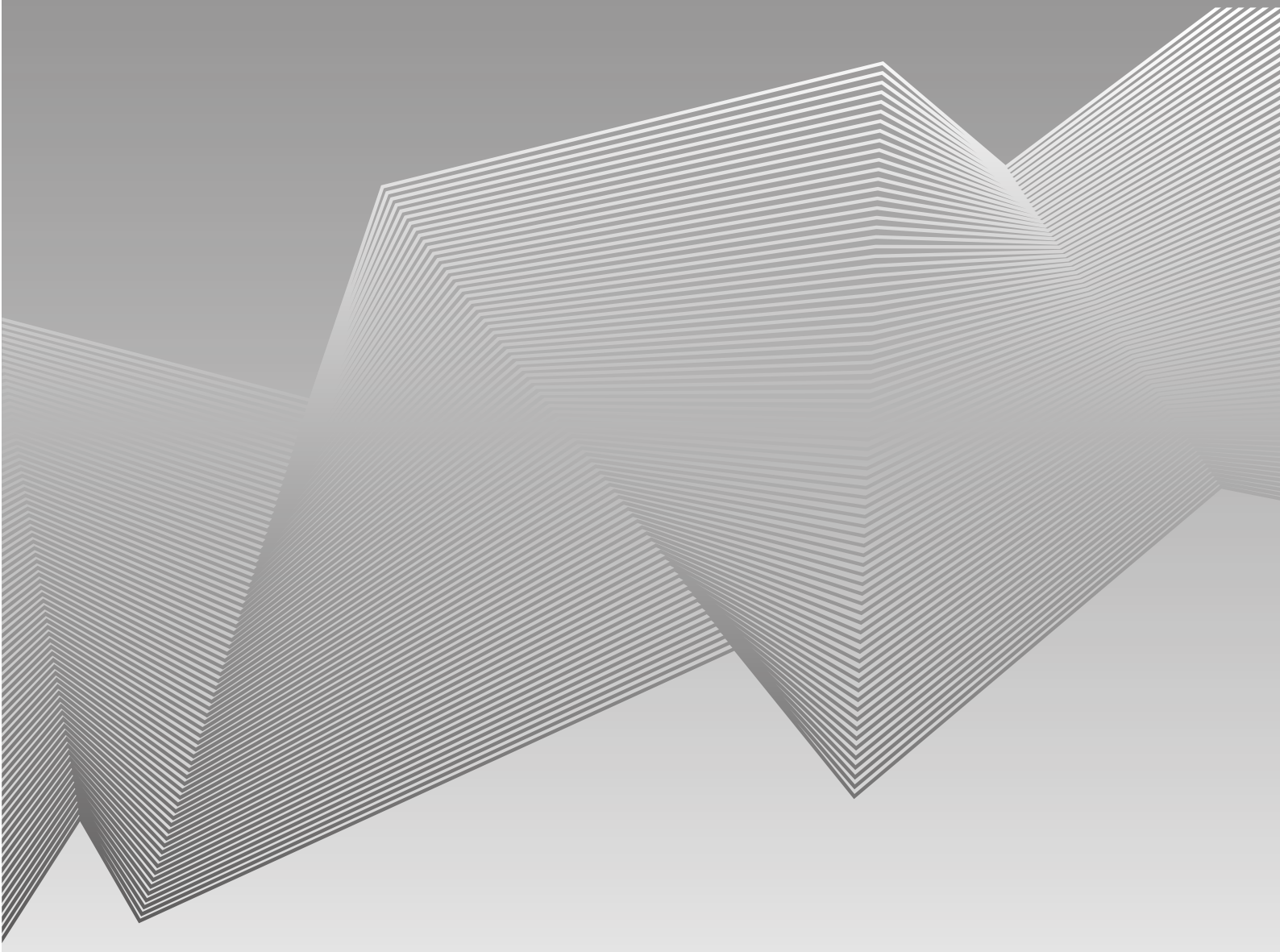
Torres and Cape Hospital and Health Service

ANNUAL REPORT 2020–2021



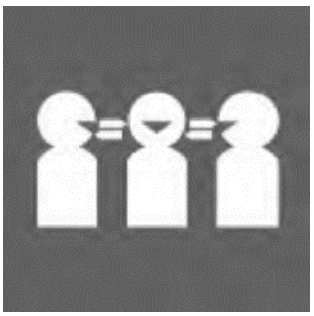
Queensland Government

Information about consultancies, overseas travel, and the Queensland language services policy is available at the Queensland Government Open Data website (qld.gov.au/data). Torres and Cape Hospital and Health Service has no expenditure on overseas travel to report on during 2020-2021.

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.

04 September 2021

The Honourable Yvette D'Ath MP

Minister for Health and Ambulance Services

GPO Box 48

Brisbane QLD 4001

Dear Minister

I am pleased to submit for presentation to the Parliament the Annual Report 2020–2021 and financial statements for 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 84 of this annual report.

Yours sincerely

Elthies (Ella) Kris

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 (TCHHS) is committed to the Unite and Recover – Queensland's Economic Recovery Plan. Our policies, strategies and services align with the outcomes of:

- Safeguarding our Health
- Backing our frontline services
- Supporting jobs
- Growing our Regions

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.

TCHHS's vision aligns with the directions outlined in My health, Queensland's future: Advancing health 2026.

MESSAGE FROM THE BOARD CHAIR AND CHIEF EXECUTIVE

In 2020-2021, we continued to build on our strong financial position, undertook significant infrastructure projects and furthered the Health Service's Strategic Plan. We have continued to be COVID-19 ready by balancing our public health response with a community-by-community vaccination rollout that has resulted in a positive community response.

The establishment of management plans for all vulnerable patients within TCHHS and the establishment of the Clinical Coordination Hub has assisted with the appropriate streaming of patients to the specialist services they require which is a key component in our strategic objective of excellence in healthcare.

We would like to acknowledge and thank all our staff for the commitment, adaptability, resilience, and empathy that they have shown during the COVID-19 pandemic and vaccination rollout. The work they continue to do to improve the health of the people of Cape York, the Northern Peninsula Area and the Torres Strait is exemplary.

We would like to thank State Government and the Honourable Yvette D'Ath MP, Minister for Health and Ambulance Services for our ongoing funding and support to maintain our services and infrastructure works. We would also like to thank the Board and the Executive for their ongoing commitment to our region and acknowledge outgoing Board Members, Mrs Tracey Jia, Mr Horace Baira and Mr Brian Woods. Mrs Jia has been a Board Member since 2014, and Mr Baira and Mr Woods since 2015. Their collective wealth of local experience and knowledge has been invaluable, and we wish them well for their future endeavours.

Joining the Board, we welcome Ms Susan Hadfield, Mr Darren Thamm, Ms Marjorie Pagani and Ms Karyn Sam. Our new Board Members bring a variety of expertise in clinical, financial; cultural and community matters and we look forward to their contributions.

The Board reviewed and amended TCHHS's Strategic Plan to reflect the impact of COVID-19 and the changes to the Queensland Government's objectives for the community. We were pleased to officially launch our Organisational Values in July 2020 of Courage, Accountability, Respect and Engage. In 2020-2021 TCHHS launched or progressed $84 million worth of new and vital infrastructure projects including:

- $46 million redevelopment of Thursday Island Hospital and Primary Health Care Centre
- $17.4 million redevelopment of five Primary Health Care Centres on Dauan, Poruma, Masig, Ugar and Moa Islands
- Opening dedicated administration space and progressing redevelopment plans for the Cooktown Multi-Purpose Health Service
- $3.6 million construction of new staff accommodation at Bamaga Hospital
- $1.9 million for the supply and installation of a CT scanner at Weipa Hospital
- $1.8 million for stage one of the Weipa Birthing project
- $840,000 for the detailed business case for the redevelopment of Cooktown Multi-Purpose Health Service

With nearly 60 per cent of our local population identified as vulnerable patients, it is critical that their healthcare is delivered by the right people with the right skills, at the right place and right time.

The Clinical Coordination Hub, a joint initiative between TCHHS and Cairns and Hinterland Hospital and Health Service, has processed nearly 17,000 patient referrals amongst 48 different specialties, ensuring a high-level traceability, security, and increased patient safety.

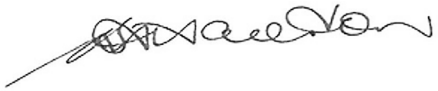
In May 2021, the Weipa Community Wellness Centre opened, providing continuity of patient care across primary, secondary and tertiary health services. The service supports early detection and management of chronic diseases, reducing the number of non-urgent presentations to Weipa Hospital's emergency department and minimizing potentially preventable hospitalisations over the longer term.

We continued our investment in ear health in January with $1.8 million to implement and evaluate a new and innovative model of service delivery across Cape York, the Northern Peninsula Area and the Torres Strait. A Rural Generalist with advanced training in ear, nose and throat (ENT) service provision, an ENT Clinical Nurse and Aboriginal and Torres Strait Islander Health Worker will work with the primary health care teams using a multidisciplinary case management approach with clinical support from a team of remote specialist otolaryngologists. The program supports upskilling, capacity and capability building of the local community teams to effectively manage ear disease in their community.

In 2020-2021, TCHHS spent $259.92 million with large investments made in infrastructure and services. We achieved a small underlying operating surplus and reported a comprehensive surplus of $2.3 million due to the re-valuation of land and recognition of property assets with historic ownership anomolies. In 2021-2022, we will continue to invest in infrastructure and services such as re-introducing a holistic low-risk maternity service for families in Weipa and Western Cape York, and defining and implementing a new model of care that is reflective of all our communities in Cape York and the Torres Strait.

It is with great pleasure that we present to you Torres and Cape Hospital and Health Service's 2020-2021 Annual Report.

Elthies (Ella) Kris
Board Chair



Beverley Hamerton
Chief Executive.

ABOUT US

TCHHS is an independent statutory body governed by a single Board established under the *Hospital and Health Boards Act 2011*. It is managed from hubs in Weipa, Cairns and Thursday Island and 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. TCHHS is comprised of 31 primary health care centres, two hospitals, a Multi Purpose Health Service and an Integrated Health Service. Sixty-four per cent of the population in the region identify as Aboriginal and/or Torres Strait Islander. We are 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 following extensive collaboration with our staff and community. It sets the future directions and actions for TCHHS 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 healthcare journeys
- Embracing cultural diversity
- Collaborating and connecting with communities and agencies
- Enhancing the capability, safety and wellbeing of the workforce
- Maximising the use of technology
- Respecting, protecting and promoting the rights and safety of all within Torres and Cape
- Sustainable financial management

OUR PRIORITIES

- Excellence in Healthcare: Healthcare 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

TARGETS AND CHALLENGES

OUR TARGETS:

- Closing the Gap
- Preventative healthcare
- 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 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 is 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.
- Patient transfer costs are high in delivering health services to a diverse population living in rural and extremely remote areas.

OUR VALUES

TCHHS officially launched its own values in July 2020. After 26 face-to-face sessions in 10 locations and more than 20 virtual consultation sessions and surveys, the values that staff decided on were:

- Courage
    - Being courageous and striving for excellence
    - Giving feedback
    - Driving innovative ideas
    - Doing the right thing
- Accountability
    - Being accountable to yourself, your commitments and your communities
- Respect
    - Being sensitive to the thoughts and feelings of others
    - Having integrity
    - Valuing the differences in others
- Engage
    - Working together
    - Continuously improving
    - Supporting others in the workplace

The values describe the core principles which shape the direction of TCHHS. New staff are introduced to our values during orientation, and they have been embedded into recruitment and training processes.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

TCHHS has the largest percentage of people in Queensland identifying as Aboriginal and Torres Strait Islander as well as the greatest diversity of Traditional Owner Groups. There are more than 16,000 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.

STRONGER MOB, LIVING LONGER

TCHHS is one of 12 key health service providers involved in the F*ar North Queensland Aboriginal and Torres Strait Islander Peoples Health Plan 2019- 2022: Stronger Mob, Living Longer* (the Plan). The coalition is made up of 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:

- promotion, prevention and public health services for Aboriginal and Torres Strait Islander peoples
- integration between Aboriginal and Torres Strait Islander peoples primary and acute health services
- more efficient, effective patient transport and accommodation services for Aboriginal and Torres Strait Islander peoples
- addressing the social determinants of health for Aboriginal and Torres Strait Islander peoples
- better access to, and sharing of data and information across providers
- coordinated and collaborative approach to Aboriginal and Torres Strait Islander workforce development.

The Plan aligns with TCHHS's priorities of 'Excellence in healthcare' and 'Advance health through strong partnerships'. Implementation of key actions under each of the priorities are expected to lead to benefits for the community and service delivery providers across both primary and acute care sectors. Some initiatives which are being, or have been progressed are:

- Care Coordination Hub, integrated health sector partnership project
- regional consultation and coordinated response to the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031
- hosting sector/industry expert’s to provide greater insight into various topics i.e. workforce, data and information, health information systems etc
- advanced and transitioned regional transport hub project

PROGRAMS FUNDED FOR ABORIGINAL AND TORRES STRAIT ISLANDER RESIDENTS

In 2020-2021 $3.29 million in funding was provided to TCHHS 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 Department of Health's Aboriginal and Torres Strait Islander Health Branch. With this funding, TCHHS undertakes a number of ongoing initiatives and projects that contribute to the improvement of Aboriginal and Torres Strait Islander health outcomes. These include:

- **Torres Strait Hostel - Meriba Mudh:** The hostel has procured new furnishings throughout the facility, improving the standard of client comfort. The centre also hosted 25 informal education sessions for clients on midwifery, early intervention parenting support, maternal and child health, renal support and diabetes. A formal process is being drafted to fully capture the provision of education and services to clients while staying at the facility.
- **Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033 - Torres Strait and Cape York:** In response to COVID-19, online cultural capability training and education has continued in 2020-21. Seventy-six per cent of staff completed the online face-to-face course throughout the year.
- **Northern Peninsula Area Maternal and Infant Service and Outreach Maternal Health Service:** The program has continued to receive positive consumer feedback with 465 antenatal occasions of service (OOS) provided between January and June 2021. The program has works closely with diabetes educators and the NGO Northern Peninsula Area Family and Community Services (NPAFACS) to deliver multidisciplinary care.
- **Child and Youth Mental Health Service - Aurukun (CYMHSA):** Despite widespread, prolonged community unrest and social distancing restrictions due to COVID-19, CYMHSA was able to maintain its service to the community of Aurukun, providing 298 OOS between January and June 2021, and increase of 54 occasions on the previous reporting period. Partnerships with Koolkan Aurukun Community School, Education Queensland and the local Indigenous Knowledge Centre provided education on transition to Boarding School, and transition from Kinder to Prep.
- **Transition to Community Control Project:** TCHHS continues to work with Apunipima, Torres Health, NPAFACS and other partners to increase community partnerships in the delivery of primary healthcare services. Napranum has been identified as the next possible community for transition to community control. COVID-19, adverse weather and cultural events saw scheduled meetings with Napranum Aboriginal Shire moved from April to July 2021.
- **North Queensland STI Action Plan:** Women's Health Program \ Aboriginal and Torres Strait Islander Sexual Health Men's program \Supporting Syphilis Outbreaks in Remote Indigenous Communities \ Enhanced Sexual Health services in Torres Strait and Northern Peninsula Area.
  COVID-19 social distancing measures continued to prevent outreach clinics for Women's and Men's Health programs, reducing service capability. Despite this, our Primary Health Care Centres have noted a reduction in STI diagnoses, with seven Primary Health Care Centres (PHCCs) achieving greater than 60 per cent in screening rates in their communities.

