, program evaluation, strategic planning, organisational development and stakeholder management. She has a Masters of Public Administration and qualifications from Australian Institute of Company Directors. Ms Chinery was a member of the Finance and Performance Committee and Safety and Quality Committee.

ROLE OF THE BOARD

Members of the Board contribute a solid mix of skills, knowledge and experience, including primary health care, health management, clinical expertise, financial management and business experience. All members either reside in the area or have substantial community and business connections with the various Torres Strait, Northern Peninsula Area and Cape York communities and have a first-hand knowledge of the health consumer and community issues of the region.

In accordance with the *Hospital and Health Boards Act 2011*, the Board ensures appropriate policies, procedures and systems are in place to optimise service performance, maintain high standards of ethical behaviour and, together with the Health Service Chief Executive, provide leadership to the Service's staff. The Board meets monthly and determines strategy, monitors performance and makes strategic decisions. Board decision-making is supported by Board briefing papers and presentations by senior managers to inform the Board members of current and forthcoming strategic, operational and performance issues including service delivery, safety and quality, finances, human resources and risk management.

Between Board meetings, the Board has delegated authority to the Chair to act on behalf of the Board in appropriate circumstances. There is continuing and extensive contact between the Chair and the Health Service Chief Executive to discuss major policy, strategic and operational matters. As part of its commitment to achieving best practice corporate governance, the Board has implemented a formal and transparent process for assessing and evaluating the performance of the Board, including individual members.

Name of committee	Number of Board members	Number of external members	Role in supporting the Board	Number of meetings held in 2018-19
Executive Committee	4		Monitoring the Health Service's overall performance and working with Service's Chief Executive in responding to critical emergent issues requiring urgent decision making	6
Safety and Quality Committee	6		Monitoring governance relating to safety and quality of health services	6
Finance and Performance Committee	5		Monitoring financial budgets and performance	8
Audit and Risk Committee	6	1	Monitoring internal controls, external audits and risk management	6

* Finance and Performance Committee had four members up until 27 June 2019 when a fifth member was added.
**Audit and Risk Committee had five members up until 27 June 2019 when a sixth member was added.

	Board Meeting	Audit & Risk	Finance & Performance	Safety & Quality	Executive
Ella Kris	2 of 2	N/A	N/A	N/A	N/A
Tracey Jia	9 of 11	5 of 6	N/A	N/A	3 of 5
Ruth Stewart	10 of 11	4 of 6	N/A	3 of 6	2 of 5
Fraser Nai	10 of 11	N/A	N/A	4 of 6	N/A
Horace Baira	7 of 11	N/A	8 of 8	4 of 6	N/A
Brian Woods	9 of 11	3 of 6	7 of 8	N/A	N/A
Scott Davis	9 of 11	N/A	7 of 8	6 of 6	N/A
Karen Price	9 of 11	6 of 6	N/A	5 of 6	N/A
Rhonda Shibasaki	2 of 2	N/A	N/A	N/A	N/A
Tina Chinery	9 of 11	N/A	4 of 8	5 of 6	N/A
Bob McCarthy	8 of 11	N/A	7 of 8	N/A	4 of 5

The Board has approved each Committee's specific Terms of Reference and Business Rules. The total out of pocket expenses paid to the Board Members during 2018-19 was $3269.32.

EXECUTIVE MANAGEMENT

HEALTH SERVICE CHIEF EXECUTIVE

Beverley Hamerton

Beverley Hamerton has been the Torres and Cape Hospital and Health Service (TCHHS) Chief Executive since April 2018. She was the TCHHS Executive General Manager South from July 2017 to March 2018.

Ms Hamerton has considerable experience in rural and remote area health service planning and delivery from both a clinical and executive perspective.

Her passion is to ensure that all people, regardless of where they live, have access to high quality, equitable health care, and is focused on improving the health and wellbeing of both individual groups and whole communities.

EXECUTIVE DIRECTOR - CORPORATE SERVICES

Dean Davidson

Mr Davidson has worked for the TCHHS for two years and commenced as the Director of Travel, Contracts and Procurement. Prior to working for TCHHS, previous positions held have been General Manager of Community and Regional Planning and Manager of Plant and Facilities within Local Government for eight years.

Mr Davidson has a Master's degree in business administration from the University of Otago and majored in Business Logistics, Business Administration and Economics at the University of Natal.

CHIEF FINANCE OFFICER

Danielle Hoins

Danielle Hoins is a qualified CPA Accountant with more than 10 years experience in financial and corporate services management in the Queensland health sector. Ms Hoins expertise is in strategic and change management, and the development and implementation of corporate governance systems.

Ms Hoins has managed all areas of corporate services, including financial services, human resource management, occupational health and safety, infrastructure services, travel services, contracts and procurement and information management. Other qualifications include; Advanced Leadership Program, Graduate Certificate in Public Sector Management and Bachelor of Commerce.

EXECUTIVE DIRECTOR - MEDICAL SERVICES

Anthony Brown

Dr Tony Brown has practiced as a rural generalist doctor in rural and remote Australia for 30 years. Dr Brown resides on Thursday Island with his wife. He is immensely proud of his four children.

Dr Brown is passionate about equity of resourcing and the delivery of excellent health care to rural and remote Australians and improving the health outcomes of Aboriginal and Torres Strait Islander peoples and strives to improve quality and safety of care in the primary and secondary health care domains. He believes that improvements will only occur through empowering our communities and stakeholders to be partners in delivery of the services that affect them.

EXECUTIVE DIRECTOR - NURSING & MIDWIFERY

Kim Veiwasenavanua

As the professional lead for the Nursing and Midwifery Services division within Torres and Cape HHS since May 2018, Ms Veiwasenavanua has driven and manages Torres and Cape's diverse nursing workforce with strategic intent to enable innovative, advanced, culturally-appropriate, safe, contemporary best practice nursing and midwifery practice in rural and remote FNQ across the entire Torres Straits region and Cape York communities.

Ms Veiwasenavanua possesses an extensive clinical and managerial background with health care experience honed within six countries and across three Australian states. She previously held the position of Executive General Manager - Northern sector and Director of Nursing - Thursday Island Hospital prior to her appointment to the EDNMS role and has worked as a Clinician and Manager in Primary Health Care, Acute Care, Community Care and Residential Aged Care Manager for a 180-bed Aged Care facility.

Ms Veiwasenavanua impressive academic history includes achievement of a Master of Public Health and has held a Nurse Lecturer position in the faculty of the Fiji School of Nursing.

CHIEF INFORMATION OFFICER

David Bullock

David Bullock commenced on 3 September 2018. Mr Bullock is a highly experienced health executive with post graduate degrees in Health Services Management, Science, Technology Studies & Strategy, and Public Health. He has been working in health leadership roles for the Australian Defence Force for several decades. Most recently his career has focussed on implementing eHealth and digitised health solutions.

Mr Bullock is based in our Cairns office.

EXECUTIVE DIRECTOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Venessa Curnow

Ms Curnow is an Ait Koedal Sumu Torres Strait Islander Registered Nurse, she has worked as an Assistant in Nursing, Registered Nurse, Clinical Nurse Consultant and Care Manager in Brisbane and also rural and remote areas of Queensland including Bamaga Hospital, NPA, Thursday Island, and Hope Vale.

Prior to commencing with TCHHS on 21 January 2019, Ms Curnow was the Director of the Aboriginal and Torres Strait Islander Health Management Unit with Cairns and Hinterland Hospital and Health Service.

Ms Curnow is a board member of Congress of Aboriginal and Torres Strait Islander Nurses and Midwives and the National Congress of Australia's First Peoples. She has more than 21 years extensive experience, including 10 years of strategic industry development at the national level and 10 years' experience in Queensland state-wide industry development. Part of this experience included, facilitating more than 40 small not-for-profit Aboriginal and Torres Strait Islander organisations to maintain viability in developing economic conditions, whilst ensuring quality and culturally safe service provision in urban, rural and remote areas.

EXECUTIVE GENERAL MANAGER SOUTHERN SECTOR

Ian Power

Prior to commencing with Torres and Cape HHS in July 2018, Mr Power has held General Manager positions at Illawarra Shoalhaven Local Health District and Griffith Health Service since 2007. He has 26 years' experience in corporate services in the health sector covering strategic planning, performance management, financial and revenue management, change management and operational management.

Most recently, Mr Power was the General Manager of the Illawarra Shoalhaven Hospital Group servicing 390,000 residents, managing a $200 million budget and 950 staff.

EXECUTIVE GENERAL MANAGER NORTHERN SECTOR

Mark Goodman

Mark Goodman is a Registered Nurse who has extensive and varied experience in healthcare management roles in Australia and New Zealand as well as significant remote area experience across South Australia, Queensland and Northern Territory.

Mr Goodman has worked as Integrated Operations and Emergency Manager at Whangarei Hospital, Associate Director of Nursing for Northland District Health Board and more recently as Director of Nursing Southern Primary Health Care Centres for Torres and Cape HHS.
He carries the Executive lead portfolios for NQSTI, the Deteriorating Patient Accreditation standard and Health Pathways project.
Mr Goodman's focus is on provision of culturally appropriate and effective Primary Health Care and building the capacity of our Primary Health Care facilities.

EXECUTIVE DIRECTOR ALLIED HEALTH

Viv Sandler

Viv Sandler started her career as a Physiotherapist and has broad clinical experience in areas including acute hospital care, rehabilitation, community health, aged care and private practice, both in Queensland and Victoria. Ms Sandler has held senior management roles at The Alfred Hospital, Royal Melbourne Hospital and the Department of Human Services, including three years as General Manager of Quality and Elective Surgery at Monash Health in Melbourne. More recently, she has also worked as a physiotherapist in Melbourne, Hervey Bay, Maryborough, Innisfail, Cairns, and short periods in Weipa, Thursday Island, North East Arnhem Land and Lesotho in Africa.

Ms Sandler is a passionate advocate for Allied Health and the role it plays in regional and remote communities in prevention and treatment of disease and injury, and in optimising people's physical and mental well-being. Allied Health have a core and important contribution to make for people from birth to old age, to enhance and improve their health in many ways. Ms Sandler is working amongst the communities and staff in the TCHHS region, to provide support and leadership to enable the best care possible from Allied Health.

EXECUTIVE DIRECTOR
RURAL & REMOTE CLINICAL SUPPORT UNIT (hosted service)

Julie Hale

Prior to commencing with Queensland Health, Julie Hale was Deputy CEO of Women's Healthcare Australasia and Children's Healthcare Australasia, twin not-for-profits with both Australian and international influence. Throughout this past year Julie has been responsible for the piloting and roll out of the Aboriginal and Torres Strait Islander Health Practitioner role for Queensland.

Ms Hale has had an influence on the drafting and modernisation of the new Health (Drugs and Poisons) legislation for Queensland. Julie has also commented on the proposed Nursing & Midwifery Board of Australia (NMBA) Prescribing in Partnership role, a newly envisioned nation-wide endorsement for Registered Nurses. Ms Hale is also a part of the Office of the Chief Nursing and Midwifery Officer (Queensland) Advisory Group for the transition of the national Rural and Isolated Practice Endorsed Nurse (RIPEN) to state based authorisation.

EXECUTIVE DIRECTOR WORKFORCE AND ENGAGEMENT

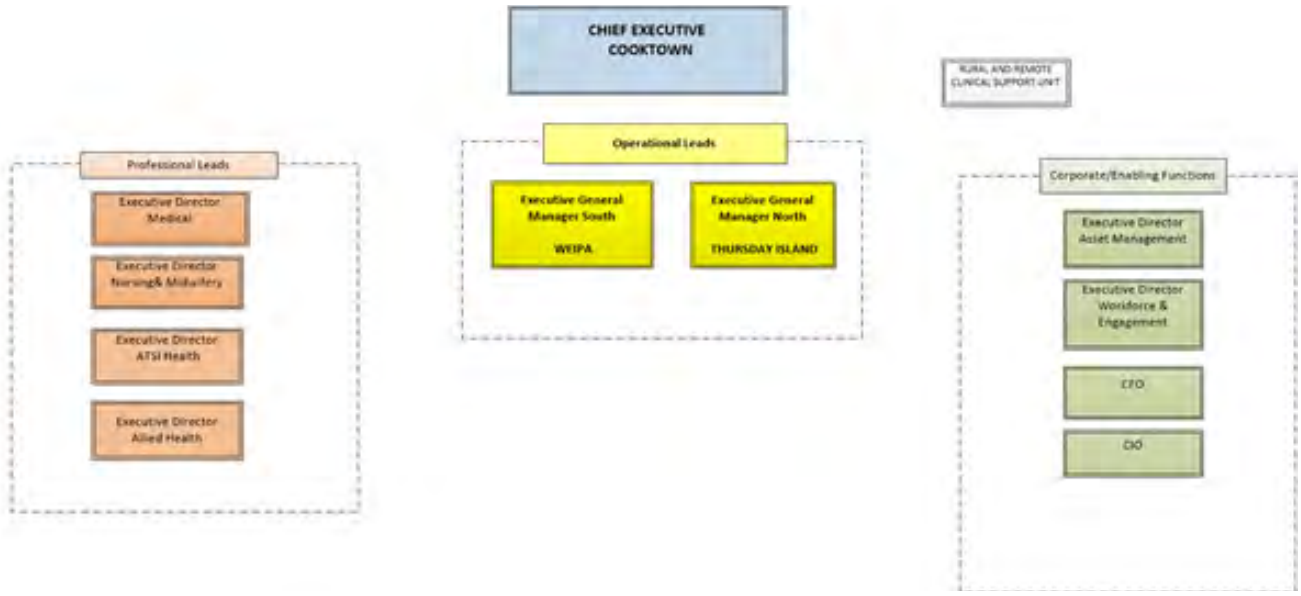
Erica Gallagher

Erica Gallagher's Human Resource career spans over 33 years with significant experience in senior leadership roles. She has worked in the Health Department, State Government Departments and Not for Profit disability sector in Western Australia. Ms Gallagher relocated to Queensland in early 2016 and joined the Public Trustee as the Senior Director Human Resource Services which included Marketing & Communications in her portfolio.

Ms Gallagher is passionate about HR and feels privileged to lead workforce cultural change and uses this as a powerful lever to make a tangible difference to the workforce, while influencing the organisation and providing services to the Queensland community. She is a Fellow Member of the Australian Human Resource Institute (AHRI) and was the WA State President for AHRI and as well as on the QLD AHRI Council.

Ms Gallagher was a finalist in 2017 for the National Dave Ulrich HR Leader Award.

ORGANISATION STRUCTURE AND WORKFORCE PROFILE



The Torres and Cape Hospital and Health Service has set out its workforce planning objectives in its *Strategic Plan 2019-2023*.

Our purpose is to improve the health and wellbeing of people in the Torres Strait, Northern Peninsula Area and Cape York by enhancing the capacity, capability and cohesion of the workforce to better support front line services within our communities.

At June 2019, our Health Service employed full-time equivalent (FTE) staff establishment of 1023.19, an increase of 73.96 staff from 2017-18. A breakdown of these totals is reflected in the tables below.
The permanent separation rate for 2018-19 was 13.85 percent.

The higher than average permanent separation rate is due to a variety of factors, including the remoteness and accessibility of some of our facilities making staff retention difficult.

Torres and Cape HHS is developing a talent management strategy as part of our workforce plan. This strategy will examine the attraction and retention of permanent staff in rural and remote areas.

Table 1: More doctors and nurses*

	2014-15	2015-16	2016-17	2017-18	2018-19
Medical staff	28	30	33	38	42
Nursing staff	290	313	309	348	373
Allied Health staff	50	50	67	72	78

Table 2: Greater diversity in our workforce**

	2014-15	2015-16	2016-17	2017-18	2018-19
Persons identifying as being Aboriginal and/or Torres Strait Islander	162	158	157	176	175

* Workforce is measured in MOHRI – Full-Time Equivalent (FTE).

ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE

In 2018-19, Torres and Cape HHS employed 175 Aboriginal and Torres Strait Islander people (17.5 per cent) across all occupational streams. Torres and Cape HHS will implement an Aboriginal and Torres Strait Islander Workforce Development Strategy to increase the percentage of employment to better reflect the population and help improve inequitable unemployment rates. The current unemployment rate amongst Aboriginal and Torres Strait Islander people living in our catchment is 24.9 percent.

AWARDS AND RECOGNITION

Torres and Cape HHS celebrates the contributions of our staff with annual Recognition Week celebrations. During this time, we acknowledge the commitment of employees who have reached length-of-service milestones. In 2018-19, we recognised more than 115 staff in these awards.

Torres and Cape HHS won four awards at the 36th CRANAplus Annual Conference in September 2018 for:

Excellence in Remote Health Practice Award:
Winner – Natalie Thaiday, Indigenous Nurse Navigator Support Officer, Torres and Cape HHS.

Excellence in Education or Research in Remote Health Award:
Winner – Torres and Cape Nursing and Midwifery Education Team

Excellence in Mentoring Award:
Winner – Josh Stafford, Director of Nursing (Lockhart River and Coen)

Collaborative Team Award:
Nurse Navigator Team, Torres and Cape HHS

Dr Ebony van der Meer received the Denis Lennox Medal for *Outstanding Rural Generalist Registrar* at the June 2019 Rural Doctors Association of Queensland (RDAQ) annual conference.

In June 2019, the Regional eHealth Project's 'River Sentiment Tracker' was a finalist in the Queensland Health eAwards.

STRATEGIC WORKFORCE PLANNING AND PERFORMANCE

WORKFORCE DIVERSITY

Torres and Cape Hospital and Health Service continues its commitment to diversity, inclusion and equity in the workplace and continues to encourage and facilitate conversations regarding contemporary flexible working arrangements supporting a healthy work-life blend for all staff.

Employees have access to an Employee Assistance Program (EAP) provided by Optum. The program provides confidential counselling and support to employees and provides information, advice and support to help improve wellness and wellbeing. In addition, the EAP provides a dedicated online service to provide professional advice on financial issues impacting on an individual's wellbeing.

The Torres and Cape HHS supports employees to access financial seminars on salary packaging and superannuation seminars to assist their understanding of retirement preparation and income protection.

CODE OF CONDUCT

As required by the *Public Service Ethics Act 1994*, the Code of Conduct in the Queensland Public Service has been in place since 2011 and applies to all Torres and Cape HHS employees. We support and uphold the Queensland Public Service Values. Staff are required to complete mandatory ethics, integrity and accountability online training annually to support an understanding of their obligations under the *Public Sector Ethics Act 1994*.

INDUSTRIAL RELATIONS

Torres and Cape HHS has engaged constructively in 2018-19 with industrial unions representing a diverse workforce. Torres and Cape HHS and the unions jointly recognise the importance of good union-management relations. We have a shared interest in working together to support a healthy and productive workplace and ensuring that the public continues to receive a quality service.

RECRUITMENT INITIATIVES

Torres and Cape HHS recruitment activities are continually driven by the identified needs of candidates in the highly competitive healthcare market. Our recruitment team, in partnership with our hiring managers, remains focused on good candidate care practices, in turn building our employment brand, and networks of prospective candidates and referrals.

The team has been focused on:

- improving processes to support the promotion of our business, and encourage hiring managers to become brand ambassadors
- delivering regular quality recruitment training and education for line/hiring managers
- leveraging technology; using and exploring new talent acquisition platforms
- participating in regional and national rural and remote medical and nursing expos
- refining and supporting onboarding processes
- improving processes to support and encourage workforce flexibility, diversity and inclusion

Recruitment and Nursing Workforce Services have been working together promoting the Regional and Rural Nursing and Midwifery campaign initiated by the Office of the Chief Nursing and Midwifery Officer to boost recruitment of experienced nurses and midwives to work with our regional and rural communities.

This campaign has seen the introduction of Live Hire to manage and establish Queensland Health Nursing and Midwifery talent community.

LEARNING AND DEVELOPMENT

In line with Torres and Cape HHS' Measures for Success identified in the HHS Strategic Plan 2019-2023, we continue to demonstrate a commitment to developing a learning culture with an increase in staff accessing staff training and development programs.

The Learning and Development team has provided several initiatives, that seek to enhance personal growth and career satisfaction, while enabling continued workforce development.

For the 2018-19 the Learning and Development Team facilitated or delivered the following training:

Mandatory Training
- Torres and Cape HHS Orientation to organisation (153 attendees)
- Bite-size training session (567 attendees)

Manager Development
- Torres and Cape HHS Line Manager training (18 attendees)
- Business case and proposal writing (24 attendees)

Leadership development
- Building future Leaders (26 Attendees)
- Enhancing leaders (12 Attendees)

Team Building
- Cooktown (7 attendees)
- Hope vale (15 Attendees)
- Napranum (12 Attendees)
- Northern Health Workers (18 Attendees)
- Resilience Training (facilitated by Clinical Excellence Division) (53 attendees)

Staff Development
- Employees accessed the Study and Research Assistance Scheme (45 personnel)
- AO incentive fund (6 personnel)
- OO incentive fund (8 personnel)
- Administration Officer foundations (42 Attendees)
- WEHO (2 Attendees)
- Occupational Violence Prevention (10 Attendees)
- Research Capacity Building (12 Attendees)

EARLY RETIREMENT, REDUNDANCY AND RETRENCHMENT

No redundancy, early retirement or retrenchment packages were paid during the 2018-2019 financial year.

COMMITTEES OF THE BOARD

To enable the Board to concentrate on substantial strategy and performance management matters, other supplementary Board work has been divested to four Board committees:

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

EXECUTIVE COMMITTEE

The Executive Committee is a formal committee of the Torres and Cape Hospital and Health Service Board (the Board) established in accordance with the *Hospital and Health Boards Act 2011*, and performs the functions described in the *Hospital and Health Boards Regulations 2012*.

The function of the Executive Committee is to support the Board in its role of controlling Torres and Cape HHS by:

- working with the Health Service Chief Executive (HSCE) to progress strategic issues identified by the Board;
- strengthening the relationship between the Board and the HSCE to ensure accountability in the delivery of services by Torres and Cape HHS;
- overseeing the performance of Torres and Cape HHS against performance measures stated in the Service Agreement between TCHHS and the Department of Health;
- supporting the Board in monitoring the effectiveness of engagement strategies with clinicians, consumers and communities and protocols with primary healthcare organisations and monitoring their implementation;
- monitoring the effectiveness of service plans and monitoring their implementation;
- providing advice on Board and committee evaluation processes and strategies for promoting interest in future board membership;
- recommending human resource management policies for health service executives and contracted health service employees and review of proposals for the delegation and sub-delegation of the Board's human resource powers to the HSCE;
- supporting the HSCE in the review and development of executive members of the management team and developing proposals for changes to their terms and conditions of employment including above award allowances;
- working with the HSCE in responding to critical emergent issues in Torres and Cape HHS;
- monitoring strategic risks and treatment plans for risks assigned by the Board;
- performing other functions specified by the Board.

During the 2018-19 year the Executive Committee considered a number of matters, including:

- The organisational Strategic Plan
- Operational planning
- Communications and engagement framework
- Organisational structure

THE SAFETY AND QUALITY COMMITTEE

The purpose of the Safety and Quality Committee is to provide advice and recommendations to the Board to assist in fulfilling its responsibilities for overseeing the safety and quality position of Torres and Cape Hospital and Health Service.

The Committee's role is to actively promote best practice and clinical excellence to minimise preventable harm to patients and consumers through sustaining the quality and safety of health care delivery within Torres and Cape HHS, while meeting the needs of local Torres Strait and Cape York communities.

During the 2018-19 year, the Safety and Quality Committee considered a number of matters, including:

- Clinical governance
- Patient safety and quality
- Staff health and safety
- Public health
- HHS and State-wide Performance activity and KPI results
- Organisation-wide assessment (accreditation) in accordance with the National Safety and Quality Health Service Standards
- Accreditation Attestation requirements
- Research governance
- Clinical Audits Schedule
- Review of Strategic Documents:
  - Clinician Engagement Strategy
  - Consumer and Community Engagement Strategy
  - Quality and Safety Strategy
  - Workforce Strategy

THE AUDIT AND RISK COMMITTEE

The purpose of the Audit and Risk Committee is to provide advice to the Board on:

- Risk, control and compliance frameworks
- The Health Service's external accountability responsibilities as prescribed in the *Financial Accountability Act 2009*, the *Financial Accountability Regulation 2009*, the *Financial and Performance Management Standard 2009*, and the *Auditor-General Act 2009*

The Audit and Risk Committee has an additional oversight role but does not replace management's primary responsibilities for the management of risks, the operations of the internal audit and risk management functions, the follow-up of internal and external audit findings or governance of Torres and Cape HHS generally.

The Committee will provide prompt and constructive reports on its findings directly to the Board, highlighting any issues which it considers are not being adequately addressed by management. The Committee Chair provides a report to the Board, promptly after each meeting.

During the 2018-19 year the Audit and Risk Committee considered, amongst others, the following matters:

- Financial statements
- Land and building asset revaluations
- Internal audit reports, strategic audit plan and charter
- Results of external audit
- Queensland Audit Office areas of significance
- Fraud and Corruption Risk Register
- Risk Registers
- Risk Appetite Statement
- Enterprise Risk Management Framework
- Compliance Register
- Department of Health and Chief Finance Officer Assurance Statements
- Changes to Accounting Standards
- Asset Stocktake and Impairment Assessment

FINANCE AND PERFORMANCE COMMITTEE

The purpose of the Finance and Performance Committee is to provide strategic advice and recommendations to the Board on the efficient, effective and economical operation of the Torres and Cape HHS and the appropriateness of resource allocations and investments.

The Committee's role is to oversee the financial position of the Torres and Cape HHS and does not replace management's primary responsibilities for the efficient management of Torres and Cape HHS resources.

During the 2018-19 year, the Finance and Performance Committee considered, amongst others, the following matters:

- 2018-2019 Service Agreement and Window Adjustments
- Organisational performance reporting
- Service delivery contracts
- Proposed growth spending
- Organisational sustainability planning
- Investment Government Committee Recommendations
- Own source revenue and
- Tender evaluations

GOVERNANCE: OUR RISK MANAGEMENT

The Torres and Cape Hospital and Health Service is committed to managing risk in a proactive, integrated and accountable manner to ensure its strategic and operational objectives are achieved. These objectives include the provision of high quality, innovative, safe, efficient and effective health services to the communities of Torres and Cape HHS.

A key achievement for 2018-19 has been the development and approval of Torres and Cape HHS' Risk Appetite Statement. Approved by the Board in February 2019, the statement captures the views on risk aligned to the Strategic Plan 2019 - 2023. The statement provides guidance on the tolerances within which the Board expects management to operate.

An Enterprise Risk Framework was adopted by Torres and Cape HHS during 2018-19. The Framework is underpinned by the Queensland Department of Health's Risk Management Framework and is aligned to the principles of ISO 31000:2018. The Framework enables Torres and Cape HHS to manage its risks to support the successful achievement of strategic objectives and to enable all decision makers to be fully informed of risk to ensure risks are appropriately managed in a structured, transparent, responsive and timely manner.

Torres and Cape HHS has a single risk register that captures the strategic and operations risks and is divided across the business functions of the service. The risk register is managed through RiskManTM, a state-wide enterprise system.

Development of a suite of strategic risk events has commenced. The establishment of a suite of strategic risk events will identify and manage multiple and cross-enterprise strategic risks. This will facilitate an effective response to the interrelated impacts and integrated responses to multiple risks.

The Enterprise Risk Management Framework has been subject to routine AS 4801 Occupational Health and Safety audits and found to be serving Torres and Cape HHS appropriately.

INTERNAL AUDIT

Torres and Cape HHS has engaged with an external consultant to undertake internal audit functions for the Health Service. Internal Audit's primary objective is to provide independent and objective assurance to the Board, via the Audit and Risk Committee, on the state of risks, internal controls and organisational governance and to provide management with recommendations to enhance current systems, processes and practices. Internal Audit assists the Board and HSCE to accomplish their strategic and operational objectives by developing a systematic, disciplined approach to evaluate and improve the effectiveness of business risk management, control and governance processes. The approach taken to achieve these objectives is outlined in the three-year audit plan.

An Internal Audit Charter has been developed and revised in the context of the following:

- *Financial Accountability Act 2009*;
- *Financial and Performance Management Standard 2009*;
- *Queensland Treasury's Audit Committee Guidelines: Improving Accountability and Performance, December 2009*; and
- *International Professional Practices Framework, Institute of Internal Auditors, January 2009*.

Internal Audit reports are communicated directly to the Audit and Risk Committee and administratively to the HSCE.

EXTERNAL SCRUTINY, INFORMATION SYSTEMS AND RECORD KEEPING

Torres and Cape HHS operations are subject to regular scrutiny from external oversight bodies. These include, but are not limited to:

- Quality Innovation Performance
- Coroner
- Office of the Health Ombudsman
- Queensland Audit Office
- Crime and Corruption Commission

For the 2018-19 financial year, Torres and Cape HHS was subject to the external audit by Queensland Audit Office. Torres and Cape HHS has received an unqualified audit report on its financial statements for the 2018-19 year. There are no significant findings or issues identified by this external reviewer on our operations or performance.

On 12 June 2019 the Northern Coroner handed down findings following the inquest into the death of Ms Holly Winta-Brown at the Laura Sports Races and Rodeo event.

The coroner found that:

1. Torres and Cape HHS had a responsibility to, but did not adequately plan for the temporary increase in population to between 2,000 – 3,000 people for the rodeo weekend and to be prepared to act as the emergency responder for those people, and
2. found that the emergency medical response was inadequate due to an absence of formal direction, guidance and policy establishing appropriate protocols

The findings of the inquest included recommendations relating to the planning, preparation and resourcing for emergency responses to mass gathering events by Hospital and Health Services in Queensland.
In response to the incident, and up to the findings handed down by the Coroner, Torres and Cape HHS has taken the initiative to improve the ability of staff and facilities to meet the abnormal demands and stresses imposed by increases in population from planned mass gathering events across the Health Service. Actions include:

- Development and implementation of a detailed planning process to assess the level of risk posed by each individual upcoming event in our region to ensure the appropriate health service resources are in place to match the level of risk. These processes have been tested on many occasions since they were implemented in January 2017 and have ensured our health facilities and our staff are well prepared to handle any issues arising from a mass gathering event in our region.
- Since 2015, Torres and Cape HHS has significantly expanded and strengthened our internal nursing relief pool, in order to minimise the use of external agency nurses and to maximise capacity to deploy relief nurses across our region who are fully experienced with remote area work and appropriately endorsed to do so.

- A standardised guideline for Emergency Response Packs for use by rural and remote facilities has been developed and implemented as a collaboration with Queensland Ambulance Service (QAS), Royal Flying Doctor Service, the Australian colleges of Emergency Medicine and Rural and Remote Medicine and the Emergency Care Institute of New South Wales.
- The Emergency Response Packs (ERP) contain items required to provide initial response care to an emergency outside a rural and remote facility – including medications, dressings and medical equipment. The packs are replenished after use in preparation for the next emergency.

Torres and Cape HHS is now working with QAS, local councils and other agencies to implement the coroner's recommendations to further strengthen emergency capability and responses for mass gatherings in our rural and remote areas.

During 2018-19 the Queensland Audit Office tabled a number of cross-service audits in Parliament relevant to the Torres and Cape HHS, including:

- The National Disability Insurance Scheme
- Queensland State Government: 2016-17 results of financial audits
- Health: 2016-17 results of financial audits
- Fraud and Risk Management

Having considered the findings and recommendations contained in these reports actions have commenced to implement recommendations or address issues raised.

