Unite & Recover

Torres and Cape Hospital and Health Service

ANNUAL REPORT 2021–2022

Queensland Government

Information about consultancies, overseas travel, and the Queensland language services policy is available at the Queensland Government Open Data website (https://data.qld.gov.au). Torres and Cape Hospital and Health Service has no expenditure on overseas travel to report on during 2021-2022.

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.

Content from this annual report should be attributed as: State of Queensland (Torres and Cape Hospital and Health Service) Annual Report 2021-2022

ISSN 2202-6401 (Print) ISSN 2203-8825 (Online)

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 2022

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 2021–2022 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 90 of this annual report.

Yours sincerely

Elthies (Ella) Kris

Chair

Torres and Cape Hospital and Health Board

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STATEMENT ON QUEENSLAND 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, safe and 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

It is with great pleasure that we present to you the Torres and Cape Hospital and Health Service's 2021-2022 Annual Report. Our year has again been dominated by the COVID-19 pandemic. Our vaccination rollout saw more than 84 per cent of people receive two or more vaccinations, a great success in a rural and remote area like ours.

As COVID-19 spread, we established our virtual COVID-19 'care in the home'. TCHHS was able to provide care and support to hundreds of people and quickly identify and transfer any patients who required tertiary care. We would like to acknowledge and thank all our staff, those on the front line and those who support them, for their ongoing commitment and resilience. We are incredibly proud of the work they do.

We would like to thank the State Government and the Honourable Yvette D'Ath MP, Minister for Health and Ambulance Services for 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 Member Ms Karen Dini Paul.

Joining the Board, we welcome Ms Tara Diversi, who also holds current roles as the President and Chair of Dietitians Australia; National Dietetic Adviser to the Department of Veterans Affairs; Co-chair of North Queensland PHN.

Despite the challenges of COVID-19, we maintained our strong financial position, furthered significant infrastructure projects and continued delivering the Health Service's Strategic Plan. Consultation across TCHHS is continuing in the development of the Health Equity Strategy and the guiding principles for a new Model of Care. Community input for both of these strategic initiatives is crucial and will define how we deliver health care in the years to come. This coincides with the development of a strong Aboriginal and Torres Strait Islander workforce strategy.

We have successfully increased our Primary Health Care Centres (PHCCs) accredited by the Royal Australian College of General Practitioners (RACGP), with more scheduled in the future. RACGP accreditation increases the self-sufficiency of our PHCCs, bringing services and primary health care closer to home.

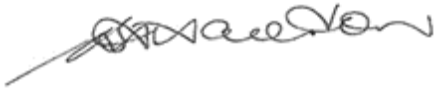
In February 2022, TCHHS began a new Midwifery Navigation Service to provide additional support for women travelling to Cairns who require specialist obstetric and maternity services to give birth. This culturally sensitive service is expected to help more than 250 women each year.

In 2021-2022, TCHHS spent $281.61 million with large investments made in infrastructure and services. In addition, TCHHS launched or progressed $95 million worth of new and vital infrastructure projects including:

- $46 million redevelopment of Thursday Island Hospital and Primary Health Care Centre
- $14.3 million redevelopment of five Primary Health Care Centres on Dauan, Poruma, Masig, Ugar Islands
- $4.6 million for Weipa Hospital heating, ventilation and air-conditioning
- $2.5 million for Kowanyama Primary Health Care Centre refurbishment
- $1.3 million to replace the Wujal Wujal Primary Health Care Centre helicopter landing site
- Completed Stage One of the $25.7 million Weipa Birthing project

In 2022-2023, we will continue to invest in infrastructure and services such as the introduction of a TCHHS Public Health Unit, the launch of the Care Coordination Service Centre and continue to progress the business case for the redevelopment of Cooktown Multipurpose Health Service.

Elthies (Ella) Kris
Board Chair



Beverley Hamerton
Chief Executive.

ABOUT US

TCHHS is an independent statutory authority governed by a Board and established under the *Hospital and Health Boards Act 2011*. It is managed from hubs in Cairns, Weipa and Thursday Island and covers an area of 129,770 square kilometres. TCHHS comprises 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:

- COVID-19 has created unprecedented challenges to health service delivery, ongoing staff recruitment and retention
- 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.

OUR VALUES

TCHHS officially launched its own values in July 2020. They are:

- 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.

MODEL OF CARE – OUR GUIDING PRINCIPLES

As part of our strategic plan to achieve “excellence in healthcare” and “advance health through strong partnerships”, TCHHS launched the Model of Care - Our Guiding Principles Project. The project aims to define a high-level set of guiding principles for how TCHHS should deliver health services for the communities that we support.

This project will build upon the work of the Torres Model of Care that was established in the 1990s. The project will ensure that the guiding principles are consistent across all of our services/regions; and are reflective of the context of today and of all the communities across our large and diverse catchment. This project won’t replace or modify the Torres Model of Care.

The project originally started in early 2021 but was paused due to the impacts of COVID-19. Staff and community consultation began in May 2022,and centred around the question “what does good healthcare look and feel like?”.

Nine common themes have been identified:

- Community-centred
- culturally appropriate
- prevention and promotion
- collaborative care
- timely and responsive
- equitable and accessible
- accountable
- trust, continuity and relations
- holistic approach.

The project closely aligns with the development of our Health Equity Strategy as well as the state-wide Local Area Needs Assessment (LANA). The project is currently scheduled to be completed by the end of 2022.

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 from over 60 different Traditional Owner Groups living in our communities. These Traditional Owner Groups comprise of 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 causes:

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

MAKING TRACKS TOGETHER - HEALTH EQUITY

Amendments to the *Hospital and Health Boards Act 2011* and the *Hospital and Health Boards Regulation 2012* requires Hospital and Health Services to partner with Aboriginal and Torres Strait Islander peoples and organisations to design, deliver and monitor the delivery of healthcare in Queensland. *Making Tracks Together - Queensland's Aboriginal and Torres Strait Islander Health Equity Framework* was released to support Hospital and Health Services develop and implement new Health Equity Strategies. Building on the foundation of the Stronger Mob, Living Longer plan, TCHHS's Health Equity Strategy has six priority areas:

1. Actively eliminating racial discrimination and institutional racism within the service
2. Increasing access to healthcare services
3. Influencing the social, cultural and economic determinants of health
4. Delivering sustainable, culturally safe, and responsive healthcare services
5. Working with First nations Peoples, communities, and organisations to design, deliver, monitor and review health services
6. Strengthen the Aboriginal and Torres Strait Islander workforce

The TCHHS Health Equity Strategy is being developed and co-designed with community three participatory groups across the Torres Strait, Cape York and Northern Peninsula Area:

1. community and its members
2. the TCHHS health workforce
3. key stakeholders of the communities

Due to COVID-19 restrictions, there were delays in progressing stakeholder and community consultation with the strategy to be completed by September 2022.

PROGRAMS FUNDED FOR ABORIGINAL AND TORRES STRAIT ISLANDER RESIDENTS

In 2021-2022 $3.19 million in cumulative funding was provided to TCHHS under the Making Tracks Investment Strategy, and the North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan. The funding is administered by the Department of Health's Aboriginal and Torres Strait Islander Health

Division. 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 instigated social distancing restrictions that reduced the hostel's booking capacity to 12 rooms. To assist with isolation and quarantine requirements, the facility coordinated with Thursday Island Hospital Clinical Support Services to increase the number of 'home visits' to the centre for new mothers and their baby.
- **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 2021-22. 71.39 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 implement COVID safe practices as a large percentage of the client base fall within the 'vulnerable patients' category. Between July and December 2021, there were 391 antenatal occasions of service (OOS). Staff from the program work closely with a Diabetes Educator to develop strategies and education for antenatal clients to best care for themselves during pregnancy.
- **Child and Youth Mental Health Service - Aurukun (CYMHSA)**: Ongoing community unrest and violence continues to have an impact on CYMHSA's accessibility to the community, with a decrease in presentations to the Primary Health Care Centre for mental health concerns. CYMHSA provided 158 OOS between July and December 2021, a decrease 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**: extensive consultation has been conducted in Napranum Community to date. This includes stakeholder mapping, and project planning. Consumer consultation suggests a preferred model of care with a focus on health promotion, social and emotional wellbeing, and prevention measures. TCHHS is currently advertising for a project officer.
- **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. Six Primary Health Care Centres (PHCCs) achieving more than 70 per cent in screening rates in their communities, with another two clinics achieving 60 per cent. Increased screening and contact tracing have contributed to the significant reduction in the prevalence of gonorrhoea in Cape York and Torres Strait 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 and procedures at Cairns, Townsville and Brisbane hospitals.

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

The TCHHS Consumer Advisory Committee (CAC) traditionally meets quarterly to facilitate discussion regarding Consumer requirements, issues and feedback. In 2021-2022, the CAC only met twice as a result of TCHHS's COVID-19 tiered response.

The CAC provides advice on improving health services to TCHHS's Governing Body, Executive and to the National Safety & Quality Health Service Standards (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.

The overall TCHHS consumer experience survey responses have continued to be positive in 2021-2022. Due to COVID-19 restrictions limiting non-critical services, the number of overall responses decreased to 149 from 234 in the previous year.

The responses are collected and collated through the Measurement and Analysis Reporting System (MARS). 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 reviewed its Consumer and Engagement Strategy 2019 – 2022 in March 2022. A key action from the review was the development of a workflow for consumer-related publications to ensure that consumer input and feedback was sought and used at appropriate times.

GOVERNANCE: OUR PEOPLE
BOARD MEMBERSHIP

Ms Elthies (Ella) Kris

Board Chair (Appointed 18/5/2019) (Current term 1/04/2022 to 31/03/2024)

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 01/04/2022 to 31/03/2026)

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 Master of 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 01/04/2022 to 31/03/2026)

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 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 the Chair of the Finance and Performance Committee and 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.