OUR COMMUNITY BASED AND HOSPITAL-BASED SERVICES

TCHHS 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.

We are 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.

Thursday Island Hospital is a Level 3 facility providing moderate-risk inpatient and ambulatory care clinical services. Weipa IHS and Cooktown 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. TCHHS 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 TCHHS's business, finance, human resources, asset management, 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. TCHHS 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.

REGIONAL HEALTH PARTNERSHIPS

As part of our strategic plan to achieve "excellence in healthcare" and "advance health through strong partnerships", TCHHS maintains agreements and close working partnerships with local healthcare 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 Hospital and Health Service
- Centre for Chronic Disease, Australian Institute of Tropical Health and Medicine – James Cook University.

Through these partnerships, we support a wide range of healthcare providers including outreach teams and visiting specialists from other health services and non-government providers to deliver healthcare for people closer to their homes. TCHHS works in collaboration with visiting specialists including paediatricians, ophthalmologists, renal specialists and surgeons who use HHS facilities and typically travel from Cairns.

CONSUMER AND COMMUNITY ENGAGEMENT

TCHHS continues to advance its Consumer and Engagement Strategy 2019 – 2022 which links in with TCHHS's Strategic Plan 2019 – 2023. The Consumer and Engagement Strategy 2019 – 2022 and the Clinician Engagement Strategy support TCHHS to deliver effective, person centred care to the diverse individuals and the communities that TCHHS serves.

The Consumer and Community Engagement Plan was reviewed and republished in 2021. The Australian Commission on Safety and Quality in Health Care's National Safety and Quality Health Service Standards (NSQHSS) 2nd edition are mapped into the

Consumer and Engagement Plan thus providing a guide for the Plan's actions to meet the required Standards.

The TCHHS Consumer Advisory Committee (CAC) meets quarterly to facilitate discussion regarding Consumer requirements, issues and feedback.

The CAC subsequently provides advice on improving health services to TCHHS's Governing Body, Executive and to the NSQHSS committees by:

- providing advice and facilitating consumer and community engagement, involvement and partnerships
- providing trained consumer representatives to contribute to engagement and partnership initiatives and statutory requirements
- advancing consumer/community understanding of NSQHSS and participating in the NSQHSS Committees
- discuss HHS performance data and how it affects consumers
- providing feedback from the TCHHS to the Community and report information/community needs and expectations back to TCHHS.

In addition, the overall TCHHS consumer experience survey responses have continued to increase.
The responses are collected and collated through the Measurement and Analysis Reporting System. Each facility is asked to collect five consumer experience surveys per month. The results demonstrate a high level of satisfaction including that the TCHHS facilities feel safe and welcoming, the consumers and healthcare Team worked together to plan care, make decisions, explained the care at a level that could easily be understood and made required referrals.

TCHHS is progressing its plans for new health infrastructure in the region. By talking with communities about their ideas and needs, TCHHS can add 'cultural character' to future building designs. An expression of interest advertisement has been released to engaged potential artists who are willing to provide works and advice for new developments. TCHHS is in the process of evaluating potential artists and their work for the redevelopment of Thursday Island Hospital and Primary Health Care Centre. It is expected that successful artists will be engaged in the first half of 2021-2022 financial year.

TCHHS has recently joined the Queensland Patient Reported Experience Measure program. This program can capture real-time patient experience measures that will support clinicians in partnering with patients to achieve safe, high quality care. The CAC will also receive the reports and participate in data analysis.
The Patient Reported Outcome Measures will be introduced in TCHHS in 2021-2022.

GOVERNANCE: OUR PEOPLE
BOARD MEMBERSHIP

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 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 healthcare and public health. Ms Kris is Chair of the Board Executive Committee and is a Member of the Finance and Performance Committee.

Karen (Kaz) Price

Board Member (Appointed 11/12/2015) (Current term 18/05/2020 to 31/03/2024)

Ms Price is currently Chief Executive Officer of the Cooktown District Community Centre and has previously served eight years as a Councillor for Cook Shire and was a former manager of the Cape York Hospital and Health Service Learning and Development Unit. Ms Price is the Chair of the Audit and Risk Committee and is a member of the Board Executive Committee.

Dr Scott Davis

Board Member (Appointed 18/05/2016) (Current term 18/05/2020 to 31/03/2022)
Dr Davis 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. He holds a doctorate in Indigenous Community Capacity Development (social and economic development) and a Masters in International Public Health.
Dr Davis is the Chair of the Safety and Quality Committee and is a member of the Board Executive 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. Ms Shibasaki is recognised for introducing management and system reforms in several community health organisations. Ms Shibasaki is a member of the Audit and Risk Committee and the Finance and Performance Committee.

Ms Karen Dini-Paul

Board Member (Appointed 18/05/2020) (Current term 15/05/2020 to 31/03/2022)

Ms Dini-Paul offers more than 20 years' experience in business management, workforce development, strategic leadership and delivery of human services for government and non-government organisations in Far

North Queensland, including Uniting Care Queensland, Wuchopperen Aboriginal Health Service, Act for Kids and the Department of Communities. Ms Dini-Paul is a member of the Finance and Performance Committee and the Safety and Quality Committee.

Ms Susan Hadfield

Board Member (Appointed 29/09/2020) (Current term 18/05/2021 to 31/03/2024)

Ms Hadfield is currently retired after more than 40 years working in clinical nursing, leadership, and management of clinical services roles throughout both rural, regional and metropolitan Queensland. Ms Hadfield is committed to improving the experience of health service users and delivery of health services and outcomes for people in rural and remote communities. An area of experience and advocacy Ms Hadfield offers is inclusion of service reforms which are sensitive to the Indigenous people and rural and remote communities. Ms Hadfield is Chair of the Finance and Performance Committee and is a member of the Board Executive Committee and the Safety and Quality Committee.

Mr Darren Thamm

Board Member (Appointed 18/05/2021) (Current term 18/05/2021 – 31/03/2024)

Mr Thamm offers more than 20 years of experience in the field of accounting within commerce and public accounting across a wide number of industry sectors. Mr Thamm is a Fellow Chartered Accountant, a Registered Company Auditor, and a Certified Internal Auditor. He is a partner of Jessups North Queensland, a specialist auditing and assurance firm based in North Queensland and has acted as Auditor for a wide range of clients across local government, indigenous organisations, charities and not-for-profit community organisations. Mr Thamm is a member of the Audit and Risk Committee and the Finance and Performance Committee.

Ms Marjorie Pagani

Board Member (Appointed 18/05/2021) (Current term 18/05/2021 – 31/03/2024)

Ms Pagani has lived in far north Queensland most of her life, commencing her profession as a barrister in 1991, then primarily involved in the Children's Court and representing young people on Palm Island. Ms Pagani has more than 30 years' experience in law, mediation and arbitration, and board positions in the private, public, and government sectors, as well as holding the rank of Squadron Leader with the Royal Australian Air Force specialist legal corps for 17 years. Ms Pagani is the Chief Executive Officer of Angel Flight which offers free non-emergency medical transport flights for people in rural and remote areas to city centres. Ms Pagani is a member of the Audit and Risk Committee and the Safety and Quality Committee.

Ms Karyn Sam

Board Member (Appointed 18/05/2021) (Current term 18/05/2021 – 31/03/2024)

Ms Sam is a proud Torres Strait Islander woman who resides in Seisia, Northern Peninsula Area of Cape York. Ms Sam has extensive knowledge of Aboriginal and Torres Strait Islander health, specific to primary healthcare. Ms Sam has worked within the primary healthcare sector for the past 16 years including seven years in management positions and has enjoyed the challenges involved with the business and tailoring services to meet the specific needs of community. Ms Sam is a member of the Audit and Risk Committee and the Safety and Quality Committee.

Mrs Tracey Jia

Board Member (Appointed 01/07/2014) (term ended 17/05/2021)

Mrs Jia previously served as a Board Member for Cape York HHS Board from 2012. Mrs Jia currently works for a private company implementing the National Disability Insurance Scheme. Mrs Jia was a member of the Audit and Risk Committee and the Safety and Quality Committee.

Mr Horace Baira

Board Member (Appointed 19/01/2015) (term ended 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 was a member of the Finance and Performance Committee and the Safety and Quality Committee.

Mr Brian Woods

Board Member (Appointed 19/01/2015) (term ended 17/05/2021)

Mr Woods was appointed as a Board Member in January 2015. Mr Woods has a 35-year career in business and financial management, with 10 plus years executive-level experience in enabling and applying high standards of corporate governance, statutory compliance, policy, strategy and business performance across the region. He is a Certified Practicing Accountant, Fellow of CPA Australia and a Graduate Member of the Australian Institute of Company Directors. Mr Woods was a member of the Finance and Performance Committee and the Audit and Risk Committee.

Mr Terry Mehan

Board Adviser (Appointed 6/12/2019) (appointment ended 05/12/2020)
Mr Mehan was appointed Board Adviser for the Torres and Cape HHS Board in December 2019 by the then Minister for Health and Minister for Ambulance Services. Mr Mehan has an internationally recognised health career with 40 years' experience in management.

ROLE OF THE BOARD

Members of the Torres and Cape Hospital and Health Board (HHB) are appointed by the Governor in Council on the recommendation of the Minister for Health and Ambulance Services. The HHB is responsible for the governance and control of the HHS, appointing the Health Service Chief Executive, setting the HHS's strategic direction and monitoring the HHS's financial and operational performance.

This is to ensure strategic objectives are met, quality healthcare services are provided, compliance and performance is monitored, financial performance is achieved, and effective systems are maintained and community engagement through meaningful consultation and collaboration is strengthened. The key focus is on patient-centred care and meeting the needs of the community in line with government policies and directives and national standards. Our Board consists of nine members who bring a wealth of experience in including primary healthcare, health management, clinical expertise, financial management and community engagement. 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. These professional skills and community-based board members contribute to the governance of the TCHHS collectively as a Board through attendance at monthly meetings.

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.
To enable the Board to concentrate on substantial strategy and performance management matters, other supplementary Board work has been divested to four Board committees: the Executive Committee, the Safety and Quality Committee, the Audit and Risk Committee and the Finance and Performance Committee.

Board and Committee meeting attendance 2020-2021

	Board Meeting	Audit & Risk	Finance & Performance	Safety & Quality	Executive
Total Number of Meetings	13	5	8	5	10
Ella Kris	12 of 13		8 of 8		10 of 10
Tracey Jia ^^	9 of 11	4 of 4		2 of 4	
Scott Davis	10 of 13		6 of 7	5 of 5	7 of 10
Brian Woods^^	10 of 11	4 of 4	6 of 6		
Horace Baira^^	7 of 11		5 of 6	4 of 4	
Karen Price	13 of 13	5 of 5			10 of 10
Rhonda Shibasaki	12 of 13	4 of 5	6 of 8		
Karen Dini-Paul	13 of 13		7 of 8	4 of 4	9 of 9
Susan Hadfield**	9 of 9		1 of 1	3 of 4	8 of 8
Darren Thamm*	2 of 2	1 of 1	1 of 1		
Marjorie Pagani*	1 of 2	1 of 1		1 of 1	
Karyn Sam*	2 of 2	1 of 1		0 of 1	
Terry Mehan (Adviser) ^^^	7 of 7		2 of 2		

^^ term of appointment ended 17/05/2021
^^^ term of appointment ended 5/12/2020
* term of appointment commenced 18/05/2021
** term of appointment extended 18/05/2021
The total out of pocket expenses paid to the Board Members during 2020-2021 was $392.82

EXECUTIVE COMMITTEE

The Executive Committee is a formal committee of the Torres and Cape Hospital and Health Board as detailed in section 32A of the *Hospital and Health Boards Act 2011*. The main function of this Committee is to support the Board to develop the service plan for the HHS and monitor implementation. In addition, this Committee supports the development of the required engagement strategies and protocols, as well as works with the Health Service Chief Executive (HSCE) in responding to critical emergent issues. The Executive Committee met on a monthly basis and during the 2020-2021 year, and the Committee considered a number of matters, including:

- Organisational Strategic Plan
- Operational planning
- Aboriginal and Torres Strait Islander Workforce Strategy
- Consumer and Community Engagement Strategy.

THE SAFETY AND QUALITY COMMITTEE

The Safety and Quality Committee is a formal Committee of the Board established in accordance with schedule 1, section 8 of the *Hospital and Health Boards Act 2011*, and performs the functions described under part 7, section 32 of the *Hospital and Health Boards Regulation 2012*. The Safety and Quality Committee is to provide advice to the Board on matters relating to safety and quality of the HHS including strategies for the following;

- minimising preventable patient harm
- reducing unjustified variation in clinical care
- improving the experience of patients and carers of the HHS receiving health services.

This Committee also ensures the HHS is complying with national and state strategies, policies, agreements and standards relevant to promoting consultation with health consumers and members of the community about the provision of health services by the HHS. The Safety and Quality Committee met on a bimonthly basis and during the 2020-2021 year, and considered a number of matters, including:

- Clinical governance
- Patient safety and quality
- Staff health and safety
- Public health
- HHS and statewide Performance
- 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
    - Clinical Governance Framework.

THE AUDIT AND RISK COMMITTEE

The Audit Committee is a formal committee of the Board established in accordance with schedule 1, section 8 of the H*ospital and Health Boards Act 2011* and section 35 of the *Financial and Performance Standard 2019*. The purpose of the of the Audit Committee is to advise the Board on the adequacy of the Health Service's financial statements, internal control structure, internal audit function and legislative compliance systems. The Committee also oversees the Health Service's liaison with the Queensland Audit Office.

The Audit and Risk Committee has observed the terms of its charter and has had due regard to Treasury's Audit Committee Guidelines and met on a bimonthly basis. During the 2020-2021 year the Audit and Risk Committee considered, amongst others, the following matters:

- Financial statements
- 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
- Legislative Compliance Register
- Health Service Directives
- Department of Health and Chief Finance Officer Assurance Statements
- Changes to Accounting Standards
- Asset Stocktake and Impairment Assessment.

FINANCE AND PERFORMANCE COMMITTEE

The Finance and Performance Committee is a formal committee of the Board established in accordance with schedule 1, section 8 of the *Hospital and Health Boards Act 2011* and performs it functions as so described under part 7, section 33 of the *Hospital and Health Boards Regulation 2012*.

The purpose of the Finance and Performance Committee is to assess the Health Service's budgets and monitor the Health Service's cash flow and its financial and operating performance. The Finance and Performance Committee met on a monthly basis during the 2020-2021 year to consider, amongst others, the following matters:

- Service Agreement and Window Adjustments
- Budget principles and financial policy
- Organisational performance reporting
- Service delivery contracts
- Organisational sustainability planning
- Capital Projects
- Investment Government Committee Recommendations
- Own source revenue.

