Torres and Cape Hospital and Health Service

2019–2020 ANNUAL REPORT

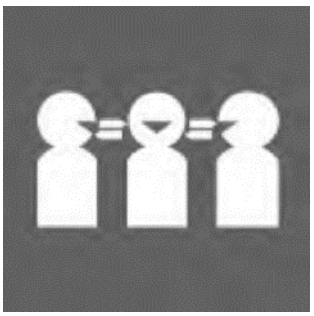
Queensland Government

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

An electronic copy of this report is available at https://www.health.qld.gov.au/torres-cape/html/publication-scheme.

Hard copies of the annual report are available by contacting the Board Secretary (07) 4226 5945. Alternatively, you can request a copy by emailing TCHHS-Board-Chair@health.qld.gov.au.

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



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

ACKNOWLEDGEMENT TO TRADITIONAL OWNERS

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

CAPE YORK

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

NORTHERN PENINSULA AREA

Atambaya, Gudang, Yadhaykenu, Angkamuthi, Wuthathi.

TORRES STRAIT ISLANDS

The five tribal nations of the Torres Strait Islands:

The Kaiwalagal

The Maluilgal

The Gudamaluilgal

The Meriam

The Kulkalgal Nations.

04 September 2020

The Honourable Steven Miles MP

Deputy Premier, Minister for Health and Minister for Ambulance Services

GPO Box 48

Brisbane QLD 4001

Dear Deputy Premier

I am pleased to submit for presentation to the Parliament the Annual Report 2019–2020 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 92 of this annual report.

Yours sincerely

Elthies (Ella) Kris

Chair

Torres and Cape Hospital and Health Board

TABLE OF CONTENTS

STATEMENT ON GOVERNMENT OBJECTIVES FOR THE COMMUNITY

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

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

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

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

This year we consolidated on our strong position from the previous financial year and moved forward with delivering services, planning new infrastructure and achieving our strategic objectives.

The impact of COVID-19 pandemic response and recovery has seen the agency significantly refocus its services in the second half of the 2019-20 year.

We would like to thank State Government and the Honourable Steven Miles MP, Deputy Premier, Minister for Health and Minister for Ambulance Services, for our ongoing funding and support to maintain our services and infrastructure works.

We would also like to thank the Board and the Executive for their ongoing commitment to our region and acknowledge outgoing Board Member, Mr Fraser Nai. Mr Nai has been a Board Member for nearly six years, joining in 2014. His wealth of local government experience and knowledge has been invaluable, and we wish him well for future endeavours.

Joining the Board, we welcome Ms Karen Dini-Paul. Ms Dini-Paul is a descendant of the Arrernte People of Alice Springs and has 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.

With the implementation of the *Human Rights Act 2019*, the Board reviewed and amended TCHHS's Strategic Plan to ensure that the human rights of Queenslanders are acknowledged and respected. We also consulted with our staff and the community to identify Organisational Values that reflect where we work and what we stand for.

In the first six months of 2019-20, TCHHS launched or progressed new services and vital infrastructure including:

- The Western Cape Chronic Kidney Disease Service.
- Beginning construction on the Torres Strait Island PHCC Redevelopment project
- Opening dedicated administration space and progressing redevelopment plans for the Cooktown Multi Purpose Health Service (MPHS)
- Roof replacement at Bamaga Hospital and Wujal Wujal Primary Health Care Centre
- Construction of new morgue in Coen
- Completing TCHHS's Infrastructure Master Plan, providing strategic direction for asset development for the next 15 years.
- Redevelopment of Thursday Island Hospital and Primary Health Care Centre

Addressing the inequity of health across Aboriginal and Torres Strait Islander peoples is a key part of Closing the Gap and something that we, as a Health Service, must continue to address. Nearly one-third of our adult population in TCHHS has some form of kidney disease.

In July 2019, TCHHS implemented the Western Cape Chronic Kidney Disease Service (CKD), a new and innovative model-of-care that brings specialist clinics into our communities to allow patients to be treated closer to their homes. In June 2020, as COVID restrictions were relaxed, the multidisciplinary CKD team visited five towns and met with more than 250 patients. Almost all these patients would have otherwise needed to travel to Cairns or Townsville for a specialist appointment. Residents in Western Cape and the Northern Peninsula Area will soon get further support through the introduction of full-time, nurse-assisted dialysis in Weipa and Bamaga.

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

In 2020-21, we will continue to be COVID-19 ready. TCHHS is now working on a transition to a virtual model-of-care and make lasting, fundamental improvements to the way we care for our community.

Some of these improvements include:

- Management plans for all vulnerable patients within TCHHS (60% of our population)
- Establishment of a centralised Clinical Coordination Hub that works with local teams to assess the required care across a range of medical disciplines
- A 50 per cent increase in Telehealth appointments, ensuring patients could receive specialist care closer to home.

With large investments made in infrastructure and services, TCHHS spent $252.45 million in 2019-20. We achieved moderate growth in overall revenue and made savings in travel costs due to COVID-19, which we will continue to invest in our communities.

It is with great pleasure that we present to you Torres and Cape Hospital and Health Service's 2019-20 Annual Report.

Eso,

Elthies (Ella) Kris

Board Chair

Beverley Hamerton

Chief Executive.

ABOUT US

TCHHS is an independent statutory body governed by a single Board established under the *Hospital and Health Boards Act 2011*. It is managed from hubs in Weipa, Cairns and Thursday Island and covers an area of 129,770 square kilometres. We serve communities that are widely spread across Cape York, the Northern Peninsula Area and the Torres Strait Islands. TCHHS is comprised of 31 primary health care centres, two hospitals, a Multi Purpose Health Service and an Integrated Health Service. Sixty-four per cent of the population in the region identify as Aboriginal and/or Torres Strait Islander. We are one of Australia's largest providers of health services to Aboriginal and Torres Strait Islander peoples.

STRATEGIC DIRECTION

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

OUR VISION

Leading connected healthcare to achieve longer, healthier lives.

OUR PURPOSE

Deliver health services that maximise potential for wellness by:

- Ensuring seamless healthcare journeys
- Embracing cultural diversity
- Collaborating and connecting with communities and agencies
- Enhancing the capability, safety and wellbeing of the workforce
- Maximising the use of technology
- Respecting, protecting and promoting the rights and safety of all within Torres and Cape
- Sustainable financial management

OUR PRIORITIES

- Excellence in Healthcare: Health care delivered by the right people with the right skills at the right place and the right time.
- Advance health through strong partnerships: Partner to optimise health and wellbeing in our communities.
- A safe, engaged, valued and skilled workforce: Inspire a culture that values collaboration, challenges the norm and promotes a welcoming workplace.
- A well governed organisation: Efficient, productive and responsive governance structures.

TARGETS AND CHALLENGES

OUR TARGETS:

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

OUR CHALLENGES:

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

OUR VALUES

TCHHS supports and upholds the Queensland Public Service values:

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

During the 2019-20 period, TCHHS launched its own values project, to promote the values and ideals unique to our staff and our Hospital and Health Service. Between November 2019 and February 2020, 26 face-to-face staff consultations were held at sites across TCHHS. The values staff decided upon were:

- Courage
- Accountability
- Respect
- Engage

Our values will be officially launched in July 2020 and will be embedded into our workplace through recruitment, orientation, training and celebrating exemplary staff throughout 2020-21.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

TCHHS has the largest per centage of people in Queensland identifying as Aboriginal and Torres Strait Islander as well as the greatest diversity of Traditional Owner Groups.

There are more than 16,000 Aboriginal and Torres Strait Islander residents in our communities from over 60 different Traditional Owner Groups. Across these Traditional Owner Groups are different languages and cultural practices which are both strong protective factors for reducing the risks of poor health.

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

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

STRONGER MOB, LIVING LONGER

TCHHS is part of the Far North Queensland Aboriginal and Torres Strait Islander Peoples Health Plan 2019-2022. It involves 12 organisations, including five Aboriginal community-controlled health organisations, Cairns and Hinterland Hospital and Health Service, Check-Up Australia, Royal Flying Doctor Service, Northern Queensland Primary Health Network, Queensland Aboriginal and Islander Health Council and the Northern Aboriginal and Torres Strait Islander Health Alliance. It was officially launched in June 2019.

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

- Renewed focus on promotion, prevention and public health services for Aboriginal and Torres Strait Islander peoples.
- Improved integration between Aboriginal and Torres Strait Islander peoples primary and acute health services.
- More efficient, effective patient transport and accommodation services for Aboriginal and Torres Strait Islander peoples.
- Addressing the importance of the broader social determinants of health for Aboriginal and Torres Strait Islander peoples.
- Better access to, and sharing of data and information across providers
- More coordinated, collaborative approach to Aboriginal and Torres Strait Islander workforce development, attraction and retention.

The plan aligns with TCHHS's priorities of 'Excellence in health care' and 'Advance health through strong partnerships'. If successful, implementation of key actions under each of the priorities are expected to lead to benefits for the community and service deliver providers across both primary and acute care sectors.

PROGRAMS FUNDED FOR ABORIGINAL AND TORRES STRAIT ISLANDER RESIDENTS

In 2019-20 $3.29 million in funding was provided to TCHHS under the *Making Tracks Investment Strategy 2018-2021*, and the *North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan 2016-2021*. The funding is administered by the Department of Health's Aboriginal and Torres Strait Islander Health Branch.

With this funding, TCHHS undertakes a number of ongoing initiatives and projects that contribute to the improvement of Aboriginal and Torres Strait Islander health outcomes . These include:

- **Torres Strait Hostel - Meriba Mudh:** The hostel recently converted four rooms into family rooms, providing more suitable accomodation for maternity patients who already have small children and who cannot be away from them for long periods.
- **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 was developed and launched in May 2020. Fifty-four per cent of staff completed the online course between May and June 2020.
- **Northern Peninsula Area Maternal and Infant Service and Outreach Maternal Health Service**: TCHHS has continued its partnership with Apunipima to provide comprehensive and culturally appropriate community-based antenatal, post-natal and infant care services. During COVID-19, staff were placed in community in a residential capacity to maintain maternal and child health services.
- **Child and Youth Mental Health Service - Aurukun:** Despite widespread, prolonged community unrest and social distancing restrictions due to COVID-19, CYMHSA was able to maintain its service to the community of Aurukun. Partnerships with Koolkan Aurukun Community School and the local Indigenous Knowledge Centre targeted children at risk of school exclusion and provided Arts Therapy and cultural activities with Wik Elders.
- **Transition to Community Control Project:** An options paper, outlining the creation of single entity service provision for each community was presented to the Boards of TCHHS and Apunipima. Full consideration and implementation of the paper was deferred in March 2020 to enable project resources to be re-directed towards our COVID-19 response. A workshop to discuss future transition is planned for July 2020.
- **North Queensland STI Action Plan:**
    - Women's Health Program
    - Aboriginal and Torres Strait Islander Sexual Health Men's program
    - Supporting Syphilis Outbreaks in Remote Indigenous Communities
    - Enhanced Sexual Health services in Torres Strait and Northern Peninsula Area

  COVID-19 social distancing measures prevented outreach clinics for Women's and Men's Health programs, reducing service capability. Despite this, 14 of our Primary Health Care Centres were able to achieve greater than 60 per cent in screening rates in the 15-29 and 30-39 year olds.