Ms Tara Diversi

Board Member (appointed 01/04/2022) (current term 01/04/2022 to 31/03/2026)

Ms Diversi is an Accredited Practising Dietitian starting her career in Cairns in private practice and in public health nutrition throughout Cape York in 2003 and since, working in almost all areas of dietetics. Ms Diversi is the CEO of Sophus Nutrition, a digital nutrition platform that improves accessibility and affordability of expert nutrition and dietetic care through the combination of evidence-based nutrition with psychology, behavioral economics and technology. She also holds current roles as the President and Chair of Dietitians Australia; National Dietetic Adviser to the Department of Veterans Affairs; Co-chair of North Queensland PHN and Entrepreneurship Facilitator for Cairns. Ms Diversi is a member of the Safety and Quality Committee and the Audit and Risk Committee.

Ms Karen Dini-Paul

Board Member (Appointed 18/05/2020) (term ended 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.

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 (HSCE), 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 they met on a monthly basis and during the 2021-2022 year.

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:

1. Audit and Risk Committee
2. Safety and Quality Committee
3. Finance and Performance Committee
4. Executive Committee

Board and Committee meeting attendance 2020-2021

Torres and Cape Hospital and Health Board					
Act or instrument		*Hospital and Health Boards Act 2011*			
Functions		Refer to section 'About Us'			
Achievements		Reported throughout the Annual Report			
Financial reporting		Refer to financial statements			
Remuneration					
Position	Name	Meetings/ sessions attendance	Approved annual, sessional or daily fee	Approved sub-committee fees if applicable	Actual fees received
Chair	Elthies Kris	30 (12 Board / 18 sub-committee)	$80,000		$80,000
Member	Scott Davis	28 (13 Board / 15 sub-committee)	$53,000		$53,000
Member	Karen Price	30 (13 Board / 17 sub-committee)	$44,000		$44,000
Member	Rhonda Shibasaki	24 (12 Board / 12 sub-committee)	$43,000		$43,000
Member	Karen Dini-Paul	16 (9 Board / 7 sub-committee)	$41,000		$41,000
Member	Susan Hadfield	33 (13 Board / 20 sub-committee)	$46,000		$46,000
Member	Darren Thamm	27 (14 Board / 13 sub-committee	$52,000		$52,000
Member	Marjorie Pagani	21 (12 Board / 9 sub-committee)	$43,000		$43,000
Member	Karyn Sam	20 (12 Board / 8 sub-committee)	$43,000		$43,000

Member	Tara Diversi	5 (3 Board / 2 sub-committee)	$11,000		$11,000
No. scheduled meetings/ sessions	14				
Total out of pocket expenses	$8,536.22				

Table 1: Board and Committee meeting attendance 2021-2022

	Board Meeting	Audit & Risk	Finance & Performance	Safety & Quality	Executive
Total Number of Meetings	14	6	8	4	12
Ella Kris	12		7		11
Scott Davis	13			4	11
Karen Price	13	6			11
Rhonda Shibasaki	12	5	7		
Karen Dini-Paul*	9		4	3	
Susan Hadfield	13		7	2	11
Darren Thamm	14	6	7		
Marjorie Pagani	12	5		4	
Karyn Sam	12	5		3	
Tara Diversi**	3	1		1	

*appointment ended 31/03/2022

** Term of appointment commenced 01/04/2022

EXECUTIVE COMMITTEE

The Executive Committee is a formal committee of the Torres and Cape Hospital and Health Board as detailed in section 32B of the *Hospital and Health Boards Act 2011*. The main function of this Committee is to support the Board in providing strategic direction 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 in responding to critical emergent issues.
The Executive Committee met on a monthly basis during 2021-2022, and considered a number of matters, including:

- Organisational Strategic Plan
- Aboriginal and Torres Strait Islander Workforce Strategy
- Operational planning
- 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.
- 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
- ensuring safety and quality responsibilities are clearly articulated throughout the organisation

The Safety and Quality Committee monitor the HHS's governance arrangements, including monitoring compliance and promoting improvements with Services' policies and plans about safety and quality.
The Safety and Quality Committee met on a bi-monthly basis and during 2020-2021, 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 and Risk Committee is a formal committee of the Board established in accordance with schedule 1, section 8 of the *Hospital and Health Boards Act 2011*. The committee is prescribed, and the functions of the committee are listed, under the *Hospital and Health Board Regulation 2012* Part 7 – sections 31 and 34; and section 35 of the *Financial and Performance Standard 2019*.

The purpose of the of the Audit, Risk and Finance Committee is to advise the Board on the adequacy of the Health Service's risk management framework, 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 and the Finance and Performance Committee have observed the terms of its charter and has had due regard to Treasury's Audit Committee Guidelines. The Audit and Risk Committee met on a bi-monthly basis, whilst the Finance and Performance Committee met monthly. 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 assist the HHS and its Board by providing over-sight and strategic direction in the key areas of financial management, financial and operating performance, revenue management, legislative compliance, and financial risks in provision of health services by TCHHS and its long-term financial viability.

The Finance and Performance Committee met on a monthly basis during the 2021-2022 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

EXECUTIVE MANAGEMENT

HEALTH SERVICE CHIEF EXECUTIVE

Beverley Hamerton

Responsibilities:

- Service Level Agreement
- HHS strategy and reform
- Whole of HHS performance
- Capital investment Governance
- Organisational units in Office of CE portfolio

Beverley was appointed as Chief Executive in April 2018. Beverley has extensive experience working in the Torres and Cape region, having previously held the roles of TCHHS Executive General Manager South and Executive Director of Nursing Services for Torres Strait and Northern Peninsula Health Service District (2009 to 2013). Beverley holds Masters of Remote Health Practice (Public Health) (Nurse Practitioner) and is a graduate of the Australian Institute of Company Directors. Beverley is passionate about the patient experience, workforce planning and management, advancing robust models of care and service planning in remote areas.

EXECUTIVE DIRECTOR – ASSET MANAGEMENT

Dean Davidson

Responsibilities:

- Strategic and operational asset management
- Planning, delivery and maintenance of assets
- Capital works
- Land and tenure
- Procurement and Contract management
- Patient and staff travel
- Fleet management
- Organisational units in Asset Management portfolio

Dean started work with the Torres and Cape Hospital and Health Service in 2016 as the Director of Travel, Contracts and Procurement. More recently, he was the Acting Executive Director of Corporate Services, before being appointed to the newly created role of Executive Director of Asset Management in August 2019.
Prior to working for TCHHS, previous positions held have been General Manager of Community and Regional Planning and Manager of Plant and Facilities within Local Government for eight years.
Dean has a Master's Degree in Business Administration from the University of Otago and majored in Business Logistics, Business Administration and Economics at the University of Natal.

EXECUTIVE DIRECTOR - FINANCE, INFORMATION AND DIGITAL SERVICES

Danielle Hoins

Responsibilities:

- Finance services and reporting
- Internal controls
- ICT Services - projects and stewardship
- Digital governance
- Digital Health Services
- Organisational units in Finance Information and Digital Services portfolio

Danielle is a qualified Certified Practicing Accountant (CPA) Accountant with 15 years' experience in financial and corporate services management in the Queensland Health sector. Danielle was appointed to the role of Executive Director of Finance, Information and Digital Services, and Chief Finance Officer in 2020, prior to that Dani has been TCHHS CFO since 2015. Dani has managed all areas of corporate services, including financial services, human resource management, occupational health and safety, ICT and health information management. Dani completed her Bachelor of Commerce at James Cook University, Cairns in 2006, attained CPA status in 2010 and awarded a Fellowship in 2022. Between 2018 and 2020 Dani further extended professional qualifications including attaining a Graduate Australian Institute of Company Directors and completing the Advanced Woman in Leadership Program, Graduate Certificate in Public Sector Management and Queensland Health Change Leadership Program.

EXECUTIVE DIRECTOR - MEDICAL SERVICES

Dr Marlow Coates

Responsibilities:

- Professional lead - medical officers
- Oral Health lead and operations
- Clinical Governance and Service delivery
- Clinical Council
- Pharmacy
- Radiology (medical imaging)
- Public Health
- Organisational units in Medical Services portfolio

Marlow is a Rural Generalist Senior Medical Officer living and working on Thursday Island and holds a FRACGP, FACRRM, AFRACMA and JCCA. Marlow also holds and maintains a role in rotary wing aeromedical retrieval via his work across the Torres Strait Islands and the Northern Peninsula Area. Marlow is committed to developing high-quality workforce and system processes that contribute towards closing the gap in health access and outcome inequity experienced by First Nations People and other Queenslanders living remotely.

EXECUTIVE DIRECTOR - NURSING & MIDWIFERY

Kim Veiwasenavanua

Responsibilities:

- Professional lead - nursing and midwifery
- Mental Health, Alcohol and Other Drugs Service
- Organisational units in Nursing & Midwifery Services portfolio

As the professional lead for the Nursing and Midwifery Services division within Torres and Cape HHS since May 2018, Kim has driven and manages Torres and Cape's diverse nursing workforce with strategic intent to enable innovative, advanced, culturally-appropriate, safe, contemporary best practice nursing and midwifery practice in rural and remote FNQ across the entire Torres Straits region and Cape York communities.
Kim previously held the position of Executive General Manager - Northern sector and Director of Nursing - Thursday Island Hospital prior to her appointment to the EDNMS role. She has worked as a Clinician and Manager in Primary Health Care, Acute Care, Community Care and Residential Aged Care Manager for a 180-bed Aged Care facility.

EXECUTIVE DIRECTOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Stephen Tillett

Responsibilities:

- Professional lead - Aboriginal and Torres Strait Islander Health worker and health practitioners
- Workforce strategic lead for Aboriginal and Torres Strait Islander health programs and services
- Closing the Gap strategy
- Executive Sponsor - Consumer Advisory Committee
- Organisational units in Aboriginal and Torres Strait Islander Health portfolio

Stephen Tillett commenced as Executive Director of Aboriginal and Torres Strait Islander Health in March 2022. Stephen is a Torres Strait Islander born at Palm Island. Stephen has a strong leadership and strategic management background, and a wealth of experience engaging with Aboriginal and Torres Strait Islander communities. He has work in the Queensland Police Service, the Queensland Department of Justice and Attorney-General and the Department of Communities, Housing and Digital Economy.