Patients and clients of the Torres and Cape HHS continue to be able to obtain access to records by applying under the *Right to Information Act (Qld) 2009* and the *Information Privacy Act (Qld) 2009*. We have made information available and processes are in place to assist patients in gaining access to their medical records.Torres and Cape HHS creates, receives and keeps clinical and business records to support legal, clinical, community, and stakeholder requirements. Business and clinical records exist and are available in physical and digital formats.

Torres and Cape HHS is reviewing systems and processes in line with the *Torres and Cape HHS – Informations, Communications, Technology Road Map 2016-2020* which has identified the need for a Corporate and Records Management Strategy. This Road Map and associated strategy is currently being reviewed with a view to providing a horizon development map of graduated technology driven implementation to assist with digital transition.

A number of improvements have been made during the year, including:

- upgrades to Clinical Information systems
- further development of the system that maintains records related to "Right To Information" (TRIM system)
- management of all confidential corporate records on the TRIM system including RCAs and Clinical Reviews
- further development and maturation of the RiskManTM system
- implemented Office365 and SharePoint Online
- implemented Clinical Governance SharePoint sites
- continued development of the Regional eHealth Project electronic patient information system
- implementation of an In Vehicle Monitoring System (IVMS)

- implementation of the State-wide HR system (MyHR)
- preparation for the implementation of the State-wide finance system (S4HANA FSR)
- implemented a Business Classification Schema to compliment Share Point use
- implemented the Nurse Navigation systems COMPASS.

Further information technology improvements are planned for the organisation including:

- roll out of the Regional e-Health Project electronic patient information system
- maturation of the improved Corporate Records Management System to align with SharePoint document management system (Record Point)
- maturation of the MyHR system
- maturation of the finance system (S4HANA FSR)
- upgrade for Best Practice to Best Practice Indigo
- maturation of the Cyber Security Committee and ISMS 2018 legislative requirements
- maturation of the business classification schema
- maturation of the Nurse Navigation system COMPASS

Through these initiatives we aim to:

- improve access and control of information across geographically remote facilities
- improve security and safety of corporate information
- improve clinical data collection, access and reduce duplication
- streamline business through electronic forms, workflows and approvals
- ensure recordkeeping compliance with the *Public Records Act 2002*

QUEENSLAND PUBLIC SERVICE ETHICS

Torres and Cape HHS is a prescribed public service agency under s2 of the *Public Sector Ethics Regulation 2010*. Since its establishment on 1 July 2014, Torres and Cape HHS has been committed to implementing and maintaining the values and standards of conduct outlined in the 'Code of Conduct for the Queensland Public Service' under the *Public Sector Ethics Act 1994*.

Staff working for Torres and Cape HHS, including the Board members, committee members, managers, clinicians, support staff, administrative staff and contractors, are provided with education and training on the Code of Conduct and workplace ethics, conduct and behaviour policies. Line managers are required to incorporate ethics priorities and statutory requirements in all employee performance agreements, assessments and feedback.

In addition to education and training at the point of recruitment, our intranet site provides staff with access to appropriate on-line education and training about public sector ethics, including their obligations under the Code of Conduct and policies. It is a requirement of the HSCE that all line managers ensure that staff regularly, at least once in every year, are given access to appropriate education and training about public sector ethics during their employment. If breaches of the Code of Conduct involving suspected unlawful conduct were to be identified, the matter would be referred to the department's Ethical Standards Unit or other appropriate agency for any further action.

In the development of the Torres and Cape *HHS Strategic Plan 2019-2023*, the Board and executive management ensured that the values inherent in the Strategic Plan were congruent with the Public Sector Ethics principles and the Code of Conduct. All Torres and Cape HHS administrative procedures and management practices therefore have proper regard to the ethics principles and values, and the approved code of conduct.

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 Torres and Cape HHS did not disclose confidential information in the public interest during 2018-19 in accordance with s160 of the *Hospital and Health Board Act 2011*.

PERFORMANCE: DEMAND ON SERVICES

In 2018-19 emergency departments across the Torres and Cape Hospital and Health Service saw an overall decrease in the number of presentations. The percentage of people treated within four hours of their arrival in Emergency was 95.1 percent, well above the target of 80 percent.

The median wait time in Emergency Departments was five minutes.

In Elective Surgery, there was a small increase in both the number of procedures performed and the number of surgeries delivered within clinically recommended timeframes.

There were 176 Gastrointestinal Endoscopies performed, an improvement of 76 on the previous year. Of these, 160 procedures were performed within clinically recommended timeframes, 91 more than in 2017-18.

The significant reduction in the number of oral health treatments for 2018-19 was due to a change in the way Weighted Occasions of Service for oral health were calculated and a recruitment shortage for the school dental program, which resulted in the service operating at 66 percent capacity compared to the previous period.

In Telehealth, Torres and Cape HHS conducted 1,926 consultations which was 380 more than the previous year, increasing the convenience for our patients in rural and remote locations.

DEMAND ON SERVICES

	2018-19	Change since last year
Babies born [a]	* 176	* 11
Oral health treatments [b]	41,997	-9,790
Emergency Department presentations [c]	22,982	-1,113
Emergency Department 'Seen in time' [c]	19,859	-160
Patient admissions (from ED) [c]	3,181	-85
Emergency surgeries [d]	134	-36
Gastrointestinal endoscopies delivered [e]	174	76
Gastrointestinal endoscopies delivered in time [e]	160	91
Elective surgeries, from a waiting list, delivered [f]	304	18
Elective surgeries, from a waiting list, delivered in time [f]	298	20
Number of telehealth services [g]	1,926	380

* Perinatal data collection is based on calendar year 2018.

Source: [a] Perinatal Data Collection, [b] Oral Health Service, [c] Emergency Data Collection, [d] GenWAU, [e] Gastrointestinal Endoscopy Data Collection, [f] Elective Surgery Data Collection, [g] Monthly Activity Collection.

PERFORMANCE: SERVICE STANDARDS

	Target	Actual
Effectiveness measures		
Percentage of patients attending emergency departments seen within recommended timeframes: [a]		
Category 1 (within 2 minutes)	100%	95.5%
Category 2 (within 10 minutes)	80%	90.8%
Category 3 (within 30 minutes)	75%	91.8%
Category 4 (within 60 minutes)	70%	92.4%
Category 5 (within 120 minutes)	70%	98.1%
Percentage of emergency department attendances who depart within four hours of their arrival in the department [a]	>80%	95.1%
Percentage of elective surgery patients treated within clinically recommended times: [b]		
Category 1 (30 days)	>98%	95.1%
Category 2 (90 days)	>95%	97.6%
Category 3 (365 days)	>95%	99.4%
Rate of healthcare associated Staphylococcus aureus (including MRSA) blood-stream (SAB) infections/10,000 acute public hospital patient days [c]	<2	0.0
Median wait time for treatment in emergency departments (minutes) [a]	..	5
Median wait time for elective surgery	..	7
Other Measures		
Number of elective surgery patients treated within clinically recommended times: [b]		
Category 1 (30 days)	44	78
Category 2 (90 days)	46	40
Category 3 (365 days)	206	180
Number of Telehealth outpatient occasions of service events [d]	1,656	1,926
Total weighted activity units (WAU's) [e]		
Acute Inpatient	5,083	5,554
Outpatients	1,876	2,223
Sub-acute	530	309
Emergency Department	2,797	2,541
Mental Health	143	101
Prevention and Primary Care	964	750
Ambulatory mental health service contact duration (hours) [f]	>8,116	12,060
Staffing [g]	943	1,023

[1] SAB data presented is preliminary.

[2] As extracted on 19 August 2019.

Source: [a] Emergency Data Collection, [b] Elective Surgery Data Collection, [c] Communicable Diseases Unit, [d] Monthly Activity Collection, [e] GenWAU, [f] Mental Health Branch [g] DSS Employee Analysis.

PERFORMANCE: FINANCIAL SUMMARY

Torres and Cape Hospital and Health Service achieved a strong financial outcome for the year ending 30 June 2019, recording a small, planned deficit of $0.4 million or $400,000. This represents additional investment in clinical and corporate service reviews and planning activities during the year.

Growth in own source revenue was reinvested in our communities to grow our frontline staff and to strengthen our governance systems HHS-wide. Other initiatives invested in this year included additional infrastructure for office space in the South and strengthening executive professional support for Allied Health and Indigenous Health Workers.

During 2018-2019, Torres and Cape HHS met its obligation to ensure all its services are provided as cost effectively as possible in a challenging high cost environment. As a majority non-activity based funded organisation we are required to continually monitor performance, manage costs and actively explore own source revenue initiatives.

WHERE THE FUNDS CAME FROM

Torres and Cape HHS income from combined funding sources was $228.15 million. Funding was primarily derived from non-activity-based funding from the Department of Health of $201.78 million. Other funding sources included other revenue $8.92 million, and grants and contributions $17.45 million; primarily from Australian Government contributions for Indigenous health programs, rural and remote medical benefits scheme and pharmaceutical benefits scheme.

WHERE FUNDING WAS SPENT

Total expenses for 2018-2019 were $228.55 million, averaging a $0.63 million per day spend on serving the communities in our jurisdiction. The largest expense was against labour costs at $126.56 million. Supplies and services represent the second highest expense at $86.17 million which includes patient travel costs of $14.53 million, Aeromedical and Queensland Ambulance retrieval costs of $4.97 million, operating leases of $12.67 million, external contractor costs of $12.2 million, Electricity and other energy costs of $3.87 million and clinical supplies and services of $3.45 million.

ANTICIPATED MAINTENANCE

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

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

As of 30 June 2019, Torres and Cape Hospital and Health Service had reported total anticipated maintenance of $57,027,500.

To mitigate any risks associated with these items, Condition Assessments Data and/or Maintenance Requests are risk assessed by the Infrastructure Team, in consultation with various internal stakeholders, to determine if work needs to be undertaken instantly or has no immediate impact on staff safety or clinical operations.

FINANCIAL POSITION

The Torres and Cape HHS's assets comprise of land, buildings, equipment, cash, inventories and receivables balances. Its liabilities are largely represented by supplier and staff accruals.

The value of our net assets increased during 2018-19 by 1.71% or $3.54 million.

FUTURE OUTLOOK

The prior year surpluses will be reinvested for better health outcomes for the community, including Cooktown Multipurpose Health Centre redevelopment planning, Thursday Island Hospital redevelopment and comprehensive set of strategic planning activities that will continue to transform the HHS.
This additional investment ensures we are well placed to achieve its strategic objectives for the current year and outer years.

See Attachment 1 for Financial Statements 2018-19.

GLOSSARY

Aboriginal and Torres Strait Islander health worker	An Aboriginal and/or Torres Strait Islander person who holds the specified qualification and works within a primary healthcare framework to improve health outcomes for Aboriginal and Torres Strait Islander people.
Acute	Having a short and relatively severe course of care in which the clinical intent or treatment goal is to: • manage labour (obstetric) • cure illness or provide definitive treatment of injury • perform surgery • relieve symptoms of illness or injury (excluding palliative care) • reduce severity of an illness or injury • protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function • perform diagnostic or therapeutic procedures
Admission	A patient who undergoes a hospital's formal admission process as an overnight-stay patient or a same-day patient.
Allied health staff	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; leisure therapy; medical imaging; music therapy; nuclear medicine technology; occupational therapy; orthopaedics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work
CAC	Community Advisory Committee
Clinical governance	A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical practice	Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/or manage illness, together with associated professional activities for patient care.
Clinical workforce or staff	Employees who are or who support health professionals working in clinical practice, have healthcare specific knowledge/experience, and provide clinical services to health consumers, either directly and/or indirectly, through services that have a direct impact on clinical outcomes.
Full-time Equivalent (FTE)	Full-time Equivalent is calculated by the number of hours worked in a period divided by the award full-time hours prescribed by the award/industrial instrument for the person's position.
Hospital	Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.
Hospital and Health Boards	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to governing a complex healthcare organisation.
Hospital and Health Service	Hospital and Health Services are separate legal entities established by Queensland Government to deliver public hospital services. Hospital and Health Services commenced in Queensland on 1 July 2012, replacing existing health service districts.
Hospital-in-the-home	Provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.
Long wait	A 'long wait' elective surgery patient is one who has waited longer than the clinically recommended time for their surgery, according to the clinical urgency category assigned. That is, more than 30 days for a category 1 patient, more than 90 days for a category 2 patient and more than 365 days for a category 3 patient.

GLOSSARY

NEAT	National Emergency Access Target. 'By 2015, 90 per cent of all patients will leave the Emergency Department (ED) within four hours through being discharged, admitted to hospital, or transferred to another hospital for treatment.'
Non-admitted patient	A patient who does not undergo a hospital's formal admission process.
NQPHN	North Queensland Primary Health Network
Nurse practitioner	A registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessing and managing clients using nursing knowledge and skills and may include, but is not limited to, direct referral of clients to other healthcare professionals, prescribing medications, and ordering diagnostic investigations.
NQPHN	North Queensland Primary Health Network
Outpatient	Non-admitted health service provided or accessed by an individual at a hospital or health service facility.
Outpatient service	Examination, consultation, treatment or other service provided to non-admitted, non-emergency patients in a speciality unit or under an organisational arrangement administered by a hospital.
Overnight-stay patient (also known as inpatient)	A patient who is admitted to, and separated from, the hospital on different dates (not same-day patients).
Public patient	A public patient is one who elects to be treated as a public patient, so cannot choose the doctor who treats them, or is receiving treatment in a private hospital under a contract arrangement with a public hospital or health authority.
Public hospital	Public hospitals offer free diagnostic services, treatment, care and accommodation to eligible patients.
QEAT	Queensland Emergency Access Target – the number of patients leaving the emergency department within four hours of arrival. As of 1 July 2016, this target has been lowered from 90 per cent to greater than 80 per cent.
RRCSU	Rural and Remote Clinical Support Unit
Registered nurse	An individual registered under national law to practice in the nursing profession as a nurse, other than as a student.
Statutory bodies	A non-departmental government body, established under an Act of Parliament. Statutory bodies can include corporations, regulatory authorities and advisory committees/councils.
TCHHS	Torres and Cape Hospital and Health Service
Telehealth	Delivery of health-related services and information via telecommunication technologies, including: live audio and or/video interactive links for clinical consultations and educational purposes store and forward Telehealth, including digital images, video, audio and clinical notes (stored) on a client computer, then transmitted securely (forwarded) to a clinic at another location where they are studied by relevant specialists tele-radiology for remote reporting and clinical advice for diagnostic images Telehealth services and equipment to monitor people's health in their home.
Triage category	Urgency of a patient's need for medical and nursing care.
Weighted Activity Unit	A standard unit used to measure all patient care activity consistently. The more resource intensive an activity is, the higher the weighted activity unit. This is multiplied by the standard unit cost to create the 'price' for the episode of care.