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. Torres and Cape HHS residents access highly complex care at Townsville or Brisbane; while the majority of all but the most highly complex patients and procedures are managed at Cairns Hospital.

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

SERVICES

Our services include emergency, primary health and acute care, medical imaging, oral health, maternity, aged care, allied health, palliative and respite services, and visiting specialist services. 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 health care" and "advance health through strong partnerships", TCHHS maintains agreements and close working partnerships with local health care organisations:

- Northern Queensland Primary Healthcare Network (NQPHN)
- Apunipima Cape York Health Council
- Northern Peninsula Area Family and Community Services Aboriginal and Torres Strait Islander Corporation
- Royal Flying Doctor Service
- Cairns and Hinterland 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.

RURAL AND REMOTE CLINICAL SUPPORT UNIT (RRCSU)

The RRCSU, hosted by TCHHS since 2012, provides support services for Queensland's rural and remote hospital and health services (HHSs), primarily Torres and Cape, Central West, North West and South West. The unit supports these services to provide quality rural and remote healthcare through the provision of clinical resources, training, credentialing, medical advisory and medical employment support. On request, support is available for all HHSs with rural and remote facilities. The RRCSU was developed in response to the need to provide governance and support services to the smaller rural and remote HHSs. In May 2020, RRCSU published the Rural and Remote Emergency Services Standardisation Guidelines, which are applicable to remote facilities whose emergency services have been assessed at level one or two.

For TCHHS, RRCSU developed three new online education modules for Nursing and Midwifery Clinical Orientation, Safe Clinical practice and contempory practice, with a 100 per cent course completion rate for the Safe Clinical Practice module. RRSCU Credentialing and Scope of Clinical Practice Committee (SoCP) processed credentialling for 469 clinical staff in TCHHS during 2019-20.

CONSUMER AND COMMUNITY ENGAGEMENT

To support our objective of advancing health through strong partnerships, the Board endorsed the *Consumer and Engagement Strategy 2019-2022*. The strategy links in with TCHHS's Strategic Plan and to *Our Future State: Advancing Queensland Priorities.*

The TCHHS Consumer Advisory Committee (CAC) meets quarterly to provide consumer advice on improving health services by:

- Providing advice and facilitate consumer and community engagement, involvement and partnerships.
- Providing trained consumer representatives to contribute to engagement and partnership initiatives and statutory requirements.
- Advances and fulfills the requirements of national safety and quality standards.

The results of a performance survey and internal audit noted CAC members were overall satisfied with their engagement with TCHHS and their influence on broader health policy and programs.

In addition, the overall TCHHS consumer satisfaction survey responses doubled on the previous year with patients using ipads in waiting rooms to complete the survey. The survey's questions also incorporated community aspirations such as Aboriginal and Torres Strait Islander language recognition.

TCHHS is progressing its plans for new health infrastructure in the region. By talking with communities about their ideas and needs, TCHHS is able to add 'cultural character' to future building designs. TCHHS will advertise expressions of interest in the first half of 2020-21 to source local traditional artists and designers to progress these vital works.

GOVERNANCE: OUR PEOPLE

BOARD MEMBERSHIP

Ms Elthies (Ella) Kris

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

Ms Kris was appointed Board Chair in May 2019. She 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 health care and public health.

Ms Kris is Chair of the Executive Committee and is Chair of the Finance and Performance Committee.

Associate Professor, Dr Ruth Stewart

Board Member *(Appointed 12/12/2014) (Current term 18/05/2019 to 31/03/2022)*

Dr Stewart is Associate Professor of Rural Medicine and Director, Rural Clinical Training and Support at James Cook University. She also has been a member of the Cape York HHS board since 2012 and the Torres and Cape HHS board. Dr Stewart is a member of the Executive, Audit and Risk, and Safety and Quality Committees.

Mrs Tracey Jia

Board Member *(Appointed 01/07/2014) (Current term 18/05/2020 to 17/05/2021)*

Mrs Jia was appointed as a Board Member in December 2014 and previously served as a Board Member for Cape York HHS Board from 2012. Mrs Jia currently works for a private company implementing the National Disability Insurance Scheme. Mrs Jia is a member of the Audit and Risk Committee and the Safety and Quality Committee.

Councillor Ted (Fraser) Nai

Board Member (Appointed 01/07/2014) (Term 18/05/2018 to 17/05/2020)

As a member of the Torres Strait Island Regional Council and respected councillor for Masig (Yorke) Island, Mr Nai brings leadership and local government experience, as well as a wealth of local knowledge to the role. Mr Nai was a member of the Executive Committee and the Safety and Quality Committee during his term which finished on the 17 May 2020.

Mr Horace Baira

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

Mr Baira is a member of the Torres Strait Regional Authority and was previously a member of the Torres Strait Island Regional Council as the Councillor for Badu. He is committed to delivering better services to his community and to preserving the environment. He will provide strong local input to the board. Mr Baira is a member of the Finance and Performance Committee and the Safety and Quality Committee.

Mr Brian Woods

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

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

Councillor Karen (Kaz) Price

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

Ms Price was appointed as a Board Member in December 2015. She is currently CEO 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 Executive Committee.

Dr Scott Davis

Board Member (Appointed 18/05/2016) (Current term 18/05/2020 to 31/03/2022)

Dr Davis was appointed as a Board Member in May 2016. He has more than 25 years' experience in senior leadership roles within the health, education and research sectors and more than 20 years of board experience. He holds a doctorate in Indigenous Community Capacity Development (social and economic development) and a Masters in International Public Health. Dr Davis is the Chair of the Safety and Quality Committee and is a member of the Executive Committee and the Finance and Performance Committee.

Ms Rhonda Shibasaki

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

Ms Shibasaki was appointed as a Board Member in May 2019. Ms Shibasaki has worked extensively in the health sector throughout Queensland in urban, regional and remote communities since 2008. Ms Shibasaki is recognised for introducing management and system reforms in several community health organisations.
Ms Shibasaki is a member of the Audit and Risk Committee and the Finance and Performance Committee.

Ms Karen Dini-Paul

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

Ms Dini-Paul was appointed as a Board Member in May 2020. 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.

Mr Terry Mehan

Board Adviser (Appointed 6/12/2019) (Current term 06/12/2019 to 7/12/2020)

Mr Mehan was appointed Board Adviser for the Torres and Cape HHS Board in December 2019 by the Minister for Health. Mr Mehan has an internationally recognised health career with 40 years' experience in health system management. In May 2020 Mr Mehan was appointed a Board Member for North West HHS.
He continues to work with the Department of Health as strategic adviser to the newly formed Office of Rural and Remote Health and the Aboriginal and Torres Strait Islander Health Division.

Ms Tina Chinery

Board Adviser (Appointed 18 May 2018) (Resigned 30 October 2019)

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

ROLE OF THE BOARD

The Board is responsible for setting the strategic direction and providing oversight of the TCHHS. 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 health care, health management, clinical expertise, financial management and community engagement. All members either reside in the area or have substantial community and business connections with the various Torres Strait, Northern Peninsula Area and Cape York communities and have a first-hand knowledge of the health consumer and community issues of the region. These professional skills and community-based board members contribute to the governance of the TCHHS collectively as a Board through attendance at monthly meetings.

In accordance with the *Hospital and Health Boards Act 2011*, the Board ensures appropriate policies, procedures and systems are in place to optimise service performance, maintain high standards of ethical behaviour and, together with the Health Service Chief Executive, provide leadership to the Service's staff.

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

Board and Committee meeting attendance 2019-2020

	Board Meeting	Audit & Risk	Finance & Performance	Safety & Quality	Executive
Total Number of Meetings	10	6	9	6	8
Ella Kris	8 of 10		7 of 9		8 of 8
Ruth Stewart	9 of 10	6 of 6		6 of 6	7 of 8
Tracey Jia*	10 of 10	3 of 6		2 of 3	3 of 4
Scott Davis *	9 of 10		8 of 9	6 of 6	3 of 4
Fraser Nai*	8 of 9		3 of 3	4 of 5	3 of 4
Brian Woods*	8 of 10	5 of 6	8 of 9		2 of 3
Horace Baira	7 of 10		7 of 9	6 of 6	
Karen Price	7 of 10				6 of 6
Rhonda Shibasaki	8 of 10	3 of 6	8 of 9		
Karen Dini-Paul ^	1 of 1		1 of 1	1 of 1	
Tina Chinery (Adviser)^	1 of 3				
Terry Mehan (Adviser)	5 of 5				

*In February 2020 Board Committee membership changed after a review of Board member skills.

^Board Adviser Tina Chinery resigned 30 October 2019.

^ Ms Karen Dini-Paul was appointed 18 May 2020.

The total out of pocket expenses paid to the Board Members during 2019-2020 was $1174.80

EXECUTIVE COMMITTEE

The Executive Committee is a formal committee of the Torres and Cape Hospital and Health Board as detailed in section 32A of the *Hospital and Health Board Act 2011*. The main function of this Committee is to support the Board to develop the service plan for the HHS and monitor implementation. In addition, this Committee supports the development of the required engagement strategies and protocols, as well as works with the Health Service Chief Executive (HSCE) in responding to critical emergent issues. During the 2019-2020 year the Executive Committee considered a number of matters, including:

- The Organisational Strategic Plan
- Operational planning
- Organisational structure
- Consumer and Community Engagement Strategy
- Communications and Engagement Strategy
- Workforce Strategy
- The Executive Committee meets on a monthly basis

THE SAFETY AND QUALITY COMMITTEE

The function of 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

This Committee also ensures the HHS is complying with national and state strategies, policies, agreement and standards. During the 2019-2020 year, the Safety and Quality Committee considered a number of matters, including:

- Clinical governance
- Patient safety and quality
- Staff health and safety
- Public health
- HHS and State-wide Performance activity and KPI results
- 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
  - Quality and Safety Strategy
- The Safety and Quality Committee meet on a bimonthly basis.

THE AUDIT AND RISK COMMITTEE

The function of the Audit and Risk Committee is to ensure the HHS meets its responsibilities as prescribed in the *Financial Accountability Act 2009*, the *Financial Accountability Regulation 2019*, the *Financial and Performance Management Standard 2019* , and the *Auditor-General Act 2009*. The Committee also overseas TCHHS's liaison with the Queensland Audit Office. The Audut Committee has observed the terms of its charter and has had due regard to Treasury's Audit Committee Guidelines. During the 2019-2020 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
- Compliance Register
- Department of Health and Chief Finance Officer Assurance Statements
- Changes to Accounting Standards
- Asset Stocktake and Impairment Assessment.
- The Audit and Risk Committee meets on a bimonthly basis

FINANCE AND PERFORMANCE COMMITTEE

The function of the Finance and Performance Committee as detailed in section 33 of the *Hospital and Health Board Regulation 2012* is to assess the HHS budgets to ensure they are consistent with organisational objectives and appropriate relevant funding. During the 2019-2020 year, the Finance and Performance Committee considered, amongst others, the following matters:

The Committee also provides a monitoring and assessment role of;

- 2019-2020 Service Agreement and Window Adjustments
- Organisational performance reporting
- Service delivery contracts
- Proposed growth spending
- Organisational sustainability planning
- Capital Infrastructure Progress updates
- Investment Government Committee Recommendations
- Own source revenue and
- Tender evaluations.
- The Finance and Performance Committee meets on a monthly basis.