EXECUTIVE GENERAL MANAGER SOUTHERN SECTOR

Ian Power

Responsibilities:

- Management of staff
- Facilities and service operations (South)
    - Safety, access and compliance
    - Performance
    - Workforce
    - Facilities
- Workforce planning
- Stakeholder engagement
- HHS wide strategy
- Organisational units in EGM Southern sector portfolio

Ian was appointed Executive General Manager, Southern Sector in July 2018 and has more than 25 years' experience in regional state health administration in NSW. Ian is passionate about ensuring that everyone who has contact with our service has a positive experience that contributes towards their comfort, recovery and wellbeing and that we strive to be an employer of choice and a point of pride for all our staff.

EXECUTIVE GENERAL MANAGER NORTHERN SECTOR

Tamara Sweeney

Responsibilities:

- Management of staff
- Facilities and service operations (Torres Strait Islands & Northern Peninsula Area)
    - safety, access and compliance
    - performance
    - workforce
    - facilities
- Workforce planning
- Stakeholder engagement
- HHS wide strategy
- Organisational units in EGM Northern sector portfolio

Tamara has been working in this position since January 2021 which includes leadership and management for Thursday Island and Bamaga Hospitals as well as the Primary Health Care Centres across the Torres Strait and Northern Peninsula Area. Prior to joining TCHHS, Tamara worked with WA Country Health Service (WACHS) providing leadership and management for Carnarvon and Exmouth Hospitals and Coral Bay and Burringurrah Nursing Posts. Tamara has a Masters of Health Management, Bachelor of Laws and Bachelor of Commerce and experience in industrial relations, employment law and medicolegal.

EXECUTIVE DIRECTOR ALLIED HEALTH

Amanda Wilson

Responsibilities:

- Professional lead - Allied Health streams
- Care at the end of Life
- Healthcare in the Home
- Strategic workforce planning
- Aged care
- National Disability Insurance Scheme (NDIS)
- Organisational units in Allied Health portfolio

Amanda is an experienced health leader and speech pathologist with broad ranging experience in hospital, community health, private practice, not for profit, and Aboriginal community controlled health sectors. She is passionate about improving equity of access to high quality clinical care and improving health outcomes in rural and remote communities. Amanda has held executive and senior management roles in rural and remote health organisations, with an interest in strategic workforce development, advocacy, and Aboriginal and Torres Strait Islander health.

ACTING EXECUTIVE DIRECTOR WORKFORCE AND ENGAGEMENT

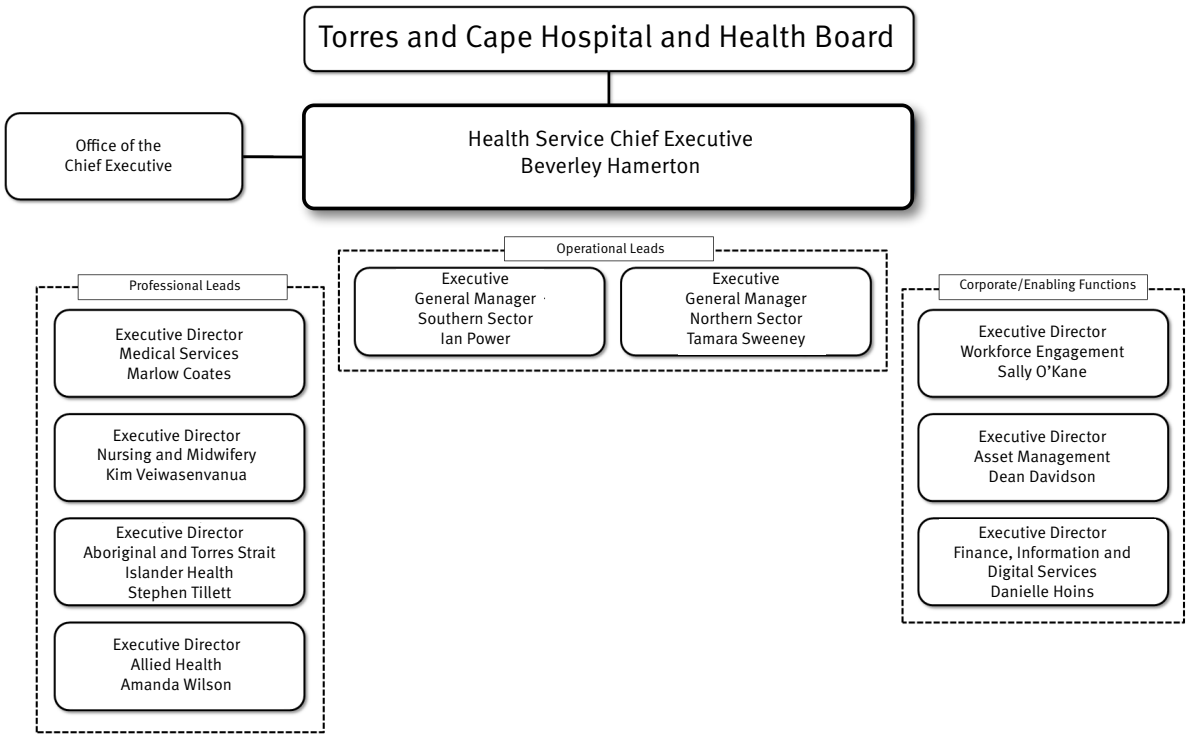
Sally O'Kane

Responsibilities:

- Strategic and operational human resources
- Strategic workforce planning
- Recruitment hub
- Industrial and employee relations
- Integrated learning centre
- Workforce health and safety
- Integrated Workforce Management System (IWMS)
- Organisational units in Workforce & Engagement portfolio

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



As at June 30 2022, TCHHS employed a full-time equivalent (FTE) staff establishment of 1064, an increase of four staff from 2020-2021. A breakdown of this total is reflected in the table below.

TCHHS has launched its Workforce Strategy 2021-2026, 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

Table 2: More doctors and nurses*

	2017-18	2018-19	2019-20	2020-21	2021-22
Medical staff [a]	38	42	43	48	54
Nursing staff [a]	348	373	393	375	347
Allied Health staff [a]	72	78	74	103	111

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-22. Source: a DSS Employee Analysis, b Queensland Health MOHRI, DSS Employee Analysis

ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE

In 2021-2022, TCHHS employed 226 Aboriginal and Torres Strait Islander people (21.24 per cent) across all occupational streams. TCHHS is continuing its development of an Aboriginal and Torres Strait Islander Workforce Development Strategy. A workforce mobilization plan for Aboriginal and Torres Strait Islander Health Workers is being drafted and is expected to be implemented in 2022-2023. Strengthening the Aboriginal and Torres Strait Islander workforce has also been identified as a key priority in our Health Equity Strategy.

The current unemployment rate amongst Aboriginal and Torres Strait Islander people living in our catchment is 23.5 per cent .

STRATEGIC WORKFORCE PLANNING AND PERFORMANCE

WORKFORCE DIVERSITY AND WELLBEING

TCHHS is committed to diversity, inclusion and equity in the workplace. We 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 offers a dedicated online service to provide professional advice on financial issues impacting on an individual's wellbeing. 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 a number of local consultative forums that support a collaborative approach to consultation with unions. The overarching Health Service Consultative Forum, attended by the Executive Directors, has strategic oversight of people management issues and is the peak body for unresolved matters from the local consultative forums.

RECRUITMENT INITIATIVES

TCHHS has partnered with Department of Health's Strategic Communications Unit to support its recruitment programs. Initially developed internally, the dept is creating content for the 'career up here' campaign. The campaign is designed to both attract and educate potential staff about our region. It will initially target nurses and midwives and will be expanded to cover medical, operational and administrative professions in 2022-2023.

LEARNING AND DEVELOPMENT

Supporting our strategic goal of a safe, valued and skilled workforce, TCHHS Learning and Development's aim is to foster a culture of continuous learning and improvement. Staff are supported from the moment they

join TCHHS, with regular induction and orientation sessions. All staff are supported through Performance and Development plans. They have access to face-to-face and online training, incentive schemes, traineeship and apprenticeship opportunities. These include:

- iLearn
- PARROT Online education
- Rural and Isolated Practice (Scheduled Medicines) Registered Nurse course (RIPRN)
- Study and Research Assistance Scheme (SARAS)
- Administrative and Operational Training and Development Education Funds (Cunningham Centre)
- Clinicians Knowledge Network (CKN)

EARLY RETIREMENT, REDUNDANCY AND RETRENCHMENT

In the 2021-2022 financial year, TCHHS did not pay any redundancy, early retirement or retrenchment packages.

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 TCHHS 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 2021-2022 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 three main areas examined during 2021-2022:

- A review of reusable medical devices (RMDs) was undertaken to provide assurance of compliance with the requirements of AS/NZ 4187 Reprocessing of reusable medical devices in health service organisations (2014) and the associated National Safety and Quality Health Service Standards (NSQHS) and Advisories.

- A review to provide assurance time and attendance management processes operate effectively, economically and efficiently and that the internal control framework governing time and attendance is adequate.
- A review of food services and nutrition to provide assurance that processes established to ensure food services and nutrition meet the requirements of the Department of Health guidelines and patient needs.

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 2021-2022 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 2021-2022 year. There are no significant findings or issues identified by this external reviewer on our operations or performance.

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*. Information is available and processes are in place to help 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 line with the *Public Records Act 2002*.

In 2021-2022, TCHHS worked towards aligning with the Digital Health Strategy for Rural and Remote Health, developing an implementation roadmap that incorporates objectives from this strategy and the *Queensland Health Digital Strategy 2031*.

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:

In line with our health service strategic objectives, a number of information technology, information management and digital health service improvements have occurred in 2021-2022 including:

- Strong TCHHS representation on the Rural and Remote Digital Healthcare Committee (RRDHC), the state-wide peak body that provides strategic advice and oversight on the priority, selection and execution of initiatives for the digital enablement of rural and remote healthcare across Queensland. Specifically relating to the Digital Strategy for Rural and Remote Healthcare and its investments roadmap.