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister/s	ARRs – section 7	4
Accessibility	Table of contents Glossary	ARRs – section 9.1	5 54,55
	Public availability	ARRs – section 9.2	2
	Interpreter service statement	Queensland Government Language Services Policy ARRs – section 9.3	2
	Copyright notice	Copyright Act 1968 ARRs – section 9.4	2
	Information Licensing	QGEA – Information Licensing ARRs – section 9.5	2
General information	Introductory Information	ARRs – section 10.1	8,9,10,11
	Machinery of Government changes	ARRs – section 10.2, 31 and 32	not applicable
	Agency role and main functions	ARRs – section 10.2	7,17,20,21,22,42
	Operating environment	ARRs – section 10.3	16,17,21,22,23,24
Non-financial performance	Government's objectives for the community	ARRs – section 11.1	6,7
	Other whole-of-government plans / specific initiatives	ARRs – section 11.2	6,7
	Agency objectives and performance indicators	ARRs – section 11.3	6,12,13,14,15,16, 24,4950,51,52
	Agency service areas and service standards	ARRs – section 11.4	50,51
Financial performance	Summary of financial performance	ARRs – section 12.1	52,53
Governance – management and structure	Organisational structure	ARRs – section 13.1	37
	Executive management	ARRs – section 13.2	25-36
	Government bodies (statutory bodies and other entities)	ARRs – section 13.3	not applicable
	Public Sector Ethics Act 1994	Public Sector Ethics Act 1994 ARRs – section 13.4	48
	Queensland public service values	ARRs – section 13.5	7
Governance – risk management and accountability	Risk management	ARRs – section 14.1	43,45
	Audit committee	ARRs – section 14.2	43,44
	Internal audit	ARRs – section 14.3	45
	External scrutiny	ARRs – section 14.4	46,47,48
	Information systems and recordkeeping	ARRs – section 14.5	46,47,48
Governance – Human Resources	Strategic workforce planning and performance	ARRs – section 15.1	39,40
	Early retirement, redundancy and retrenchment	Directive No.04/18 Early Retirement, Redundancy and Retrenchment ARRs – section 15.2	41
Open Data	Statement advising publication of information	ARRs – section 16	2
	Consultancies	ARRs – section 33.1	https://data.qld.gov.au
	Overseas travel	ARRs – section 33.2	https://data.qld.gov.au
	Queensland Language Services Policy	ARRs – section 33.3	https://data.qld.gov.au
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 17.1	attachment 1
	Independent Auditor's Report	FAA – section 62 FPMS – section 50 ARRs – section 17.2	attachment 1

Torres and Cape Hospital and Health Service
ABN 60 821 496 581

Financial Statements 30 June 2019

30 June 2019

Contents

Statement of Comprehensive Income
For the year ended 30 June 2019

	Note	2019 Actual $'000	2019 Original Budget $'000	2019 *Budget Variance $'000	2018 Actual $'000
Income					
User charges and fees	2	208,726	200,634	8,092	197,475
Grants and other contributions	3	17,512	12,140	5,372	13,855
Other revenue	4	1,906	920	986	1,086
Interest		3	2	1	2
Total revenue		**228,147**	**213,696**	**14,451**	**212,418**
Expenses					
Employee expenses	5	17,244	15,165	2,079	15,319
Department of Health contract staff	6	109,319	103,253	6,066	100,393
Supplies and services	7	86,172	81,255	4,917	81,048
Depreciation	12	13,850	13,102	748	12,253
Impairment losses		58	9	49	34
Other expenses	8	1,910	912	998	2,570
Total expenses		**228,553**	**213,696**	**14,857**	**211,617**
Operating result for the year		**(406)**	**-**	**(406)**	**801**
Other comprehensive income					
Items that will not be reclassified subsequently to operating result					
Increase in asset revaluation surplus	15	5,457			1,425
Total other comprehensive income		5,457			1,425
Total comprehensive income		**5,051**			**2,226**

**An explanation of major variances is included at Note 26*

The above Statement of Comprehensive Income should be read in conjunction with the accompanying notes

Statement of Financial Position
As at 30 June 2019

	Note	2019 Actual $'000	2019 Original Budget $'000	2019 *Budget Variance $'000	2018 Actual $'000
Current assets					
Cash and cash equivalents	9	39,944	38,780	1,164	41,243
Receivables	10	3,975	1,934	2,041	2,389
Inventories	11	477	408	69	470
Other current assets		349	78	271	90
Total current assets		**44,745**	**41,200**	**3,545**	**44,192**
Non-current assets					
Property, plant and equipment	12	188,006	199,291	(11,285)	183,090
Total non-current assets		**188,006**	**199,291**	**(11,285)**	**183,090**
Total assets		**232,751**	**240,491**	**(7,740)**	**227,282**
Current liabilities					
Payables	13	18,639	19,769	(1,130)	16,488
Accrued employees benefits	14	1,363	1,178	185	906
Unearned revenue		2,688	-	2,688	3,365
Total current liabilities		**22,690**	**20,947**	**1,743**	**20,759**
Total liabilities		**22,690**	**20,947**	**1,743**	**20,759**
Net assets		**210,061**	**219,544**	**(9,483)**	**206,523**
Equity					
Contributed equity		177,717	189,197	(11,480)	179,230
Accumulated surplus		14,269	13,873	396	14,675
Asset revaluation surplus	15	18,075	16,474	1,601	12,618
Total equity		**210,061**	**219,544**	**(9,483)**	**206,523**

**An explanation of major variances is included at Note 26*

The above Statement of Financial Position should be read in conjunction with the accompanying notes

Statement of Changes in Equity
For the year ended 30 June 2019

	Contributed equity $'000	Accumulated surplus $'000	Asset revaluation surplus $'000	Total equity $'000
Balance at 1 July 2017	186,690	13,874	11,193	211,757
Operating result for the year	-	801	-	801
Total other comprehensive income				
Increase in asset revaluation surplus	-	-	1,425	1,425
Total comprehensive income for the year	-	801	1,425	2,226
Transactions as owners				
Equity asset transfer during the year	3	-	-	3
Equity injections	4,790	-	-	4,790
Equity withdrawals (depreciation funding)	(12,253)	-	-	(12,253)
Balance at 30 June 2018	**179,230**	**14,675**	**12,618**	**206,523**
Balance at 1 July 2018	179,230	14,675	12,618	206,523
Operating result for the year	-	(406)	-	(406)
Total other comprehensive income				
Increase in asset revaluation surplus	-	-	5,457	5,457
Total comprehensive income for the year	-	(406)	5,457	5,051
Transactions as owners				
Equity asset transfer during the year	6,242	-	-	6,242
Equity injections	6,095	-	-	6,095
Equity withdrawals (depreciation funding)	(13,850)	-	-	(13,850)
Balance at 30 June 2019	**177,717**	**14,269**	**18,075**	**210,061**

The above Statement of Changes in Equity should be read in conjunction with the accompanying notes

Notes to the Financial Statements
30 June 2019

Statement of Cash Flows
For the year ended 30 June 2019

	Note	2019 Actual $'000	2019 Original Budget $'000	2019 *Budget Variance $'000	2018 Actual $'000
Cash flows from operating activities					
Inflows:					
User charges and fees		192,846	200,634	(7,788)	191,729
Grants and other contributions		17,481	12,144	5,337	13,855
Interest received		3	2	1	2
GST collected from customers		613	-	613	583
GST input tax credits from ATO		5,282	3,903	1,379	4,949
Other		1,646	920	726	1,074
Outflows:					
Employee expenses		(17,469)	(15,115)	(2,354)	(16,403)
Department of Health contract staff		(108,408)	(103,253)	(5,155)	(100,426)
Supplies and services		(84,399)	(80,897)	(3,502)	(83,057)
Grants and subsidies		(612)	-	(612)	(375)
GST paid to suppliers		(5,441)	(3,905)	(1,536)	(4,757)
GST remitted to ATO		(613)	-	(613)	(630)
Other expenses		(1,263)	(853)	(410)	(1,193)
Net cash from/(used in) operating activities	21	**(334)**	**13,580**	**(13,914)**	**5,351**
Cash flows from investing activities					
Payments for property, plant and equipment		(7,059)	(3,153)	(3,906)	(4,710)
Net cash from/(used in) investing activities		**(7,059)**	**(3,153)**	**(3,906)**	(4,710)
Cash flows from financing activities					
Proceeds from equity injections		6,095	(10,885)	16,980	4,790
Net cash from/(used in) financing activities		**6,095**	**(10,885)**	**16,980**	**4,790**
Net increase/(decrease) in cash and cash equivalents		(1,298)	(458)	(840)	5,431
Cash and cash equivalents at the beginning of the financial year		41,243	39,238	2,005	35,812
Cash and cash equivalents at the end of the financial year	9	**39,944**	**38,780**	**1,164**	**41,243**

**An explanation of major variances is included at Note 26*

The above Statement of Cash Flows should be read in conjunction with the accompanying notes

Notes to the Financial Statements
30 June 2019

Notes to the Financial Statements
30 June 2019

Note 1. Objectives and principal activities of Torres and Cape Hospital and Health Service

Torres and Cape Hospital and Health Service (TCHHS) is a not-for-profit statutory body under the *Hospital and Health Boards Act 2011* and is domiciled in Australia.

TCHHS is governed by a local Board with responsibility for providing public hospital and primary health services in the Torres Strait and Cape York Peninsula Region.

TCHHS is controlled by the State of Queensland which is the ultimate parent.

The head office and principal place of business of TCHHS is:

Cooktown Multi-Purpose Health Service
Cnr Walker and Helen Street
Cooktown Qld 4895

TCHHS serves a population of approximately 26,000 people. This includes direct management of 31 primary health centres and four hospitals within the geographical boundaries including:

Bamaga Hospital
Cooktown Multipurpose Health Facility
Thursday Island Hospital
Weipa Integrated Health Facility

TCHHS provides services and outcomes as defined in a publicly available service agreement with the Department of Health (DoH) as manager of the public hospital system.

The principal accounting policies adopted in the preparation of the financial statements are set out below and throughout the notes to the financial statements.

(a) Statement of compliance

The financial statements:

- have been prepared in compliance with section 62(1) of the *Financial Accountability Act 2009* and section 43 of the *Financial and Performance Management Standard 2009*;
- have been prepared in accordance with all applicable new and amended Australian Accounting Standards and Interpretations as well as the Queensland Treasury's Minimum Reporting Requirements for the year ended 30 June 2019, and other authoritative pronouncements;
- 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, where the amount is $500 or less or to zero unless the disclosure of the full amount is specifically required;
- classify assets and liabilities as either current or non-current in the Statement of Financial Position and associated notes. Assets are classified as current where their carrying amount is expected to be realised within 12 months after the reporting date. Liabilities are classified as current when they are due to be settled within 12 months after the reporting date, or when TCHHS does not have an unconditional right to defer settlement to beyond 12 months after the reporting period and
- present reclassified comparative information where required for consistency with the current year's presentation.

(b) Issuance of financial statements

The financial statements are authorised for issue by the Health Service Chief Executive, the Chief Finance Officer of TCHHS, and the Board Chair of TCHHS as at the date of signing the Management Certificate.

(c) Investment in North Queensland Primary Health Network Limited

North Queensland Primary Health Network Limited (NQPHNL) was established as a public company limited by guarantee on 21 May 2015. Torres and Cape Hospital and Health Service is one of 11 members along with Cairns and Hinterland Hospital and Health Service, Mackay Hospital and Health Service, Townsville Hospital and Health Service, the Pharmacy Guild of Australia, Australian College of Rural and Remote Medicine, Council on The Ageing,

Notes to the Financial Statements
30 June 2019

Note 1. Objectives and principal activities of the Torres and Cape Hospital and Health Service (continued)

(c) Investment in North Queensland Primary Health Network Limited (continued)
Northern Aboriginal and Torres Strait Islander Health Alliance, Australian Primary Healthcare Nurses Association, CheckUp and Queensland Alliance for Mental Health with each member holding one voting right in the company.

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

As each member has the same voting entitlement, it is considered that none of the individual members has power over NQPHNL (as defined by AASB 10 *Consolidated Financial Statements*) and therefore none of the members individually control NQPHNL. While TCHHS currently holds one 11th of the voting power of the NQPHNL, the fact that each other member also has 1/11th voting power limits the extent of any influence that TCHHS may have over NQPHNL.

Each member's liability to NQPHNL is limited to $10. NQPHNL is legally prevented from paying dividends to its members and its constitution also prevents any income or property of NQPHNL being transferred directly or indirectly to or amongst the members.

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

(d) Investment in Tropical Australia Academic Health Centre Limited

Tropical Australian Academic Health Centre Limited (TAAHCL) registered as a public company limited by guarantee on 3 June 2019. TCHHS, is one of seven founding members along with Cairns and Hinterland Hospital and Health Service, Mackay Hospital and Health Service, North West 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 TCHHS and is not considered a joint operation or an associate of TCHHS, financial results of TAAHCL are not required to be disclosed in these statements.

Notes to the Financial Statements
30 June 2019

Note 2. User charges and fees

	2019 $'000	2018 $'000
State Government block funding	77,153	75,676
System manager funding	124,631	117,315
Hospital fees	541	613
Multi-purpose nursing fees	340	375
Inter-hospital and health service recoveries	1,880	627
Pharmaceutical benefits scheme reimbursement	470	140
Training fees	20	61
Rental income	107	118
Non-capital project recoveries	2,598	1,593
Radiology service delivery	840	778
Other	146	179
	208,726	197,475

TCHHS receives health service funding from DoH for specific public health services delivery by TCHHS as per a service agreement between DoH and TCHHS. The service agreement is reviewed periodically and updated for changes in activities programs and prices. The funding from DoH is received fortnightly in advance. At the end of the financial year, a financial adjustment may be required where the level of services provided is above or below the agreed level.

User charges and fees are recognised as revenues when the revenue has been earned and can be measured reliably with a sufficient degree of certainty. Revenue recognition for user charges and fees is based on either invoicing for related goods or delivery of services. Accrued revenue is recognised if the revenue has been earned but not yet invoiced.

TCHHS receives funding from DoH to cover depreciation costs. However, as depreciation is a non-cash expenditure item, the Minister of Health has approved a withdrawal of equity by the State for the same amount, resulting in non-cash revenue and non-cash equity withdrawal.

Note 3. Grants and other contributions

	2019 $'000	2018 $'000
Australian Government – home and community support program	1,111	884
Rural and remote medical benefits	4,408	3,501
Pharmaceutical benefits scheme section 100 arrangement	2,350	2,078
Rural health outreach fund	910	812
Commonwealth indigenous health programs	4,075	3,768
Services below fair value	1,849	-
Practice incentive payments	1,663	2,133
Commonwealth after hours services	1,034	679
Other grants and contributions	81	-
Donations	31	-
	17,512	13,855

Grants, contributions, donations and gifts that are non-reciprocal in nature are recognised as revenue in the year in which TCHHS obtains control over them.

Services below fair value
During 2018-19 TCHHS received services below fair value from the Department of Health in the form of payroll, accounts payable and banking services. TCHHS has recognised income this year and a corresponding expense for the fair value of these service received. The fair value of these services amounted to $1.849m in 2019 (2018: $1.801m) and in 2019 is recognised in "Grants and other contributions" in the statement of comprehensive income.

Notes to the Financial Statements
30 June 2019

Note 3. Grants and other contributions (continued)

In 2018 the income was not recognised as it was assessed as immaterial and only disclosed in the notes. Please see Note 7 for the disclosure of the corresponding expense recognised for services received below fair value.

Note 4. Other revenue

	2019 $'000	2018 $'000
Contract staff and recoveries	1,579	998
Other	327	88
	1,906	1,086

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.

Contract staff and recoveries
These are primarily made up of the James Cook University Australian General Practice Training recoveries and incentive payments, along with recoveries from arrangements where TCHHS staff are placed with external organisations.

Note 5. Employee expenses

	2019 $'000	2018 $'000
Wages and salaries	13,830	12,179
Annual leave levy	845	796
Employer superannuation contributions	1,002	919
Long service leave levy	306	272
Sick leave	143	112
Other employee related expenses	1,118	1,041
	17,244	15,319

The number of directly engaged employees is 47 as at 30 June 2019 (2018: 43), including 38 full time equivalent employees and nine board members.

Workers' compensation insurance is a consequence of employing employees but is not counted in an employee's total remuneration package. They are not employee benefits and are recognised separately as employee related expenses. Key management personnel and remuneration disclosures are set out in Note 23. Refer to Note 14 for details regarding accrued employee benefits policies and disclosures.