EXECUTIVE MANAGEMENT

HEALTH SERVICE CHIEF EXECUTIVE

Beverley Hamerton

Beverley Hamerton has been TCHHS's Chief Executive since April 2018. Ms Hamerton has considerable experience in rural and remote area health service planning and delivery from both a clinical and executive perspective. Her passion is to ensure that all people have access to high quality, equitable health care.

EXECUTIVE DIRECTOR – ASSET MANAGEMENT

Dean Davidson

Mr Davidson has worked for the TCHHS since October 2016 and commenced as the Director of Travel, Contracts and Procurement. Prior to working for TCHHS, previous positions held have been General Manager of Community and Regional Planning and Manager of Plant and Facilities within Local Government for eight years.

EXECUTIVE DIRECTOR – EXECUTIVE DIRECTOR FINANCE, INFORMATION AND DIGITAL SERVICES

Danielle Hoins

Danielle Hoins is a qualified Certified Practicing A Accountant with more than 13 years experience in financial and corporate services management in the Queensland health sector. Ms Hoins expertise is in financial management, strategic and change management, and the development and implementation of corporate governance systems.

EXECUTIVE DIRECTOR - MEDICAL SERVICES

Dr Anthony Brown

Dr Tony Brown has practiced as a rural generalist doctor in rural and remote Australia for 30 years. Dr Brown is passionate about equity of resourcing and the delivery of excellent health care to rural and remote Australians and improving the health outcomes of Aboriginal and Torres Strait Islander peoples and strives to improve quality and safety of care in the primary and secondary health care domains.

EXECUTIVE DIRECTOR - NURSING & MIDWIFERY

Kim Veiwasenavanua

As the lead for Nursing and Midwifery Services May since 2018, Ms Veiwasenavanua has driven and manages Torres and Cape's diverse nursing workforce with strategic intent to enable innovative, advanced, culturally-appropriate, safe, contemporary best practice nursing and midwifery practice in rural and remote Far North Queensland.

EXECUTIVE DIRECTOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Venessa Curnow

Ms Curnow is an Ait Koedal Sumu Torres Strait Islander Registered Nurse, she has worked as an Assistant in Nursing, Registered Nurse, Clinical Nurse Consultant and Care Manager in Brisbane and also rural and remote areas of Queensland. She has more than 21 years experience in strategic industry development at a national and state-wide level.

EXECUTIVE GENERAL MANAGER SOUTHERN SECTOR

Ian Power

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

EXECUTIVE GENERAL MANAGER NORTHERN SECTOR

Mark Goodman

Mark Goodman is a Registered Nurse who has extensive and varied experience in healthcare management roles in Australia and New Zealand as well as significant remote area experience across South Australia, Queensland and Northern Territory. Mr Goodman's focus is on provision of culturally appropriate and effective Primary Health Care and building the capacity of our Primary Health Care facilities.

EXECUTIVE DIRECTOR ALLIED HEALTH

Viv Sandler

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

EXECUTIVE DIRECTOR WORKFORCE AND ENGAGEMENT

Erica Gallagher

Erica Gallagher's Human Resource career spans over 33 years with significant experience in senior leadership roles. She has worked in the Health Department, State Government Departments and not for profit disability sector in Western Australia. Ms Gallagher is passionate about Human Resources and feels privileged to lead workforce cultural change and uses this as a powerful lever to make a tangible difference to the workforce, while influencing the organisation and providing services to the Queensland community.

CHIEF INFORMATION OFFICER

David Bullock (until May 2020)

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

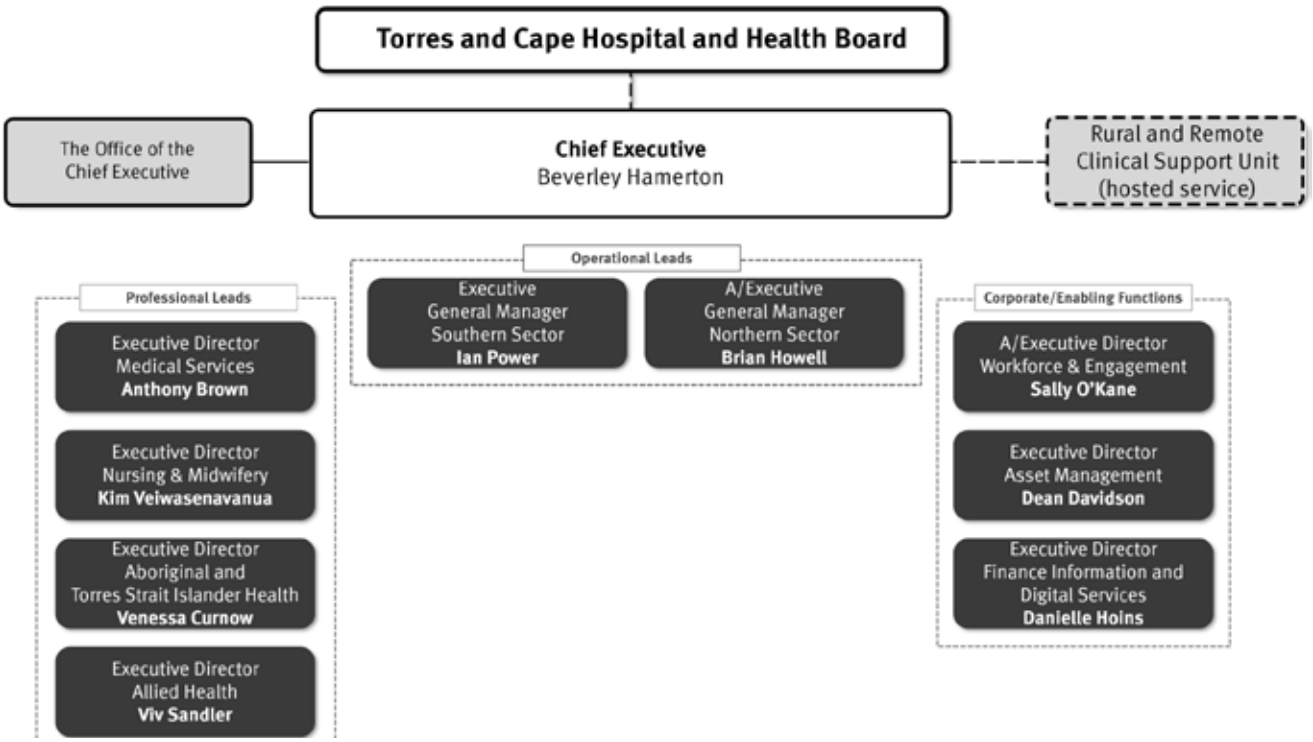
EXECUTIVE DIRECTOR RURAL & REMOTE CLINICAL SUPPORT UNIT (hosted service)

Julie Hale (until May 2020)

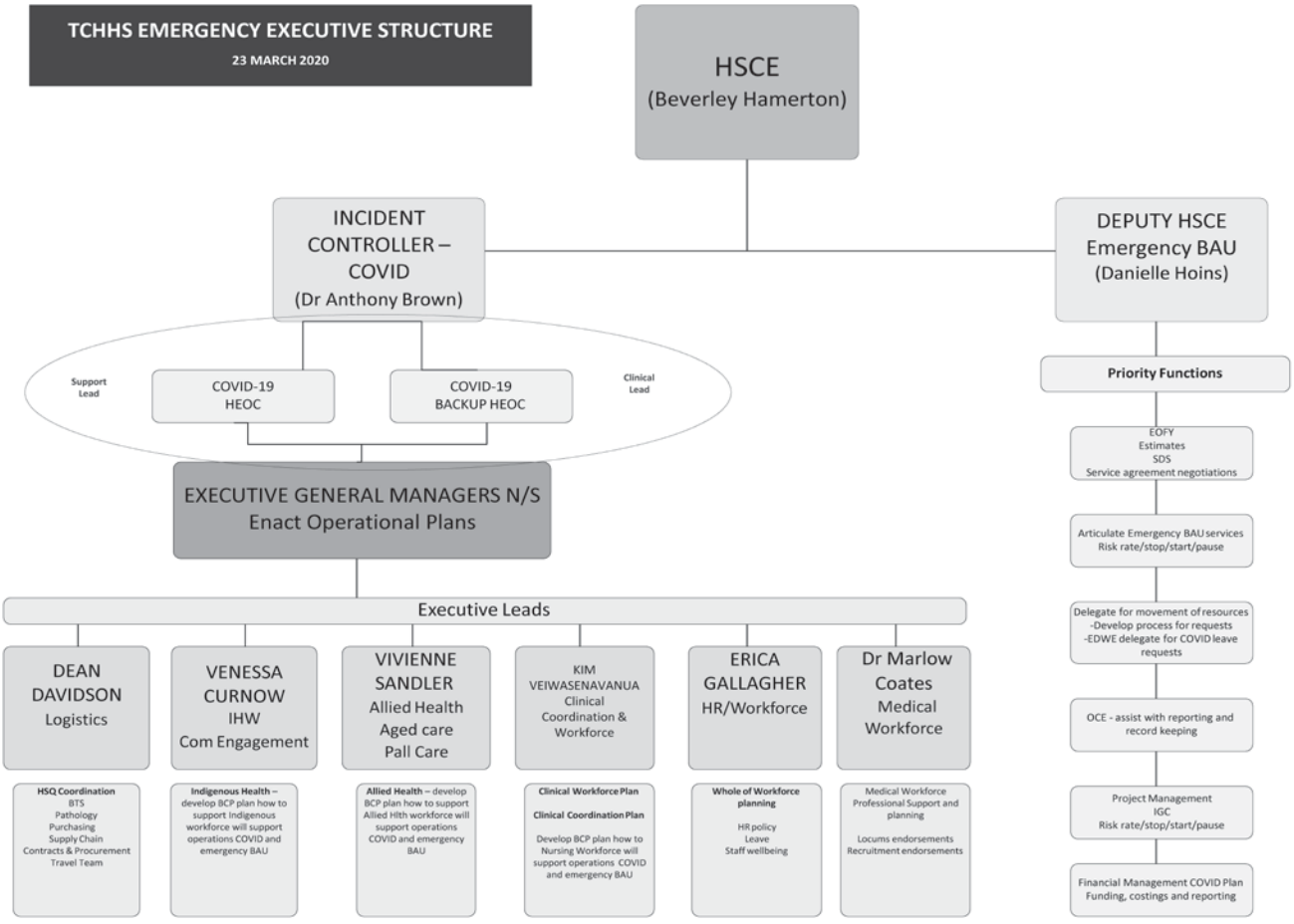
Prior to commencing with Queensland Health, Julie Hale was Deputy CEO of Women's Healthcare Australasia and Children's Healthcare Australasia, twin not-for-profits with both Australian and international influence. Ms Hale is responsible for the piloting and roll out of the Aboriginal and Torres Strait Islander Health Practitioner role for Queensland and is also a part of the Office of the Chief Nursing and Midwifery Officer (Queensland) Advisory Group for the transition of the national Rural and Isolated Practice Endorsed Nurse (RIPEN) to state based authorisation.

ORGANISATION STRUCTURE AND WORKFORCE PROFILE

The Torres and Cape Hospital and Health Service has set out its workforce planning objectives in its *Strategic Plan 2019-2023*. Our purpose is to improve the health and wellbeing of people in the Torres Strait, Northern Peninsula Area and Cape York by enhancing the capability, safety and wellbeing of the workforce to better support front line services within our communities.