- Digitally enabled healthcare during the COVID-19 pandemic, including significant investment in telehealth equipment at the PHCCs.
- Enhanced local support for remote clinicians and use of critical electronic clinical information systems across TCHHS facilities.
- Ongoing implementation of Digital Foundations within TCHHS such as infrastructure uplifts and digital capabilities to support new or enhanced digital models of care.
- Completion of major network infrastructure upgrades in partnership with eHealth Queensland including commissioning satellite redundancy almost all of TCHHS facilities, never before seen in a rural and remote setting.
- Early adoption of enhanced cyber-security protection on all workstations in partnership with eHealth Cyber Security Group.
- Improved access to education and training for remote staff through the design and implementation of eLearning data quality and electronic medical record programs.
- Infrastructure and software upgrades for critical clinical information systems.
- Facilitating information sharing pathways with Department of Health and our other key partners in the region that will result in the development of an Information Sharing Framework inclusive of all healthcare partners in the Far Northern region.
- Enhancements of the Primary Health Care Data Warehouse to support Business Intelligence and Information Management across TCHHS facilities.
- Digital enhancements to assist with Own Source Revenue opportunities.
- Data quality initiatives, including intensive face-to-face training and education roadshow.

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. 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 continues to progress against its strategic measures of success, as outlined in our Strategic Plan. Some data results for 2021-2022 have been delayed, caused by the ongoing impacts of COVID-19 to staffing and service delivery. The data will be available in the first half 2022-2023.

EXCELLENCE IN HEALTHCARE

The assessment for the NSQHSS has been re-scheduled to August 2022 due to COVID-19. The NSQHSS committees completed the gathering of evidence of proficiency in all standards on 1 July 2022.

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 Dec 2021 FYTD) with 98.6 percent attendance recorded and 90.1 per cent of babies born at a healthy weight.

TCHHS continues to work towards the goal of increasing self-sufficiency in its hospitals, achieving 54.77 per cent as of 30 June 2022. Ear, Nose and Throat outpatient clinics reported a 139 per cent increase in attendance over the previous year.

Due to staffing and recruitment shortages throughout 2021-2022 as a result of COVID-19, the CT Scanner at Weipa Hospital has been limited to delivering service to Weipa and nearby towns of Mapoon and Napranum. Telehealth usage during 2021-2022 remained below expectations, as face-to-face outreach services returned to our communities. A communications and education campaign on the benefits of telehealth will be implemented in 2022-2023.

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. Consultations with community members and stakeholders for the guiding principles for Our Model of Care are proceeding, as is their involvement in our Health Equity Strategy.

TCHHS is collaborating with our regional health partners in developing a comprehensive Local Area Needs Assessment (LANA), with a completion expected in October 2022. Student clinical placements were suspended during 2021 due to COVID-19 restrictions, with a total of 26 placements for the full financial year. With COVID-19 restrictions currently removed, it is expected that placement numbers will increase in 2022-2023.

A SAFE, ENGAGED, VALUED AND SKILLED WORKFORCE

Seventy-eight per cent of staff completed their mandatory training in 2021-2022, a 13 per cent increase over the previous year. Our Learning and Development team has continued face-to-face and virtual training sessions to support a higher training uptake for professional development plans and cultural awareness training in 2022-23. TCHHS's percentage of Aboriginal and Torres Strait Islander Peoples in the workforce increased to 226 (21.24 percent), 11 more than the previous year. Information on the number of staff

undertaking scholarships and training pathways is only available by calendar year. By 30 June 2022, 22 people had successfully applied for the Study and Research Assistance Scheme (SARAS). TCHHS will increase visibility and education around training opportunities in 2022-2023, in conjunction with the 'Career up Here' recruitment campaign. Business confidence in proactive hazard reporting has dramatically increased in 2021-2022, with 100 per cent of the 36 scheduled facility audits completed.

A WELL GOVERNED ORGANISATION

TCHHS has achieved its planned financial position for 2021-2022, with a small operating deficit of $34,986. This meets its obligation to ensure all its services are provided as cost effectively as possible in a challenging high-cost environment.

We have successfully delivered or progressed several projects including the redevelopment of Thursday Island Hospital and Primary Health Care Centre, and the business case for the redevelopment of Cooktown Multipurpose Health Service.

As noted in the service standards section, TCHHS has achieved the majority of its key performance indicators for 2021-2022. Improvements in data quality has led to the development and increased utilisation of new Business Intelligence Dashboards at both an Executive and operational level across the Health Service, contributing to cost savings and improved service delivery.

PERFORMANCE: SERVICE STANDARDS

Emergency departments across TCHHS performed above expectations in the percentage of people attending emergency departments seen within recommended timeframes. The percentage of people treated within four hours of their arrival in an emergency department was 96 per cent, well above the target of 80 per cent.

The median wait time in emergency departments was 10 minutes. In elective surgery, TCHHS exceeded all targets in the percentage of patients being treated within clinically recommended times, with all categories achieving 100 percent.

In telehealth, there has been continued downward trend as services return to visiting communities. The 2021-2022 target of 3,265 was based on projections which included the COVID-19 surge in Telehealth. The planned refocus in local facilities and community services has increased the accessibility of telehealth in our communities, with the service now available through people's personal mobile devices. TCHHS is currently implementing a communications campaign for 2022-2023, focusing on the reduction of Failure to Attend rates.

Table 3: Service Standards – Performance 2021-22

Torres and Cape Hospital and Health Service	2021-22 Target	2021-22 Actual
Effectiveness measures		
Percentage of emergency department patients seen within recommended timeframes[1]		
• Category 1 (within 2 minutes)	100%	100%
• Category 2 (within 10 minutes)	80%	94%
• Category 3 (within 30 minutes)	75%	92%
• Category 4 (within 60 minutes)	70%	92%
• Category 5 (within 120 minutes)	70%	98%
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]	..	100%
Median wait time for treatment in emergency departments (minutes)[1]	..	10
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	18
• Category 2 (90 days)[3]	..	36
• Category 3 (365 days)[3]	..	74
Number of Telehealth outpatients service events[4]	3,265	2,598
Total weighted activity units (WAU)[5]		
• Acute Inpatients	6,018	9,025
• Outpatients	2,841	2,994
• Sub-acute	385	216
• Emergency Department	2,474	2,630
• Mental Health	114	78
• Prevention and Primary Care	851	644
Ambulatory mental health service contact duration (hours)[6]	>8,116	7,843
Staffing[7]	1,061	1,064

1	During the COVID-19 pandemic Emergency Departments across Queensland were presented with demand from both COVID-19 and regular patients. In response many public Emergency Departments established fever clinics to assess and treat suspected COVID-19 cases in a safe and effective manner. As fever clinic services represent an extension of regular operational services and as a result, the 2021-2022 Actual includes some fever clinic activity. Emergency Department performance (including POST) has been impacted by the increased patient treatment time and resources required to manage COVID-19 precautions.
2	In response to the COVID-19 pandemic the delivery of planned care services has been impacted. This has resulted from occasions of temporary suspension of routine planned care services to manage priority demand, increased cancellations resulting from patient illness and staff furloughing as a result of illness or Health Service Directives.
3	As the system focuses to manage the backlog of deferred care patients, treated in time performance will continue to be impacted. As a result, the continuation of treat in time performance targets for category 2 and 3 patients applicable for 2021-2022 will be carried forward into 2022-2023.
4	Telehealth 2021-2022 Actual is as of 18 August 2022.
5	The 2021-2022 Actual is below target due to a decrease in routine care services resulting from occasions of temporary suspension of routine planned care services to manage priority demand, increased cancellations resulting from patient illness and staff furloughing as a result of illness or Health Service Directives. The 2021-2022 Target varies from the published 2021-2022 Service Delivery Statement due to a change in the WAU phase. All measures are reported in QWAU Phase Q24. The 2021-2022 Actual figures are as of 22 August 2022. As the Hospital and Health Services have operational discretion to respond to service demands and deliver activity across services streams to meet the needs of the community, variation to the Target can occur.
6	Due to a range of factors, including the stretch nature of the target and the impact of the COVID-19 pandemic on service access and capacity, the 2021-2022 Target has not been met. Figures are as of 16 August 2022.
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. 2021-2022 Actual is for pay period ending 26 June 2022.

PERFORMANCE: FINANCIAL SUMMARY

TCHHS achieved close to a balanced position with a small operating deficit for the year ending 30 June 2022 of $34,986, aproximately 0.01 percent of our budget. The operating position is a result of strong financial stewardship in a challenging environment of significant cost increases in a rural and remote region. TCHHS continues to invest in enhanced digital enablement and Virtual Care Coordination to bring care closer to home for our communities. Other initiatives continue to include significant investment in infrastructure to update the HHSs facilities.

During 2021-2022 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 $281.58 million. Funding was primarily derived from non-activity-based funding from the Department of Health of $256.24 million. Other funding sources included other revenue $4.8 million, and grants and contributions $17.26 million, primarily from Australian Government contributions for Indigenous health programs, rural and remote medical benefits scheme and pharmaceutical benefits scheme. The National Partnership Agreement between the State and Commonwealth Governments funded the TCHHS COVID-19 response and vaccination roll-out $16.12 million.

WHERE FUNDING WAS SPENT

Total expenses for 2021-2022 were $281.61 million, averaging a $771,000 per day spend on serving the communities in our jurisdiction. The largest expense was against labour costs at $149.72 million. Supplies and services represent the second highest expense at $97.09 million which includes patient travel costs of $13.48 million, charter costs of $10.13 million, aeromedical retrieval costs (patient transport) of $4.362 million, lease costs of $11.679 million, external contractor costs of $20.34 million, computer services of 3.99 million, electricity and other energy costs of $3.52 million and clinical supplies and services of $4.66 million. Total cost of the COVID-19 response and vaccinations roll-out was $16.12 million.

FINANCIAL POSITION

TCHHS's assets comprise 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 2021-2022 by 5.5 per cent or $12.32 million. This was primarily due to the increase in revaluation surplus of $11.12 million.

ANTICIPATED MAINTENANCE

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

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

As of 30 June 2022, TCHHS had reported total anticipated maintenance of $42.37 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 continues to transform with the growth in services such as Paediatrics, Cardiac, ENT and our own Public Health Unit to service the communities in the HHS. The HHS will be implementation Portfolio Management will enhance investments decisions and the successful implementation of the Own Source Revenue Optimisation Project significantly enhance primary health care in our communities.