EXECUTIVE MANAGEMENT

HEALTH SERVICE CHIEF EXECUTIVE

Beverley Hamerton

Beverley Hamerton has been TCHHS's Chief Executive since April 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 have access to high quality, equitable healthcare.

EXECUTIVE DIRECTOR – ASSET MANAGEMENT

Dean Davidson

Dean Davidson started with TCHHS in 2016 as the Director of Travel, Contracts and Procurement and acted as the Executive Director Corporate Services prior to being appointed as the Executive Director Asset Management in 2019. Dean has a Bachelor of Commerce Degree (majoring in Economics, Logistics and Accounting) and a Master's in Business Administration and is focused on contemporary management practices, health equity and ensuring that TCHHS moves from managing assets to Asset Management.

EXECUTIVE DIRECTOR - FINANCE, INFORMATION AND DIGITAL SERVICES

Danielle Hoins

Danielle Hoins is a qualified Certified Practicing A Accountant with more than 15 years' experience in financial and corporate services management in the Queensland health sector. Ms Hoins expertise is in financial management, strategic and change management, and the development and implementation of corporate governance systems.

EXECUTIVE DIRECTOR - MEDICAL SERVICES

Dr Anthony Brown

Dr Tony Brown has practiced as a rural generalist doctor in rural and remote Australia for 30 years. Dr Brown is passionate about equity of resourcing and the delivery of excellent healthcare 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 healthcare domains.

EXECUTIVE DIRECTOR - NURSING & MIDWIFERY

Kim Veiwasenavanua

Kim Veiwasenavenua is the lead for Nursing and Midwifery Services 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 Far North Queensland.

EXECUTIVE DIRECTOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Venessa Curnow

Venessa 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. She has more than 21 years experience in strategic industry development at a national and state-wide level.

EXECUTIVE GENERAL MANAGER SOUTHERN SECTOR

Ian Power

Ian 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.

EXECUTIVE GENERAL MANAGER NORTHERN SECTOR

Tamara Sweeney

Tamara Sweeney recently worked for the Western Australia Country Health Service (WACHS) as the Operations Manager for the Gascoyne district which includes Carnarvon and Exmouth Hospitals and Coral Bay and Burringurrah Nursing Posts. Prior to working with WACHS, Tamara worked as a solicitor with DLA Piper working on coronial and medico-legal cases and with the Department of Health in WA working in industrial relations and employment law.

EXECUTIVE DIRECTOR ALLIED HEALTH

Viv Sandler

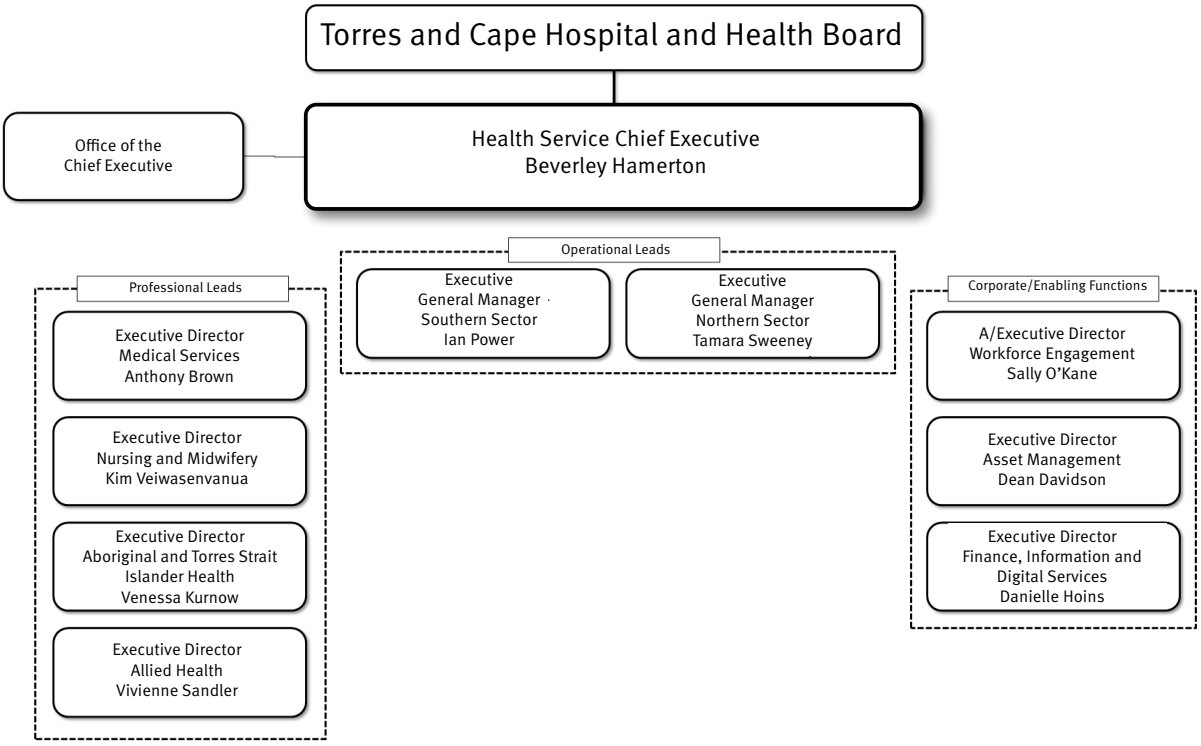
Viv Sandler started her career as a Physiotherapist and has broad clinical experience in areas including acute hospital care, rehabilitation, community health, aged care and private practice. Ms Sandler is a passionate advocate for Allied Health and the role it plays in regional and remote communities in prevention and treatment of disease and injury, and in optimising people's physical and mental wellbeing.

ACTING EXECUTIVE DIRECTOR WORKFORCE AND ENGAGEMENT

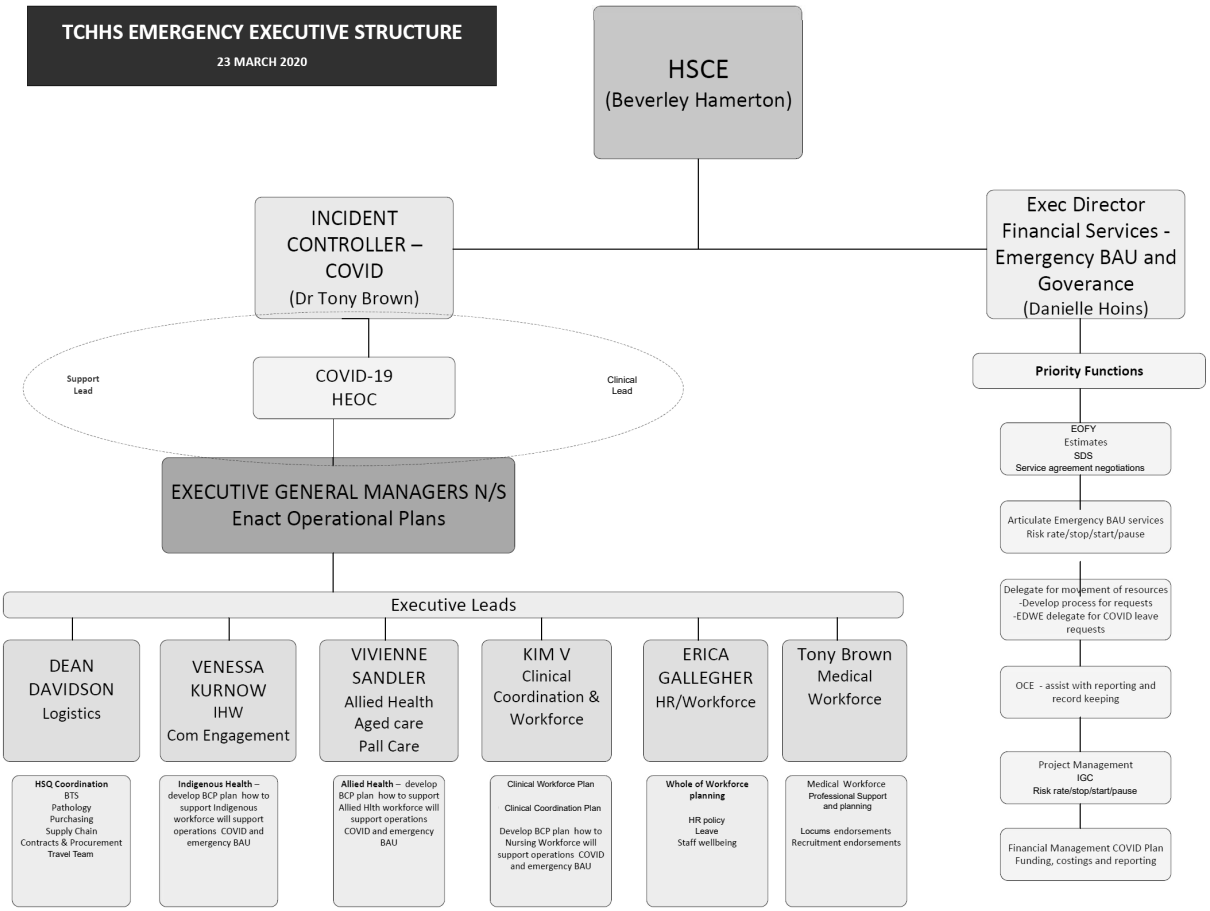
Sally O'Kane

Sally O'Kane's Human Resource career spans over 25 years and is responsible for all human resource related services provided to the employees of the Torres and Cape. She is passionate about improving the workplace culture and embracing our cultural diversity so employees truly feel valued and respected in a workplace so they can bring their best self to work.

ORGANISATION STRUCTURE AND WORKFORCE PROFILE



COVID-19 Health Emergency Organisation Centre (HEOC) 23 March 2020 – 10 July 2020



As part of our response to the COVID-19 Pandemic, TCHHS transitioned to a temporary organisational structure on 30 March 2020. The structure gave the organisation the agility to quickly respond in the event a confirmed case of COVID-19 was found in one or more of our communities. The structure also allowed for the continued delivery of emergent care and support for vulnerable members of the community. TCHHS reverted to its normal organisational structure on 10 July 2020.

At June 2021, TCHHS employed full-time equivalent (FTE) staff establishment of 1060.82, an increase of 13.38 staff from 2019-2020. A breakdown of these totals is reflected in the tables below. The permanent separation rate for 2020-2021 was 21.56 per cent. The permanent separation rate is due to a variety of factors, including the remoteness and accessibility of some of our facilities making staff retention difficult.

TCHHS has developed a draft Workforce Strategy 2021-2026 that will support its strategic objectives efficiently and effectively from a human resource, workforce planning and talent management perspective. Aligning with our HHS Strategic Plan, the Workforce Strategy focuses on:

- Growing the future workforce
- Recruiting for today and the changing world of work
- Building and retaining an effective, highly skilled, future focused and engaged workforce

Implementation of the strategy will begin in the first half of 2021-2022.

Table 1: More doctors and nurses*

	2016-17	2017-18	2018-19	2019-20	2020-21
Medical staff [a]	33	38	42	43	48
Nursing staff [a]	309	348	373	393	375
Allied Health staff [a]	67	72	78	74	103

Table 2: Greater diversity in our workforce*

	2016-17	2017-18	2018-19	2019-20	2020-21
Persons identifying as being First Nations [b]	157	176	175	195	203

Note: * Workforce is measured in MOHRI – Full-Time Equivalent (FTE). Data presented reflects the most recent pay cycle at year's end. Data presented is to June-21. Source: a DSS Employee Analysis, b Queensland Health MOHRI, DSS Employee Analysis

ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE

In 2020-2021, TCHHS employed 215 Aboriginal and Torres Strait Islander people (18.46 per cent) across all occupational streams. Supported by the Office of the Chief Aboriginal and Torres Strait Islander Health Officer, the Workforce Strategy Branch and the Office for Rural and Remote Health, TCHHS is continuing its implementation of an Aboriginal and Torres Strait Islander Workforce Development Strategy. Extensive consultation took place with staff and key stakeholders in the community from December 2020 through to February 2021 to identify the key recommendations to ensure:

- Professional development, leadership and career pathways for Health and Operational Workers
- Updated policies and procedures to enable Aboriginal and Torres Strait Islander Health Workers to work their full scope of practice
- Orientation packages developed by local staff to ensure cultural and clinical relevance to the community

The current unemployment rate amongst Aboriginal and Torres Strait Islander people living in our catchment is 23.4 per cent.

STRATEGIC WORKFORCE PLANNING AND PERFORMANCE

WORKFORCE DIVERSITY AND WELLBEING

TCHHS 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 Service (EAS) 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 EAS provides a dedicated online service to provide professional advice on financial issues impacting on an individual's wellbeing. The TCHHS 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

TCHHS has engaged constructively in 2020-2021 with industrial unions representing a diverse workforce. TCHHS 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

TCHHS's Recruitment Services are continually working to improve recruitment practices across the TCHHS with a key focus on contemporary recruitment practices, onboarding, the development of talent pools, and the delivery of robust recruitment and selection training.

In March 2021, a Nursing and Midwifery Recruitment Hub was established to focus on critical vacancies (PHCC Clinical Nurses and Clinical Nurse Consultants) and high turnover areas that were identified following resumption of our normal organisational structure. The hub was involved in 21 recruitment campaigns which resulted in 12 permanent positions and 13 relief pool positions being filled. Nursing and Midwifery workforce is also working to establish a centralised orientation model, financially viable reliever models and have partnered with the Department of Health's Nursing and Midwifery's Resource Team to examine Flexible Working Arrangements throughout TCHHS.

LEARNING AND DEVELOPMENT

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

Learning and Development adapted to the changing work environment that COVID-19 created throughout 2020-2021. Face to Face training has continued to occur where possible; however, this has been supplemented with virtual and on-line training. This change in delivery method required a shift in the format of content and an awareness campaign in the access and use of on-line delivery.

For the 2020-2021, Learning and Development Team facilitated or delivered the following training:

- Orientation to the organisation
- Line Manager training for Leading Teams, Human Resources and Finance Fundamentals
- Business Case in Practice via Queensland Treasury Corporation
- Lifestyles Inventory Leadership Development Programs
- Mentoring Programs with Better Health North
- Aboriginal and Torres Strait Islander Leadership Programs

EARLY RETIREMENT, REDUNDANCY AND RETRENCHMENT

No redundancy, early retirement or retrenchment packages were paid during the 2020-2021 financial year.

GOVERNANCE: OUR RISK MANAGEMENT

TCHHS 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 our region.

TCHHS uses an Enterprise Risk Framework, underpinned by the Queensland Department of Health's Risk Management Framework and is aligned to the principles of *ISO 31000:2018*. The Framework enables TCHHS 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.

TCHHS 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 RiskMan, a state-wide system.
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.

The *Hospital and Health Boards Act 2011* requires annual reports to state each direction given by the Minister to the HHS during the financial year and the action taken by the HHS as a result of the direction. During the 2020-2021 period, no directions were given by the Minister to TCHHS.

INTERNAL AUDIT

TCHHS has an established Internal Audit function in accordance with section 29 of the *Financial and Performance Management Standard 2019*. The organisation has engaged with an external consultant with the expertise 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 by:

- determining compliance with established policies, procedures, and statutory requirements
- identifying opportunities to improve business processes and recommending improvements to existing systems and
- conducting investigations and special reviews requested by management of the Audit and Risk Committee

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.
There were four main areas examined during 2020-2021:

- A review of the Work Health and Safety (WHS) Management Framework was undertaken to provide assurance that the WHS Framework was appropriately designed and operating effectively, in addition identify any gaps in WHS legislative compliance.