COVID-19 Health Emergency Organisation Centre (HEOC)



There were several key changes to TCHHS's organisational structure in 2019-20, continuing the work from the previous year. Our Corporate Services branch was restructured into two departments: Asset Management and Workforce Engagement. Asset Management allowed us to increase focus on our capital investment program, progressing our strategic objectives of achieving self-sufficiency and sustainability for our facilities, while Workforce Engagement developed our own Organisational Values through consultation with staff and the community. Other executive functions were streamlined, creating a more efficient and affordable structure. The role of Chief Finance Officer and Chief Information Officer was combined into the single position of Executive Director Finance, Information and Digital Services.

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

At June 2020, our Health Service employed full-time equivalent (FTE) staff establishment of 1047.44, an increase of 24.25 staff from 2018-19. A breakdown of these totals is reflected in the tables below.
The permanent separation rate for 2019-20 was 18.50% per cent. The permanent separation rate is due to a variety of factors, including the remoteness and accessibility of some of our facilities making staff retention difficult.

TCHHS is developing a Workforce Strategy that will support the Torres and Cape HHS to achieve its strategic objectives efficiently and effectively from a human resource, workforce planning and talent management perspective with a key focus on the attraction and retention of staff to rural and remote communities. Development of the strategy has been impacted due to the COVID-19 response and we expect to recommence our focus on its development in July 2020.

The 2019-2024 Strategic Workforce Plan for Nurses and Midwives has been developed to map the workforce priorities and it articulates the key focus areas to be addressed, as well as the strategies that will be engaged to deal with workforce challenges facing remote health services. This Strategic Plan partners with the 2019-2024 Torres and Cape HHS Strategic Professional Workforce Model for Nurses and Midwives.

*Table 1: More doctors and nurses**

	2015-16	2016-17	2017-18	2018-19	2019-20
Medical staff [a]	30	33	38	42	43
Nursing staff [a]	313	309	348	373	393
Allied Health staff [a]	50	67	72	78	74

*Table 2: Greater diversity in our workforce**

	2015-16	2016-17	2017-18	2018-19	2019-20
Persons identifying as being First Nations [b]	158	157	176	175	195

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-20. **Source:** [a] DSS Employee Analysis, [b] Queensland Health MOHRI, DSS Employee Analysis

ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE

In 2019-20, Torres and Cape HHS employed 195 Aboriginal and Torres Strait Islander people (18.62 per cent) across all occupational streams. Supported by the Office of the Chief Aboriginal and Torres Strait Islander Health Officer, the Workforce Strategy Branch and the Office for Rural and Remote Health, Torres and Cape HHS is implementing an Aboriginal and Torres Strait Islander Workforce Development Strategy to increase the per centage of indigenous employment to better reflect the population and help improve inequitable unemployment rates. The current unemployment rate amongst Aboriginal and Torres Strait Islander people living in our catchment is 23.4 per cent.

STRATEGIC WORKFORCE PLANNING AND PERFORMANCE

WORKFORCE DIVERSITY AND WELLBEING

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

Employees have access to an Employee Assistance 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 EAP provides a dedicated online service to provide professional advice on financial issues impacting on an individual's wellbeing. The Torres and Cape HHS supports employees to access financial seminars on salary packaging and superannuation seminars to assist their understanding of retirement preparation and income protection.

CODE OF CONDUCT

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

INDUSTRIAL RELATIONS

Torres and Cape HHS has engaged constructively in 2019-20 with industrial unions representing a diverse workforce. Torres and Cape HHS and the unions jointly recognise the importance of good union-management relations. We have a shared interest in working together to support a healthy and productive workplace and ensuring that the public continues to receive a quality service.

RECRUITMENT INITIATIVES

TCHHS Recruitment Services continue to support hiring managers to attract, empower and retain candidates in a highly competitive health care industry. Recruitment Services are continually working to improve recruitment practices across the Torres and Cape HHS with a key focus on contemporary recruitment practices, onboarding, the development of talent pools, and the delivery of robust recruitment and selection training.

The team has been focused on:

- delivering a balanced approach to recruitment activities
- promoting and improving candidate care to foster a better connection with candidates
- recruitment outcomes that can be measured on performance and compliance
- delivering training and education that is easily accessible to all staff
- partnering with hiring/line managers to improve onboarding practices
- improving and streamlining internal recruitment process

Planning for a new recruitment campaign for nursing and midwifery began in January 2020 but was deferred due to COVID-19. Planning and implementation is set to recommence in August 2020.

LEARNING AND DEVELOPMENT

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

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

For the 2019-20 the Learning and Development Team facilitated or delivered the following training:

- Torres and Cape HHS Orientation to organisation
- Torres and Cape HHS Line Manager training
- Business Case in Practice via Queensland Treasury Corporation
- Building future Leaders
- Enhancing leaders
- Resilience Training
- Employees Study and Research Assistance scheme
- Administration Officer incentive funding
- Operational Officer incentive funding
- Fundamentals of Business Administration
- Workplace Equity and Harrasment
- Occupational Violence Prevention
- Research Capacity Building

EARLY RETIREMENT, REDUNDANCY AND RETRENCHMENT

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

GOVERNANCE: OUR RISK MANAGEMENT

TCHHS is committed to managing risk in a proactive, integrated and accountable manner to ensure its strategic and operational objectives are achieved. These objectives include the provision of high quality, innovative, safe, efficient and effective health services to the communities of our region .

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

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

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

The *Hospital and Health Boards Act 2011* requires annual reports to state each direction given by the Minister to the HHS during the financial year and the action taken by the HHS as a result of the direction. During the 2019-20 period, no directions were given by the Minister to TCHHS.

INTERNAL AUDIT

TCHHS has engaged with an external consultant to undertake internal audit functions for the Health Service. Internal Audit's primary objective is to provide independent and objective assurance to the Board, via the Audit and Risk Committee, on the state of risks, internal controls and organisational governance and to provide management with recommendations to enhance current systems, processes and practices.

Internal Audit assists the Board and HSCE to accomplish their strategic and operational objectives by developing a systematic, disciplined approach to evaluate and improve the effectiveness of business risk management, control and governance processes.

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

- *Financial Accountability Act 2009;*
- *Financial and Performance Management Standard 2019;*
- Queensland Treasury's Audit Committee Guidelines: Improving Accountability and Performance, December 2009; and
- International Professional Practices Framework, Institute of Internal Auditors, January 2009.

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

EXTERNAL SCRUTINY, INFORMATION SYSTEMS AND RECORD KEEPING

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 2019-20 financial year, TCHHS was subject to the external audit by Queensland Audit Office. We have received an unqualified audit report on its financial statements for the 2019-20 year. There are no significant findings or issues identified by this external reviewer on our operations or performance.

During 2019-20 the Queensland Audit Office tabled a number of cross-service audits in Parliament relevant to the Torres and Cape HHS, including:

- **Managing Cyber Security Risks** - TCHHS has a robust cybersecurity framework and works in conjunction with eHealth Queensland to maintain system integrity.
- **Health: 2018-19 results of financial audit**s - As per the report's recommendations, TCHHS is utilising the s4-HANA financial system, continues to regularly address risks within agreed timelines and has established the Department of Asset Management, bringing focus asset valuation and high-risk maintenance.

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

During 2019-20 TCHHS has achieved a significant digital footprint in the digital and information management ecosystem of Queensland Health with the advent of digital technology and digital healthcare. Aligning strategic objectiives, TCHHS has entered an exciting era on the digital transformation journey which will result in new way of delivery health care closer to home and allow our clinicians and communities to be more self-sufficient in a challenging remote environment.

A number of information technology and information management improvements have occurred in 2019-20 including:

- Digitally enabling health providers to support health service delivery during the COVID 19 pandemic.
- Facilitation of COVID 19 Public Health platforms
- Regional e-Health Project electronic patient information system change readiness across the TCHHS.
- Virtual care planning including the development of the clinical coordination hub

- Implementation of the Smart Referrals System to streamline referral services
- Maturation of the MyHR system
- Maturation of the finance system (S4HANA FSR)
- Infrastructure and software upgrade for Best Practice electronic patient information system moving clinicians to a contemporary platform and more secure and stable infrastructure
- Maturation of the Cyber Security Committee and ISMS 2018 legislative requirements
- Implementation of Measurement Analysis and Reporting System (MARS)
- Maturation of the business classification scheme
- Maturation of the Nurse Navigation system COMPASS
- Through the Patient Identifier Project all NPA and Southern Facilities have been decanted of in-scope records and have been provided training and education for ongoing facility management of records management and archiving practices.
- Development and Planning of the Quality Safety and Risk Auditing platform
- Implementation of major network infrastructure upgrades in partnership with eHealth QLD.

TCHHS is updating its five-year Digital Strategy which will align to the Rural and Remote Digital Strategy. The strategy will highlight area of focus for the HHS over several horizons, including:

- Improve governance of information management and digital investment
- Improve the quality and accuracy of patient data collection and reporting
- Improve access and control of information across geographically remote facilities
- Maintain cyber security and safety of corporate information
- Improve compliance and alignment to Queensland Health and Queensland Government mandatory standards and policies.
- Streamline business through electronic forms, workflows and approvals.
- Streamline data and information sharing through a coordinated approach to information management and architecture.
- Streamline digital service delivery and asset, software and application management
- Enable anytime, anywhere and any platform approach to service deliver to support virtual care and improve mobility services.
- Enhance our digital workforce.
- Building the digital capability for our consumers and our workforce.

QUEENSLAND PUBLIC SERVICE ETHICS

TCHHS is a prescribed public service agency under s2 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

The performance of actions to further the objects of the *Human Rights Act 2019* (HRA) and reviews for compatibility with human rights have been impacted as a result of COVID-19. Whilst relevant actions in 2020 have been different to what was anticipated, TCHHS undertook significant work within the 2019-20 period, with more work ongoing.

In October and November 2019, training sessions for TCHHS's Board and Executive were conducted to familiarise members with the HRA, and to begin integration at a strategic level. In February 2020, the Board included the statement "We will respect, protect and promote human rights in our decision-making and actions" into the Health Service's Strategic Plan 2019-2023.

Human rights have been integrated into the development of TCHHS's workplace values, which saw extensive staff and consumer consultation between January and June 2020. Our unique values will be launched and embedded during the first half of the 2020-21 financial year.

As part of staff mandatory training, our Learning and Development team developed online staff training packages for clinical and non-clinical staff (titled 'Promoting Human Rights and Reducing Restrictive Services') and integrated human rights awareness material into foundational courses for our line managers, business administration staff and the Health Service's 'Orientation to our Organisation' course.

This was combined with regular staff communications from our Chief Executive and Executive Director of Medical Services that provided additional information, resources, and links to the HRA and the Queensland Human Rights Commission.

To properly review our policies, procedures and guidelines, TCHHS provided training sessions for relevant staff in October 2019. All 64 of TCHHS's Human Resources and Work Health and Safety policies, procedures and guidelines were reviewed under a two-stage process to ensure their compatibility with the HRA. All documents were updated to include a human rights statement, a hyperlink to more information on the HRA, and how to make a human rights complaint.