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

Financial Statements 30 June 2022

30 June 2022

Contents

Statement of Comprehensive Income
For the year ended 30 June 2022

	Note	2022 Actual $'000	2022 Original Budget $'000	2022 *Budget Variance $'000	2021 Actual $'000
Income					
User charges and fees	2	3,279	3,432	(153)	3,062
Funding for public health services	3	256,239	227,734	28,505	235,868
Grants and other contributions	4	17,262	17,533	(271)	17,082
Other revenue	5	4,798	1,321	3,477	6,234
Interest		2	3	(1)	2
Total revenue		**281,580**	**250,023**	**31,557**	**262,248**
Expenses					
Employee expenses	6	20,196	21,865	(1,669)	19,358
Department of Health contract staff	7	129,524	124,758	4,766	124,428
Supplies and services	8	97,091	79,260	17,831	86,032
Depreciation	14	22,042	19,889	2,153	20,033
Impairment losses		31	10	21	32
Other expenses	9	12,730	4,241	8,489	10,036
Total expenses		**281,614**	**250,023**	**31,591**	**259,919**
Operating result for the year		**(34)**	**-**	**(34)**	**2,329**
Other comprehensive income					
Items that will not be reclassified to operating result					
Increase in asset revaluation surplus	18	11,119	-	-	16,568
Total other comprehensive income		11,119			16,568
Total comprehensive income		**11,085**			**18,897**

**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 2022

	Note	2022 Actual $'000	2022 Original Budget $'000	2022 *Budget Variance $'000	2021 Actual $'000
Current assets					
Cash and cash equivalents	10	33,700	24,395	9,305	32,540
Receivables	11	5,656	1,205	4,451	5,996
Inventories	12	818	552	266	585
Other assets	13	1,137	1,252	(115)	1,315
Total current assets		**41,311**	**27,404**	**13,907**	**40,436**
Non-current assets					
Property, plant and equipment	14	226,903	228,428	(1,525)	214,095
Right-of-use-assets	14	11,397	2,064	9,333	6,624
Total non-current assets		**238,300**	**230,492**	**7,808**	**220,719**
Total assets		**279,611**	**257,896**	**21,715**	**261,155**
Current liabilities					
Payables	15	30,249	17,459	12,790	28,386
Lease liabilities	19	2,977	909	2,068	3,057
Accrued employee benefits	16	1,422	1,452	(30)	1,408
Other liabilities	17	218	22	196	779
Total current liabilities		**34,866**	**19,842**	**15,024**	**33,630**
Non-current liabilities					
Lease liabilities	19	8,462	2,581	5,881	3,561
Unearned revenue		-	-	-	-
Total non-current liabilities		**8,462**	**2,581**	**5,881**	**3,561**
Total liabilities		**43,328**	**22,423**	**20,905**	**37,191**
Net assets		**236,283**	**235,473**	**810**	**223,964**
Equity					
Contributed equity		173,014	196,558	(23,544)	171,780
Accumulated surplus		6,763	4,468	2,295	6,797
Asset revaluation surplus	18	56,506	34,447	22,059	45,387
Total equity		**236,283**	**235,473**	**810**	**223,964**

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

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 2022

	Contributed equity $'000	Accumulated surplus $'000	Asset revaluation surplus $'000	Total equity $'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**
Balance at 1 July 2021	171,780	6,797	45,387	223,964
Operating result for the year	-	(34)	-	(34)
Other comprehensive income				
Increase in asset revaluation surplus	-	-	11,119	11,119
Total comprehensive income for the year	-	(34)	11,119	11,085
Transactions with owners as owners				
Equity asset transfer during the year	6,369	-	-	6,369
Equity injections	16,908	-	-	16,908
Equity withdrawals (depreciation funding)	(22,043)	-	-	(22,043)
Balance at 30 June 2022	**173,014**	**6,763**	**56,506**	**236,283**

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 2022

	Note	2022 Actual $'000	2022 Original Budget $'000	2022 *Budget Variance $'000	2021 Actual $'000
Cash flows from operating activities					
Inflows:					
User charges and fees		2,381	3,401	(1,020)	3,364
Funding for public health services		234,458	207,845	26,613	211,842
Grants and other contributions		17,799	15,423	2,376	16,921
Interest received		2	3	(1)	2
GST collected from customers		485	-	485	438
GST input tax credits from ATO		7,601	-	7,601	6,134
Other		5,159	6,704	(1,545)	3,802
Outflows:					
Employee expenses		(20,182)	(21,855)	1,673	(19,343)
Department of Health contract staff		(129,091)	(124,758)	(4,333)	(128,353)
Supplies and services		(100,498)	(84,353)	(16,145)	(78,589)
Grants and subsidies		(3)	-	(3)	(73)
GST paid to suppliers		(7,822)	-	(7,822)	(6,470)
GST remitted to ATO		(485)	-	(485)	(438)
Interest payments on lease liabilities		(143)	-	(143)	(149)
Other expenses		(7,973)	(2,061)	(5,912)	(1,411)
Net cash from/(used in) operating activities	25	**1,688**	**349**	**1,339**	**7,677**
Cash flows from investing activities					
Payments for property, plant and equipment		(13,446)	(28,826)	15,380	(19,167)
Net cash used in investing activities		**(13,446)**	**(28,826)**	**15,380**	**(19,167)**
Cash flows from financing activities					
Inflows:					
Proceeds from equity injections		16,908	809	16,099	20,648
Outflows:					
Lease payments	26	(3,990)	(810)	(3,180)	(3,286)
Net cash from financing activities		**12,918**	**(1)**	**12,919**	**17,362**
Net increase/(decrease) in cash and cash equivalents		1,160	(28,478)	29,638	5,872
Cash and cash equivalents at the beginning of the financial year		32,540	32,540	-	26,668
Cash and cash equivalents at the end of the financial year	10	**33,700**	**4,062**	**29,638**	**32,540**

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

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

Notes to the Financial Statements
30 June 2022

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:
William McCormack Building
Level 6, 5b Sheridan Street
Cairns Qld 4870

TCHHS serves a population of approximately 27,000 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 the system 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 2022, 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 (MHHS), North West Hospital and Health Service (NWHHS), Townsville Hospital and Health Service (THHS), North Queensland Primary Health Network Limited (NQPHNL) and James Cook University (JCU). 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.

(f) Collaboration in Better Health NQ Alliance

Better Health NQ Alliance (BHNQA) is a collaboration between five Northern Hospital and Health Services: TCHHS, CHHHS, MHHS, NWHHS, THHS plus NQPHNL, Western Queensland Primary Health Network Limited, Queensland Aboriginal and Island Health Council and the DoH. It is anticipated that this alliance will result in a more strategic approach to the system and service aligning the northern region.

The principal function of the BHNQA is to improve the health outcomes of North Queensland residents by undertaking a collective approach to planning, designing, alliancing and commissioning of health services. The Alliance is a decision-making body and provides resources and authorises funding for the program. BHNQA is not controlled by TCHHS and there have been no transactions between TCHHS and BHNQA during this financial year.

Note 2. User charges and fees

	2022 $'000	2021 $'000
Revenue from contracts with customers		
Dental service fees	207	278
Hospital fees	550	515
Multi-purpose nursing home fees	353	360
Pharmaceutical benefits scheme	831	669
Primary clinical care manual	-	44
Queensland community support scheme	76	82
Radiology service delivery	1,052	944
Other user charges and fees		
Other	89	26
Rental income	121	144
	3,279	3,062

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.

Note 2. User charges and fees (continued)

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

	2022 $'000	2021 $'000
ABF Funding - Revenue from contracts with customers		
Specific purpose funding	6,003	6,375
Non-ABF Funding - Other funding for public health services		
Block funding	70,110	87,041
General purpose funding	163,602	131,498
COVID-19 response and vaccination	16,524	8,423
COVID-19 first nations	-	2,531
	256,239	235,868

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 2022 was $24.7m (2021: $4.211m).

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.

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 2022: 2.3% (2021: 2.70%) of TCHHS's overall public health services revenue. Funding relating to oral health services makes up 2022: 87% or $5.22m (2021: 78.0% or $5.009m) of total ABF revenue.

Based on these proportions of ABF revenue for TCHHS at 30 June 2022, the contract liability arising from ABF is not material. Any amounts repayable to DoH at year end are shown as a payable in note 15. The contract asset balance is not 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

Note 3. Funding for public health services (continued)

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 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 both response recovery of expenditure totalling 2022: $7.652m (2021: $7.070m) and the COVID vaccination program totalling $8.467m (2021: $2.140m). Expenditure Items include labour, travel, clinical supplies, freight, planning, administration and roll-out costs.

Note 4. Grants and other contributions

	2022 $'000	2021 $'000
Revenue from contracts with customers		
Commonwealth home support programme	1,135	1,011
Rural and remote medical benefits	6,143	5,993
Indigenous health incentive	134	498
Other grants and contributions	137	150
Other grants and contributions		
Remote area aboriginal health services S100	-	(30)
Rural health outreach fund	1,185	1,018
Commonwealth indigenous health programs	3,716	3,763
Services below fair value	1,998	1,857
Practice incentive payments	1,351	1,029
Commonwealth after hours and health pathways services	941	874
My health for life	18	42
Other grants and contributions	41	10
Donations	463	867
	17,262	17,082

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 a contract liability 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 2021-22 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 $1.998m in 2022 (2021: $1.857m) which are 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

	2022 $'000	2021 $'000
Contract staff and recoveries	1,471	1,063
Asset revaluation increment	-	451
Contributed assets	53	1,800
Non-capital project recoveries	2,735	2,504
Other	539	416
	4,798	6,234

Other revenue does not relate to the HHS's ordinary activities and is accounted for 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 land decrement loss of $0.451m from 2018 was reversed on the Statement of Comprehensive Income in the prior year as an asset revaluation increment under other revenue. Refer to Note 14.

Contributed assets
TCHHS acquired three building assets in the prior year after long standing tenure issues were resolved. 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. TCHHS had only one asset which was similar this year and recognised at no cost and then adjusted to fair value of $0.044m as at 30 June 2022.

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

	2022 $'000	2021 $'000
Wages and salaries	15,172	15,364
Annual leave levy	1,090	1,039
Employer superannuation contributions	1,268	1,148
Long service leave levy	424	387
Sick leave	213	144
Other employee related expenses	2,029	1,276
	20,196	19,358

The number of directly engaged employees is 46 as at 30 June 2022 (2021: 46) which comprise 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 1,060 (2021: 1,018) full time equivalent roles in a contracting capacity as at 30 June 2022. 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.