- A review to provide assurance that Service Level Agreement Outreach Services operates effectively, economically, and efficiently and that the internal control framework governing Service Level Agreements Outreach Services is adequate.
- A review of Own Source Revenue processes was undertaken to provide assurance that TCHHS processes operate effectively, economically, and efficiently and that the internal control framework governing own source revenue is adequate.
- A review of the Medical Workforce Strategy and Management was undertaken to provide assurance that;
- Medical Workforce Strategy and Management operates effectively, economically and efficiently
- The internal control framework governing Medical Workforce Strategy and Management is adequate
- TCHHS has controls in place to monitor and comply with the state award and agreement obligations for fatigue and leave management.

EXTERNAL SCRUTINY, INFORMATION SYSTEMS AND RECORD KEEPING

TCHHS's operations are subject to regular scrutiny from external oversight bodies. These include, but are not limited to:

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

For the 2020-2021 financial year, TCHHS was subject to the annual external audit by Queensland Audit Office. We have received an unqualified audit report on its financial statements for the 2020-2021 year. There are no significant findings or issues identified by this external reviewer on our operations or performance.
During 2020-2021 the Queensland Audit Office tabled a number of cross-service audits in Parliament relevant to TCHHS, including:

- Planning for sustainable health services - As per the report's recommendations, TCHHS demonstrated its alignment with statewide priorities, has integrated operational plans that incorporate environment action plans, has developed appropriate performance indicators and regularly evaluates the success of long-term plans.

The Office of the Health Ombudsman (OHO) finalised its review into the quality of services provided by Bamaga Hospital in August 2020. TCHHS accepted the 20 recommendations from the report and worked with the OHO to develop and implement an action plan, providing quarterly updates on its progress. There have been significant improvements at Bamaga Hospital since the death of Charles Gowa in 2017, including:

- Four medial officers in the Northern Peninsula Area offering seven day per week services (previously two medical officers).
- Regular programmed visits by our Consumer Liaison Officer
- Training and auditing of National Standard Eight is undertaken regularly
- a functioning multiagency Health Action Team at Bamaga Hospital

- Appropriate multiagency governance within the HHS to manage public health alerts
- Open disclosure and clinic governance frameworks have been reviewed within last 12 months
- The electronic medical record system used across the Torres and Northern Peninsula area is more functional

Patients and clients of TCHHS continue to be able to obtain access to records by applying under the *Right to Information Act 2009* and the *Information Privacy Act 2009*. We have made information available and processes are in place to assist patients in gaining access to their medical records. TCHHS 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.

In 2020-2021 TCHHS is an emerging lead in Digital Health Services in Rural and Remote Queensland and has made significant progress by implementing virtual models of cares in collaboration with key partners in the region. Consistent with the strategic objectives, a number of information technology, information management and digital health service improvements have occurred in 2020-2021 including:

- Enhancing digitally enabled healthcare during the COVID-19 pandemic
- Implementation of COVID-19 Public Health platforms to support vaccination rollout such as the Queensland COVID-19 Vaccination Management System
- Joint electronic primary health patient information system implementation across the TCHHS Cape York facilities
- Digital design and analytics to support the development of the Care Coordination Hub
- Development and deployment of clinical and business support dashboards to assist in the management of specialist's outpatient services It will also enhance the analysis of health service activities and key performance indicators under the Service Agreement with Department of Health. With the deployment of clinic schedule and capacity dashboards the HHS is able to direct service delivery based on capacity and demand rather than historical service pathways
- Introduction of a digital disaster and emergency management system
- Implementation of a patient and staff travel system
- Infrastructure and software upgrades for critical clinical information systems
- Development of Information Sharing protocols with Department of Health and our other key partners in the region
- Implementation of major network infrastructure upgrades in partnership with eHealth Queensland including satellite redundancy project at TCHHS facilities
- Implementation of secure firewall technologies in support of care closer to home and virtual care technologies
- Continual improvement of the TCHHS Information Security Management System and cyber security compliance and reporting
- Development of a Primary Health Care Data Warehouse to support enhanced Business Intelligence.

TCHHS has developed the Digital Health Strategy 2021-2025, with the aim to align to the Queensland Rural and Remote Digital Strategy. The goal of the strategy is to:

- utilise digital technologies to support face-to-face care
- to improve access to care where this is not possible
- enable transparent and equitable prioritisation of clinical resources when demand exceeds supply

As at 30 June 2021, the strategy was in its final round of staff consultation and is expected to be implemented early in 2021-2022.

During the mandatory annual Information Security reporting process, our HSCE attested to the appropriateness of the information security risk management within the TCHHS to the Queensland Government Chief Information Security Officer, noting that appropriate assurance activities have been undertaken to inform this opinion and TCHHS's security risk position.

QUEENSLAND PUBLIC SERVICE ETHICS

TCHHS is a prescribed public service agency under section 2 of the *Public Sector Ethics Regulation 2010* and is 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 TCHHS, 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 TCHHS's *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 TCHHS administrative procedures and management practices therefore have proper regard to the ethics principles and values, and the approved code of conduct.

HUMAN RIGHTS

TCHHS has integrated human rights into its *Strategic Plan 2019-2023*, organisational values, and mandatory training for clinical and non-clinical staff. All of our Human Resources and Work Health and Safety policies, procedures and guidelines were reviewed under a two-stage process last financial year to ensure their compatibility with the *Human Rights Act 2019*.

TCHHS has continued to play an essential role in the State Government's efforts to protect and support Queenslanders. From a human rights perspective, the following human rights were protected through actions taken by TCHHS:

- the right to health services
- the right to protection of families and children
- the right to human treatment when deprived of liberty
- the right to life

TCHHS was mindful of its obligation to act compatibly with human rights, by ensuring that any limitations on human rights were reasonable and justified. Actions taken by TCHHS include:

- Developed plans and procedures which would maximise the health service's ability to respond to COVID-19 and deliver COVID-19 vaccines whilst minimising its impact on the community
- Suspended services which could not be conducted in compliance with social distancing requirements or that would increase the risk of spreading COVID-19 throughout our communities
- Ensured flexible responses so that some services could continue despite social distancing requirements
- Increased funding to services working to support vulnerable communities and persons vulnerable to COVID-19
- Chartered aircraft to maintain to deliver COVID-19 vaccines to our communities

No Human Rights complaints were received by TCHHS during the reporting period.

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. TCHHS did not disclose confidential information in the public interest during 2020-2021 in accordance with s160 of the *Hospital and Health Board Act 2011*.

PERFORMANCE

TCHHS continue to progress against its strategic measures of success in 2020-2021. Some data results for 2020 - 2021 have been delayed, caused by the redeployment of staff during our COVID-19 response, the vaccination rollout and TCHHS's implementation of a new data collection system. The data will be available in the first half 2021-2022.

EXCELLENCE IN HEALTHCARE

The assessment for the NSQHS Standards has been re-scheduled to May 2022 due to COVID-19. Despite this, we have established Standards Committees that are tasked with education and gathering of evidence of proficiency in all standards. We have continued to make progress against the Closing the Gap targets, including maintaining a high level of performance in the proportion of women who attended five or more antenatal visits (as at December 2020 FYTD) with 95.6 per cent attendance recorded and 91.3 per cent of babies born at a healthy weight. TCHHS continues to work towards the goal of increasing self-sufficiency in its hospitals, achieving 55.14 per cent as of December 2020. The opening of the CT Scanner at Weipa Hospital and the implementation of a primary health patient information system across our facilities in Cape York in the second half of 2020-2021 will see a further increase in efficiency. TCHHS had a drop in its use of telehealth during 2020-2021, as face-to-face outreach services returned to our communities.

ADVANCE HEALTH THROUGH STRONG PARTNERSHIPS

TCHHS continues its strong partnership with consumers, with CAC members satisfied with their engagement with TCHHS and their influence on broader health policy and programs, such as the Thursday Island Hospital redevelopment and involvement in the Model of Care project. We have continued to participate in healthcare design and delivery and been consistent in participation with peak strategic bodies such as the Regional Health Partners (RHD) group. COVID-19 quarantines and restrictions have continued to impact on the number of clinical student placements throughout TCHHS, with 56 people placed as of December 2020, compared to 127 placements at the same time previous year. It is expected that numbers will remain below expectations until the COVID-19 pandemic ends.

A SAFE, ENGAGED, VALUED AND SKILLED WORKFORCE

Sixty-five per cent of staff completed their mandatory training in 2020-2021, a decrease over the previous year. Our Learning and Development team is undertaking face-to-face training sessions in Cairns, Cooktown, Weipa, Bamaga and Thursday Island to support a higher training uptake for 2021-22. Proactive hazard reporting steadily increased on last year with 54 per cent reported in December 2020, 34 per cent higher than the same time previous year. Information on the number of staff undertaking scholarships and training pathways is only available by calendar year. For 2020, 23 staff applied for training, less than half on the previous year. TCHHS has undertaken to increase visibility and education around training opportunities in 2021. Although TCHHS's percentage of Aboriginal and Torres Strait Islander Peoples in the workforce decreased from 18.62 to 18.46 percent, the actual number of employees increased 2020-2021 from 195 to 215.

The organisation is implementing an Aboriginal and Torres Strait Islander Workforce Development Strategy. Extensive consultation has taken place with staff and key stakeholders in the community to support professional development, leadership and career pathways for our Indigenous workforce.

A WELL GOVERNED ORGANISATION

TCHHS has met its planned financial position for 2020-2021, meeting its obligation to ensure all its services are provided as cost effectively as possible in a challenging high cost environment. We have succesfully delivered a number of projects, including the launch of the Clinical Coordination Hub, the redevelopment of five PHCCs on the outer islands of the Torres Strait and a new CT scanner for Weipa Hospital. As shown in the service standards section, TCHHS has acheived the majority of its key performance indicators for 2020-2021. Our executive is closely involved in developing and utilizing Business Intelligence Dashboards.

PERFORMANCE: SERVICE STANDARDS

Emergency departments across the Torres and Cape Hospital and Health Service performed above expectations in the per centage of people attending emergency departments seen within recommended timeframes. The per centage of people treated within four hours of their arrival in Emergency was 96 per cent, well above the target of 80 per cent.

The median wait time in Emergency Departments was eight minutes. In Elective Surgery, TCHHS exceeded all targets in the percentage of patients being treated within clinically recommended times, including 99 per cent of our category 3 patients.

In Telehealth, there has been an expected down trend this year as services return to visiting communities. The 2020-2021 target of 3,265 was OOS based on previous years projections which included the COVID-19 surge in Telehealth. Telehealth services expect to see an increase in activity in the 2021-2022 year, with an increase in the ability to capture Store and Forward images in treatment plans for services such as wound management, Ophthalmology and Ear, Nose and Throat services. There is a planned refocus in local facilities and community services on reduction of Failure to Attend rates and cancellation of services.

Table 3: Service Standards – Performance 2020-21

Torres and Cape Hospital and Health Service	2020-21 Target	2020-21 Actual
Effectiveness measures		
Percentage of emergency department patients seen within recommended timeframes[1]		
• Category 1 (within 2 minutes)	100%	98%
• Category 2 (within 10 minutes)	80%	94%
• Category 3 (within 30 minutes)	75%	91%
• Category 4 (within 60 minutes)	70%	91%
• Category 5 (within 120 minutes)	70%	97%
Percentage of emergency department attendances who depart within 4 hours of their arrival in the department[1]	>80%	96%
Percentage of elective surgery patients treated within the clinically recommended times[2]		
• Category 1 (30 days)	>98%	100%
• Category 2 (90 days)[3]	..	100%
• Category 3 (365 days)[3]	..	99%
Median wait time for treatment in emergency departments (minutes)[1]	..	8
Median wait time for elective surgery treatment (days)[2]	..	1
Efficiency measure		
Not identified		
Other measures		
Number of elective surgery patients treated within clinically recommended times[2]		
• Category 1 (30 days)	64	108
• Category 2 (90 days)[3]	..	43
• Category 3 (365 days)[3]	..	121
Number of Telehealth outpatients service events[4]	3,265	2,784
Total weighted activity units (WAU)[5]		
• Acute Inpatients	5,547	4,812
• Outpatients	2,319	3,775
• Sub-acute	395	618
• Emergency Department	2,405	2,605
• Mental Health	111	146
• Prevention and Primary Care	838	819
Ambulatory mental health service contact duration (hours)[6]	>8,116	11,233
Staffing[7]	1,059	1,061

1	During the rapid response to the COVID-19 pandemic, facilities utilised existing systems to manage presentations at fever clinics. In some cases, the management of these clinics was closely related to the management of the emergency department meaning that some fever clinic activity was managed via the emergency department systems. As a result, the 2020-21 Actual includes some fever clinic activity.
2	In preparation for COVID-19 and consistent with the National Cabinet decision, Queensland Health temporarily suspended non-urgent elective surgery in 2019-20. This has impacted the treat in time performance and has continued to impact performance during 2020-21 as the system worked to reduce the volume of patients waiting longer than clinically recommended.
3	Given the System's focus on reducing the volume of patients waiting longer than clinically recommended for elective surgery, and the continual impacts to services as a result of responding to COVID-19, treated in time performance targets for category 2 and 3 patients are not applicable for 2020-21.
4	Telehealth data reported as at 23 August 2021.
5	The 2020-21 Target varies from the published 2020-21 Service Delivery Statement due to a change in the WAU phase. All measures are reported in QWAU Phase Q23. As HHSs have operational discretion to respond to service demands and deliver activity across services streams to meet the needs of the community, variation to target can occur. Data reported as at 23 August 2021.
6	Mental Health measures reported as at 22 August 2021.
7	Corporate FTEs are allocated across the service to which they relate. The department participates in a partnership arrangement in the delivery of its services, whereby corporate FTEs are hosted by the department to work across multiple departments.

PERFORMANCE: FINANCIAL SUMMARY

TCHHS achieved small underlying operating surplus for the year ending 30 June 2021 of $216,000 and reported a comprehensive surplus of $2.3 million which was due to the recognition of an additional $2.1 million in re-valuation of land and recognition of property assets with historic ownership anomolies. The underlying operating surplus is a result of strong financial stewardship in a challenging environment of increasing costs pressures in a rural and remote region. TCHHS has invested in enhanced digital enablement and established a Virtual Care Coordination Hub to bring care closer to home for our communities. Other initiatives included significant investment in infrastructure to update the HHSs facilities.

During 2020-2021 TCHHS 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, look for efficiencies, manage costs and actively explore own source revenue initiatives while expanding services to our communities.

WHERE THE FUNDS CAME FROM

TCHHS income from combined funding sources was $262.25 million. Funding was primarily derived from non-activity-based funding from the Department of Health of $235.87 million. Other funding sources included other revenue $8.27 million, and grants and contributions $18.11 million, primarily from Australian Government contributions for Indigenous health programs, rural and remote medical benefits scheme and pharmaceutical benefits scheme. The Nation Partnership Agreement between the State and Commonwealth Governments funded the TCHHS COVID-19 response $8.42 million and First Nations COVID-19 funded the TCHHS $2.53 million.