During COVID-19, TCHHS played an essential role in the State Government's efforts to protect and support Queenslanders. From a human rights perspectives TCHHS took actions and made decisions which protected the following rights: The right to health services, The right to protection of families and children, The right to human treatment when deprived of liberty and the right to life.

In protecting these rights, other human rights at times were limited such as The right to freedom of mfggovement, the right to liberty and security of person, the right to peaceful assembly and cultural rights.

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

- Developed plans and procedures which would maximise the health service's ability to respond to COVID-19 while minimising its impact on the community
- Suspended services which could not be conducted in compliance with social distancing requirements or that would increase the risk of spreading COVID-19 throughout our communities
- Ensured flexible responses so that some services could continue despite social distancing requirements
- Increased funding to services working to support vulnerable communities and persons vulnerable to COVID-19, including providing accommodation and healthcare to patients and their families who were displaced from their communities as a result of COVID-19 travel restrictions
- Chartered aircraft to maintain our ability to transport patients, pathology and medical supplies to and from our remote facilities

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 2019-20 in accordance with s160 of the *Hospital and Health Board Act 2011*.

PERFORMANCE

TCHHS continue to progress against its strategic measures of success in 2019-20. Some data results for 2019-20 have been delayed, caused by the redeployment of staff during our COVID-19 response. These results will be available in the first half of 2020-21.

EXCELLENCE IN HEALTH CARE

Although the assessment for the National Safety and Quality Health Service (NSQHS) Standards has been re-scheduled to 2021 due to COVID-19, we have continued to provide education and gather evidence of proficiency in all standards. We have continued to make progress against the Closing the Gap targets, including maintaining a high level of performance in the proportion of women who attended five or more antenatal visits (as at March 2020 FYTD) with 97.2 per cent attendance recorded. TCHHS continues to work towards the goal of increasing self sufficiency in its hospitals, achieving 39 per cent as of March 2019. TCHHS has increased its use of Telehealth during 2019-20, exceeding its service target by more than 75 per cent.

ADVANCE HEALTH THROUGH STRONG PARTNERSHIPS

We have enhanced our community engagement processes, with CAC members satisfied with their engagement with TCHHS and their influence on broader health policy and programs. We have continued to participate in health care design and delivery and been consistent in participation with peak strategic bodies such as the Regional Health Partners (RHD) group. Although there was growth in clinical student placements with 127 people placed in the first half of 2019, COVID-19 quarantine and travel restrictions saw this reduced to 33 placements from January to July 2020. It is expected that numbers will increase in 2020-21, new restrictions notwithstanding.

A SAFE, ENGAGED, VALUED AND SKILLED WORKFORCE

We have increased the use of staff training and development programs with the implementation of a Learning and Development dashboard. Sixty-eight per cent of staff completed their mandatory training in 2019-20, an increase over the previous year. Proactive hazard reporting increased by 33 per cent in the first half of 2019-20, however decreased 20 per cent by March 2020. The reduction in hazard reporting is due to the decrease in activity during the COVID-19 restrictions. Due to the COVID-19 Pandemic, information on the number of staff undertaking scholarships and training pathways is not available.

A WELL GOVERNED ORGANISATION

TCHHS has met its planned financial position for 2019-20, meeting its obligation to ensure all its services are provided as cost effectively as possible in a challenging high cost environment. We have succesfully delivered a number of projects, including the Western Cape Chronic Kidney Disease Service and TCHHS's Infrastructure Master Plan, providing strategic direction for asset development for the next 15 years. As shown in the service standards section, TCHHS has acheived the majority of its key performance indicators for 2019-20. We have continued to develop our Service Agreement and Operational KPI dashboards and have developed a COVID-19 vulnerable patients dashboard that will assist staff in delivering care closer to home.

PERFORMANCE: SERVICE STANDARDS

Emergency departments across the Torres and Cape Hospital and Health Service performed above expectations in the per centage of people attending emergency departments seen within recommended timeframes. The per centage of people treated within four hours of their arrival in Emergency was 94.7 per cent, well above the target of 80 per cent.

The median wait time in Emergency Departments was five minutes. In Elective Surgery, TCHHS exceeded all targets in the percentage of patients being treated within clinically recommended times, including 100 per cent of our category 3 patients.

The variance between the 2019-20 target/estimate and the 2019-20 actual result in elective surgery and weighted activity units (WAUs) can be attributed to the impact of COVID-19 and TCHHS's response, including the reallocation of resources to prepare for positive COVID cases. The target for this measure will be reviewed in subsequent years in order to take into consideration the longer-term impact of the COVID-19 response and recovery.

In Telehealth, TCHHS conducted over 3,000 consultations as part of our COVID-19 response, more than 75 per cent over the expected target. A virtual model-of-care was implemented so that our most vulnerable patients could continue to receive care and access services from home, helping to keep them safe and maintain social distancing requirements.

Table 3: Service Standards – Performance 2019-20

Service Standards	Target	Actual
Effectiveness measures		
Percentage of patients attending emergency departments seen within recommended timeframes: [a]		
Category 1 (within 2 minutes)	100%	100.0%
Category 2 (within 10 minutes)	80%	94.0%
Category 3 (within 30 minutes)	75%	93.0%
Category 4 (within 60 minutes)	70%	92.7%
Category 5 (within 120 minutes)	70%	97.9%
Percentage of emergency department attendances who depart within four hours of their arrival in the department [a]	›80%	94.9%
Percentage of elective surgery patients treated within clinically recommended times: [b]		
Category 1 (30 days)	›98%	98.1%[1]
Category 2 (90 days)	›95%	96.6%
Category 3 (365 days)	›95%	100.0%
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days [c]	N/A	0.0 [2]
Median wait time for treatment in emergency departments (minutes) [a]	..	5
Median wait time for elective surgery (days) [b]	..	23
Other Measures		
Number of elective surgery patients treated within clinically recommended times: [b]		
Category 1 (30 days)	64	52 [1]
Category 2 (90 days)	47	57
Category 3 (365 days)	210	150
Number of Telehealth outpatient occasions of service events [d]	1,797	3,147
Total weighted activity units (WAU's) [e]		
Acute Inpatient	5,616	5,141 [3]
Outpatients	2,306	2,143
Sub-acute	434	396
Emergency Department	2,552	2,340
Mental Health	145	125
Prevention and Primary Care	-	544
Ambulatory mental health service contact duration (hours) [f]	›8,116	10,992
Staffing [g]	1,005	1,047

g

1 Non urgent elective surgery were temporarily suspended as part of COVID-19 preparation. Seen in time performance and service volumes were impacted as a result.

2 The Epidemiology and Research Unit in the Communicable Diseases Branch are unable to provide full year SAB data as resources are redirected to the COVID-19 response. SAB data presented as Mar-20 FYTD and is preliminary.

3 Delivery of activity and weighted activity units was impacted by two significant factors in 2019-20; the introduction of a revised Australian Coding Standard "0002 Additional diagnoses" from 1 July 2019, resulted in lower weighted activity units being calculated for admitted patients relative to the same casemix of 2018-19 year and COVID-19 preparation and the temporary suspension of non urgent planned care services reduced the volume of patient activity. Activity data presented is preliminary. Data presented is full year as at 17 August 2020.

Source: [a] Emergency Data Collection, [b] Elective Surgery Data Collection, [c] Communicable Diseases Unit, [d] Monthly Activity Collection, [e] GenWAU, [f] Mental Health Branch, [g] DSS Employee Analysis. Note: Targets presented are full year targets as published in 2019-20 Service Delivery Statements.

PERFORMANCE: FINANCIAL SUMMARY

Torres and Cape Hospital and Health Service achieved a strong underlying financial outcome for the year ending 30 June 2020, recording planned deficit of $9.8 million. This was a result of the transfer of $10 million to the Department of Health for the redevelopment of Thursday Island Primary Health Care Centre and an investment of $1.2 million in office accommodation in Cooktown.

Despite the planned deficit, TCHHS achieved an underlying surplus of $0.7 million due to moderate growth of own source revenue, and significant reduction in travel costs due to the COVID-19 pandemic response. This was reinvested in our communities to design virtual models of care, enhance digital enablement and establish a virtual Clinical Coordination Hub. Other initiatives invested in this year included additional infrastructure to update the HHSs facilities.

During 2019-2020, 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. This includes improving Medicare revenue to reinvest in health services, and telehealth and virtual care opportunities that have improved access to services while reducing costs.

WHERE THE FUNDS CAME FROM

Torres and Cape HHS income from combined funding sources was $242.64 million. Funding was primarily derived from non-activity-based funding from the Department of Health of $216.99 million. Other funding sources included other revenue $4.76 million, and grants and contributions $20.88 million; primarily from Australian Government contributions for Indigenous health programs, rural and remote medical benefits scheme and pharmaceutical benefits scheme. The Nation Partnership Agreement between the State and Commonwealth Governments funded the TCHHS COVID-19 response $3.925 million.

WHERE FUNDING WAS SPENT

Total expenses for 2019-2020 were $252.45 million, averaging a $0.68 million per day spend on serving the communities in our jurisdiction. The largest expense was against labour costs at $136.90 million. Supplies and services represent the second highest expense at $82.21 million which includes patient travel costs of $14.33 million, aeromedical retrieval costs of $3.47 million, lease costs of $13.01 million, external contractor costs of $13.32 million, electricity and other energy costs of $3.45 million and clinical supplies and services of $4.09 million. Total cost of the COVID-19 response was $4.325 million.

FINANCIAL POSITION

TCHHS's assets comprise of land, buildings, equipment, cash, inventories and receivables balances. Its liabilities are largely represented by supplier and staff accruals. The value of our net assets decreased during 2019-20 by 2.8% or $6.06 million. This was primarily due to the transfer of $10 million to Department of Health to fund an infrastructure project on Thursday Island.

ANTICIPATED MAINTENANCE

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

Anticipated maintenance is maintenance that is necessary to prevent the deterioration of an asset or its function, but which has not been carried out. Some anticipated maintenance activities can be postponed without immediately having a noticeable effect on the functionality of the building. All anticipated maintenance items are risk assessed to identify any potential impact on users and services and are closely managed to ensure all facilities are safe. Anticipated maintenance items are identified through the completion of triennial condition assessments, and the value and quantum of anticipated maintenance will fluctuate in accordance with the assessment programs and completed maintenance works.

As of 3 June 2019, TCHHS had reported total anticipated maintenance of $33.9 million. TCHHS is currently completing a 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 actioned or backlogged.
- If eligible, high risk backlog items will be requested through the internal Minor Capital funding source.
- All grant applications where backlog 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 high-risk backlog issues and will continue to seek this funding source for any further high-risk backlog items.

FUTURE OUTLOOK

TCHHS is embarking on a transformation strategy that will introduce a virtual model of care by leveraging from the COVID-19 pandemic response, that will increase self-sufficiency in our regions and bring care closer to home. Critical to the success of this transformation is the implementation of an integrated multi-disciplinary primary health care patient information system in the Cape York region during 2020-21.

The comprehensive set of strategic planning activities and projects will continue to transform and position the HHS as a leader in digital rural and remote primary health care.