All non-executive employees of the DoH and HHS's were granted an additional 2 days of leave 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 by 31 March 2023 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 2022	As at 30 June 2021
Number of employees	46	46
Number of health service employees	1,060	1,018
	1,106	1,064

Note 8. Supplies and services

	2022 $'000	2021 $'000
Building services	2,374	1,990
Catering and domestic supplies	528	486
Clinical supplies and services	4,658	3,963
Communications	2,380	2,359
Computer services	3,998	3,223
Consultants	2,869	2,067
Contractors - clinical	18,539	13,869
Contractors - non-clinical	1,796	1,225
Drugs	1,792	1,980
Electricity and other energy	3,516	3,508
Expenses relating to minor works	529	1,175
Freight	1,502	1,733
Motor vehicles	538	300
Lease expenses	11,679	9,994
Other supplies and services	2,069	2,579
Other travel	10,125	8,412
Pathology, blood and related equipment	2,967	2,814
Patient transport	4,362	4,036
Patient travel	14,246	13,753
Repairs and maintenance	4,626	4,709
Services below fair value	1,998	1,857
	97,091	86,032

Contractors
During the year $3.777m (2021: $4.894m) was expensed in relation to services purchased from Non-Government Organisations (NGO) with Apunipima Cape York Health Council and Royal Flying Doctor Service for the provision of health services to public patients.

Lease expenses
Lease expenses for the 2022 financial year include lease rental for short-term building leases ($1.643m), Q-Fleet vehicle leases ($1.424m), leases governed by Queensland Government Accommodation Office (QGAO) and Government Employee Housing (GEH) ($8.598m) and other variable lease payments ($0.014m) in accordance with the requirements of the AASB 16 *Leases.* Refer to Note 19 for 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 $1.998m in 2022 (2021: $1.857m) 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

	2022 $'000	2021 $'000
Advertising	241	78
Audit fees - internal and external	355	311
Funding returns	10,011	6,901
Insurances other	102	94
Insurance premiums QGIF	1,124	1,021
Losses from the disposal of non-current assets	76	223
Other legal costs	344	904
Inventory stock adjustments	40	50
Interest on leases	143	149
Other	294	305
	12,730	10,036

Note 9. Other expenses (continued)

Audit fees – internal and external
Total external audit fees quoted by the Queensland Audit Office relating to the 2021-22 financial statements are $0.163m (2021: $0.163m).

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 nil ex gratia payments to report (2021: $nil).

Note 10. Cash and cash equivalents

	2022 $'000	2021 $'000
Cash on hand	1	1
Cash at bank	33,464	32,305
QTC cash funds	235	234
	33,700	32,540

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 2022 was $0.235m (2021: $0.234m) and the annual effective interest rate was 0.76% (2021: 0.51%).

Note 11. Receivables

	2022 $'000	2021 $'000
Receivables	805	510
Less: Allowance for impairment of receivables	(201)	(189)
	604	321
GST input tax credits receivable	984	704
GST payable	(78)	(19)
	906	685
Public health service funding	4,146	4,990
	4,146	4,990
	5,656	5,996

Note 11. Receivables (continued)

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.

The closing balance of receivables arising from contracts with customers at 30 June 2022 is $0.200m (2021: $0.194m).

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 2022 is $0.558m (2021: $0.260m).

The provision matrix uses historical observed default rates calculated using credit losses experienced on past transactions during the last two years preceding 30 June 2022.

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 2022 have been correlated against changes in the unemployment rate and based on those results, the historical default rates are adjusted based on expected changes in employment 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.

Note 11. Receivables (continued)

	Less than 30 days $'000	31 - 60 days $'000	61 - 90 days $'000	More than 90 days $'000	Total $'000
Ageing of receivables 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
Ageing of receivables 2022 (Dental Patients)					
Receivables	1	2	1	6	9
Loss rate (%)	15.90%	100.00%	100.00%	100.00%	100
Allowance for impairment (Expected Credit loss)	-	(2)	(1)	(6)	(8)
Carrying amount	1	-	-	-	1
Ageing of receivables 2022 (Other patients and customers)					
Receivables	45	-	4	188	238
Loss rate (%)	1.80%	28.50%	69.50%	100.00%	
Allowance for impairment (Expected Credit loss)	(1)	-	(3)	(188)	(192)
Carrying amount	44	-	1	-	46
Ageing of receivables 2022 (Government agency / low risk)					
Receivables	558	-	-	-	558
Loss rate (%)	0.00%	0.00%	0.00%	0.00%	
Allowance for impairment (Expected Credit loss)	-	-	-	-	-
Carrying amount	558	-	-	-	558
Total carrying amount	603	-	1	-	604
Total receivables	604	2	5	194	805

Note 11. Receivables (continued)

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.

	2022 $'000	2021 $'000
Movements in the provision for impairment of receivables are as follows:		
Balance at the start of the year	189	230
Receivables written off during the year as uncollectable	(21)	(82)
Decrease in provision recognised	33	41
Balance at the end of the year	201	189

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. This year, an increase of COVID-19 related inventory was ordered and held for ready use in the wards to address the pandemic.

Note 13. Other assets

	2022 $'000	2021 $'000
Current		
Prepayments	436	608
Contract assets	511	252
Other	190	455
	1,137	1,315

Prepayments
Prepayments derive from a number of expenditure items including Q-Fleet vehicle hire, council rates, Workcover premium costs and Covid-19 special leave which are all recognised when the payment is made up-front.

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 & land improvements $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
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)	-
Transfer 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	30,497	16,832	478,312
Accumulated depreciation	-	(246,968)	(17,249)	-	(264,217)
Carrying amount at 30 June 2021	**9,847**	**174,168**	**13,248**	**16,832**	**214,095**
Carrying amount at 1 July 2021	9,847	174,168	13,248	16,832	214,095
Additions	-	6,866	2,842	3,813	13,521
Disposals	-	(779)	(75)	-	(854)
Asset revaluation increment	-	11,119	-	-	11,119
Asset not previously recognised	-	(38)	11	-	(27)
Transfers between classes	-	13,612	566	(14,178)	-
Transfers in from other Queensland Government	-	7,000	220	-	7,220
Depreciation expense	-	(15,465)	(2,706)	-	(18,171)
Carrying amount at 30 June 2022	**9,847**	**196,483**	**14,106**	**6,467**	**226,903**
As at 30 June 2022					
Gross value	9,847	456,824	32,242	6,467	505,380
Accumulated depreciation	-	(260,341)	(18,136)	-	(278,477)
Carrying amount at 30 June 2022	**9,847**	**196,483**	**14,106**	**6,467**	**226,903**

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 2020	2,114	4,290	6,404
Additions	1,173	2,319	3,492
Depreciation expense	(177)	(3,086)	(3,263)
Carrying amount at 30 June 2021	**3,125**	**3,499**	**6,624**
As at 30 June 2021			
Gross value	3,352	8,528	11,880
Accumulated depreciation	(227)	(5,029)	(5,256)
Carrying amount at 30 June 2021	**3,125**	**3,499**	**6,624**
Carrying amount at 1 July 2021	3,125	3,499	6,624
Additions	1,161	7,650	8,811
Depreciation expense	(154)	(3,717)	(3,871)
Disposals	-	-	-
Derecognition of asset	-	(167)	(167)
Carrying amount at 30 June 2022	**4,132**	**7,265**	**11,397**
As at 30 June 2022			
Gross value	4,498	14,793	19,291
Accumulated depreciation	(366)	(7,528)	(7,894)
Carrying amount at 30 June 2022	**4,132**	**7,265**	**11,397**

(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.

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

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

(c) Accounting policies – recognition and acquisition (continued)
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 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.

(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.

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

(e) Fair value measurement and valuation (continued)

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.

2021	**Level 2 $'000**	**Level 3 $'000**	**Total $'000**
Assets			
Land	9,847	-	9,847
Buildings (health service sites)	-	174,168	174,168
Total	9,847	174,168	184,015
2022			
Assets			
Land	9,847	-	9,847
Buildings (health service sites)	-	196,483	196,483
Total	9,847	196,483	206,330

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 2021-22 no comprehensive valuation was carried out on all TCHHS land parcels as one was completed in the prior year. Alternatively, an indexation report was completed by the

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

(e) Fair value measurement and valuation (continued)

State Valuation Service which resulted in nil movements as each parcel of land returned a 1.0 indexation factor for the period between June 2021 to June 2022.

Buildings and land improvements
In 2021-22 TCHHS engaged independent experts, Jacobs, to undertake building revaluations in accordance with the fair value methodology. TCHHS had 44 buildings and land improvements comprehensively revalued during 2021-22 which represented 20.6% of the total asset class building portfolio. All remaining buildings had an indexation applied as recommended by Jacobs.

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 five years using the cost valuation approach (current replacement cost). Indexation was assessed as 6.5% and applied to all gross buildings and land improvements asset values that were not comprehensively revalued during this financial year. There are many factors that are currently impacting construction market pricing including market uncertainty driven by increasing labour and material prices after the market has emerged from the impacts of COVID-19. The effective date of valuations was primarily 30 June 2022.

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 2021-22 resulted in a net increment of $11.119m to the carrying amount of buildings all from the independent comprehensive valuation net increment. The change in net book value is mainly due to major refurbishment of several assets and agreed changes to the remaining useful lives.

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.

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) 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.

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

(f) Fair value measurement and valuation (continued)

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 – 77 years
Plant and equipment	3.3% – 50.0%	2 – 30 years
Right-of-use assets	2.5% – 50.0%	2 – 40 years

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 the statement of comprehensive income.

Note 15. Payables

	2022 $'000	2021 $'000
Payables	8,321	7,453
Accrued expenses	9,111	12,175
Department of Health contract staff wages	1,562	1,129
Payables - refund liabilities	11,255	7,629
	30,249	28,386

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.