Note 6. Department of Health contract staff

TCHHS through service arrangements with DoH has engaged 955 (2018: 940) full time equivalent roles in a contracting capacity as at 30 June 2019. These personnel remain employees of DoH as established under the *Hospital and Health Boards Act 2011*. The number of health service employees reflects full-time and part-time health service employees measured on a full time equivalent basis.

Department employees engaged as contractors
TCHHS is not a prescribed service and accordingly all non-executive staff are employed by DoH.
Under this arrangement:
- DoH provides employees to perform work for TCHHS, and DoH acknowledges and accepts its obligations as the employer of these departmental employees.
- TCHHS is responsible for the day to day management of these departmental employees.
- TCHHS reimburses DoH for the salaries and on-costs of these employees.
- TCHHS pays premiums to WorkCover Queensland in respect of its obligations for employee compensation.

As a result of this arrangement, TCHHS treats the reimbursements to DoH for departmental employees in these financial statements as DoH contract staff.

Notes to the Financial Statements
30 June 2019

Note 7. Supplies and services

	2019 $'000	2018 $'000
Building services	1,974	1,724
Catering and domestic supplies	771	792
Clinical supplies and services	3,456	3,346
Communications	2,127	1,857
Computer services	1,957	2,092
Consultants	1,389	1,250
Contractors	12,203	17,230
Drugs	2,083	2,137
Electricity and other energy	3,867	3,820
Expenses relating to minor works	1,280	963
Freight	1,015	1,068
Motor vehicles	265	393
Operating lease rentals	12,671	11,472
Other supplies and services	2,131	971
Other travel	8,219	7,049
Pathology, blood and related equipment	5,116	4,456
Patient transport	4,966	4,059
Patient travel	14,527	12,687
Repairs and maintenance	4,306	3,682
Services below fair value	1,849	-
	86,172	81,048

Contractors
During the year $5.217m (2018: $5.218m) was expensed in relation to services purchased from Non-Government Organisations (NGO) with Apunipima Cape York Health Council and Royal Flying Doctor Service for the provision of health services to public patients.

Services below fair value
Services below fair value from the Department of Health in the form of payroll, accounts payable and banking services amounted to $1.849m in 2019 (2018: $1.801m) and in 2019 were recognised in "supplies and services" in the statement of comprehensive income. Please see Note 3 for the disclosure of the corresponding income recognised for services received below fair value.

Operating lease rentals
Operating leases are entered into as a means of acquiring access to office accommodation facilities, staff accommodation and motor vehicles. Lease terms range between one to five years except for Indigenous Land Use Agreements (ILUAs) which have a lease term of either 30 or 40 years. TCHHS has no option to purchase the leased item at the conclusion of the lease although the lease provides for a right of renewal at which time the lease terms are renegotiated. Operating lease rental expenses comprises the minimum lease payments payable under operating lease contracts.

Notes to the Financial Statements
30 June 2019

Note 8. Other expenses

	2019 $'000	2018 $'000
Advertising	108	195
Audit fees - internal and external	374	278
Insurances other	71	65
Insurance premiums QGIF	502	469
Losses from the disposal of non-current assets	24	123
Special payments - ex gratia	202	18
Other legal costs	442	600
Asset revaluation decrement	-	451
Inventory stock adjustments	28	66
Other	159	305
	1,910	2,570

Audit fees – internal and external
Total external audit fees quoted by the Queensland Audit Office relating to the 2018-19 financial statements are $0.159m (2018: $0.155m).

Insurance premiums QGIF
TCHHS insure with Queensland Government Insurance Fund (QGIF) which is a Queensland Treasury self-insurance fund covering the State's insurable liabilities. Property and general losses above a $10,000 threshold are insured through the QGIF. Health litigation payments above a $20,000 threshold and associated legal fees are also insured through QGIF. Premiums are calculated by QGIF on a risk assessed basis.

Special payments – ex gratia
Special payments include ex gratia expenditure and other expenditure that TCHHS is not contractually or legally obligated to make to other parties. In compliance with the *Financial and Performance Management Standard 2009*, TCHHS maintains a register setting out details of all special payments exceeding $5,000. During the year there was one ex gratia payment of $0.202m (2018: $nil).

Note 9. Cash and cash equivalents

	2019 $'000	2018 $'000
Cash on hand	1	1
Cash at bank	39,861	41,162
QTC cash funds	82	80
	39,944	41,243

Cash includes all cash on hand and in banks, cheques receipted but not banked at the reporting date as well as all deposits at call with financial institutions.

TCHHS's bank accounts are grouped with the whole of Government set-off arrangement with Queensland Treasury Corporation (QTC). As a result, TCHHS does not earn interest on surplus funds. Interest earned on the aggregate set-off arrangement balance accrues to the Department of Health Consolidated Fund.

A deposit is held with QTC reflecting the value of the TCHHS general trust funds. The value of this deposit as at 30 June 2019 was $0.082m (2018: $0.080m) and the annual effective interest rate was 2.38% (2018: 2.41%).

Notes to the Financial Statements
30 June 2019

Note 10. Receivables

	2019 $'000	2018 $'000
Receivables	3,105	1,662
Less: Allowance for impairment of receivables	(77)	(73)
	3,028	1,589
GST input tax credits receivable	603	445
GST payable	(45)	(46)
	558	399
Health service funding in arrears	389	373
Other	-	28
	389	401
	3,975	2,389

Receivables are initially recognised at the amount invoiced to customers. They are presented as current assets and their carrying amount is the amount invoiced less any impairment. Receivables are generally settled within 90 days. No collaterals are held as security and there are no other credit enhancements relating to receivables.

Aged care, dental billing, ineligibles, training incentives and salary reimbursements make up the majority of aged receivables.

Impairment of receivables
TCHHS uses a provision matrix to measure the lifetime expected credit loss on trade debtors. Loss rates are calculated based on historical observed default rates calculated using credit losses experienced on past transactions and then adjusted for supportable forward-looking employment information.

TCHHS has determined there is one material group for measuring expected credit loss excluding government agencies. No loss allowance is recorded for Australia and Queensland Government agency debtors on the basis of materiality and positive credit rating.

The provision matrix uses historical observed default rates calculated using credit losses experienced on past transactions during the last two years preceding 30 June 2019.

For TCHHS, a change in the unemployment rate is determined to be the most relevant forward-looking indicator. Actual credit losses over the two years preceding 30 June 2019 have been correlated against changes in the unemployment rate and based on those results, the historical default rates are adjusted based on expected changes in employment.

Where TCHHS has no reasonable expectation of recovering an amount owed by a debtor, the debt is written-off by directly reducing the receivable against the loss allowance. This occurs when TCHHS has ceased enforcement activity which is usually 180 days. If the amount of debt written off exceeds the loss allowance, the excess is recognised as an impairment loss.

Notes to the Financial Statements
30 June 2019

Note 10 Receivables (continued)

	Less than 30 days $'000	31 - 60 days $'000	61 - 90 days $'000	More than 90 days $'000	Total $'000
Ageing of receivables 2018					
Receivables	1,428	187	12	35	1,662
Allowance for impairment	(24)	(13)	(4)	(32)	(73)
Carrying amount	1,404	174	8	3	1,589
Ageing of receivables 2019 (Government agency / low risk)					
Receivables	2,733	-	-	-	2,733
Loss rate (%)	0.0%	0.0%	0.0%	0.0%	
Allowance for impairment (Expected Credit loss)	-	-	-	-	-
Carrying amount	2,733	-	-	-	2,733
Ageing of receivables 2019 (Sale of goods and services)					
Receivables	321	11	10	30	372
Loss rate (%)	12.1%	58.9%	58.2%	87.9%	
Allowance for impairment (Expected Credit loss)	(39)	(6)	(6)	(26)	(77)
Carrying amount	282	5	4	4	295

All known bad debts were written off once approved by either the Health Service Chief Executive or the Chief Finance Officer if less than $10,000 in accordance with financial delegations.

	2019 $'000	2018 $'000
Movements in the provision for impairment of receivables are as follows:		
Balance at the start of the year	73	182
Receivables written off during the year as uncollectable	(65)	(146)
Increase in provision recognised	69	37
Balance at the end of the year	77	73

Note 11. Inventories

Inventories consist mainly of pharmaceutical and medical supplies held for distribution in hospitals and are provided to patients at a subsidised rate. Material pharmaceutical holdings are recognised as inventory at balance date through the annual stocktake process at weighted average cost.

Unless over $10,000, inventories do not include supplies held for ready use in the wards throughout the hospital facilities. These items are expensed on issue from storage facilities.

Notes to the Financial Statements
30 June 2019

Note 12. Property, plant and equipment

(a) Balances and reconciliation of carrying amounts

	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Carrying amount at 1 July 2017	9,386	167,302	11,732	1,350	189,770
Additions	-	-	1,865	2,845	4,710
Disposals	-	-	(123)	-	(123)
Asset revaluation increment	-	1,425	-	-	1,425
Asset revaluation decrement	(451)	-	-	-	(451)
Asset not previously recognised	-	-	9	-	9
Transfers between classes	-	1,209	290	(1,499)	-
Transfers in from other Queensland Government	-	-	3	-	3
Depreciation expense	-	(10,200)	(2,053)	-	(12,253)
Carrying amount at 30 June 2018	**8,935**	**159,736**	**11,723**	**2,696**	**183,090**
As at 30 June 2018					
Gross value	8,935	357,354	25,216	2,696	394,201
Accumulated depreciation	-	(197,618)	(13,493)	-	(211,111)
Carrying amount at 30 June 2018	**8,935**	**159,736**	**11,723**	**2,696**	**183,090**
Carrying amount at 1 July 2018	8,935	159,736	11,723	2,696	183,090
Additions	-	-	866	6,224	7,090
Disposals	-	-	(23)	-	(23)
Asset revaluation increment	-	5,457	-	-	5,457
Transfers between classes	-	5,161	368	(5,529)	-
Transfers in from other Queensland Government	-	6,191	51	-	6,242
Depreciation expense	-	(11,679)	(2,171)	-	(13,850)
Carrying amount at 30 June 2019	**8,935**	**164,866**	**10,814**	**3,391**	**188,006**
As at 30 June 2019					
Gross value	8,935	376,959	26,159	3,391	415,444
Accumulated depreciation	-	(212,093)	(15,345)	-	(227,438)
Carrying amount at 30 June 2019	**8,935**	**164,866**	**10,814**	**3,391**	**188,006**

Notes to the Financial Statements
30 June 2019

Note 12. Property, plant and equipment (continued)

(b) Accounting policies

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

Class	Threshold
Land	$ 1
Buildings and land improvements	$ 10,000
Plant and equipment	$ 5,000

Land improvements undertaken by TCHHS are included in the Buildings class.

Acquisition
Actual cost is used for the initial recording of all non-current physical asset acquisitions. Cost is determined as consideration plus any costs directly incurred in getting the asset ready for use. Any training costs are expensed as incurred. The cost of items acquired during the financial year has been judged by management to materially represent the fair value at the end of the reporting period.

Assets under construction are recorded at cost until they are ready for use. These assets are assessed at fair value upon practical completion.

Where assets are received from Queensland Government agencies free of charge, the acquisition cost is recognised as the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation. Assets acquired at no cost or for nominal consideration are initially recorded at their fair value at the date of acquisition.

Measurement
Plant and equipment is measured at historical cost in accordance with Queensland Treasury's *Non-Current Asset Policies for the Queensland Public Sector.* The carrying amount for such plant and equipment at cost is not materially different from their fair value.

Land and buildings are measured at fair value as required by Queensland Treasury's *Non-Current Asset Policies for the Queensland Public Sector.* These assets are reported by their revalued amount, being the fair value at the date of valuation, less any subsequent accumulated depreciation and impairment losses where applicable.

Deed of Grant in Trust land
Some of TCHHS facilities are located on land assigned to it under a Deed of Grant in Trust (DOGIT) under Section 341 of the Land Act 1994.

Land parcels within TCHHS which are located on DOGIT land and which cannot be bought or sold, are recorded in the land assets for a nominal fair value of $1 as there is no active and liquid market for these land sections. TCHHS has constructed buildings as health care centres in DOGIT areas on both freehold and reserve land. While the buildings are recorded as assets in the financial statements, the land is not. TCHHS does not control the land element of these properties. The land element is recorded in the Government Land Register as improvements only.

Depreciation
Property, plant and equipment is depreciated on a straight-line basis so as to allocate the net cost or revalued amount of each asset, less any estimated residual value, progressively over its estimated useful life to TCHHS.

Land is not depreciated as it has an unlimited useful life.

Notes to the Financial Statements
30 June 2019

Note 12. Property, plant and equipment (continued)

(b) Accounting policies (continued)

Key judgement: The depreciation rate is determined by application of appropriate useful life to relevant non-current asset classes. The useful lives could change significantly as a result of change in use of the asset, technical obsolescence or some other economic event. The impact on depreciation can be significant and could also result in a write-off of the asset.

Buildings, plant and equipment are depreciated on a straight-line basis. Land is not depreciated. Assets under construction or work-in-progress are not depreciated until they reach service delivery capacity.

Any expenditure that increases the originally assessed service potential of an asset is capitalised and depreciated over the remaining useful life of the asset. The depreciable amount of improvements to leasehold property is allocated progressively over the shorter of the estimated useful lives of the improvements or the unexpired period of the lease, which is inclusive of any option period where exercise of the option is probable.

The estimated useful lives of the assets are reviewed annually and, where necessary, are adjusted to better reflect the pattern of consumption of the asset. In reviewing the useful life of each asset, factors such as asset usage and the rate of technical obsolescence are considered.

Key estimate: Depreciation rates used for each asset class are as follows:

Class	Depreciation rates used	Useful lives
Buildings	1.3% – 4%	8 – 79 years
Plant and equipment	4% – 20%	5 – 27 years

Impairment
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 TCHHS determines the asset's recoverable amount. The asset's recoverable amount is determined as the higher of the asset's fair value less costs to sell or value in use.

(c) Fair value measurement and valuation

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

Observable inputs are publicly available data that are relevant to the characteristics of the assets/liabilities being valued. Observable inputs used by TCHHS include, but are not limited to, published sales data for land and general office buildings.

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

A fair value measurement of a non-financial asset takes into account a market participant's ability to generate economic benefits by using the asset in its highest and best use.

Notes to the Financial Statements
30 June 2019

Note 12. Property, plant and equipment (continued)

(c) Fair value measurement and valuation (continued)

Accounting for changes in fair value
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.

Use of Independent professional valuers
Revaluations using independent professional valuers are undertaken 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 practicable, regardless of the timing of the last specific appraisal.

The fair values reported by TCHHS are based on appropriate valuation techniques that maximise the use of available and relevant observable inputs and minimise the use of unobservable inputs. Materiality is considered in determining whether the difference between the carrying amount and the fair value of an asset is material (in which case revaluation is warranted).

Where assets have not been specifically appraised in the reporting period, their previous valuations are materially kept up-to-date via the application of relevant indices. TCHHS ensures that the application of such indices results in a valid estimation of the assets' fair values at reporting date.

In years when indexation is applied, the valuer supplies the indices used for the various types of assets. Such indices are either publicly available or are derived from market information available to the valuer. The valuer provides assurance of their robustness, validity and appropriateness for the application to the relevant assets.

The land and building revaluation process for financial reporting purposes is overseen by the Audit and Risk Committee and coordinated by senior management.

Land
Independent asset specific revaluations are performed with sufficient regularity to ensure land assets are carried at fair value in accordance with Queensland Treasury Non-Current Asset Policies. The independent revaluations are required to be carried out at least once every five years and in the off-cycle years indexation is applied where the cumulative increase since the last revaluation is greater than or less than 5%. In 2017-18 a comprehensive valuation was carried out on all TCHHS land parcels.