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

Financial Statements 30 June 2020

30 June 2020

Contents

Statement of Comprehensive Income
For the year ended 30 June 2020

	Note	2020 Actual $'000	2020 Budget $'000	2020 *Budget Variance $'000	2019 Actual $'000
Income					
User charges and fees	2	1,558	2,812	(1,254)	1,350
Funding for public health services	3	216,999	205,403	11,596	201,784
Grants and other contributions	4	20,882	16,043	4,839	18,866
Other revenue	5	3,203	1,114	2,089	6,144
Interest		2	2	-	3
Total revenue		**242,644**	**225,374**	**17,270**	**228,147**
Expenses					
Employee expenses	6	18,061	17,100	961	17,244
Department of Health contract staff	7	118,840	113,451	5,389	109,319
Supplies and services	8	82,209	77,531	4,678	86,172
Depreciation	14	18,065	14,503	3,562	13,850
Impairment losses		165	10	155	58
Other expenses	9	15,105	2,779	12,326	1,910
Total expenses		**252,445**	**225,374**	**27,071**	**228,553**
Operating result for the year		**(9,801)**	**-**	**(9,801)**	**(406)**
Other comprehensive income					
Items that will not be reclassified to operating result					
Increase in asset revaluation surplus	18	10,744			5,457
Total other comprehensive income		10,744			5,457
Total comprehensive income		**943**			**5,051**

**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 2020

	Note	2020 Actual $'000	2020 Budget $'000	2020 *Budget Variance $'000	2019 Actual $'000
Current assets					
Cash and cash equivalents	10	26,668	40,100	(13,432)	39,944
Receivables	11	3,610	2,001	1,609	1,242
Inventories	12	531	501	30	477
Other assets	13	1,252	146	1,106	3,082
Total current assets		**32,061**	**42,748**	**(10,687)**	**44,745**
Non-current assets					
Property, plant and equipment	14	192,185	181,987	10,198	188,006
Right-of-use-assets	14	6,404	-	6,404	-
Total non-current assets		**198,589**	**181,987**	**16,602**	**188,006**
Total assets		**230,650**	**224,735**	**5,915**	**232,751**
Current liabilities					
Payables	15	18,823	21,879	(3,056)	18,639
Lease liabilities	19	2,962	-	2,962	-
Accrued employee benefits	16	1,393	1,141	252	1,363
Other liabilities	17	22	-	22	2,688
Total current liabilities		**23,200**	**23,020**	**180**	**22,690**
Non-current liabilities					
Lease liabilities	19	3,450	-	3,450	-
Total non-current liabilities		**3,450**	**-**	**3,450**	**-**
Total liabilities		**26,650**	**23,020**	**3,630**	**22,690**
Net assets		**204,000**	**201,715**	**2,285**	**210,061**
Equity					
Contributed equity		170,713	168,794	1,919	177,717
Accumulated surplus		4,468	14,675	(10,207)	14,269
Asset revaluation surplus	18	28,819	18,246	10,573	18,075
Total equity		**204,000**	**201,715**	**2,285**	**210,061**

**An explanation of major variances is included 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 2020

	Contributed equity $'000	Accumulated surplus $'000	Asset revaluation surplus $'000	Total equity $'000
Balance at 1 July 2018	179,230	14,675	12,618	206,523
Operating result for the year	-	(406)	-	(406)
Other comprehensive income				
Increase in asset revaluation surplus	-	-	5,457	5,457
Total comprehensive income for the year	-	(406)	5,457	5,051
Transactions with owners as owners				
Equity asset transfer during the year	6,242	-	-	6,242
Equity injections	6,095	-	-	6,095
Equity withdrawals (depreciation funding)	(13,850)	-	-	(13,850)
Balance at 30 June 2019	**177,717**	**14,269**	**18,075**	**210,061**
Balance at 1 July 2019	177,717	14,269	18,075	210,061
Operating result for the year	-	(9,801)	-	(9,801)
Other comprehensive income				
Increase in asset revaluation surplus	-	-	10,744	10,744
Total comprehensive income for the year	-	(9,801)	10,744	943
Transactions with owners as owners				
Equity injections	11,062	-	-	11,062
Equity withdrawals (depreciation funding)	(18,066)	-	-	(18,066)
Balance at 30 June 2020	**170,713**	**4,468**	**28,819**	**204,000**

**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

Statement of Cash Flows
For the year ended 30 June 2020

	Note	2020 Actual $'000	2020 Budget $'000	2020 *Budget Variance $'000	2019 Actual $'000
Cash flows from operating activities					
Inflows:					
User charges and fees		3,383	2,776	607	5,295
Funding for public health services		195,908	205,403	(9,495)	187,551
Grants and other contributions		20,438	14,151	6,287	17,481
Interest received		2	2	-	3
GST collected from customers		732	-	732	613
GST input tax credits from ATO		5,959	5,399	560	5,282
Other		2,625	1,114	1,511	1,646
Outflows:					
Employee expenses		(18,041)	(17,040)	(1,001)	(17,469)
Department of Health contract staff		(117,459)	(113,451)	(4,008)	(108,408)
Supplies and services		(95,953)	(77,153)	(18,800)	(84,399)
Grants and subsidies		-	-	-	(612)
GST paid to suppliers		(5,750)	(5,399)	(351)	(5,441)
GST remitted to ATO		(732)	-	(732)	(613)
Interest payments on lease liabilities		(126)	-	(126)	-
Other expenses		(3,704)	(808)	(2,896)	(1,263)
Net cash from/(used in) operating activities	25	**(12,718)**	**14,994**	**(27,712)**	**(334)**
Cash flows from investing activities					
Payments for property, plant and equipment		(8,509)	(3,226)	(5,283)	(7,059)
Net cash used in investing activities		**(8,509)**	**(3,226)**	**(5,283)**	**(7,059)**
Cash flows from financing activities					
Inflows:					
Proceeds from equity injections		11,062	(12,177)	23,239	6,095
Outflows:					
Lease payments	26	(3,111)	-	(3,111)	-
Net cash from/(used in) financing activities		**7,951**	**(12,177)**	**20,128**	**6,095**
Net decrease in cash and cash equivalents		(13,276)	(409)	(12,867)	(1,298)
Cash and cash equivalents at the beginning of the financial year		39,944	40,509	(565)	41,242
Cash and cash equivalents at the end of the financial year	10	**26,668**	**40,100**	**(13,432)**	**39,944**

**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 2020

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

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

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

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

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

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

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

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

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

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

(a) Statement of compliance

The financial statements:

- have been prepared in compliance with section 62(1) of the *Financial Accountability Act 2019* 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 2020, and other authoritative pronouncements;
- are general purpose financial statements prepared on a historical cost basis, except where stated otherwise;
- are presented in Australian dollars;
- have been rounded to the nearest $1,000, where the amount is $500 or less or to zero unless the disclosure of the full amount is specifically required;
- classify assets and liabilities as either current or non-current in the Statement of Financial Position and associated notes. Assets are classified as current where their carrying amount is expected to be realised within 12 months after the reporting date. Liabilities are classified as current when they are due to be settled within 12 months after the reporting date, or when TCHHS does not have an unconditional right to defer settlement to beyond 12 months after the reporting period and;
- present reclassified comparative information where required for consistency with the current year's presentation.

(b) Issuance of financial statements

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

(c) Investment in North Queensland Primary Health Network Limited

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

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

(c) Investment in North Queensland Primary Health Network Limited (continued)

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

As each member has the same voting entitlement, it is considered that none of the individual members has power over NQPHNL (as defined by AASB 10 *Consolidated Financial Statements*) and therefore none of the members individually control NQPHNL. While TCHHS currently holds one-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.

(d) Investment in Tropical Australia Academic Health Centre Limited

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

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

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

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

Note 2. User charges and fees

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Dental service fees	221	196
Hospital fees	332	196
Multi-purpose nursing home fees	331	340
Pharmaceutical benefits scheme	390	470
Primary clinical care manual	132	20
Other user charges and fees		
Other	30	21
Rental income	122	107
	1,558	1,350

Note 2. User charges and fees (continued)

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.

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.

The adoption of AASB 15 *Revenue from Contracts with Customers* in 2019-20 did not materially change the timing of revenue recognition for the sale of goods and services.

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

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Specific purpose funding	5,304	-
Other funding for public health services		
Block funding	106,740	77,153
General purpose funding	101,029	124,631
COVID-19 refund - state	1,963	-
COVID-19 refund - commonwealth	1,963	-
	216,999	201,784

TCHHS receives funding under a service agreement with the DoH to deliver public health services. 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 plus an end of financial year technical adjustment. 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.

Revenue from contracts with customers
Revenue 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 (2.4%) of TCHHS's overall public health services revenue. Funding relating to oral health services makes up 87% or $4.6m of total ABF revenue.

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

Note 3. Funding for public health services (continued)

Other funding for public health services
TCHHS receives general purpose non-specific funding for Non-ABF block funded rural hospitals, facilities and services, mental health services, service specific funding commitments and primary health care. Revenue is recognised upon receipt of fortnightly payments for these services under AASB 1058 *Income of Not-for-Profit Entities.* At the end of the financial year, a financial adjustment may be required for service specific commitments that are not considered sufficiently specific in accordance with AASB 15. Funding received under AASB1058 that is required to be returned is recorded as an expense under other expense, 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 refund – state and commonwealth
TCHHS's financial impact arising from the COVID-19 pandemic is not considered significant. The total COVID-19 pandemic refund will recover expenditure totalling $3.926m for items such as labour, travel, clinical supplies and freight.

Note 4. Grants and other contributions

	2020 $'000	2019 $'000
Revenue from contracts with customers		
Commonwealth home support programme	1,002	1,111
Rural and remote medical benefits	5,424	4,586
Radiology service delivery	875	840
Indigenous health incentive	509	510
Other grants and contributions	173	224
Queensland community support scheme	67	104
Other grants and contributions		
Remote area aboriginal health services S100	2,448	2,350
Rural health outreach fund	1,191	910
Commonwealth indigenous health programs	4,257	4,075
Services below fair value	2,008	1,849
Practice incentive payments	1,219	1,153
Commonwealth after hours and health pathways services	1,417	1,034
My health for life	180	-
Other grants and contributions	65	87
Donations	47	33
	20,882	18,866

Grants, contributions and donations are non-reciprocal transactions where TCHHS does not directly give approximately equal value to the grantor. Revenue recognition for most grants and contributions did not change under AASB 1058, as compared to AASB 1004 *Contributions*. Revenue will continue to be recognised when TCHHS gains control of the asset (e.g. cash or receivable) in most instances.

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.

Note 4. Grants and other contributions (continued)

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

Services below fair value
During 2019-20 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 $2.008m in 2020 (2019: $1.849m) and in 2020 is recognised in “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

	2020 $'000	2019 $'000
Contract staff and recoveries	1,093	1,355
Asset adjustments (changes of inventory)	32	-
Non-capital project recoveries	1,823	2,598
Other	255	2,191
	3,203	6,144

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

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

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

	2020 $'000	2019 $'000
Wages and salaries*	14,436	13,830
Annual leave levy	914	845
Employer superannuation contributions	1,058	1,002
Long service leave levy	360	306
Sick leave	98	143
Other employee related expenses	1,195	1,118
	18,061	17,244

The number of directly engaged employees is 43 as at 30 June 2020 (2019: 47), including 34 full time equivalent employees and nine board members.

*Wages and salaries include $0.473m of $1,250 one-off, pro-rata payments for 385 full-time equivalent employees (announced in September 2019).