WHERE FUNDING WAS SPENT

Total expenses for 2020-2021 were $259.92 million, averaging a $710,000 per day spend on serving the communities in our jurisdiction. The largest expense was against labour costs at $143.79 million. Supplies and services represent the second highest expense at $86.03 million which includes patient travel costs of $13.75 million, charter costs of $8.41 million, aeromedical retrieval costs (patient transport) of $4.04 million, lease costs of $13.26 million, external contractor costs of $15.09 million, electricity and other energy costs of $3.50 million and clinical supplies and services of $3.96 million. Total cost of the COVID-19 response was $8.01 million.

FINANCIAL POSITION

TCHHS'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 2020-2021 by 9.8 per cent or $19.96 million. This was primarily due to the increase in revaluation surplus of $16.57 million and reported financial surplus contribution from the recognition of historic asset anomalies inherited from the Department of Health.

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. Anticipated maintenance items are identified through the completion of triennial condition assessments, and the value and quantum of anticipated maintenance will fluctuate in accordance with the assessment programs and completed maintenance works.

As of 30 June 2021, TCHHS had reported total anticipated maintenance of $33.9 million. TCHHS has a rolling condition assessment program for its major facilities, and the value of anticipated maintenance may vary as a result. We have the following strategies in place 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. After review, work is either actioned promptly or deferred if it is safe to do so.
- If eligible, high risk anticipated maintenance items will be requested through the internal Minor Capital funding source and prioritised based on risk.
- All grant applications where anticipated maintenance items are eligible to receive funding are submitted.
- Currently the HHS has obtained funding from Priority Capital Program and a further allocation from the Emergent Works Program to address current critical anticipated maintenance issues and will continue to seek this funding source for any further anticipated maintenance items that are not safe to defer.

FUTURE OUTLOOK

TCHHS has begun an exciting transformational journey with the introduction of virtual care coordination and enhanced digital monitoring which will start to realise the benefits of self-sufficiency and care closer to home. A comprehensive set of strategic planning activities and projects has commenced to continue to transform and position the HHS as a leader in digital rural and remote primary healthcare.

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

Financial Statements 30 June 2021

30 June 2021

Contents

Statement of Comprehensive Income
For the year ended 30 June 2021

	Note	2021 Actual $'000	2021 Adjusted Budget $'000	2021 *Budget Variance $'000	2020 Actual $'000
Income					
User charges and fees	2	2,036	4,906	(2,870)	1,558
Funding for public health services	3	235,868	216,890	18,978	216,999
Grants and other contributions	4	18,108	17,069	1,039	20,882
Other revenue	5	6,234	1,289	4,945	3,203
Interest		2	-	2	2
Total revenue		**262,248**	**240,154**	**22,094**	**242,644**
Expenses					
Employee expenses	6	19,358	19,698	(340)	18,061
Department of Health contract staff	7	124,428	123,627	801	118,840
Supplies and services	8	86,032	74,882	11,150	82,209
Depreciation	14	20,033	18,649	1,384	18,065
Impairment losses		32	10	22	165
Other expenses	9	10,036	3,288	6,748	15,105
Total expenses		**259,919**	**240,154**	**19,765**	**252,445**
Operating result for the year		**2,329**	**-**	**2,329**	**(9,801)**
Other comprehensive income					
Items that will not be reclassified to operating result					
Increase in asset revaluation surplus	18	16,568			10,744
Total other comprehensive income		16,568			10,744
Total comprehensive income		**18,897**			**943**

**An explanation of major variances is included at Note 31*

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

Statement of Financial Position
As at 30 June 2021

	Note	2021 Actual $'000	2020 Actual $'000
Current assets			
Cash and cash equivalents	10	32,540	26,668
Receivables	11	5,996	3,610
Inventories	12	585	531
Other assets	13	1,315	1,252
Total current assets		**40,436**	**32,061**
Non-current assets			
Property, plant and equipment	14	214,095	192,185
Right-of-use-assets	14	6,624	6,404
Total non-current assets		**220,719**	**198,589**
Total assets		**261,155**	**230,650**
Current liabilities			
Payables	15	28,386	18,823
Lease liabilities	19	3,057	2,962
Accrued employee benefits	16	1,408	1,393
Other liabilities	17	779	22
Total current liabilities		**33,630**	**23,200**
Non-current liabilities			
Lease liabilities	19	3,561	3,450
Total non-current liabilities		**3,561**	**3,450**
Total liabilities		**37,191**	**26,650**
Net assets		**223,964**	**204,000**
Equity			
Contributed equity		171,780	170,713
Accumulated surplus		6,797	4,468
Asset revaluation surplus	18	45,387	28,819
Total equity		**223,964**	**204,000**

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 2021

	Contributed equity $'000	Accumulated surplus $'000	Asset revaluation surplus $'000	Total equity $'000
Balance at 1 July 2019	177,717	14,269	18,075	210,061
Operating result for the year	-	(9,801)	-	(9,801)
Other comprehensive income				
Increase in asset revaluation surplus	-	-	10,744	10,744
Total comprehensive income for the year	-	(9,801)	10,744	943
Transactions with owners as owners				
Equity asset transfer during the year	-	-	-	-
Equity injections	11,062	-	-	11,062
Equity withdrawals (depreciation funding)	(18,066)	-	-	(18,066)
Balance at 30 June 2020	**170,713**	**4,468**	**28,819**	**204,000**
Balance at 1 July 2020	170,713	4,468	28,819	204,000
Operating result for the year	-	2,329	-	2,329
Other comprehensive income				
Increase in asset revaluation surplus	-	-	16,568	16,568
Total comprehensive income for the year	-	2,329	16,568	18,897
Transactions with owners as owners				
Equity asset transfer during the year	452	-	-	452
Equity injections	20,648	-	-	20,648
Equity withdrawals (depreciation funding)	(20,033)	-	-	(20,033)
Balance at 30 June 2021	**171,780**	**6,797**	**45,387**	**223,964**

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

Statement of Cash Flows
For the year ended 30 June 2021

	Note	2021 Actual $'000	2020 Actual $'000
Cash flows from operating activities			
Inflows:			
User charges and fees		2,338	3,383
Funding for public health services		211,842	195,908
Grants and other contributions		17,947	20,438
Interest received		2	2
GST collected from customers		438	732
GST input tax credits from ATO		6,134	5,959
Other		3,802	2,625
Outflows:			
Employee expenses		(19,343)	(18,041)
Department of Health contract staff		(128,353)	(117,459)
Supplies and services		(78,589)	(95,953)
Grants and subsidies		(73)	-
GST paid to suppliers		(6,470)	(5,750)
GST remitted to ATO		(438)	(732)
Interest payments on lease liabilities		(149)	(126)
Other expenses		(1,411)	(3,704)
Net cash from/(used in) operating activities	25	**7,677**	**(12,718)**
Cash flows from investing activities			
Payments for property, plant and equipment		(19,167)	(8,509)
Net cash used in investing activities		**(19,167)**	**(8,509)**
Cash flows from financing activities			
Inflows:			
Proceeds from equity injections		20,648	11,062
Outflows:			
Lease payments	26	(3,286)	(3,111)
Net cash from financing activities		**17,362**	**7,951**
Net increase/(decrease) in cash and cash equivalents		5,872	(13,276)
Cash and cash equivalents at the beginning of the financial year		26,668	39,944
Cash and cash equivalents at the end of the financial year	10	**32,540**	**26,668**

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

Notes to the Financial Statements
30 June 2021

Notes to the Financial Statements
30 June 2021

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) Basis of measurement

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

- Land, buildings, infrastructure and plant and equipment are measured at fair value;
- Provisions expected to be settled 12 or more months after reporting date which are measured at their present value; and
- Inventories which are measured at the lower of cost and net realisable value.

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

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

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

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

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

(b) Statement of compliance

The financial statements:

- have been prepared in compliance with section 62(1) of the *Financial Accountability Act 2009* and section 39 of the *Financial and Performance Management Standard 2019*;
- 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 2021, 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 is rounded 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.

(c) Issuance of financial statements

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

(d) 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. TCHHS is one of 11 members along with Cairns and Hinterland Hospital and Health Service (CHHHS), 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, 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 AASB 128 *Investments in Associates and Joint Ventures*) and therefore none of the members individually control NQPHNL. While TCHHS currently holds one-eleventh of the voting power of the NQPHNL, the fact that each other member also has one-eleventh 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.

(e) 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 CHHHS, Mackay Hospital and Health Service, North West Hospital and Health Service, Townsville Hospital and Health Service, North Queensland Primary Health Network Limited and James Cook University. Each founding member holds two voting rights in the company and is entitled to appoint two directors.

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

(e) Investment in Tropical Australia Academic Health Centre Limited (continued)

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

As each member has the same voting entitlement one-seventh, 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.

Note 2. User charges and fees

	2021 $'000	2020 $'000
Revenue from contracts with customers		
Dental service fees	278	221
Hospital fees	515	332
Multi-purpose nursing home fees	360	331
Pharmaceutical benefits scheme	669	390
Primary clinical care manual	44	132
Other user charges and fees		
Other	26	30
Rental income	144	122
	2,036	1,558

Revenue from contracts with customers – User charges and fees
User charges and fees revenue from contracts with customers is recognised when the goods or services are provided to patients as this is the sole performance obligation and the transaction is accounted for under AASB 15 *Revenue from Contracts with Customers* at the agreed transaction price. Revenue is recognised net of discounts provided in accordance with approved policies.

Contract assets arise from contracts with customers and are transferred to receivables when TCHHS's right to payment becomes unconditional which usually occurs when an invoice is issued to the patient.

Revenue is deferred as a contract liability where patient services revenue has been received in advance. Revenue is then recognised when the services are delivered to the patient which is the sole performance obligation. Contract liabilities in relation to user charges and fees revenue is not expected to be material.

Other user charges and fees
Other user charges and fees are recognised upfront under AASB 1058 *Income of Not-for-Profit Entities*. Revenue recognition is based on invoicing for related goods or services provided or direct debits for employee rental income. Accrued revenue is recognised if the revenue has been earned and can be measured reliably with a sufficient degree of certainty. Accrued revenue and unearned revenue are reported separately under other assets and other liabilities.

Note 3. Funding for public health services

	2021 $'000	2020 $'000
Revenue from contracts with customers		
Specific purpose funding	6,375	5,304
Other funding for public health services		
Block funding	87,041	106,740
General purpose funding	131,498	101,029
COVID-19 response and vaccination	8,423	3,926
COVID-19 first nations	2,531	-
	235,868	216,999

Funding is provided predominantly from the DoH for specific public health services purchased by the Department in accordance with a service agreement. The service level agreement is a legally enforceable agreement that has both specific and non-specific performance obligations which are accounted for under either AASB 15 *Revenue from Contracts with Customers* or AASB 1058 *Income of Not-for-Profit Entities.* Performance obligations under the service agreement are monitored throughout the financial year. Funding adjustments for new or amended public health services occur at three window intervals during the financial year. The Board and management believe that the terms and conditions of its funding arrangements under the Service Agreement Framework will provide TCHHS with sufficient cash resources to meet its financial obligations for at least the next year.

The Australian Government pays its share of National Health funding directly to the DoH, for on forwarding to the Hospital and Health Service. The service agreement is reviewed periodically and updated for changes in activities and prices of services delivered by TCHHS. Cash funding from the DoH is received fortnightly for State payments and monthly for Commonwealth payments and is recognised as revenue as the performance obligations under the service level agreement are discharged. Commonwealth funding to TCHHS in 2021 was $4.211m (2020: $1.963m).

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

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

Revenue from contracts with customers
Revenue from contracts with customers is recognised when activity targets are met for activity-based funded (ABF) services. The HHS receives funding on a Weighted Average Unit (WAU) price and or Weighted Occasion of Service Unit (WOO) price. ABF from the DoH represents a small percentage 2021: 2.70% (2020: 2.40%) of TCHHS's overall public health services revenue. Funding relating to oral health services makes up 2021: 78.0% or $5.009m (2020: 87.0%) of total ABF revenue.

The contract liability balance is not expected to be material as funding for undelivered activity is generally required to be returned at the end of each financial year. Funding required to be returned is recorded as a payable. The contract asset balance is not expected to be material due to cash payments being received on a fortnightly basis. Public health services contract revenue owing to TCHHS at the end of the financial year is recorded under receivables as the unconditional right to payment is established prior to the end of financial year.

Other funding for public health services
TCHHS receives general purpose non-specific funding for Non-ABF block funded rural hospitals, facilities and services, mental health services, service specific funding commitments and primary health care. Revenue is recognised upon receipt of fortnightly payments for these services under AASB 1058 *Income of Not-for-Profit Entities.* At the end of the financial year, a financial adjustment may be required for service specific commitments that are not considered sufficiently specific in accordance with AASB 15. Funding received under AASB 1058 that is required to be returned is

Note 3. Funding for public health services (continued)

recorded as an expense under Other expenses - funding returns along with a payable. Accrued revenue relates to end of financial year service delivery funding adjustments and is recorded as a receivable as the unconditional right to payment is established prior to the end of financial year.

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

COVID-19 response and vaccination
TCHHS's income arising from the COVID-19 pandemic relates to a response recovery of expenditure totalling $7.070m for items such as labour, travel, clinical supplies and freight. This year the NPA funding also provided funding totalling $2.140m towards the COVID vaccination program which covered planning, administration and roll-out costs.

Note 4. Grants and other contributions

	2021 $'000	2020 $'000
Revenue from contracts with customers		
Commonwealth home support programme	1,011	1,002
Rural and remote medical benefits	5,993	5,424
Radiology service delivery	944	875
Indigenous health incentive	498	509
Other grants and contributions	150	173
Queensland community support scheme	82	67
Other grants and contributions		
Remote area aboriginal health services S100	(30)	2,448
Rural health outreach fund	1,018	1,191
Commonwealth indigenous health programs	3,763	4,257
Services below fair value	1,857	2,008
Practice incentive payments	1,029	1,219
Commonwealth after hours and health pathways services	874	1,417
My health for life	42	180
Other grants and contributions	10	65
Donations	867	47
	18,108	20,882

Revenue from contracts with customers
Where the grant agreement is enforceable and contains sufficiently specific performance obligations for the transfer of goods or services to a patient on the grantor's behalf, the transaction is accounted for under AASB 15 *Revenue from Contracts with Customers* at the agreed transaction price. Revenue is recognised as services are provided to patients as this is the sole performance obligation.

Revenue is initially deferred as a contract liability if funding is received in advance. Contract assets arise from grants and contributions and are transferred to receivables when TCHHS's right to payment becomes unconditional, which usually occurs when an invoice is issued to the grantor. Contract asset and liability balances for grants and contributions are not expected to be material due to the timing of cash payments and refund obligations under the agreements.

Other grants and contributions
Other grants and contributions are accounted for upfront under AASB 1058 *Income of Not-for-Profit Entities*, whereby revenue is recognised upon receipt of the grant funding, except for special purpose capital grants received to construct non-financial assets to be controlled by the TCHHS. Special purpose capital grants are recognised as unearned revenue when received, and subsequently recognised progressively as revenue as the asset is constructed. Accrued revenue and unearned revenue from other grants and contributions are reported separately under other assets and other liabilities.