In 2018-19 management requested land indices from the State Valuation Service of Department of Natural Resources Mines and Energy for all TCHHS land parcels. All TCHHS land parcels indices were 1.15% or less, therefore, no indexation was applied to the land assets this year due to the change in the market being not material.

Buildings
In 2018-19 TCHHS engaged independent experts AECOM to undertake building revaluations in accordance with the fair value methodology.

For the year ended 2019, approximately 23.6% of buildings were comprehensively revalued at fair value using current replacement cost methodology and three newly constructed buildings were also comprehensively revalued.

Since the introduction of a standardised approach to the valuation of all Queensland public infrastructure, management have had almost 50% of TCHHS buildings comprehensively revalued in the last two years using the cost valuation approach (current replacement cost). Indexation of 2.5% was applied to all building assets not comprehensively revalued during the current year. The effective date of valuations was primarily 30 June 2019. Newly constructed assets were valued at practical completion date and at 30 June 2019.

The valuations were carried out using the current replacement cost approach to determine fair value. The replacement cost is based on current construction market rates that any market participant would likely expect to pay. The valuation is provided for a replacement building of the same age, location, size, shape, functionality that

Notes to the Financial Statements
30 June 2019

Note 12. Property, plant and equipment (continued)

c) Fair value measurement and valuation (continued)

meets current design standards, physical condition of all component parts and is based on estimates of gross floor area, number of floors, number of lifts, staircases and obsolescence.

The building valuation for 2018-19 resulted in a net increment of $5.457m to the carrying amount of buildings. This is made up of the indexation adjustment which resulted in a net increment of $3.262m and the independent comprehensive valuation net increment of $2.195m.

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

Level 1: Quoted prices (unadjusted) in active markets for identical assets that the entity can access at the measurement date.

Level 2: Inputs other than quoted prices included within Level 1 that are observable for the assets, either directly or indirectly.

Level 3: Unobservable inputs for the assets are data, assumptions and judgements that are not available publicly, but are relevant to the characteristics of the assets being valued such as a cost estimate by an independent valuer.

	Level 2 $'000	Level 3 $'000	Total $'000
2018			
Assets			
Land	8,935	-	8,935
Buildings (health service sites)	-	159,736	159,736
Total assets	8,935	159,736	168,671
2019			
Assets			
Land	8,935	-	8,935
Buildings (health service sites)	-	164,867	164,866
Total assets	8,935	164,867	173,801

There were no transfers between levels during the financial year.

Note 13. Payables

	2019 $'000	2018 $'000
Payables - other	4,094	2,876
Department of Health contract staff	3,683	3,452
Accrued expenses - other	10,862	10,160
	18,639	16,488

These amounts represent liabilities for goods and services provided to TCHHS prior to the end of the financial year and which are unpaid. Due to their short-term nature they are measured at amortised cost and are not discounted. The amounts are unsecured and are usually paid within 30 – 60 days of recognition.

Notes to the Financial Statements
30 June 2019

Note 14. Accrued employee benefits

The following relates to TCHHS directly engaged employees.

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

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

Annual leave and long service leave
TCHHS participates in the Annual Leave Central Scheme and the Long Service Leave Scheme.

Under the Queensland Government's Annual Leave Central Scheme and the Long Service Leave Central Scheme, levies are payable by TCHHS to cover the cost of employees' annual leave (including leave loading and on-costs) and long service leave. These levies are expensed in the period in which they are payable. Amounts paid to employees for annual leave and long service leave are claimed from the schemes quarterly in arrears which is currently facilitated by DoH.

No provision for annual leave or long service leave is recognised in the financial statements of TCHHS, as the liability for these schemes 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.*

Superannuation
Employer superannuation contributions are paid to an eligible complying superannuation fund at rates determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are payable and the obligation of TCHHS is limited to its contribution paid to the eligible complying superannuation fund.

The QSuper scheme has defined benefit and defined contribution categories. 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.*

Therefore, no liability is recognised for accruing superannuation benefits in these financial statements. Refer to Note 5 for details regarding employee expense disclosures.

Note 15. Asset revaluation surplus

	Land $'000	Buildings $'000	Total $'000
Balance 1 July 2017	-	11,193	11,193
Revaluation increment	-	1,425	1,425
Balance - 30 June 2018	-	12,618	12,618
Balance at 1 July 2018	-	12,618	12,618
Revaluation increment	-	5,457	5,457
Balance - 30 June 2019	-	18,075	18,075

Accounting policy
The revaluation surplus represents the net effect of upwards and downwards revaluations of assets to fair value.

Notes to the Financial Statements
30 June 2019

Note 15. Asset revaluation surplus (continued)

Any revaluation increment arising from the revaluation of an asset is credited to the asset revaluation surplus of the appropriate asset 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.

The building revaluation for 2018-19 resulted in a net increment of $5.457m to the carrying amount of buildings. TCHHS uses the gross method of reporting assets. This method restates separately the gross amount and related accumulated depreciation of the assets comprising the class of revalued assets (current replacement cost). Accumulated depreciation is restated proportionally in accordance with the independent advice of the appointed valuer.

Note 16. Financial instruments

A financial instrument is any contract that gives rise to both a financial asset of one entity and a financial liability or equity instrument of another entity. Financial instruments now include where identified non-contractual receivables arising from statutory requirements.

TCHHS holds financial instruments in the form of cash, receivables and payables. TCHHS had no statutory receivables at the reporting date.

Recognition
Financial assets and financial liabilities are recognised in the Statement of Financial Position when TCHHS becomes party to the contractual provisions of a financial instrument or where a non-contractual statutory receivable arises.

Classification
Financial assets are classified into one of three underlying measurement bases, amortised cost, fair value through other comprehensive income and fair value through profit or loss. The classification is based on the HHS business model and whether the financial asset's contractual cash flows represent solely payments of principal and interest.

TCHHS's financial instruments are classified and measured as follows;
- Cash and cash equivalents – held at fair value through profit or loss
- Receivables - held at amortised cost
- Payables - held at amortised cost
- TCHHS does not have equity instruments, derivates, bonds, notes or loans

TCHHS has the following categories of financial assets and financial liabilities:

	2019 $'000	2018 $'000
Financial assets		
Cash and cash equivalents	39,944	41,243
Financial assets at amortised cost:		
Receivables	3,975	2,389
Total financial assets	43,919	43,632
Financial liabilities		
Financial liabilities at amortised cost - comprising:		
Payables	18,110	16,126
Total financial liabilities at amortised cost	18,110	16,126

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

TCHHS is exposed to a variety of financial risks - credit risk, liquidity risk and market risk.

Notes to the Financial Statements
30 June 2019

Note 16. Financial instruments (continued)

Financial risk management is implemented pursuant to Queensland Government and TCHHS policies. The policies provide principles for overall risk management and aim to minimise potential adverse effects of risk events on the financial performance of TCHHS. TCHHS measures risk exposure using a variety of methods as follows:

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

(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 (expected credit loss).

TCHHS uses a provision matrix to measure the expected credit loss on debtors. Refer to Note 10.

Credit risk on cash deposits is considered minimal given all TCHHS deposits are held with the Commonwealth Bank of Australia Ltd and Queensland Treasury Corporation and TCHHS does not earn interest on these cash deposits.

(b) Liquidity risk
Liquidity risk is the risk that TCHHS will not have the resources required at a particular time to meet its obligations to settle its financial liabilities. TCHHS is exposed to liquidity risk through its trading in the normal course of business. TCHHS aims to reduce the exposure to liquidity risk by ensuring that sufficient funds are available to meet employee and supplier obligations at all times.

The only financial liabilities which expose TCHHS to liquidity risk are trade and other payables. All financial liabilities are current in nature and will be due and payable within 12 months. As such no discounting of cash flows has been made to these liabilities in the Statement of Financial Position.

(c) Market risk
TCHHS is not exposed to interest rate risk as it does not hold any finance leases, borrowings or cash deposited in interest bearing accounts. TCHHS does not undertake any hedging in relation to interest rate risk and manages its risk as per the liquidity risk management strategy articulated in TCHHS's Financial Management Practice Manual.

(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 allowances made for impairment, which given the short-term nature of these assets, is assumed to represent fair value.

Note 17. Contingent liabilities

Litigation in progress
As at 30 June 2019 there were no cases filed in the courts naming the State of Queensland acting through TCHHS as defendant.

As of 30 June, 2019 there were two open general liability claims managed by QGIF. At this stage, it is unknown if any will be litigated or result in payments of claims, therefore, no contingent liabilities are projected. All claims lodged, tribunals, commissions and board figures represent the matters that have been referred to QGIF for management. The maximum exposure to TCHHS under this policy is $20,000 for each insurable event.

There are currently 11 claims underway with Workcover, three are pending decision. It is not possible to give a clear indication of the final financial outcome due to the nature of the claims and the set processes that will follow. The maximum exposure to TCHHS under the Workcover policy is $700 per insurable event.

Notes to the Financial Statements
30 June 2019

Note 17. Contingent liabilities (continued)

Native title
The *Native Title Act 1993* (Cth) (NTA) validates past acts that may have extinguished or impaired native title rights through the establishment of public works and the issue of freehold, leasehold and other tenures. Section 51 of the NTA provides that native title holders can claim compensation on just terms for acts that have extinguished or impaired native title.

All dealings in relation to native title are through DoH, as legal owner of the land. In accordance with State Government land policies, when native title over a particular holding has been cleared, State agencies are required to convert the tenure to freehold ownership. Where native title can continue to exist, (Reserve or in DOGIT for example), dealings cannot proceed until native title has been addressed. Where DoH is the trustee of reserve land, native title will need to be addressed over the whole of the reserve before dealings proceed.

In some cases, facilities have been constructed on DOGIT land, which is Aboriginal or Torres Strait Islander community land in where the title was created in 1986. Facilities constructed on DOGIT land have no tenure and agencies are required under state land policies to obtain tenure via the negotiation of a trustee lease, which can also provide for existing and future development of the facility. In order to validate tenure and register a trustee lease, native title must be addressed by means of a registered Indigenous Land Use Agreement (ILUA). TCHHS has administered reserves within DOGIT land, these reserves are held in the name of DoH as trustee and recorded in TCHHS's Statement of Financial Position at a nominal value of $1.

TCHHS has where necessary been undertaking a tenure project over the past two years to assess all tenure title issues in order to validate and correct records relating to ownership and residual contingent liabilities. DoH has provided TCHHS additional funding through the service agreement to meet the legal and finance lease costs associated with the settlement of these tenure issues.

Registered trustee leases on DOGIT land held by other organisations have been negotiated for 21 facilities which have terms for generally 30 to 40 years. DOGIT land is being recognised as finance leases and are disclosed in the Statement of Financial Position. TCHHS has eight ILUAs and the corresponding leases either have not yet commenced or are being currently negotiated.

Note 18. Commitments

	2019 $'000	2018 $'000
Commitments - capital expenditure		
Committed at the reporting date but not recognised as liabilities, payable:		
Not later than 1 year	1,848	477
Commitments - operating expenditure		
Committed at the reporting date but not recognised as liabilities, payable:		
Not later than 1 year	15,966	14,957
Later than 1 year but not later than 5 years	3,901	1,809
Later than 5 years	3,447	4,947
	25,162	22,191

Leases
Operating lease commitments include contracted amounts for various residential properties, office space, storage containers and vehicles. The leases have various escalation clauses. Lease payments are generally fixed, but with inflation escalation clauses on which contingent rentals are determined.

Operating commitments also includes service contracts between Apunipima, Royal Flying Doctor Service and with Cairns and Hinterland Hospital and Health Service that TCHHS is currently obligated to pay.

Notes to the Financial Statements
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Note 19. Patient trust transactions and balances

Patient trust receipts and payments	2019 $'000	2018 $'000
Receipts		
Opening balance	5	5
Amounts receipted on behalf of patients	3	18
Total receipts	8	23
Payments		
Amounts paid to or on behalf of patients	3	18
Total payments	3	18
Trust assets and liabilities		
Assets		
Cash held and bank deposits	5	5
Total assets	5	5

TCHHS acts in a trust capacity in relation to patient trust accounts. These transactions and balances are not recognised in the financial statements. Although patient funds are not controlled by TCHHS, trust activities are included in the audit performed annually by the Auditor-General of Queensland.

Note 20. Events after the reporting period

There are no matters or circumstances that have arisen since 30 June 2019 that have significantly affected, or may significantly affect TCHHS's operations, the results of those operations, or the HHS's state of affairs in future financial years.

Note 21. Reconciliation of operating result to net cash from operating activities

Operating result for the year	(406)	801
Non-cash movements:		
Depreciation	13,850	12,253
Depreciation offset from DoH	(13,850)	(12,253)
Loss on disposal	24	123
Asset valuation decrement	-	451
Donated assets	(31)	-
Impairment of inventory	-	(9)
Movements in impairment loss receivables	69	-
Change in operating assets and liabilities		
(Increase)/decrease in receivables	(1,525)	4,442
(Increase)/decrease in GST receivables	(159)	142
Decrease in inventories	21	5
Increase in prepayments	(258)	(14)
Increase/(decrease) in payables	1,218	(408)
Increase/(decrease) in accrued employee benefits	457	(72)
Increase/(decrease) in accrued contract labour	933	(2,284)
(Decrease)/increase in unearned revenue	(677)	2,174
Net cash from/(used in) operating activities	(334)	5,351

Notes to the Financial Statements
30 June 2019

Note 21. Reconciliation of operating result to net cash from operating activities (continued)

Non-cash investing and financing activities
Assets and liabilities received or donated are recognised as revenues (refer to Note 2) or expenses (refer to Note 7) as applicable.

Note 22. General trust

TCHHS receives cash contributions primarily from private practice clinicians and from external entities to provide for education, study and research in clinical areas. Contributions are also received from benefactors in the form of gifts, donations and bequests for stipulated purposes. Contributions are collected and held within the general trust.

Payments are made from the general trust for specific purposes in accordance with the general trust policy.

	2019 $'000	2018 $'000
Opening balance	95	93
Revenue received during the year	4	2
Expenditure made during the year	1	-
Balance of general trust	98	95

The closing cash balance of the general trust at 30 June 2019 is $0.098m (2018: $0.095m). This is held on deposit with the Queensland Treasury Corporation $0.082m (2018: $0.080m) and the Commonwealth Bank of Australia $0.016m (2018: $0.015m).

Note 23. Key management personnel disclosures

TCHHS's responsible Minister is identified as part of its key management personnel, consistent with guidance included in AASB 124 *Related Party Disclosures*. That Minister is Steven Miles MP, Minister for Health and Minister for Ambulance Services.

Notes to the Financial Statements
30 June 2019

Note 23. Key management personnel disclosures (continued)

The following persons were considered key management personnel of TCHHS during the current financial year and the prior financial year. Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of TCHHS, directly or indirectly, including any director of TCHHS.