Note 6. Employee expenses (continued)

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 986 (2019: 955) full time equivalent roles in a contracting capacity as at 30 June 2020. These personnel remain employees of DoH as established under the *Hospital and Health Boards Act 2011*. The number of health service employees reflects full-time and part-time health service employees measured on a full-time equivalent basis.

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

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

Note 8. Supplies and services

	2020 $'000	2019 $'000
Building services	1,977	1,974
Catering and domestic supplies	497	771
Clinical supplies and services	4,085	3,456
Communications	2,392	2,127
Computer services	3,258	1,957
Consultants	1,719	1,389
Contractors - clinical	12,677	11,440
Contractors - non-clinical	644	763
Drugs	2,178	2,083
Electricity and other energy	3,447	3,867
Expenses relating to minor works	552	1,280
Freight	1,584	1,015
Motor vehicles	243	265
Lease expenses	9,891	12,671
Other supplies and services	1,829	2,131
Other travel	6,683	8,219
Pathology, blood and related equipment	4,953	5,116
Patient transport	3,482	4,966
Patient travel	14,324	14,527
Repairs and maintenance	3,786	4,306
Services below fair value	2,008	1,849
	82,209	86,172

Contractors
During the year $4.799m (2019: $5.217m) 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.

Note 8. Supplies and services (continued)

Lease expenses
Lease expenses for the 2020 financial year include lease rental for short-term building leases, Q-Fleet vehicle leases, leases governed by QGAO and GEH and other variable lease payments in accordance with the requirements of the new lease accounting standard under AASB 16. Lease expenses for the prior year have been accounted for under the previous standard, AASB 117. Refer to Notes 14 and 19 for breakdowns of lease expenses and other lease disclosures.

Services below fair value
Services below fair value from the Department of Health in the form of payroll, accounts payable and banking services amounted to $2.008m in 2020 (2019: $1.849m) 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

	2020 $'000	2019 $'000
Advertising	115	108
Audit fees - internal and external	295	374
Funding returns	2,259	-
Insurances other	96	71
Insurance premiums QGIF	1,025	502
Losses from the disposal of non-current assets	168	24
Special payments - ex gratia	132	202
Other legal costs	553	442
Inventory stock adjustments	25	28
Interest on leases	126	-
Other	10,311	159
	15,105	1,910

Audit fees – internal and external
Total external audit fees quoted by the Queensland Audit Office relating to the 2019-20 financial statements are $0.198m (2019: $0.159m).

Funding returns
At the end of the financial year unspent program funding is returned to the Department of Health. 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 two ex gratia payments to report totalling $0.132m (2019: $0.202m).

Other
Other includes a $10m transfer to the Department of Health for the redevelopment of Thursday Island Hospital and Primary Health Care Health Care Centre.

Note 10. Cash and cash equivalents

	2020 $'000	2019 $'000
Cash on hand	1	1
Cash at bank	26,584	39,861
QTC cash funds	83	82
	26,668	39,944

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 Department of Health Consolidated Fund. A deposit is held with QTC reflecting the value of the TCHHS general trust funds. The value of this deposit as at 30 June 2020 was $0.083m (2019: $0.082m) and the annual effective interest rate was 1.93% (2019: 2.38%).

Note 11. Receivables

	2020 $'000	2019 $'000
Receivables	830	372
Less: Allowance for impairment of receivables	(230)	(77)
	600	295
GST input tax credits receivable	419	603
GST payable	(70)	(45)
	349	558
Public health service funding	2,659	389
Other	2	-
	2,661	389
	3,610	1,242

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

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

Impairment of receivables
TCHHS uses a provision matrix to measure the lifetime expected credit loss on 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 provision matrix uses historical observed default rates calculated using credit losses experienced on past transactions during the last two years preceding 30 June 2020.

Note 11. Receivables (continued)

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 2020 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 ($0.025m).

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

	Less than 30 days	31 - 60 days	61 - 90 days	More than 90 days	Total
	$'000	$'000	$'000	$'000	$'000
Ageing of receivables 2019 (Government agency / low risk)					
Receivables	128	-	-	-	128
Loss rate (%)	0.0%	0.0%	0.0%	0.0%	
Allowance for impairment (Expected Credit loss)	-	-	-	-	-
Carrying amount	128	-	-	-	128
Ageing of receivables 2019 (Dental patients)					
Receivables	7	3	3	9	22
Loss rate (%)	21.4%	60.1%	71.4%	91.6%	
Allowance for impairment (Expected Credit loss)	(2)	(2)	(2)	(8)	(14)
Carrying amount	5	1	1	1	8
Ageing of receivables 2019 (Other patients and customers)					
Receivables	186	8	7	21	222
Loss rate (%)	20.2%	52.5%	55.4%	84.7%	
Allowance for impairment (Expected Credit loss)	(37)	(4)	(4)	(18)	(63)
Carrying amount	149	4	3	3	159
Ageing of receivables 2020 (Government agency / low risk)					
Receivables	426	100	1	26	553
Loss rate (%)	0.0%	0.0%	0.0%	0.0%	
Allowance for impairment (Expected Credit loss)	-	-	-	-	-
Carrying amount	426	100	1	26	553
Ageing of receivables 2020 (Dental Patients)					
Receivables	1	1	-	42	44
Loss rate (%)	10.6%	62.7%	100.0%	100.0%	
Allowance for impairment (Expected Credit loss)	-	-	-	(42)	(42)
Carrying amount	1	1	-	-	2

Note 11. Receivables (continued)

Ageing of receivables 2020 (Other patients and customers)

Receivables	8	16	8	201	233
Loss rate (%)	23.8%	33.4%	51.1%	87.8%	
Allowance for impairment (Expected Credit loss)	(2)	(5)	(4)	(177)	(188)
Carrying amount	6	11	4	24	45

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

	2020 $'000	2019 $'000
Movements in the provision for impairment of receivables are as follows:		
Balance at the start of the year	77	73
Receivables written off during the year as uncollectable	(18)	(65)
Increase in provision recognised	171	69
Balance at the end of the year	230	77

The closing balance of receivables arising from contracts with customers at 30 June 2020 is $0.230m.

Note 12. Inventories

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

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

Note 13. Other assets

	2020 $'000	2019 $'000
Current		
Prepayments	307	349
Accrued revenue	-	2,733
Contract assets	358	-
Other – non-contract with customers	587	-
	1,252	3,082

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 asset balance movements during the year:
Contract assets decreased by $0.612m primarily as a result of the reassessment of progress of services under the rural and remote medical benefits scheme.

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

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

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

(a) Property, plant and equipment

	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Carrying amount at 1 July 2018	8,935	159,736	11,723	2,696	183,090
Additions	-	-	866	6,224	7,090
Disposals	-	-	(23)	-	(23)
Asset revaluation increment	-	5,457	-	-	5,457
Transfers between classes	-	5,161	368	(5,529)	-
Transfers in from other Queensland Government	-	6,191	51	-	6,242
Depreciation expense	-	(11,679)	(2,171)	-	(13,850)
Carrying amount at 30 June 2019	**8,935**	**164,866**	**10,814**	**3,391**	**188,006**
As at 30 June 2019					
Gross value	8,935	376,959	26,159	3,391	415,444
Accumulated depreciation	-	(212,093)	(15,345)	-	(227,438)
Carrying amount at 30 June 2019	**8,935**	**164,866**	**10,814**	**3,391**	**188,006**
Carrying amount at 1 July 2019	8,935	164,866	10,814	3,391	188,006
Additions	-	1,283	2,629	4,605	8,517
Disposals	-	-	(168)	-	(168)
Asset revaluation increment	-	10,744	-	-	10,744
Asset not previously recognised	-	18	14	-	32
Transfers between classes	-	693	(50)	(643)	-
Depreciation expense	-	(12,711)	(2,235)	-	(14,946)
Carrying amount at 30 June 2020	**8,935**	**164,893**	**11,004**	**7,353**	**192,185**
As at 30 June 2020					
Gross value	8,935	397,955	27,447	7,353	441,690
Accumulated depreciation	-	(233,062)	(16,443)	-	(249,505)
Carrying amount at 30 June 2020	**8,935**	**164,893**	**11,004**	**7,353**	**192,185**

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

(b) Right-of-use assets

A new accounting standard AASB 16 *Leases* came into effect 2019-20, resulting in significant changes to the HHS's accounting for leases for which it is a lessee. The transitional impacts of the new standard are disclosed in Note 30.

	Land $'000	Buildings $'000	Total $'000
As at 30 June 2019			
Gross value	-	-	-
Accumulated depreciation	-	-	-
Carrying amount at 30 June 2019	**-**	**-**	**-**
Carrying amount at 1 July 2019	1,930	5,870	7,800
Additions	254	1,469	1,723
Depreciation expense	(70)	(3,049)	(3,119)
Carrying amount at 30 June 2020	**2,114**	**4,290**	**6,404**
As at 30 June 2020			
Gross value	2,184	7,339	9,523
Accumulated depreciation	(70)	(3,049)	(3,119)
Carrying amount at 30 June 2020	**2,114**	**4,290**	**6,404**

(c) Accounting policies

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

Class	Threshold
Land	$ 1
Buildings and land improvements	$ 10,000
Plant and equipment	$ 5,000
Right-of-use assets	$ 10,000

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

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

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

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 Housing and Public Works (DHPW) provides TCHHS with access to office accommodation, employee housing and motor vehicles under government-wide frameworks. These arrangements are categorised as

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

(c) Accounting policies (continued)

procurement of services rather than as leases because DHPW has substantive substitution rights over the assets. The related service expenses are included in Note 8.

Measurement
Plant and equipment and right-of-use assets are measured at amortised 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.

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.

On transition, TCHHS elected to measure the right-of-use assets at an amount equal to the lease liability adjusted for any prepaid or accrued leased payments that existed at the date of transition. When measuring the lease liability, 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.

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.

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

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

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

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

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

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

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

(c) Accounting policies (continued)

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

Class	Depreciation rates used	Useful lives
Buildings	1.3% – 4%	8 – 79 years
Plant and equipment	4% – 20%	5 – 27 years
Right-of-use assets	2.5% - 50%	2 – 40 years

Impairment
All property, plant and equipment and right-of-use assets are assessed for indicators of impairment on an annual basis or where the asset is measured at fair value, for indicators of a change in fair value/service potential since the last valuation was completed. Where indicators of a material change in fair value or service potential since the last valuation arise, the asset is revalued at the reporting date under AASB 13 *Fair Value Measurement.* If an indicator of possible impairment exists TCHHS determines the asset's recoverable amount. The asset's recoverable amount is determined as the higher of the asset's fair value less costs to sell or value in use. For assets measured at cost, an impairment loss is recognised immediately in the statement of comprehensive income. Consequently, if reversals of impairment losses occur, they are reversed through income.

(d) Fair value measurement and valuation

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

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

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

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

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

Use of Independent professional valuers
Revaluations using independent professional valuers are undertaken at least once every five years. However, if a particular asset class experiences significant and volatile changes in fair value, that class is subject to specific appraisal in the reporting period, where practicable, regardless of the timing of the last specific appraisal.

The fair values reported by TCHHS are based on appropriate valuation techniques that maximise the use of available and relevant observable inputs and minimise the use of unobservable inputs. Materiality is considered in determining

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

(d) Fair value measurement and valuation (continued)

whether the difference between the carrying amount and the fair value of an asset is material (in which case revaluation is warranted).