Services below fair value
During 2020-21 TCHHS received services below fair value from DoH in the form of payroll, accounts payable and banking services. TCHHS has recognised income and a corresponding expense for the fair value of these services received. The fair value of these services amounted to $1.857m in 2021 (2020: $2.008m) and in 2021 is recognised in

Note 4. Grants and other contributions (continued)

"Grants and other contributions" in the statement of comprehensive income. See Note 8 for the disclosure of the corresponding expense recognised for services received below fair value.

Note 5. Other revenue

	2021 $'000	2020 $'000
Contract staff and recoveries	1,063	1,093
Asset revaluation increment	451	-
Contributed assets	1,800	32
Non-capital project recoveries	2,504	1,823
Other	416	255
	6,234	3,203

Other revenue does not relate to the HHS's ordinary activities and is accounted for up front under AASB 1058 *Income of Not-for-Profit Entities*. Other revenue is recognised when the revenue has been earned and can be measured reliably with a sufficient degree of certainty. Revenue recognition for other revenue is based on invoicing for related goods or delivery of services. Accrued revenue is recognised if the revenue has been earned but not yet invoiced and is reported separately under other assets. TCHHS did not identify any contracts with customers under other revenue.

Contract staff and recoveries
Revenue primarily relates to Australian General Practice Training recoveries. Revenue is recognised based on employee hours worked and teaching incentive payments. Other revenue also includes employee WorkCover recoveries which is recognised when received.

Asset revaluation increment
A prior year land decrement loss of $0.451m has been reversed on the Statement of Comprehensive Income this year as asset revaluation increment under Other revenue. Refer to Note 14.

Contributed assets
TCHHS acquired 3 building assets this year after long standing tenure issues were resolved throughout the year. These were recognised as assets acquired at no cost and initially brought in at net book value totalling $1.662m and then adjusted to fair value totalling $1.955m as at 30 June 2021.

Non-capital project recoveries
Revenue is recognised monthly. Accrued revenue is recorded under receivables as the right to payment is unconditional.

Note 6. Employee expenses

	2021 $'000	2020 $'000
Wages and salaries	15,364	14,436
Annual leave levy	1,039	914
Employer superannuation contributions	1,148	1,058
Long service leave levy	387	360
Sick leave	144	98
Other employee related expenses	1,276	1,195
	19,358	18,061

The number of directly engaged employees is 46 as at 30 June 2021 (2020: 43) which Executives, Board Members and Senior Health Service Employees as they are deemed to employed by the HSCE.

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 28. Refer to Note 16 for details regarding accrued employee benefits policies and disclosures.

Note 7. Department of Health contract staff

TCHHS through service arrangements with DoH has engaged 1,018 (2020: 986) full time equivalent roles in a contracting capacity as at 30 June 2021. 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
All non-executive health service TCHHS employees are employed by DoH who 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.

As an additional 2 days of leave was granted to all non-executive employees of the DoH and HHS's in November 2020 based on set eligibility criteria as recognition of the effects of the COVID-19 pandemic on staff wellbeing. This leave must be taken within 2 years or eligibility is lost. The entire value of the leave was paid by TCHHS to the DoH in advance. The leave is expensed in the period in which it is taken, and the remaining balance treated as a pre-payment to the DoH.

	As at 30 June 2021	As at 30 June 2020
Number of employees	46	43
Number of health service employees	1,018	986
	1,064	1,029

Note 8. Supplies and services

	2021 $'000	2020 $'000
Building services	1,990	1,977
Catering and domestic supplies	486	497
Clinical supplies and services	3,963	4,085
Communications	2,359	2,392
Computer services	3,223	3,258
Consultants	2,067	1,719
Contractors - clinical	13,869	12,677
Contractors - non-clinical	1,225	644
Drugs	1,980	2,178
Electricity and other energy	3,508	3,447
Expenses relating to minor works	1,175	552
Freight	1,733	1,584
Motor vehicles	300	243
Lease expenses	9,994	9,891
Other supplies and services	2,579	1,829
Other travel	8,412	6,683
Pathology, blood and related equipment	3,774	4,953
Patient transport	4,036	3,482
Patient travel	13,753	14,324
Repairs and maintenance	3,749	3,786
Services below fair value	1,857	2,008
	86,032	82,209

Note 8. Supplies and services (continued)

Contractors
During the year $4.894m (2020: $4.799m) was expensed in relation to services purchased from Non-Government Organisations (NGO) with Apunipima Cape York Health Council, Royal Flying Doctor Service and NPA Family and Community Services Aboriginal and Torres Strait Islander Corporation for the provision of health services to public patients.

Lease expenses
Lease expenses for the 2021 financial year include lease rental for short-term building leases, Q-Fleet vehicle leases, leases governed by Queensland Government Accommodation Office (QGAO) and Government Employee Housing (GEH) and other variable lease payments in accordance with the requirements of the AASB 16 *Leases.* Refer to Notes 14 and 19 for breakdowns of lease expenses and other lease disclosures.

Services below fair value
Services below fair value from the DoH in the form of payroll, accounts payable and banking services amounted to $1.857m in 2021 (2020: $2.008m) and are recognised in "supplies and services" in the statement of comprehensive income. See Note 4 for the disclosure of the corresponding income recognised for services received below fair value.

Note 9. Other expenses

	2021 $'000	2020 $'000
Advertising	78	115
Audit fees - internal and external	311	295
Funding returns	6,901	2,259
Insurances other	94	96
Insurance premiums QGIF	1,021	1,025
Losses from the disposal of non-current assets	223	168
Special payments - ex gratia	-	132
Other legal costs	904	553
Inventory stock adjustments	50	25
Interest on leases	149	126
Other	305	10,311
	10,036	15,105

Audit fees – internal and external
Total external audit fees quoted by the Queensland Audit Office relating to the 2020-21 financial statements are $0.163m (2020: $0.198m).

Funding returns
At the end of the financial year unspent program funding is returned to the DoH. A corresponding liability is recognised under payables.

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 2019*, TCHHS maintains a register setting out details of all special payments exceeding $5,000. During the year there were no ex gratia payments to report (2020: $0.132m).

Note 10. Cash and cash equivalents

	2021 $'000	2020 $'000
Cash on hand	1	1
Cash at bank	32,305	26,584
QTC cash funds	234	83
	32,540	26,668

For the purposes of the statement of financial position and the statement of cash flows, 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 DoH 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 2021 was $0.234m (2020: $0.083m) and the annual effective interest rate was 0.51% (2020: 1.93%).

Note 11. Receivables

	2021 $'000	2020 $'000
Receivables	510	830
Less: Allowance for impairment of receivables	(189)	(230)
	321	600
GST input tax credits receivable	704	419
GST payable	(19)	(70)
	685	349
Public health service funding	4,990	2,659
Other	-	2
	4,990	2,661
	5,996	3,610

Receivables are initially recognised at amortised cost 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 receivables and other 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 data which includes the impact of COVID-19. TCHHS has determined there are two material groups for measuring expected credit loss excluding government agencies. No loss allowance is recorded for Australian and Queensland Government agency debtors on the basis of materiality and positive credit rating. The ageing receivables carrying amount total for government agencies for 2021 is $2.440m (2020: $0.553m).

The provision matrix uses historical observed default rates calculated using credit losses experienced on past transactions during the last two years preceding 30 June 2021.

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 2021 have been correlated against changes in the unemployment

Note 11. Receivables (continued)

rate and based on those results, the historical default rates are adjusted based on expected changes in employment including from the impact of COVID-19. The COVID-19 impact on impairment is not considered material.

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 after 180 days. If the amount of debt written off exceeds the loss allowance, the excess is recognised as an impairment loss. Other receivables and expected credit loss and rates are disclosed in the below table.

	Less than 30 days	31 - 60 days	61 - 90 days	More than 90 days	Total
	$'000	$'000	$'000	$'000	$'000
Ageing of receivables 2020 (Dental patients)					
Receivables	1	1	-	42	44
Loss rate (%)	10.60%	62.70%	100.00%	100.00%	
Allowance for impairment (Expected Credit loss)	-	-	-	(42)	(42)
Carrying amount	1	1	-	-	2
Ageing of receivables 2020 (Other patients and customers)					
Receivables	8	16	8	201	233
Loss rate (%)	23.80%	33.40%	51.10%	87.80%	
Allowance for impairment (Expected Credit loss)	(2)	(5)	(4)	(177)	(188)
Carrying amount	6	11	4	24	45
Ageing of receivables 2020 (Government agency / low risk)					
Receivables	426	100	1	26	553
Carrying amount	426	100	1	26	553
Total receivables	435	117	9	269	830
Ageing of receivables 2021 (Dental Patients)					
Receivables	4	6	2	4	16
Loss rate (%)	19.20%	44.40%	53.20%	88.10%	
Allowance for impairment (Expected Credit loss)	(1)	(2)	(1)	(4)	(8)
Carrying amount	3	4	1	-	8
Ageing of receivables 2021 (Other patients and customers)					
Receivables	37	1	18	178	234
Loss rate (%)	2.20%	6.40%	53.10%	95.90%	
Allowance for impairment (Expected Credit loss)	(1)	-	(9)	(171)	(181)
Carrying amount	36	1	9	7	53
Ageing of receivables 2021 (Government agency / low risk)					
Receivables	228	-	18	14	260
Carrying amount	228	-	18	14	260
Total receivables	269	7	38	196	510

All known bad debts were written off once approved by either the HSCE or the CFO if less than $10,000 in accordance with financial delegations.

Note 11. Receivables (continued)

	2021 $'000	2020 $'000
Movements in the provision for impairment of receivables are as follows:		
Balance at the start of the year	230	77
Receivables written off during the year as uncollectable	(82)	(18)
Increase in provision recognised	41	171
Balance at the end of the year	189	230

The closing balance of receivables arising from contracts with customers at 30 June 2021 is $0.230m.

Note 12. 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.

Note 13. Other assets

	2021 $'000	2020 $'000
Current		
Prepayments	608	307
Contract assets	252	358
Other	455	587
	1,315	1,252

Contract assets
Contract assets arise from contracts with customers and are transferred to receivables when TCHHS's right to payment becomes unconditional, which usually occurs when the invoice is issued to the customer or when the unconditional right to payment is established prior to the end of financial year.

Contract assets were not impaired given the high probability that the future economic benefits will flow to the HHS.

Other
Accrued revenues that do not arise from contracts with customers are reported as part of Other.

Note 14. Property, plant and equipment and right-of-use assets

(a) Property, plant and equipment

	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Carrying amount at 1 July 2019	8,935	164,866	10,814	3,391	188,006
Additions	-	1,283	2,629	4,605	8,517
Disposals	-	-	(168)	-	(168)
Asset revaluation increment	-	10,744	-	-	10,744
Asset not previously recognised	-	18	14	-	32
Transfers between classes	-	693	(50)	(643)	-
Depreciation expense	-	(12,711)	(2,235)	-	(14,946)
Carrying amount at 30 June 2020	**8,935**	**164,893**	**11,004**	**7,353**	**192,185**
As at 30 June 2020					
Gross value	8,935	397,955	27,447	7,353	441,690
Accumulated depreciation	-	(233,062)	(16,443)	-	(249,505)
Carrying amount at 30 June 2020	**8,935**	**164,893**	**11,004**	**7,353**	**192,185**
Carrying amount at 1 July 2020	8,935	164,893	11,004	7,353	192,185
Additions	-	4,654	4,691	10,612	19,957
Disposals	-	75	(133)	-	(58)
Asset revaluation increment	912	16,107	-	-	17,019
Asset not previously recognised	-	1,794	5	-	1,799
Transfers between classes	-	976	157	(1,133)	-
Transfers in from other Queensland Government	-	-	(37)	-	(37)
Depreciation expense	-	(14,331)	(2,439)	-	(16,770)
Carrying amount at 30 June 2021	**9,847**	**174,168**	**13,248**	**16,832**	**214,095**
As at 30 June 2021					
Gross value	9,847	421,136	30,484	16,832	478,299
Accumulated depreciation	-	(246,968)	(17,236)	-	(264,204)
Carrying amount at 30 June 2021	**9,847**	**174,168**	**13,248**	**16,832**	**214,095**

Note 14. Property, plant and equipment and right-of-use assets (continued)

(b) Right-of-use assets

	Land $'000	Buildings $'000	Total $'000
Carrying amount at 1 July 2019	1,930	5,870	7,800
Additions	254	1,469	1,723
Depreciation expense	(70)	(3,049)	(3,119)
Carrying amount at 30 June 2020	**2,114**	**4,290**	**6,404**
As at 30 June 2020			
Gross value	2,184	7,335	9,519
Accumulated depreciation	(70)	(3,045)	(3,115)
Carrying amount at 30 June 2020	**2,114**	**4,290**	**6,404**
Carrying amount at 1 July 2020	2,114	4,290	6,404
Additions	1,173	2,319	3,492
Depreciation expense	(177)	(3,086)	(3,263)
Disposals	(5)	(4)	(9)
Other adjustments	20	(20)	-
Carrying amount at 30 June 2021	**3,125**	**3,499**	**6,624**
As at 30 June 2021			
Gross value	3,318	8,682	12,000
Accumulated depreciation	(193)	(5,183)	(5,376)
Carrying amount at 30 June 2021	**3,125**	**3,499**	**6,624**

(c) Accounting policies – recognition and acquisition

Accounting policy - recognition

Basis of capitalisation and recognition thresholds
Items of property, plant and equipment and right-of-use assets with a historical 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
Right-of-use assets	$ 10,000

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

Expenditure on property, plant and equipment is capitalised where it is probable that the expenditure will produce future service potential for TCHHS. Subsequent expenditure is only added to an asset's carrying amount if it increases the service potential or useful life of that asset and is approximately 5% or more of the total value of asset or greater than $0.200m. Maintenance expenditure that merely restores original service potential (lost through ordinary wear and tear) is expensed.

Note 14. Property, plant and equipment and right-of-use assets (continued)

Accounting policy - acquisition

Acquisition
Historical cost is used for the initial recording of all non-current physical asset acquisitions. Historical cost is determined as the value given as consideration and costs incidental to the acquisition (such as architects' fees and engineering design fees), plus any costs directly incurred in getting the asset ready for use. Any training costs are expensed as incurred.

Assets acquired at no cost or for nominal consideration, other than from another Queensland Government entity, are recognised at their fair value at date of acquisition. TCHHS acquired 3 building assets this year after long standing tenure issues were resolved throughout the year. These were recognised as assets acquired at no cost and initially brought in at net book value totalling $1.662m and then adjusted to fair value totalling $1.955m as at 30 June 2021.

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

TCHHS is lessee in relation to all the right-of-use assets which cover leases for staff accommodation and commercial buildings both from private entities plus Indigenous Land Use agreements where leases are related to Deed of Grant in Trust (DOGIT) and reserve land.

The Department of Energy and Public Works (DEPW) provides TCHHS with access to office accommodation, employee housing and motor vehicles under government-wide frameworks. These arrangements are categorised as procurement of services rather than as leases because DEPW has substantive substitution rights over the assets. The related service expenses are included in Note 8.