Position	Name	Contract classification and appointment authority	Initial appointment date
Non-executive Board Chairperson - Provides strategic leadership and guidance and effective oversight of management, operations and financial performance	Robert McCarthy Elthies Kris	*S25 Hospital and Health Board Act 2011 by Governor in Council*	1 July 2014 to 17 May 2019 18 May 2019
Non-executive Board member - Provides strategic guidance and effective oversight of management, operations and financial performance	Horace Baira Tracey Jia Fraser (Ted) Nai Brian Woods Karen Price Scott Davis Ruth Stewart Rhonda Shibasaki Tina Chinery (Board member)	*S23 Hospital and Health Board Act 2011*	19 January 2015 1 July 2014 1 July 2014 19 January 2015 11 December 2015 18 May 2016 18 May 2018 18 May 2019 18 May 2018 to 17 May 2019
Health Service Chief Executive (HSCE) - Responsible for the overall management of TCHHS through major functional areas to ensure the delivery of key government objectives in improving the health and well-being of Queenslanders	Beverley Hamerton	*S24/S70 Hospital and Health Boards Act 2011*	31 March 2018
Chief Finance Officer (CFO) - Responsible for providing strategic leadership, direction, stewardship, governance, effective controls and day-to-day financial management and statutory reporting obligations	Danielle Hoins	*DSO1 Hospital and Health Boards Act 2011*	17 April 2015
Executive General Manager - Northern Sector - Responsible for providing strategic leadership, direction and day to day management to the Torres Strait and Northern Peninsula area within the TCHHS	Mark Goodman	*HES2 Hospital and Health Boards Act 2011*	7 May 2018
Executive General Manager - Southern Sector - Responsible for providing strategic leadership, direction and day to day management to the Cape York area within the TCHHS.	Brian Howell Ian Power	*HES2 Hospital and Health Boards Act 2011*	31 March 2018 to 27 July 2018 23 July 2018
Executive Director Corporate Services - Responsible for providing strategic leadership and governance of the corporate services function including human resources, occupational health and safety, learning and development, assets and infrastructure, travel, contracts and procurement	Andrew Marshall Dean Davidson (acting)	*HES2 Hospital and Health Boards Act 2011*	27 February 2017 to 19 October 2018 17 September 2018

Notes to the Financial Statements
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Note 23. Key management personnel disclosures (continued)

Position	Name	Contract classification and appointment authority	Initial appointment date
Executive Director - Medical Services - Responsible for leading, directing, implementing, planning and evaluating the delivery of medical and dental across all departments and facilities within the TCHHS	Anthony Brown	*MMOI1 Hospital and Health Boards Act 2011*	12 February 2018
Executive Director - Nursing and Midwifery Services - Responsible for providing nursing leadership and governance to TCHHS Nursing and Mental Health Services; whilst providing professional line management for Nurse Leaders (including DON, mental health and Nurse Educators) and supporting the implementation of primary health care principles and practices throughout TCHHS	Kim Veiwasenavanua Samuel Schefe (acting)	*NRG12* *NRG13 Hospital and Health Boards Act 2011*	7 May 2018 26 September 2018 to 16 October 2018 21 December 2018 to 29 January 2019 14 February 2019 to 1 March 2019
Principal Advisor Aboriginal and Torres Strait Islander Health - Provides strategic advice on primary health initiatives, community engagement and community partnerships across both the Torres Strait and Cape York sectors	Sean Taylor	*A08 Hospital and Health Boards Act 2011*	22 May 2017 to 3 August 2018
Executive Director Aboriginal and Torres Strait Islander Health - to provide a professional lead for Aboriginal and Torres Strait Islander Health workers and Health Practitioners, designing workforce strategies that will strengthen opportunities for Aboriginal and Torres Strait Islander peoples' career growth and help deliver the best possible health care to our region	Venessa Curnow	*DSO2 Hospital and Health Boards Act 2011*	21 January 2019
Chief Information Officer - Provides leadership of the Information and Communication Technologies strategy; including information and communication technology management of enablers of systems for healthcare delivery	David Bullock	*DSO2 Hospital and Health Boards Act 2011*	4 September 2018
Executive Director Allied Health - Provide allied services within a number of program areas, to inform service planning and development activities and support partner services and key stakeholder in understanding the scope and breath of allied health services provision	Vivienne Sandler	*HP6 Hospital and Health Boards Act 2011*	18 February 2019

Notes to the Financial Statements
30 June 2019

Note 23. Key management personnel disclosure (continued)

Key management personnel – Minister for Health and Minister for Ambulance Services
The Legislative Assembly of Queensland's Members' Remuneration Handbook outlines the ministerial remuneration entitlements. TCHHS does not incur any remuneration costs for the Minister of Health and Minister of Ambulance Services, but rather ministerial entitlements are paid primarily by the Legislative Assembly with some remaining entitlements provided by the Ministerial Services Branch within the Department of Premier and Cabinet. All ministers are reported as key management personnel of the Queensland Government. As such the aggregate remuneration expenses for all ministers are disclosed in the Queensland Government and Whole of Government consolidated financial statements, which are published as part of the Queensland Treasury report on State finances.

Key management personnel – Board
TCHHS appoints the Board and sets out the Board Charter in exercising control over TCHHS. Remuneration arrangements of the Board are approved by the Governor in Council and the Board members are paid annual fees consistent with the government titled "Remuneration procedures for part-time chairs and members of Queensland Government bodies".

Remuneration packages for Board members comprise the following components:

- Short term employee base benefits which include allowances and salary sacrifice components expensed for the entire year or for that part of the year during which the employee occupied the specified position.
- Short term non-monetary benefits consisting of non-monetary benefits including FBT exemptions on benefits.
- Post-employment benefits which include amounts expensed in respect of employer superannuation obligations

The Audit and Risk Committee appointed Mr Ian Jessup as an external advisor for a term of three years commencing 1 July 2017. Mr Jessup is not considered part of TCHHSs' key management personnel however he provides independent technical advice to the Audit and Risk Committee on assurance and risk management. Remuneration is paid based on a sitting fee in accordance with the Department of Justice and Attorney-General in the document titled 'Remuneration of Part-time Chairs and Members of Government Boards, Committees and Statutory Authorities', 26 February 2010.

Key management personnel – Executive management
Section 74 of the *Hospital and Health Boards Act 2011* provides that the contract of employment for health executive staff must state the term of employment, the person's functions and any performance criteria as well as the person's classification level and remuneration package.

Remuneration policy for key executive management personnel is set by direct engagement common law employment contracts and various award agreements. The remuneration and other terms of employment for the key executive management personnel are also addressed by these common law employment contracts and awards. The remuneration packages provide for the provision of some benefits including motor vehicles.

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

- Short term employee base benefits which include salary, allowances, salary sacrifice component and leave entitlements expensed for the entire year or for that part of the year during which the employee occupied the specified position.
- Short term non-monetary benefits consisting of provision of vehicle and other non-monetary benefits including FBT exemptions on benefits.
- Long term employee benefits which include amounts expensed in respect of long service leave.
- Post-employment benefits which include amounts expensed in respect of employer superannuation obligations

There were no performance bonuses paid in the 2018-19 financial year (2018: $nil).

Redundancy payments are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu of notice on termination, regardless of the reason for termination. Performance bonuses are not paid under the contracts in place. Total fixed remuneration is calculated on a 'total cost' basis and includes the base and non-monetary benefits, long term employee benefits and post-employment benefits.

Notes to the Financial Statements
30 June 2019

Note 23. Key management personnel disclosure (continued)

The value of remuneration received by Board Members in their capacity as Board Members and the Executive Management Team is disclosed in the following sections.

2019 **Remuneration Expenses**

Name	Monetary	Non-monetary	Post-employment benefits	Long-term benefits	Termination benefits	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Board						
Robert McCarthy	64	-	6	-	-	70
Elthies Kris	4	-	-	-	-	4
Horace Baira	39	-	4	-	-	43
Tracey Jia	39	-	4	-	-	43
Fraser (Ted) Nai	39	-	4	-	-	43
Brian Woods	39	-	4	-	-	43
Karen Price	39	-	4	-	-	43
Scott Davis	39	9	4	-	-	52
Ruth Stewart	41	-	4	-	-	45
Rhonda Shibasaki	4	-	1	-	-	5
Tina Chinery	-	-	-	-	-	-
Executive						
Beverley Hamerton	270	9	24	5	-	308
Danielle Hoins	159	9	18	3	-	189
Mark Goodman	193	9	19	4	-	225
Brian Howell	16	1	1	-	-	18
Ian Power	164	7	16	3	-	190
Andrew Marshall	61	5	5	1	63	135
Dean Davidson	150	9	13	3	-	175
Anthony Brown	441	-	34	9	-	484
Kim Veiwasenavanua	187	9	20	3	-	219
Samuel Schefe	49	9	4	1	-	63
Sean Taylor	6	-	-	-	1	7
Venessa Curnow	66	9	8	1	-	84
David Bullock	121	-	14	2	-	137
Vivienne Sandler	59	4	7	1	-	71

Notes to the Financial Statements
30 June 2019

Note 23. Key management personnel disclosure (continued)

2018 **Remuneration Expenses**

Name	Monetary	Non-monetary	Post-employment benefits	Long-term benefits	Termination benefits	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Board						
Robert McCarthy	73	-	7	-	-	80
Horace Baira	39	-	4	-	-	43
Greg Edwards	35	-	3	-	-	38
Tracey Jia	39	-	4	-	-	43
Fraser (Ted) Nai	39	-	4	-	-	43
Brian Woods	39	-	4	-	-	43
Karen Price	39	-	4	-	-	43
Scott Davis	39	9	4	-	-	52
Ruth Stewart	41	-	4	-	-	45
Tina Chinery	-	-	-	-	-	0
Executive						
Michael Lok	89	9	9	2	-	109
Terry Mehan	173	7	17	3	1	201
Beverley Hamerton	205	-	20	4	-	229
Danielle Hoins	154	9	18	3	-	184
Mark Goodman	34	-	3	1	-	38
Brian Howell	59	-	6	1	-	66
Kim Veiwasenavanua	198	6	20	4	-	228
Allyson Cousens	22	10	-	2	-	34
Andrew Marshall	196	8	20	4	-	228
Katherine McConnon	122	9	8	2	-	141
Anthony Brown	185	-	14	4	-	203
Lyn Wardlaw	35	-	2	-	2	39
Samuel Schefe	154	9	13	3	-	179
Sean Taylor	133	-	12	3	-	148
Andrew Berry	88	9	1	9	3	110

Note 24. Related party transactions

Transactions with Queensland Government controlled entities
Material related party transactions for 2018-19 are disclosed in this note.

Department of Health
DoH receives its revenue from the Queensland Government (funding) and the Commonwealth. TCHHS is funded for eligible services through non-Activity Based Funding. Refer to Note 2. The funding from DoH is provided predominantly for specific public health services purchased by DoH from TCHHS in accordance with a Service Agreement between DoH and TCHHS. The Service Agreement is amended periodically and updated for new program initiatives delivered by TCHHS.

The TCHHS signed Service Agreement is published on the Queensland Government website and is publicly available. As outlined in Note 6, TCHHS is not a prescribed employer and health service employees are employed by the Department of Health and contracted to work for the TCHHS.

Queensland Treasury Corporation
TCHHS has accounts with the Queensland Treasury Corporation for general trust monies. Refer to Note 9.

Department of Housing and Public Works
TCHHS pays rent to the Department of Housing and Public Works for office and staff accommodation. In addition, the Department of Housing and Public Works provides vehicle fleet management services (Qfleet) to TCHHS.

Notes to the Financial Statements
30 June 2019

Note 24. Related party transactions (continued)

Transactions with other related parties
In the ordinary course of business conducted under normal terms and conditions, TCHHS has the following key management personnel (KMP) related parties' transaction disclosures:

NQPHN is a limited company which works with various clinicians employed by DoH or TCHHS to improve and coordinate primary health care across the local health system for patients requiring care from multiple providers. The transactions with this company were at arm's length and are in accordance with the entity's constitution. TCHHS receives funding from two funding sources; Primary Health Network Health Pathways and integrated care incentive funding and mental health after hours.

TCHHS is a member of TAAHC. Members are incorporated in a unified company and governance structure to enhance health and health services research in the region, leveraging economies of scale and the proven opportunities of the Academic Health Centre concept for northern Queensland. TCHHS have only paid their 2018-19 TAAHC membership contribution in June 2019 which will be held in trust by James Cook University on behalf of TAAHC as the TAAHC company accounts have not been established yet. This transaction was endorsed by the TCHHS Board and is considered to be at arm's length considering this company has just been established.

Mr Terry Mehan owns Terry Mehan and Associates Pty Ltd. This company provides management consultancy services to TCHHS. All transactions during the year are included as supplies and services in the Statement of Comprehensive Income.

TCHHS employees that are close family members of TCHHS key management personnel were recruited in accordance with the standard TCHHS recruitment policies and procedures. As Anthony Brown (KMP) is a close related family member to Board member Ruth Stewart, his total remuneration figures are disclosed in Note 23 and not included in the table below.

Notes to the Financial Statements
30 June 2019

Note 24. Related party transactions (continued)

Related Party transaction values and outstanding balances

Related Party	Transaction Type	2019		2018	
		Transaction value Revenue/ (expense)	Receivables/ (payables) net	Transaction value Revenue/ (expense)	Receivables/ (payables) net
		$'000	$'000	$'000	$'000
Department of Health	Service Agreement	201,784	389	192,991	522
Department of Health	Prescribed employee costs	(109,319)	(3,683)	(100,393)	(3,452)
Department of Health	Services support costs	(15,182)	(1,429)	(14,199)	(3,842)
Department of Health	Locally receipted programs *	(1,792)	-	(1,600)	-
Inter-company (other Hospital and Health Services)	Funded programs **	-	-	-	-
Inter-company (other Hospital and Health Services)	Renal, interpretation and legal services, pharmacy supplies, office space, courier fees, contract labour, training costs, manuals and course fees.	(611)	(953)	(1,507)	(509)
Department of Housing and Public Works	Building/fleet leases	(8,008)	-	(8,695)	(51)
NQPHN	Primary Health care support ***	(83)	(155)	-	(91)
TAAHCL	Membership fee	(25)	-	-	-
Close family members that are TCHHS employees	Salary and Wages (aggregated total)	(261)	-	(617)	-
T Mehan	Management consultancy services	(145)	-	(45)	-

** DoH for locally receipted programs (2019: $3.707m revenue and $5.499m expenses) (2018: $1.829m revenue and $3.429m expenses)*

*** Other Hospital and Health Services (Inter-company) for unfunded programs (2019: $0.130m revenue and $0.130m expenses) (2018: $0.210m revenue and $0.210 expenses)*

**** NQPHN revenue and expenses (2019: $1.034m of revenue and $1.117m of expenses) (2018: $ 0.583m of revenue and $0.583m expenses). NQPHN receivables and payables (2019: $0.068m receivables and $0.223m payables) (2018: $0.028m receivables and $0.119m payables).*

Notes to the Financial Statements
30 June 2019

Note 25. Other information

(a) Goods and Services Tax (GST) and other similar taxes

The only federal taxes that TCHHS is assessed for are Fringe Benefits Tax (FBT) and Goods and Services Tax (GST).

All FBT and GST reporting to the Commonwealth is managed centrally by DoH, with payments/receipts made on behalf of TCHHS reimbursed to/from DoH on a monthly basis. GST credits receivable from, and GST payable to the Australian Tax Office (ATO), are recognised on this basis.

Both TCHHS and DoH satisfy section 149-25(e) of the A New Tax System (Goods and Services) Act 1999 (Cth) (the GST Act). Consequently, they were able, with other Hospital and Health Services, to form a "group" for GST purposes under Division 149 of the GST Act. Any transactions between the members of the "group" do not attract GST.

(b) First year application of new standards or change in policy

Accounting standards applied for the first time

TCHHS applied AASB 9 *Financial Instruments* for the first time in 2018-19. Comparative information for 2017-18 has not been restated and continues to be reported under AASB 139 *Financial Instruments Recognition and Measurement.*

The nature and effect of the changes as a result of adoption of this new accounting standard are described below.

Classification and measurement
Under AASB 9, debt instruments are categorised into one of three measurement bases – amortised cost, fair value through other comprehensive income (FVOCI) or fair value through profit or loss (FVTPL).

The classification is based on two criteria:
a) whether the financial asset's contractual cash flows represent 'solely payments of principal and interest', and
b) the entity's business model for managing the assets.

The HHS's debt instruments comprise of receivables disclosed in Note 10. They were classified as receivables as at 30 June 2018 (under AASB 139) and were measured at amortised cost. These receivables are held for collection of contractual cash flows that are solely payments of principal and interest. As such, they continue to be measured at amortised cost beginning 1 July 2018.