Post-employment benefits for superannuation are provided through defined contribution (accumulation) plans or the Queensland Government's defined benefit plan (the former QSuper defined benefit categories now administered by the Government Division of the Australian Retirement Trust) as determined by the employee's conditions of employment. 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

	2022 $'000	2021 $'000
Current		
Contract liabilities	218	779
	218	779

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 contract liabilities, 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 2021-22 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 2020	-	28,819	28,819
Revaluation increment	461	16,107	16,568
Balance - 30 June 2021	461	44,926	45,387
Balance at 1 July 2021	461	44,926	45,387
Revaluation increment	-	11,119	11,119
Balance - 30 June 2022	461	56,045	56,506

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 2021-22 resulted in a net increment of $11.119m 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:

	2022 $'000	2021 $'000
Current		
Lease liabilities	2,977	3,057
	2,977	3,057
Non-Current		
Lease liabilities	8,462	3,561
	8,462	3,561
	11,439	6,618

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

Note 19. Lease liabilities (continued)

(ii) Amounts recognised in profit or loss

	2022 $'000	2021 $'000
Interest expense on lease liabilities	143	149
Breakdown of 'Lease expenses' included in Note 8		
- Expenses relating to short-term leases	1,643	759
Income from subleasing included in 'Rental income' in Note 2	121	144
(iii) Total cash outflow for leases		
Total cash outflow for leases	3,823	3,286

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.

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:

	2022 $'000	2021 $'000
Financial assets		
Financial assets at amortised cost - comprising:		
Cash and cash equivalents	33,700	32,540
Receivables	5,656	5,996
Total financial assets	39,356	38,536
Financial liabilities		
Financial liabilities at amortised cost - comprising:		
Payables	30,249	28,386
Lease liabilities	11,439	6,618
Total financial liabilities at amortised cost	41,688	35,004

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

Note 20. Financial instruments (continued)

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.

(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 2022 there were two cases in progress filed in the courts naming the State of Queensland acting through TCHHS as defendant.

As of 30 June, 2022 there were 8 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 13 claims underway and 3 pending 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.

Note 21. Contingent liabilities (continued)

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

Where native title continues to exist, (Reserve or in DOGIT for example), dealings cannot proceed until native title has been addressed.

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 may 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) or Future Act Notices (FAN). TCHHS has administered reserves within DOGIT land containing TCHHS building assets. These reserves are held in the name of TCHHS 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 27 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 13 ILUAs, 12 of which provide native title consent to existing registered trustee leases that have commenced. TCHHS has also issued two Future Act Notices (FAN) each with contingent liability for compensation. These FANs were needed in order for DOGIT leases or works in Reserve to be valid under the *Native Title Act 1993*.

Note 22. Commitments

	2022 $'000	2021 $'000
Commitments - capital expenditure		
Committed at the reporting date but not recognised as liabilities, payable:		
Not later than 1 year	16,107	6,911
Commitments - operating expenditure		
Committed at the reporting date but not recognised as liabilities, payable:		
Not later than 1 year	15,258	14,758
Later than 1 year but not later than 5 years	1,480	1
Later than 5 years	490	-
	33,335	21,670

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	2022 $'000	2021 $'000
Receipts		
Opening balance	7	5
Amounts receipted on behalf of patients	5	4
Total receipts	12	9
Payments		
Amounts paid to or on behalf of patients	5	2
Total payments	5	2
Trust assets and liabilities		
Assets		
Cash held and bank deposits	7	7
Total assets	7	7

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 2022 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

	2022 $'000	2021 $'000
Operating result for the year	(34)	2,329
Non-cash movements:		
Depreciation	22,042	20,033
Depreciation offset from DoH	(22,042)	(20,033)
Loss on disposal	76	223
Asset valuation decrement	-	(451)
Donated assets	(75)	(790)
Contributed assets	(53)	(1,800)
Movements in impairment loss receivables	21	80
Change in operating assets and liabilities		
(Increase)/decrease in receivables	540	(2,133)
(Increase)/decrease in GST receivables	(221)	(336)
Decrease in inventories	(233)	(52)
Increase in prepayments	437	(169)
(Increase)/decrease in contract assets	(259)	106
Increase/(decrease) in payables	4,667	11,641
Increase/(decrease) in accrued employee benefits	14	15
Increase/(decrease) in accrued contract labour	(2,631)	(1,743)
Increase/(decrease) in contract liabilities	(561)	757
Net cash from/(used in) operating activities	1,688	7,677

Note 26. Changes in liabilities arising from financing activities

2021		Non-cash changes		Cash flows	
	Opening balance $'000	New leases acquired $'000	Early terminated leases $'000	Cash repayments $'000	Closing balance $'000
Lease liabilities	6,412	3,515	(23)	(3,286)	6,618
Total	6,412	3,515	(23)	(3,286)	6,618

2022					
	Opening balance $'000	New leases acquired $'000	Early terminated leases $'000	Cash repayments $'000	Closing balance $'000
Lease liabilities	6,618	8,811	(167)	(3,823)	11,439
Total	6,618	8,811	(167)	(3,823)	11,439

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.

	2022 $'000	2021 $'000
Opening balance	382	100
Revenue received during the year	16	432
Expenditure made during the year	(9)	(150)
Balance of general trust	389	382

The closing cash balance of the general trust at 30 June 2022 is $0.389m (2021: $0.382m). This is held on deposit with the QTC $0.235m (2021: $0.234m) and the Commonwealth Bank of Australia $0.154m (2021: $0.148m).

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.

Note 28. Key management personnel disclosures (continued)

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

Position	Name	Contract classification and appointment authority	Initial appointment date
Non-executive Board Chairperson - Provides strategic leadership and guidance and effective oversight of management, operations and financial performance	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	Karen Price Scott Davis Rhonda Shibasaki Karen Dini-Paul Susan Hadfield Marjorie Pagani Karyn Sam Darren Thamm Tara Diversi	*S23 Hospital and Health Boards Act 2011*	11 December 2015 18 May 2016 18 May 2019 18 May 2020 to 31 March 2022 29 September 2020 18 May 2021 18 May 2021 18 May 2021 31 March 2022
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 control, financial management and statutory reporting obligations plus executive lead for information management, health information, digital services and disaster and emergency management	Danielle Hoins	*HES2 Hospital and Health Boards Act 2011*	15 June 2020
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	Tamara Sweeney	*HES2 Hospital and Health Boards Act 2011*	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 Vikki Jackson (acting)	*HES2 Hospital and Health Boards Act 2011*	23 July 2018 10 December 2021 to 10 January 2022
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	Marlow Coates	*MMOI1 Hospital and Health Boards Act 2011*	16 April 2021

Note 28. Key management personnel disclosures (continued)

Position	Name	Contract classification and appointment authority	Initial appointment date
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	*NRG13* *Hospital and Health Boards Act 2011*	7 May 2018
Executive Director Aboriginal and Torres Strait Islander Health - to provide a professional lead for Aboriginal and Torres Strait Islander Health workers and Health Practitioners, designing workforce strategies that will strengthen opportunities for Aboriginal and Torres Strait Islander peoples' career growth and help deliver the best possible health care to our region	Vanessa Curnow Loretta Rigby (acting) Stephen Tilley	*DSO2* *Hospital and Health Boards Act 2011*	1 June 2021 to 12 July 2021 30 August 2021 to 3 April 2022 21 March 2022
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	*HP6* *Hospital and Health Boards Act 2011*	18 February 2019
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 Timothy Todd Sue Cooper	*DSO1* *Hospital and Health Boards Act 2011*	1 September 2019 28 June 2021 to 11 July 2021 18 October 2021 to 3 November 2021 24 January 2022 to 30 June 2022 5 October 2021 to 17 October 2021 24 December 2021 to 9 January 2022 10 January 2022 to 23 January 2022
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	*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
The Board decides the objectives, strategies and policies to be followed by TCHHS and ensure it performs it's functions in a proper, effective and efficient way. The Board appoints the Health Service Chief Executive and exercises significant responsibilities at a local level, including controlling the financial management of the Service and the management of the Service's land and buildings (Section 7 *Hospital and Health Boards Act 2011*). 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

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 2021-22 financial year (2021: $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.

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.

Note 28. Key management personnel disclosures (continued)

2022 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
Karen Price	40	-	4	-	-	44
Scott Davis	40	9	4	-	-	53
Rhonda Shibasaki	39	-	4	-	-	43
Karen Dini-Paul	29	9	3	-	-	41
Marjorie Pagani	39	-	4	-	-	43
Karyn Sam	39	-	4	-	-	43
Darren Thamm	39	9	4	-	-	52
Susan Hadfield	42	-	4	-	-	46
Tara Diversi	10	-	1	-	-	11
Executive						
Beverley Hamerton	264	9	25	6	-	304
Danielle Hoins	195	9	20	4	-	228
Tamara Sweeney	195	-	19	4	-	218
Ian Power	182	9	18	4	-	213
Vikki Jackson	14	-	2	-	-	16
Marlow Coates	585	8	38	14	-	645
Kim Veiwasenavanua	185	9	20	4	-	218
Vanessa Curnow	1	-	-	-	14	15
Loretta Rigby	82	8	9	2	-	101
Stephen Tilley	45	-	5	1	-	51
Vivienne Sandler	29	9	5	1	-	44
Dean Davidson	174	-	20	4	-	198
Timothy Todd	84	9	8	2	-	103
Sue Cooper	28	8	2	-	-	38
Sally O'Kane	162	-	15	4	-	181

Note 28. Key management personnel disclosures (continued)

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 29. Related party transactions

Transactions with Queensland Government controlled entities
Material related party transactions for 2021-22 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.

Note 29. Related party transactions (continued)

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.

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 2021-2022 membership contribution directly to TAAHC. This transaction was endorsed by the TCHHS Board and is considered to be at arm's length.

TCHHS is in a partnership with BHNQA to form an Alliance. The Alliance is a decision-making body and provides resources and authorises funding for the program. There have been no related party transactions between TCHHS and BHNQA during this financial year.