(d) Accounting policy - measurement

Measurement using historic cost
Plant and equipment and right-of-use assets are measured at historical cost in accordance with QTC'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.

Measurement using fair value
Land and buildings are measured at fair value as required by QTC'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.

The cost of items acquired during the financial year less depreciation has been judged by management to materially represent the fair value at the end of the reporting period.

Right-of-use assets are initially measured by the lease liability, lease payments made at or before the commencement date, less any lease incentives received, initial direct costs incurred and the initial estimate of restoration costs.

TCHHS uses QTC's incremental borrowing rates depending on the term of the lease as the discount rate. TCHHS has elected not to recognise right-of-use assets and lease liabilities arising from short-term leases and leases of low value assets. An asset is considered short-term when the full term is 12 months or less and is considered low value where it is expected to cost less than $10,000 when new. When measuring the lease liability, TCHHS uses QTC's incremental borrowing rates depending on the term of the lease as the discount rate.

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.

Note 14. Property, plant and equipment and right-of-use assets (continued)

(e) Fair value measurement and valuation

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.

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.

Use of indices
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.

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.

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).

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.

Note 14. Property, plant and equipment and right-of-use assets (continued)

(e) Fair value measurement and valuation

2020	**Level 2 $'000**	**Level 3 $'000**	**Total $'000**
Assets			
Land	8,935	-	8,935
Buildings (health service sites)	-	164,893	164,893
Total	8,935	164,893	173,828
2021			
Assets			
Land	9,847	-	9,847
Buildings (health service sites)	-	174,168	174,168
Total	9,847	174,168	184,015

There were no transfers between levels during the financial year.

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 5%. In 2020-21 a comprehensive valuation was carried out on all TCHHS land parcels by the State Valuation Service. The land revaluations for 2020-21 resulted in an increment of $0.912m to the carrying amount of land assets. This increment includes Other revenue – asset revaluation increment of $0.451m. Refer to Notes 5 and 18.

Buildings
In 2020-21 TCHHS engaged independent experts, Jacobs, to undertake building revaluations in accordance with the fair value methodology.

Since the introduction of a standardised approach to the valuation of all Queensland public infrastructure, management have had all of TCHHS buildings comprehensively revalued in the last four years using the cost valuation approach (current replacement cost). Indexation was assessed as 0% (nil), therefore, not applied to all building assets not comprehensively revalued during the current year. The effective date of valuations was primarily 30 June 2021.

The valuations of the comprehensively revalued assets 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 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 2020-21 resulted in a net increment of $16.107m to the carrying amount of buildings all from the independent comprehensive valuation net increment.

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

Deed of Grant in Trust land (DOGIT)
Some of TCHHS facilities are located on land assigned to it under a 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. The land element is recorded in the Government Land Register as improvements only.

Note 14. Property, plant and equipment and right-of-use assets (continued)

(e) Accounting policy – fair value measurement and valuation (continued)

Indigenous Land Use Agreement (ILUA)
TCHHS does not control the land element of these properties, but in some cases has an ILUA which is recognised as a right-of-use asset, under the land class.

(f) Accounting policy – depreciation expense

Depreciation expense
Property, plant and equipment and right-of-use assets are 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.

Key judgement: The depreciation rate is determined by application of appropriate useful lives 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 and right-of-use assets 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 is considered.

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

Class	Depreciation rates used	Useful lives
Buildings	1.3% – 12.5%	8 – 79 years
Plant and equipment	4.0% – 20.0%	5 – 25 years
Right-of-use assets	2.5% – 50.0%	2 – 40 years

(g) Accounting policy – impairment

All property, plant and equipment and right-of-use 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. For assets measured at cost, an impairment loss is recognised immediately in the statement of comprehensive income. Consequently, if reversals of impairment losses occur, they are reversed through income.

Note 15. Payables

	2021 $'000	2020 $'000
Payables	7,453	1,298
Accrued expenses	12,175	9,993
Department of Health contract staff wages	1,129	5,054
Payables - refund liabilities	7,629	2,478
	28,386	18,823

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.

Payables - refund liabilities
At the end of the financial year unspent program funding is returned to the DoH. A corresponding liability is recognised under payables when there is an obligation to repay unspent program funding.

Note 16. 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 6 for details regarding employee expense disclosures.

Note 17. Other liabilities

	2021 $'000	2020 $'000
Current		
Contract liabilities	779	22
	779	22

Contract liabilities (deferred revenue) arise from contracts with customers while other unearned revenue arises from transactions that are not contracts with customers.

For the purpose of determining deferred revenue, TCHHS has assumed that the goods or services will be transferred to the customer as promised in accordance with the existing contract and that the contract will not be cancelled, renewed or modified. There was no revenue recognised during 2020-21 that related to the previous year's performance obligations based on a review of TCHHS's contracts with customers.

Specific-purpose capital grants
AASB 1058 allows deferral of revenue from capital grants. TCHHS generally does not receive capital grant funding for recognisable capital assets. At the end of the financial year there was no revenue deferred relating to capital grants.

Note 18. Asset revaluation surplus

	Land $'000	Buildings $'000	Total $'000
Balance 1 July 2019	-	18,075	18,075
Revaluation increment	-	10,744	10,744
Balance - 30 June 2020	-	28,819	28,819
Balance at 1 July 2020	-	28,819	28,819
Revaluation increment	461	16,107	16,568
Balance - 30 June 2021	461	44,926	45,387

Accounting policy
The revaluation surplus represents the net effect of upwards and downwards revaluations of assets to fair value. 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 2020-21 resulted in a net increment of $16.107m 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 19. Lease liabilities

TCHHS as lessee has recognised a right-of-use asset representing its right to use the underlying leased asset and a lease liability representing its obligations to make lease payments. Right-of-use assets under *AASB 16 Leases* are disclosed in Note 14 Property, plant and equipment and right-of-use assets. See below the breakdown of the lease liability:

Note 19. Lease liabilities (continued)

	2021 $'000	2020 $'000
Current		
Lease liabilities	3,057	2,962
	3,057	2,962
Non-Current		
Lease liabilities	3,561	3,450
	3,561	3,450
	6,618	6,412

Refer to Note. 26 for the movement in Lease liabilities.

Disclosures – Leases as a lessee

(i) Details of leasing arrangements as lessee

Type of lease	Right-of-use class	Description of arrangement
Private residential leases (staff accommodation)	Building	Total lease terms between 12 months to 5 years
Private commercial leases (office space)	Building	Total lease terms between 12 months to 5 years
Indigenous Land Use Agreements on DOGIT/reserves	Land	Total lease terms between 30 – 40 years

(ii) Amounts recognised in profit or loss

	2021 $'000	2020 $'000
Interest expense on lease liabilities	149	126
Breakdown of 'Lease expenses' included in Note 8		
- Expenses relating to short-term leases	759	653
Income from subleasing included in 'Rental income' in Note 2	144	122

(iii) Total cash outflow for leases

Total cash outflow for leases	3,286	3,111

Note 20. 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 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.

Note 20. Financial instruments (continued)

TCHHS's financial instruments are classified and measured as follows:
- Cash and cash equivalents – held at amortised cost
- Receivables – held at amortised cost
- Payables – held at amortised cost

TCHHS does not have equity instruments, derivatives, bonds, notes or loans.

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

	2021 $'000	2020 $'000
Financial assets		
Financial assets at amortised cost - comprising:		
Cash and cash equivalents	32,540	26,668
Receivables	5,996	3,610
Total financial assets	38,536	30,278
Financial liabilities		
Financial liabilities at amortised cost - comprising:		
Payables	28,386	18,823
Lease liabilities	6,618	6,412
Total financial liabilities at amortised cost	35,004	25,235

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. 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 11.

Credit risk on cash deposits is considered minimal given all TCHHS deposits are held with the Commonwealth Bank of Australia Ltd and QTC 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 and lease liabilities. All financial liabilities that are current in nature will be due and payable within 12 months. Whereas, all financial liabilities that are non-current in nature will be due and payable between 1-40 years. All lease liabilities are disclosed as undiscounted cash flows and discounted lease liabilities in the Statement of Financial Position.

Note 20. Financial instruments (continued)

(c) Market risk
TCHHS is not exposed to interest rate risk for borrowings or cash deposited in interest bearing accounts as it does not hold any of these types of finance leases. TCHHS is also not exposed to interest rate risk through its leases as all our leases do not factor an interest component. 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
All 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 21. Contingent liabilities

Litigation in progress
As at 30 June 2021 there were no cases filed in the courts naming the State of Queensland acting through TCHHS as defendant.

As of 30 June, 2021 there were 9 open medical indemnity and 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.

Workcover currently has 9 claims underway, 3 pending claims and 2 common law claims. 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.

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 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 three 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 lease costs associated with the settlement of these tenure issues. Registered trustee leases on DOGIT land held by other organisations have been negotiated for 24 facilities which have terms for generally 30 to 40 years. DOGIT land is being recognised as right-of-use assets and lease liabilities and disclosed in the Statement of Financial Position. TCHHS has nine ILUAs, eight of which relate to existing registered trustee leases that have commenced.

Note 22. Commitments

	2021 $'000	2020 $'000
Commitments - capital expenditure		
Committed at the reporting date but not recognised as liabilities, payable:		
Not later than 1 year	6,911	12,830
Commitments - operating expenditure		
Committed at the reporting date but not recognised as liabilities, payable:		
Not later than 1 year	14,758	13,676
Later than 1 year but not later than 5 years	1	171
Later than 5 years	-	1,143
	21,670	27,820

Leases
Only leases that do not fall within the scope of *AASB 16 Leases* or are exempt from *AASB 16 Leases* have been included in this note. Operating lease commitments include contracted amounts for office space from Government Employee Housing (GEH). 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 include service contracts between Apunipima Cape York Health Council, Royal Flying Doctor Service, CHHHS and other professional and consultant agreements that TCHHS is currently obligated to pay.

Note 23. Patient trust transactions and balances

Patient trust receipts and payments	2021 $'000	2020 $'000
Receipts		
Opening balance	5	5
Amounts receipted on behalf of patients	4	2
Total receipts	9	7
Payments		
Amounts paid to or on behalf of patients	2	2
Total payments	2	2
Trust assets and liabilities		
Assets		
Cash held and bank deposits	7	5
Total assets	7	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 24. Events after the reporting period

There are no matters or circumstances that have arisen since 30 June 2021 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 25. Reconciliation of operating result to net cash from operating activities

	2021 $'000	2020 $'000
Operating result for the year	2,329	(9,801)
Non-cash movements:		
Depreciation	20,033	18,065
Depreciation offset from DoH	(20,033)	(18,065)
Loss on disposal	223	168
Asset valuation decrement	(451)	-
Donated assets	(790)	(8)
Contributed assets	(1,800)	(32)
Movements in impairment loss receivables	80	132
Change in operating assets and liabilities		
(Increase)/decrease in receivables	(2,133)	25
(Increase)/decrease in GST receivables	(336)	209
Decrease in inventories	(52)	(56)
Increase in prepayments	(169)	(545)
(Increase)/decrease in contract assets	106	(358)
Increase/(decrease) in payables	11,641	(318)
Increase/(decrease) in accrued employee benefits	15	30
Increase/(decrease) in accrued contract labour	(1,743)	502
Increase/(decrease) in contract liabilities and unearned revenue	757	(2,666)
Net cash from/(used in) operating activities	7,677	(12,718)

Note 26. Changes in liabilities arising from financing activities

2020		Non-cash changes	Cash flows	
	Opening balance $'000	New leases acquired $'000	Cash repayments $'000	Closing balance $'000
Lease liabilities	7,800	1,723	(3,111)	6,412
Total	7,800	1,723	(3,111)	6,412

2021	Opening balance $'000	New leases acquired $'000	Cash repayments $'000	Closing balance $'000
Lease liabilities	6,412	3,492	(3,286)	6,618
Total	6,412	3,492	(3,286)	6,618

Assets and liabilities received or donated are recognised as revenues (refer to Note 4) or expenses (refer to Note 8) as applicable.

Note 27. 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.

Note 27. General trust (continued)

	2021 $'000	2020 $'000
Opening balance	100	98
Revenue received during the year	432	2
Expenditure made during the year	(150)	-
Balance of general trust	382	100

The closing cash balance of the general trust at 30 June 2021 is $0.382m (2020: $0.100m). This is held on deposit with the QTC $0.234m (2020: $0.083m) and the Commonwealth Bank of Australia $0.148m (2020: $0.017m).

Note 28. 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 Yvette D'Ath MP, Minister for Health and Minister for Ambulance Services since October 2020 previously Steven Miles MP.

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.

Note 28. Key management personnel disclosures (continued)

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	Elthies Kris	*S25 Hospital and Health Boards Act 2011 by Governor in Council*	18 May 2019
Non-executive Board member - Provides strategic guidance and effective oversight of management, operations and financial performance	Horace Baira Tracey Jia Brian Woods Karen Price Scott Davis Rhonda Shibasaki Karen Dini-Paul Susan Hadfield Marjorie Pagani Karyn Sam Darren Thamm	*S23 Hospital and Health Boards Act 2011*	19 January 2015 to 17 May 2021 1 July 2014 to 17 May 2021 1 July 2014 to 17 May 2021 11 December 2015 18 May 2016 18 May 2019 18 May 2020 29 September 2020 18 May 2021 18 May 2021 18 May 2021
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
Executive Director of Finance, Information and Digital Services (and CFO) - Responsible for providing strategic leadership, direction, stewardship, governance, effective controls and day-to-day financial management and statutory reporting obligations as well as leadership of the Information and Communication Technologies strategy; including information and communication technology management of enablers of systems for healthcare delivery	Danielle Hoins Brendan Cann (acting)	*HES2 Hospital and Health Boards Act 2011*	15 June 2020 27 August 2020 to 1 September 2020 8 March 2021 to 28 March 2021
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 Brian Howell (acting) Emma Pickering Tamara Sweeney	*HES2 Hospital and Health Boards Act 2011*	7 May 2018 to 31 July 2020 28 September 2020 to 25 October 2020 26 October 2020 to 3 January 2021 4 January 2021
Executive General Manager - Southern Sector - Responsible for providing strategic leadership, direction and day to day management to the Cape York area within the TCHHS.	Ian Power Christopher Emerick (acting)	*HES2 Hospital and Health Boards Act 2011*	23 July 2018 11 December 2020 to 12 January 2021 5 March 2021 to 12 March 2021

Note 28. 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 Marlow Coates (acting)	*MMOI1* *Hospital and Health Boards Act 2011*	12 February 2018 6 July 2020 to 7 August 2020 16 April 2021 to 30 June 2021
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 and Nurse Educators) and supporting the implementation of primary health care principles and practices throughout TCHHS	Kim Veiwasenavanua Sam Schefe (acting)	*NRG13* *Hospital and Health Boards Act 2011*	7 May 2018 23 December 2020 to 29 January 2021
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 Noeleen Mulley (acting)	*DSO2* *Hospital and Health Boards Act 2011*	21 January 2019 22 February 2021 to 30 June 2021
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 breadth of allied health services provision	Vivienne Sandler Amy O'Hara (acting)	*HP6* *Hospital and Health Boards Act 2011*	18 February 2019 1 October 2020 to 31 October 2020
Executive Director Asset Management - Responsible for providing strategic and operational leadership and governance of the asset management function including capital works, planning, delivery and maintenance of assets, procurement, contract management, patient and staff travel and fleet management	Dean Davidson	*DSO1* *Hospital and Health Boards Act 2011*	1 September 2019
Executive Director Workforce & Engagement - Responsible for providing strategic and operational leadership and governance of the human resources function including workforce planning, recruitment, industrial and employee relations, integrated learning centre and workforce health and safety	Sally O'Kane (acting)	*DSO1* *Hospital and Health Boards Act 2011*	11 June 2020

Note 28. Key management personnel disclosures (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 Darren Thamm as an external advisor for a term of three years commencing 16 July 2020. Mr Thamm was not considered part of TCHHSs' key management personnel during this period however he was providing 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. Mr Thamm was appointed a board member on 18 May 2021 and will now be the board representative of this committee.