Impact summary
- There will be no change to either the classification or measurement of the cash and cash equivalent item.
- There will be no change to either the classification or measurement of financial liabilities
- The HHS does not have any debt instruments such as loans or bonds.
- The HHS does not have any equity instruments such as shares.
- The HHS does not have any derivatives such as futures or swaps.
- The HHS had no statutory receivables at the reporting date.
- The primary impact although considered immaterial was to the calculation of trade receivables impairment loss.

Receivables
At the end of the reporting period TCHHS assessed impairment loss using the simplified impairment approach in accordance with AASB 9 to always measure the impairment allowance at lifetime expected 'credit loss'. It differs from the prior year under which impairment was recorded in accordance with AASB 139 using the 'incurred loss' model.

In applying the simplified approach, TCHHS developed a provision matrix to assign expected loss percentages to different aging bands of receivables to estimate the expected credit loss. The percentages were calculated based on regional historical credit loss experience, adjusted for current regional conditions and forward-looking macroeconomic data. The primary data set used was unemployment information sourced from the Queensland Government Statistician's office.

Notes to the Financial Statements
30 June 2019

Note 25. Other information (continued)

(b) First year application of new standards or change in policy (continued)

In determining the regional historical credit loss percentages TCHHS reviewed the results from the previous two financial years as compared with Treasury guidance as trade receivable recoveries have improved in this period due to robust debt management procedures.

(c) New accounting standards and interpretations not yet effective

Accounting standards early adopted

Australian Accounting Standards and Interpretations that are not yet mandatory were not adopted early by TCHHS in 2018-19. TCHHS is not permitted to early adopt accounting standards unless approved by Queensland Treasury. At the date of authorisation of the financial report, the expected impacts of new or amended Australian Accounting Standards issued but with future effective dates are set out below.

AASB 1058 *Income of Not-for-profit Entities* and AASB 15 *Revenue from Contracts with Customers*
These Standards first apply to TCHHS's financial statements from 2019-20 and supersede AASB 118 *Revenue*, AASB 111 *Construction Contracts* and parts of AASB 1004 *Contributions*. AASB 15 defines the methodology for recognising revenue from contracts with customers and the disclosures required. Appendix F of AASB 15 provides for implementation guidance for not-for-profit entities such as TCHHS.

TCHHS has considered both AASB 15 and AASB 1058 when accounting for grants and contributions commencing 2019/20. AASB 1058 may apply to an entire grant, or a portion of the grant, that does not meet the enforceable and sufficiently specific performance obligations of AASB 15. The nature of TCHHS's contracts with customers, and the terms and conditions, will determine which standard is applicable:

- Revenue from contracts with customers where the contract is not legally enforceable and/or not sufficiently specific will not qualify for deferral and revenue will continue to be recognised up front as soon as it is controlled under AASB 1058 to the extent a liability should be recognised under AASB1058 or AASB 137.
- Revenue from contracts with customers where the contract is legally enforceable, and the performance obligations are sufficiently specific will qualify for deferral of revenue. Revenue will be recognised as the performance obligations are satisfied. Depending on the timing of payments in relation to contract performance obligations TCHHS may recognise either a contract asset or contract liability in accordance with AASB 15.
- Special purpose grants received to construct non-financial assets controlled by TCHHS will be recognised as a liability, and subsequently recognised progressively as revenue as TCHHS satisfies its performance obligations under the grant.
- AASB 15 is likely to impact revenue disclosures, particularly in relation to contract balances, performance obligations and judgements made in applying the standard. As contractual circumstances change over time, TCHHS shall update its measure of progress to reflect any changes in performance obligation. Changes to measures of progress toward performance obligations shall be accounted for as a change in accounting estimate in accordance with AASB 108.
- TCHHS plans to adopt the transitional retrospective approach whereby the 2019-20 financial statements will not restate 2018-19 comparatives and recognise the transitional accounting differences if any in accumulated surpluses on 1 July 2019.
- TCHHS has reviewed the impact on all current contracts with customers and does not expect an adjustment given most of the HHS contracts with customers are considered not sufficiently specific. For those contracts that fall within the scope of AASB 15 current accounting practices result in no adjustment as a liability is recognised for these contracts on the same basis as the requirements of AASB 15. These liabilities (2019: $0.199m) (2018: $0.290m) are reflected within the total balance of payables other in Note 13. In the 2019-20 financial statements this liability will be presented as a contract liability.

Notes to the Financial Statements
30 June 2019

Note 25. Other information (continued)

(c) New accounting standards and interpretations not yet effective (continued)

AASB 16 *Leases*
This standard will first apply to TCHHS in its financial statements for 2019-20. When applied, the standard supersedes AASB 117 *Leases*, AASB Interpretation 4 *Determining Whether an Arrangement Contains a Lease*, AASB Interpretation 115 *Operating Leases – Incentives* and AASB Interpretation 127 *Evaluating the Substance of Transactions Involving the Legal Form of a Lease*. This standard introduces a single lease accounting model for lessees. Lessees will be required to recognise a right-of-use asset (representing rights to use the underlying leased asset) and a liability (representing the obligation to make lease payments) for all leases with a term of more than 12 months, unless the underlying assets are of low value.

The lease liability will be initially recognised at an amount equal to the present value of the lease payments during the lease term that are not yet paid. Current operating lease rental payments will no longer be expensed in the Statement of Comprehensive Income. They will be apportioned between a reduction in the recognised lease liability and the implicit finance cost (the effective rate of interest) in the lease. The finance cost will also be recognised as an expense. The right-of-use asset will give rise to a depreciation expense.

TCHHS has performed a review of all its leases to assess the impact on the Statement of Comprehensive Income or the Statement of Financial Position when applying AASB 16 to its current operating leases as disclosed in Note 18, including the extent of additional disclosures required. Leases that fall within the scope of this standard will no longer be included in Note 18 as a commitment.

TCHHS have identified the following lease portfolios as a right-of-use asset as at 30 June 2019; private residential leases (101), private commercial leases (1) and Indigenous Land Use Agreements (ILUAs) (27). TCHHS will elect not to apply the requirements of AASB 16 to leases that have a term of 12 months or less from commencement date, including any extension option and low-value items of $10,000 or less. TCHHS have applied Queensland Treasury guidance and consider Government Employee Housing (GEH), Queensland Government Accommodation Office (QGAO) and Qfleet leases to be out of scope under AASB 16 due to substantive substitution rights of the lessor.

Peppercorn leases dated prior to 1 July 2019 will be measured at cost for the transition period only. TCHHS have peppercorn leases which have no value but are already recognised on the balance sheet. TCHHS has elected to exclude these leases based on immateriality.

TCHHS will use the modified retrospective approach (or cumulative approach) rather than full retrospective approach to recognising existing operating leases in accordance with Queensland Treasury's policy. When applying the 'cumulative approach', TCHHS will not need to restate comparative information. Instead, the cumulative effect of applying the standard is recognised as an adjustment to the opening balance of accumulated surplus at the date of initial application. The new criteria in AASB 16 for identifying a lease will be applied for all new leases and lease modifications from the date of initial application.

On transition, any lease incentives liability and assets or liabilities from straight-line accounting of operating leases will be derecognised, against opening accumulated surplus under option C8(b)(i) of the AASB Standard *Leases*. In effect, the majority of operating leases (as defined by the current AASB 117) will be reported on the Statement of Financial Position under AASB 16.

Once the standard comes into effect, TCHHS will disclose right-of-use assets as a separate class of assets and the lease liabilities separately from other liabilities as well as provide a note disclosure.

From 1 July 2019 the funding arrangements will change from being all operating revenue to an interest portion funded by operating revenue and the principal portion being funded as capital equity injection.

Notes to the Financial Statements
30 June 2019

Note 25. Other information (continued)

(c) New accounting standards and interpretations not yet effective (continued)

The impact for TCHHS due to the changes from AASB 16 effective 1 July 2019 compared to the current application of AASB 117 is demonstrated in the table below, plus the impact on the Statement of Comprehensive Income in the first year;

TRANSITIONAL IMPACT OF AASB 16 STANDARD	
	$'000
Statement of Financial Position	**As at 1 July 2019**
Increase in right-of-use assets	10,743
Increase in lease liabilities	11,076
Net effect	**(333)**
Statement of Changes in Equity	**As at 1 July 2019**
Adjustment in opening accumulated surplus	333
Total adjustment	**333**
Statement of Comprehensive Income	**Year ending 30 June 2020**
Increase in interest expense	240
Increase in depreciation expense	2,539
Decrease in operating lease rentals	(2,261)
Net effect	**518**

There are no other standards effective for future reporting periods that are expected to have a material impact on TCHHS.

Notes to the Financial Statements
30 June 2019

Note 26. Budget vs actual comparison

Explanations of major variances
Major variances are generally considered to be variances that are material within the 'Total' line item that the item falls within.

Major variances have been identified and explained:

Statement of Comprehensive Income

User charges and fees:	The increase of $8.092m (4.0%) is partly due to growth in State funding through window adjustments ($3.9m). This relates to an increase in funding for depreciation ($0.913m), enterprise bargain funds ($0.835m) and movements for State and Commonwealth program initiative funding ($2.152m). State and Commonwealth program initiatives include nurse midwives ($0.201m), health practitioner education ($0.305m), activity improvements ($0.325m), dental integrated care innovation ($0.806m) and a nurse educator ($0.243m). Other increases relate to capital infrastructure project recoveries ($2.597m), natural disaster recoveries ($0.601), information technology recoveries ($0.265m) and the pharmaceutical benefit scheme ($0.339m)
Grants and other contributions:	The increase of $5.372m (44.2%) primarily relates to improvements in Rural and Remote Medical Benefits Scheme ($0.784m), Commonwealth practice incentive payments ($0.762m) and Commonwealth program funding ($1.439m), high drug cost recoveries ($0.364m) and recognition of services below fair value ($1.849m)
Employee expenses:	The increase of $2.079m (13.7%) relates partly to improvements in recruitment and retention of senior medical officers that were budgeted in the original Service Delivery Statements (SDS) as contractors ($1.012m) along with an increase of two medical staff funded from revenue improvements ($0.936m)
Department of Health contract staff:	The increase of $6.066m (5.8%) relates to higher than expected external labour costs where premium costs are charged
Supplies and services:	The increase of $4.917m (6.0%) relates primarily to increases in patient transport travel costs ($3.9m), consultancies ($0.885m), electricity ($0.254m), funded State and Commonwealth program costs ($0.840m), operating lease costs ($1.127m) and the recognition of services below fair value ($1.849m). These increases were offset by a reduction in contractor costs ($3.783m)

Notes to the Financial Statements
30 June 2019

Note 26. Budget vs actual comparison (continued)

Statement of Financial Position

Cash and cash equivalents:	Refer to commentary under Statement of Cash Flows
Receivables:	The increase of $2.041m (105.5%) relates to an increase in capital project recoveries ($0.241m), rural generalist medical officer salary recoveries ($0.209m), natural disaster recoveries ($0.469m), Queensland ambulance facility fees ($0.131m) and revenue improvements in the remote medical benefit scheme in the last quarter of 2018-19 ($0.907m)
Property, plant and equipment:	The decrease of $11.285m (5.7%) primarily relates to the delay in capital projects at Mer, Coconut and Stephen islands due to land tenure issues
Payables:	The decrease of $1.130m (5.7%) relates primarily to a reduction in the use of external contract labour liabilities ($1.102m) as well as a reduction in grants payable ($0.519m)
Unearned revenue:	The increase of $2.687m relates to unplanned State and Commonwealth program surpluses
Contributed equity:	The decrease of $11.480m (6.1%) primarily relates to the delay in capital projects at Mer, Coconut and Stephen islands due to land tenure issues
Asset revaluation surplus:	The increase of $1.601m (9.7%) in relates to actual indexation for built assets being 1.5% higher than planned indexation of 1.00%

Notes to the Financial Statements
30 June 2019

Note 26. Budget vs actual comparison (continued)

Statement of Cash Flows

User charges and fees:	The decrease in cash inflows is lower than budgeted primarily due to the same factors outlined in the major variances for the Statement of Comprehensive Income.
Grants and other contributions:	The increase in cash inflows is higher than budgeted primarily due to the same factors outlined in the major variances for the Statement of Comprehensive Income.
Employee expenses, Department of Health contract staff and supplies and services:	The increase in cash outflows is higher than budgeted primarily due to the same factors outlined in the major variances for the Statement of Comprehensive Income.
Payments for property, plant and equipment:	The increase in cash flows from investing activities is higher than the budgeted figure due to the same factors outlined in the major variances for the Statement of Financial Position.
Proceeds from equity injections:	The decrease in cash flows from the financing activities is higher than the budgeted figure due to the same factors outlined in the major variances for the Statement of Financial Position.

Torres and Cape Hospital and Health Service
Management Certificate
For the year ended 30 June 2019

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

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

b) the financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Torres and Cape Hospital and Health Service for the financial year ended 30 June 2019 and of the financial position of Torres and Cape Hospital and Health Service at the end of that year; and

We acknowledge responsibility under s.8 and s.15 of the *Financial and Performance Management Standard 2009* 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 throughout the reporting period.

Elthies Kris
Board Chair

23/8/19

Beverley Hamerton
Health Service
Chief Executive

23/8/19

Danielle Hoins - CPA
Chief Finance Officer

23/8/2019

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INDEPENDENT AUDITOR'S REPORT

To the Board of Torres and Cape Hospital and Health Service

Report on the audit of the financial report

Opinion

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

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2019, and its financial performance and cash flows for the year then ended

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

The financial report comprises the statement of financial position as at 30 June 2019, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

Basis for opinion

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

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

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

Key audit matters

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

Queensland Audit Office
Better public services

Specialised buildings valuation ($164.8m)

Refer to Note 12 in the financial report.

Key audit matter	How my audit addressed the key audit matter

Buildings were material to Torres and Cape Hospital and Health Service at balance date, and were measured at fair value using the current replacement cost method. Torres and Cape Hospital and Health Service performed a comprehensive revaluation of approximately 23.6% of its building assets this year with the balance being revalued using indexation.
 	
The current replacement cost method comprises:
• Gross replacement cost, less
• Accumulated depreciation
 	
Torres and Cape 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; and
• 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 forecasting the remaining useful lives of building components.
The significant judgements required for gross replacement cost and useful lives are also significant for calculating annual depreciation expense.
	My procedures included, but were not limited to:
	• Assessing the adequacy of management's review of the valuation process.
	• Assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices.
	• Assessing the competence, capabilities and objectivity of the experts used to develop the models;
	• Reviewing the scope and instructions provided to the valuer, and obtaining an understanding of the methodology used and assessing its appropriateness with reference to common industry practices
	• For unit rates associated with buildings that were comprehensively revalued this year on a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the:
	  ○ modern substitute (including locality factors and oncosts)
	  ○ adjustment for excess quality or obsolescence.
	• For unit rates associated with the remaining specialised buildings:
	  ○ Evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices; and
	  ○ Recalculating the application of the indices to asset balances.
	• Evaluating useful life estimates for reasonableness by:
	  ○ Reviewing management's annual assessment of useful lives;
	  ○ Testing that no 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; and
	  ○ Reviewing assets with an inconsistent relationship between condition and remaining useful life.
	• Where changes in useful lives were identified, evaluating whether they were supported by appropriate evidence.
	• Reconciling the fair value of the buildings as determined by the valuer to the underlying accounting records and disclosures in the financial statements

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Better public services

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 2009* and Australian Accounting Standards, and for such internal control as the Board determines is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

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

Report on other legal and regulatory requirements

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2019:

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

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

C. G. Strickland

29 August 2019

C G Strickland
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

Annual Report 2018–2019
Torres and Cape Hospital and Health Service
www.health.qld.gov.au/torres-cape