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	2022		2021	
		Transaction value Revenue/ (expense)	Receivables/ (payables)	Transaction value Revenue/ (expense)	Receivables/ (payables)
		$'000	**$'000**	**$'000**	**$'000**
DoH	Service Agreement *	256,239	(9,288)	235,868	(3,891)
DoH	Non-executive health service employees	(129,524)	(1,559)	(124,428)	(1,129)
DoH	Services support costs	(16,349)	(1,006)	(16,325)	(1,200)
Other Hospital and Health Services	Renal, interpretation and legal services, pharmacy supplies, office space, courier fees, contract labour and training.	(1,177)	-	(1,461)	-
Department of Energy and Public Works	Building/fleet leases	(10,514)	(118)	(9,784)	(46)
NQPHN	Primary Health care support **	283	(283)	121	(121)
TAAHC	Membership fee	(150)	-	(150)	-
Close family members	Aggregated salary and wages	(590)	-	(593)	-

* *DoH Service Agreement receivables and payables (2022: $0.723m receivables and $10.011m payables) (2021: $3.083m receivables and $6.974m payables)*

** *NQPHN revenue and expenses (2022: $1.120m of revenue and $0.837m of expenses) (2021: $0.953m of revenue and $0.832m of expenses). NQPHN receivables and payables (2022: $0.283m payables) (2021: $0.121m 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 did not apply any other new accounting standards for the first time and there were no changes in policies for 2021-22.

Following the issuance of IFRIC's agenda decision in April 2021, TCHHS have not incurred any costs towards the configuration or customisation in a Cloud Computing Arrangement for software-as-a-service (SaaS). Therefore, TCHHS is not required to revise its accounting policy in relation to SaaS arrangements.

(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 Whole-of-Government climate related publications including the Climate Action Plan 2030 and Queensland Sustainability Report.

(e) Significant financial impacts from COVID-19

TCHHS did not have any significant financial impacts from COVID-19. This is due to the Commonwealth government providing guarantee to fully fund the costs directly related to the pandemic in accordance with the National Reform Agreement for the 2019-2022 years. TCHHS had short periods of time that affected 'business as usual' which impacted own source revenue generation however workforce availability reduced costs to a nil impact.

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

Funding for public health services:	The increase of $28.505m (12.52%) related to additional DoH Service Agreement funding for the delivery of increased public hospital and health services and NPA COVID-19 response and vaccination funding of $15.762m. In addition to this there were revenue clawback and program deferrals $9.150m recognised under AASB 1058 *Income of Not-for-Profit Entities.*
Employee expenses:	The decrease of $1.669m (7.63%) relates to the number of vacancies for Senior Medical officer's positions due to labour shortages across the health service.
Department of Health contract staff:	The increase of $4.766m (3.82%) directly relates to higher than anticipated FTE's employed throughout the year, due to increases in funding provided in DoH's funding amendment windows 2 and 3, and COVID-19 response and vaccination funding when looking at total labour costs including external labour.
Supplies and services:	The increase overall of $17.831m (22.50%) relates primarily to higher external labour ($13.152m), travel costs ($2.551m) and consultancies ($1.938m) costs. These increases also comprises of freight, travel, leases and clinical supplies costs relating to COVID-19 response and vaccinations ($5.669m). Reductions in building lease costs ($1.547m) due to the changes relating to lease accounting under the new accounting standard AASB 16 *Leases* have offset these increases.
Depreciation expense:	The increase of $2.153m (10.83%) relates to the depreciation expense from right-of-use assets of $1.117m that were not included in the budget, prior year's revaluation being higher than budget plus the timing of completed capital projects $1.037m.
Other expenses:	The increase of $8.489m relates to Treasury treatment of unspent grants under AASB 1058 of $10.011m (which was not factored into the budget) offset by classification difference between other expenses and supplies and services.

Note 31. Budget vs actual comparison (continued)

Statement of Financial Position

Cash and cash equivalents:	Refer to commentary under Statement of Cash Flows.
Receivables:	The majority of the $4.451m (369.38%) increase relates to the $4.416m Department of Health technical end of year adjustment which includes the Enterprise Bargaining (EB) adjustment and COVID recovery costs.
Inventories:	The increase of $0.266m (48.19%) relates to recognition of COVID-19 rapid antigen test, personal protective equipment and pulse oximeters which exceed TCHHS inventory thresholds in 2021-22.
Property, plant and equipment:	The decrease of $1.525m (0.1%) relates to the delay in major projects practical completion which were later than initial forecast. This decrease was offset by increases due to the comprehensive revaluation which resulted in an increment of $11.119m inclusive of an indexation factor of 6.5% to the remaining built assets whereas the budgeted increment assumption was 1.0%.
Right-of-use assets:	The increase of $9.333m relates to a commercial lease for the Clinical Coordination Hub and private leases which were renewed in 2021-22 with lease terms in excess of 12 months that are now not exempt or out of scope under AASB 16 Leases are therefore capitalised.
Payables:	The increase of $12.790m (73.26%) relates to revenue clawback and program deferrals $9.150m recognised under AASB 1058 Income of Not-for-Profit Entities and Department of Health payroll settlement for first pay period 2022-23.
Lease liabilities:	Refer to commentary under right-of-use assets.
Asset revaluation surplus:	The increase of $22.059m (64.04%) relates to the comprehensive revaluation and indexation outlined above under property, plant and equipment.

Note 31. Budget vs actual comparison (continued)

Statement of Cash Flows

Funding for public health services:	The increase in cash inflows is higher than budgeted primarily due to the depreciation funding that is not a cash item plus other factors outlined in the major variances for the Statement of Comprehensive Income.
Grants and other contributions:	The increase in cash inflows is higher than budgeted primarily due to the timing of cash payments versa revenue recognition of trust donations.
Employee expenses, Department of Health contract staff and supplies and services:	The increase in cash outflows is higher than budgeted primarily due to the same factors outlined in the major variances for the Statement of Comprehensive Income.
Payments for property, plant and equipment	The decrease in cash flows from investing activities is due to delays in the practical completion of the Thursday Island redevelopment project.
Proceeds from equity injections:	The increase in cash flows from financing activities is higher than the budgeted figure due to the same factors outlines in the major variances for the Statement of Financial Position.
Lease payments:	The increase in cash outflows from investing activities is due to the increase recognition of right of use assets as outline in the major variances for the Statement of Comprehensive Income.

Torres and Cape Hospital and Health Service
Management Certificate
For the year ended 30 June 2022

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 2022 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	Beverley Hamerton Health Service Chief Executive	Danielle Hoins - CPA Executive Director Finance Information and Digital Services (and CFO)
26/08 / 2022	26/ 08 / 2022	26/ 08 / 2022

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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 2022, 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 2022, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

Basis for opinion

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

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

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

Key audit matters

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

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Key audit matter	How my audit addressed the key audit matter

Buildings were material to Torres and Cape's 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 21 per cent of its building assets this year as part of the rolling revaluation program. All other buildings were assessed using relevant indices.
 	
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:
  ○ estimating the current cost for a modern substitute (including locality factors and oncosts), expressed as a rate per unit (e.g. $/square metre)
  ○ identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference.
 	
The measurement of accumulated depreciation involved significant judgements for determining condition and forecasting the remaining useful lives of building components.
 	
The significant judgements required for gross replacement cost and useful lives are also significant judgements for calculating annual depreciation expense.
 	
Using indexation required:
	My procedures included, but were not limited to:
	• assessing the adequacy of management's review of the valuation process and results
	• reviewing the scope and instructions provided to the valuer
	• assessing the appropriateness of the valuation methodology and the underlying assumptions with reference to common industry practices
	• assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices
	• assessing the competence, capabilities and objectivity of the experts used to develop the models
	• for unit rates, on a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the:
	  ○ modern substitute (including locality factors and oncosts)
	  ○ adjustment for excess quality or obsolescence.
	• evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices
	• evaluating useful life estimates for reasonableness by:
	  ○ reviewing management's annual assessment of useful lives
	  ○ at an aggregated level, reviewing asset management plans for consistency between renewal budgets and the gross replacement cost of assets
	  ○ testing that no building asset still in use has reached or exceeded its useful life
	  ○ enquiring of management about their plans for assets that are nearing the end of their useful life
	  ○ reviewing assets with an inconsistent relationship between condition and remaining useful life.
	• Where changes in useful lives were identified, evaluating whether the effective dates of the changes applied for depreciation expense were supported by appropriate evidence.

Key audit matter	How my audit addressed the key audit matter
• significant judgement in determining changes in cost and design factors for each asset type since the previous revaluation • reviewing previous assumptions and judgements used in the last comprehensive valuation to ensure ongoing validity of assumptions and judgements used.	

Responsibilities of the entity for the financial report

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

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

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

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

Statement

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2022:

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.

29 August 2022

D J Toma
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
NSQHSS	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.
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.
Weighted Activity Unit	A standard unit used to measure all patient care activity consistently. The more resource intensive an activity is, the higher the weighted activity unit. This is multiplied by the standard unit cost to create the 'price' for the episode of care.

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, 88,89
	• **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	39,40
Governance – management and structure	• **Organisational structure**	ARRs – section 13.1	29
	• **Executive management**	ARRs – section 13.2	17-28
	• **Government bodies (statutory bodies and other entities)**	ARRs – section 13.3	22,23
	• **Public Sector Ethics**	*Public Sector Ethics Act 1994* ARRs – section 13.4	34
	• **Human Rights**	*Human Rights Act 2019* ARRs – section 13.5	35
	• **Queensland public service values**	ARRs – section 13.6	10,34
Governance – risk management and accountability	• **Risk management**	ARRs – section 14.1	32
	• **Audit committee**	ARRs – section 14.2	20
	• **Internal audit**	ARRs – section 14.3	28
	• **External scrutiny**	ARRs – section 14.4	33
	• **Information systems and recordkeeping**	ARRs – section 14.5	33
	• **Information Security attestation**	ARRs – section 14.6	34
Governance – human resources	• **Strategic workforce planning and performance**	ARRs – section 15.1	29
	• **Early retirement, redundancy and retrenchment**	Directive No.04/18 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	31
Open Data	• **Statement advising publication of information**	ARRs – section 16	2
	• **Consultancies**	ARRs – section 31.1	https://data.qld.gov.au
	• **Overseas travel**	ARRs – section 31.2	nil
	• **Queensland Language Services Policy**	ARRs – section 31.3	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	84-87

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2019*

ARRs *Annual report requirements for Queensland Government agencies*

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https://www.torres-cape.health.qld.gov.au/