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 2020-21 financial year (2020: $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.

Note 28. Key management personnel disclosures (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.

2021 **Remuneration expenses**

Name	Monetary	Non-monetary	Post-employment benefits	Long-term benefits	Termination benefits	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Board						
Elthies Kris	73	-	7	-	-	80
Horace Baira	35	-	3	-	-	38
Tracey Jia	35	-	3	-	-	38
Brian Woods	35	-	3	-	-	38
Karen Price	40	-	4	-	-	44
Scott Davis	42	9	4	-	-	55
Rhonda Shibasaki	39	-	4	-	-	43
Karen Dini-Paul	41	-	4	-	-	45
Marjorie Pagani	5	-	-	-	-	5
Karyn Sam	5	-	-	-	-	5
Darren Thamm	5	-	-	-	-	5
Susan Hadfield	29	-	3	-	-	32
Executive						
Beverley Hamerton	284	9	25	6	-	324
Anthony Brown	470	-	37	10	-	517
Danielle Hoins	179	9	17	4	-	209
Brendan Cann	33	1	2	1	-	37
Kim Veiwasenavanua	183	9	20	4	-	216
Dean Davidson	159	9	18	3	-	189
Mark Goodman	4	-	(1)	-	-	3
Ian Power	175	9	17	4	-	205
Venessa Curnow	91	4	10	2	-	107
Vivienne Sandler	155	9	17	3	-	184
Sally O'Kane	163	9	16	3	-	191
Tamara Sweeney	96	-	10	2	-	108
Noelene Mulley	44	-	4	1	-	49
Christopher Emerick	26	-	3	1	-	30
Marlow Coates	151	2	14	3	-	170
Samuel Schefe	26	1	2	-	-	29
Brian Howell	64	-	6	1	-	71
Emma Pickering	38	2	3	1	-	44
Amy O'Hara	17	-	1	-	-	18

Note 28. Key management personnel disclosures (continued)

2020 **Remuneration expenses**

Name	Monetary	Non-monetary	Post-employment benefits	Long-term benefits	Termination benefits	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Board						
Elthies Kris	77	-	7	-	-	84
Horace Baira	39	-	4	-	-	43
Tracey Jia	39	-	4	-	-	43
Fraser (Ted) Nai	34	-	3	-	-	37
Brian Woods	40	-	4	-	-	44
Karen Price	40	-	4	-	-	44
Scott Davis	41	9	4	-	-	54
Ruth Stewart	41	-	4	-	-	45
Rhonda Shibasaki	39	-	4	-	-	43
Karen Dini-Paul	5	-	-	-	-	5
Executive						
Beverley Hamerton	277	9	25	6	-	317
Danielle Hoins	131	8	15	3	-	157
Brendan Cann	93	6	10	2	-	111
Mark Goodman	193	9	19	4	-	225
Ian Power	172	9	17	4	-	202
Dean Davidson	161	9	18	3	-	191
Anthony Brown	455	-	35	10	-	500
Kim Veiwasenavanua	182	9	21	4	-	216
Venessa Curnow	135	9	15	3	-	162
David Bullock	83	1	8	1	36	129
Erica Gallagher	145	9	16	3	-	173
Vivienne Sandler	146	9	17	3	-	175

Note 29. Related party transactions

Transactions with Queensland Government controlled entities
Material related party transactions for 2020-21 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 3. 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 7, TCHHS is not a prescribed employer and health service employees are employed by the DoH and contracted to work for the TCHHS.

Queensland Treasury Corporation
TCHHS has accounts with the QTC for general trust monies. Refer to Note 10.

Department of Energy and Public Works (DEPW)
TCHHS pays rent to the DEPW for office and staff accommodation. In addition, the Department of Energy and Public Works provides vehicle fleet management services (Q-Fleet) to TCHHS.

Note 29. 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 TAAHCL. 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 has paid its 2020-2021 membership contribution directly to TAAHC. This transaction was endorsed by the TCHHS Board and is considered to be at arm's length.

TCHHS employees that are close family members of TCHHS key management personnel were recruited in accordance with the standard TCHHS recruitment policies and procedures.

Related Party transaction values and outstanding balances

Related Party	Transaction Type	2021		2020	
		Transaction value Revenue/ (expense)	Receivables/ (payables)	Transaction value Revenue/ (expense)	Receivables/ (payables)
		$'000	**$'000**	**$'000**	**$'000**
DoH	Service Agreement *	235,868	(3,891)	216,999	(3)
DoH	Non-executive health service employees	(124,428)	(1)	(118,840)	(5,644)
DoH	Services support costs	(16,325)	(1,200)	(16,189)	(1,080)
Other Hospital and Health Services	Renal, interpretation and legal services, pharmacy supplies, office space, courier fees, contract labour, training costs, manuals and course fees	(1,461)	-	(779)	(110)
Department of Energy and Public Works	Building/fleet leases	(9,784)	(46)	(9,200)	-
NQPHN	Primary Health care support **	121	(121)	(23)	(23)
TAAHC	Membership fee	(150)	-	(75)	(75)
Close family members	Aggregated salary and wages	(593)	-	(387)	-

** DoH Service Agreement receivables and payables (2021: $3.083m receivables and $6.974m payables) (2020: $2.452m receivables and $2.455m payables)*

*** NQPHN revenue and expenses (2021: $0.953m of revenue and $0.832m of expenses) (2020: $1.450m of revenue and $1.427m of expenses). NQPHN receivables and payables (2021: $0.121m payables) (2020: $0.023m payables).*

Note 30. 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* (Cwt.) (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 has no contractual arrangements that falls under AASB 1059 *Service Concession Arrangements*; therefore, this standard has not been applied in 2020-21. TCHHS did not apply any other new accounting standards for the first time and there were no changes in policies for 2020-21.

(c) New accounting standards and interpretations not yet effective

Accounting standards early adopted

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

(d) Climate risk

TCHHS has not identified any material climate related risks relevant to the financial report at the reporting date, however, constantly monitors the emergence of such risks under the Queensland Government's Climate Transition Strategy.

(e) Significant financial impacts from COVID-19

TCHHS did not have any significant financial impacts from COVID-19 as the Commonwealth government guaranteed funding in accordance with the National Reform Agreement for 2019-20 and 2020-21 years to TCHHS via DoH to cover effects of this pandemic. TCHHS had short periods of time that affected 'business as usual' however, the reduction of revenue was offset by the reduction of expenditure. Balance sheet items and equity also had no significant financial impacts from COVID-19.

Note 31. 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 decrease of $2.870m (58.5%) relates to the realignment of actual revenue under AASB 1058 *Income of Not-for-Profit Entities* from user charges and fees to other revenue for non-capital project recoveries and salary reimbursements.
Funding for public health services:	The increase of $18.978m (8.75%) related to additional funding provided through amendments to the Service Agreement with the DoH for the delivery of increased public hospital and health services including Northern retrieval services, Weipa birthing, COVID-19 response and vaccination funding of $8.869m under the National Partnership Agreement, First Nations COVID-19, enterprise bargaining agreement updates, depreciation adjustment and funding deferrals from 2019-20 financial years. This has been offset by the AASB 1058 *Income of Not-for-Profit Entities r*evenue clawbacks and program deferrals from 2020-21.
Grants and other contributions:	The increase of $1.039m (6.09%) is due primarily to the recognition of donations for the Weipa CT scanner and renal expansion. The increases in rural and remote medical benefits scheme revenue through renal expansion HHS wide was offset by reductions in Practice Incentive Payments, Changing the Gap registrations and Rural Generalist Trainee payment due to COVID-19 travel restrictions.
Other revenue:	The increase of $4.945m (383.63%) is due to the recognition of contributed assets of $1.794m relating to three buildings identified as TCHHS assets after land tenure issues finalised in 2020-21, non-capital project recoveries of $1.497m after COVID-19 travel restrictions impacted numerous capital projects progressing to completion and a reversal of a one-off land asset revaluation decrement loss of $0.451m. These are all offset by a reduction of general medical training revenue (GMT) salary reimbursements/training and teaching allowances and CheckUp which were impacted by COVID-19 travel restrictions.
Supplies and services:	The increase overall of $11.150m (14.89%) relates primarily to the COVID-19 general response expenses, vaccination rollout costs and non-capital project works. The COVID-19 costs included increases in travel- other of $2.813m for charters as this mode of transport increased, patient travel $0.842m - due to Federal biosecurity zones, clinical supplies $0.646m and freight $0.359m. Consultancies - professional and technical of $0.857m increased due to capital maintenance project works.
Depreciation expense:	The increase of $1.384m (7.42%) relates to new assets commissioned throughout the year as well as an increase in right of use assets.
Other expenses:	The increase of $6.748m (205.23%) relates to the accounting treatment of unspent grant money returned under AASB1058 *Income of Not-for-Profit Entities* previously treated as unearned revenue.

Torres and Cape Hospital and Health Service
Management Certificate
For the year ended 30 June 2021

These general-purpose financial statements have been prepared pursuant to s.62 (1) of the *Financial Accountability Act 2009* (the Act), section 39 of the *Financial and Performance Management Standard 2019* and other prescribed requirements. In accordance with 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 2021 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.7 and s.11 of the *Financial and Performance Management Standard 2019* for the establishment and maintenance, in all material respects, of an appropriate and effective system of internal controls and risk management processes with respect to financial reporting throughout the reporting period.

Elthies Kris
Board Chair
Officer

20 / 08 / 2021

Beverley Hamerton
Health Service
Chief Executive

20 / 08 / 2021

Danielle Hoins - CPA
Executive Director Finance
Information and Digital
Services (and CFO)

20 / 08 / 2021

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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 2021, and its financial performance and cash flows for the year then ended;

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

The financial report comprises the statement of financial position as at 30 June 2021, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

Basis for opinion

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

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

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

Key audit matters

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

Key audit matter	How my audit addressed the key audit matter

Specialised buildings valuation ($174m)
 	
Refer to Note 14 in the financial report.
 	
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 34% 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
• developing a unit rate for each of these components, including:
  o estimating the current cost for a modern substitute (including locality factors and oncosts), expressed as a rate per unit (e.g. $/square metre)
  o identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference.
 	
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 value, 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:
	  o on a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the:
	  ▪ modern substitute (including locality factors and oncosts)
	  ▪ adjustment for excess quality or obsolescence
	• for unit rates associated with the remaining specialised buildings:
	  o evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices
	  o recalculating the application of the indices to asset balances.
	• evaluating useful life estimates for reasonableness by:
	  o reviewing management's annual assessment of useful lives
	  o at an aggregate level, review asset management plans for consistency between renewal budgets and the gross replacement cost of assets (consideration of backlog maintenance)
	  o testing that no asset still in use has reached or exceeded its useful life
	  o enquiring of management about their plans for assets that are nearing the end of their useful life
	  o reviewing assets with an inconsistent relationship between condition and remaining useful life.
	• where changes in useful lives were identified, evaluating whether they were supported by appropriate evidence
	• reviewing the results of the indexation revaluation and performing the following procedures:

Key audit matter	How my audit addressed the key audit matter
	○ assessing the reasonableness of the indexation percentage by benchmarking it to other Queensland hospitals and government buildings ○ 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 perform the indexation ○ 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.

Responsibilities of the entity for the financial report

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

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

Auditor's responsibilities for the audit of the financial report

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

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

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances. This is not done for the purpose of expressing an opinion on the effectiveness of the entity's internal controls, but allows me to express an opinion on compliance with prescribed requirements.

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- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the entity.
- Conclude on the appropriateness of the entity's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. I base my conclusions on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance 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 2021:

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

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

Prescribed requirements scope

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

C. G. Strickland

25 August 2021

C G Strickland
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

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.
Coronavirus	See COVID-19
COVID-19	The COVID-19 novel coronavirus is a strain of coronavirus affecting humans. Some coronaviruses can cause illness similar to the common cold and others can cause more serious diseases such as Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS).
ENT	Ear Nose and Throat
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.
HSCE	Health Service Chief Executive
IHS	Integrated Health Service
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
MPHS	Multi-Purpose Health Service

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.
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
NSQHS	National Safety and Quality Health Service Standards
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).
PHCC	Primary Health Care Centre
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.
STI	Sexually Transmitted Disease
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.

COMPLIANCE CHECKLIST

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	• **A letter of compliance from the accountable officer or statutory body to the relevant Minister/s**	ARRs – section 7	4
Accessibility	• **Table of contents** • **Glossary**	ARRs – section 9.1	5, 83,84
	• **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	7,8
Non-financial performance	• **Government's objectives for the community and whole-of-government plans/specific initiatives**	ARRs – section 11.1	6
	• **Agency objectives and performance indicators**	ARRs – section 11.2	6-15, 25,33,34
	• **Agency service areas and service standards**	ARRs – section 11.3	13-15, 24-35
Financial performance	• **Summary of financial performance**	ARRs – section 12.1	36,37
Governance – management and structure	• **Organisational structure**	ARRs – section 13.1	24
	• **Executive management**	ARRs – section 13.2	16-23
	• **Government bodies (statutory bodies and other entities)**	ARRs – section 13.3	20,21
	• **Public Sector Ethics**	*Public Sector Ethics Act 1994* ARRs – section 13.4	31
	• **Human Rights**	*Human Rights Act 2019* ARRs – section 13.5	31
	• **Queensland public service values**	ARRs – section 13.6	10,31
Governance – risk management and accountability	• **Risk management**	ARRs – section 14.1	28
	• **Audit committee**	ARRs – section 14.2	20
	• **Internal audit**	ARRs – section 14.3	28
	• **External scrutiny**	ARRs – section 14.4	29
	• **Information systems and recordkeeping**	ARRs – section 14.5	29
	• **Information Security attestation**	ARRs – section 14.6	31
Governance – human resources	• **Strategic workforce planning and performance**	ARRs – section 15.1	26
	• **Early retirement, redundancy and retrenchment**	Directive No.04/18 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	27
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	nil
	• **Queensland Language Services Policy**	ARRs – section 33.3	https://data.qld.gov.au

Summary of requirement		Basis for requirement	Annual report reference
Financial statements	• **Certification of financial statements**	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	78
	• **Independent Auditor's Report**	FAA – section 62 FPMS – section 46 ARRs – section 17.2	79-82

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2019*

ARRs *Annual report requirements for Queensland Government agencies*

ANNUAL REPORT 2020–2021
www.health.qld.gov.au/torres-cape

Torres and Cape Hospital and Health Service