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

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

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

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

In 2019-20 management requested land indices from the State Valuation Service of Department of Natural Resources Mines and Energy for all TCHHS land parcels. All TCHHS land parcels indices were 1.1% or less, therefore, no indexation was applied to the land assets this year due to the change in the market not being material.

Buildings
In 2019-20 TCHHS engaged independent experts Jacobs to undertake building revaluations in accordance with the fair value methodology.

For the year ended 2020, approximately 33.1% of buildings were comprehensively revalued at fair value using current replacement cost methodology.

Since the introduction of a standardised approach to the valuation of all Queensland public infrastructure, management have had 78% of TCHHS buildings comprehensively revalued in the last three years using the cost valuation approach (current replacement cost). Indexation of 2% was applied to all building assets not comprehensively revalued during the current year. The effective date of valuations was primarily 30 June 2020.

The valuations were carried out using the current replacement cost approach to determine fair value. The replacement cost is based on current construction market rates that any market participant would likely expect to pay. The valuation is provided for a replacement building of the same age, location, size, shape, functionality that 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 2019-20 resulted in a net increment of $10.744m to the carrying amount of buildings. This is made up of the indexation adjustment which resulted in a net increment of $2.104m and the independent comprehensive valuation net increment of $8.640m.

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.

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

(d) Fair value measurement and valuation (continued)

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.

2019	**Level 2 $'000**	**Level 3 $'000**	**Total $'000**
Assets			
Land	8,935	-	8,935
Buildings (health service sites)	-	164,866	164,866
Total	8,935	164,866	173,801
2020			
Assets			
Land	8,935	-	8,935
Buildings (health service sites)	-	164,893	164,893
Total	8,935	164,893	173,828

There were no transfers between levels during the financial year.

Note 15. Payables

	2020 $'000	**2019 $'000**
Payables - other	1,298	3,091
Accrued expenses - other	9,993	10,862
Department of Health contract staff wages	5,054	3,683
Payables - refund liabilities	2,478	1,003
	18,823	18,639

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 Department of Health. 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.

Note 16. Accrued employee benefits (continued)

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

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

No provision for annual leave or long service leave is recognised in the financial statements of TCHHS, as the liability for these schemes is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*.

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

The QSuper scheme has defined benefit and defined contribution categories. The liability for defined benefits is held on a Whole of Government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*.

Therefore, no liability is recognised for accruing superannuation benefits in these financial statements. Refer to Note 6 for details regarding employee expense disclosures.

Note 17. Other liabilities

	2020 $'000	2019 $'000
Current		
Unearned revenue	-	2,688
Contract liabilities	22	-
	22	2,688

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

For the purpose of determining deferred revenue, TCHHS has assumed that the goods or services will be transferred to the customer as promised in accordance with the existing contract and that the contract will not be cancelled, renewed or modified.

There was no revenue recognised during 2019-20 that related to the previous year's performance obligations based on a review of TCHHS's contracts with customers.

Specific-purpose capital grants
In contrast with previous standards such as AASB 1004, 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 2018	-	12,618	12,618
Revaluation increment	-	5,457	5,457
Balance - 30 June 2019	-	18,075	18,075
Balance at 1 July 2019	-	18,075	18,075
Revaluation increment	-	10,744	10,744
Balance - 30 June 2020	-	28,819	28,819

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 2019-20 resulted in a net increment of $10.744m 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. Leases liabilities

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:

	2020 $'000	2019 $'000
Current		
Lease liabilities	2,962	-
	2,962	-
Non-Current		
Lease liabilities	3,450	-
	3,450	-
	6,412	-

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. Leases liabilities (continued)

(ii) Amounts recognised in profit or loss

	2020 $'000	2019 $'000
Interest expense on lease liabilities	126	-
Breakdown of 'Lease expenses' included in Note 8		-
- Expenses relating to short-term leases	653	-
Income from subleasing included in 'Property rental' in Note 2	122	-

(iii) Total cash outflow for leases

Total cash outflow for leases	3,111	-

See Note 22. Commitments for 2019-20 disclosures under AASB 117.

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, derivates, bonds, notes or loans.

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

	2020 $'000	2019 $'000
Financial assets		
Financial assets at amortised cost - comprising:		
Cash and cash equivalents	26,668	39,944
Receivables	3,610	1,242
Total financial assets	30,278	41,186
Financial liabilities		
Financial liabilities at amortised cost - comprising:		
Payables	18,823	18,639
Lease liabilities	6,412	-
Total financial liabilities at amortised cost	25,235	18,639

Note 20. Financial instruments (continued)

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

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

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

(a) Credit risk
Credit risk is the potential for financial loss arising from a counterparty defaulting on its obligations. The maximum exposure to credit risk at balance date is equal to the gross carrying amount of the financial asset, inclusive of any allowance for impairment (expected credit loss).

TCHHS uses a provision matrix to measure the expected credit loss on debtors. Refer to Note 11.

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

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

The only financial liabilities which expose TCHHS to liquidity risk are trade and other payables 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 finance 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 2020 there were no cases filed in the courts naming the State of Queensland acting through TCHHS as defendant.

As of 30 June, 2020 there were two open general liability claims managed by QGIF. At this stage, it is unknown if any will be litigated or result in payments of claims, therefore, no contingent liabilities are projected. All claims lodged, tribunals, commissions and board figures represent the matters that have been referred to QGIF for management. The maximum exposure to TCHHS under this policy is $20,000 for each insurable event.

Note 21. Contingent liabilities (continued)

There are currently seven claims underway with Workcover and no 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.

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

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

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

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

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

Note 22. Commitments

	2020 $'000	2019 $'000
Commitments - capital expenditure		
Committed at the reporting date but not recognised as liabilities, payable:		
Not later than 1 year	12,830	1,848
Commitments - operating expenditure		
Committed at the reporting date but not recognised as liabilities, payable:		
Not later than 1 year	13,676	15,966
Later than 1 year but not later than 5 years	171	3,901
Later than 5 years	1,143	3,447
	27,820	25,162

Leases
Only leases that did not fall within the scope of *AASB 16 Leases* or are exempt from *AASB 16 Leases* have been included in this note. Refer to Note 30 for reconciliation of operating lease commitments at 30 June 2019 to the lease liabilities at 1 July 2019. Operating lease commitments include contracted amounts for office space from Government Employee Housing (GEH), storage containers and Q-Fleet vehicles. The leases have various escalation clauses. Lease payments are generally fixed, but with inflation escalation clauses on which contingent rentals are determined.

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

Note 23. Patient trust transactions and balances

Patient trust receipts and payments	2020 $'000	2019 $'000
Receipts		
Opening balance	5	5
Amounts receipted on behalf of patients	2	3
Total receipts	7	8
Payments		
Amounts paid to or on behalf of patients	2	3
Total payments	2	3
Trust assets and liabilities		
Assets		
Cash held and bank deposits	5	5
Total assets	5	5

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

Note 24. Events after the reporting period

There are no matters or circumstances that have arisen since 30 June 2020 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

	2020 $'000	2019 $'000
Operating result for the year	(9,801)	(406)
Non-cash movements:		
Depreciation	18,065	13,850
Depreciation offset from DoH	(18,065)	(13,850)
Loss on disposal	168	24
Donated assets	(8)	(31)
Asset not previously recognised	(32)	-
Movements in impairment loss receivables	132	69
Change in operating assets and liabilities		
(Increase)/decrease in receivables	25	(1,525)
(Increase)/decrease in GST receivables	209	(159)
Decrease in inventories	(56)	21
Increase in prepayments	(545)	(258)
(Increase)/decrease in contract assets	(358)	-
Increase/(decrease) in payables	(318)	1,218
Increase/(decrease) in accrued employee benefits	30	457
Increase/(decrease) in accrued contract labour	502	933
Increase/(decrease) in contract liabilities and unearned revenue	(2,666)	(677)
Net cash from/(used in) operating activities	(12,718)	(334)

Note 26. Changes in liabilities arising from financing activities

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

Assets and liabilities received or donated are recognised as revenues (refer to Note 2) or expenses (refer to Note 7) 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.

	2020 $'000	2019 $'000
Opening balance	98	95
Revenue received during the year	2	4
Expenditure made during the year	-	(1)
Balance of general trust	100	98

The closing cash balance of the general trust at 30 June 2020 is $0.100m (2019: $0.098m). This is held on deposit with the QTC $0.083m (2019: $0.082m) and the Commonwealth Bank of Australia $0.017m (2019: $0.016m).

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 Steven Miles MP, Minister for Health and Minister for Ambulance Services.

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 Deputy Chairperson - Provides strategic leadership and guidance and effective oversight of management, operations and financial performance	Scott Davis	*S25 Hospital and Health Boards Act 2011 by Governor in Council*	4 October 2019 to 17 May 2020
Non-executive Board member - Provides strategic guidance and effective oversight of management, operations and financial performance	Horace Baira Tracey Jia Fraser (Ted) Nai Brian Woods Karen Price Scott Davis Ruth Stewart Rhonda Shibasaki Karen Dini-Paul	*S23 Hospital and Health Boards Act 2011*	19 January 2015 1 July 2014 1 July 2014 to 17 May 2020 19 January 2015 11 December 2015 18 May 2016 18 May 2018 18 May 2019 18 May 2020
Health Service Chief Executive (HSCE) - Responsible for the overall management of TCHHS through major functional areas to ensure the delivery of key government objectives in improving the health and well-being of Queenslanders	Beverley Hamerton	*S24/S70 Hospital and Health Boards Act 2011*	31 March 2018
Chief Finance Officer (CFO) - Responsible for providing strategic leadership, direction, stewardship, governance, effective controls and day-to-day financial management and statutory reporting obligations	Danielle Hoins Brendan Cann (acting)	*DSO1 Hospital and Health Boards Act 2011*	17 April 2015 to 14 June 2020 29 October 2019 to 2 February 2020 23 March 2020 to 14 June 2020

Note 28. Key management personnel disclosures (continued)

Position	Name	Contract classification and appointment authority	Initial appointment date
Executive Director of Finance, Information and Digital Services - Responsible for providing strategic leadership, direction, stewardship, governance, effective controls and day-to-day financial management and statutory reporting obligations as well as leadership of the Information and Communication Technologies strategy; including information and communication technology management of enablers of systems for healthcare delivery	Danielle Hoins	*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	Mark Goodman	*HES2 Hospital and Health Boards Act 2011*	7 May 2018
Executive General Manager - Southern Sector - Responsible for providing strategic leadership, direction and day to day management to the Cape York area within the TCHHS	Ian Power	*HES2 Hospital and Health Boards Act 2011*	23 July 2018
Executive Director Corporate Services - Responsible for providing strategic leadership and governance of the corporate services function including human resources, occupational health and safety, learning and development, assets and infrastructure, travel, contracts and procurement	Dean Davidson	*HES2 Hospital and Health Boards Act 2011*	17 September 2018 to 31 August 2019
Executive Director - Medical Services - Responsible for leading, directing, implementing, planning and evaluating the delivery of medical and dental across all departments and facilities within the TCHHS	Anthony Brown	*MMOI1 Hospital and Health Boards Act 2011*	12 February 2018
Executive Director - Nursing and Midwifery Services - Responsible for providing nursing leadership and governance to TCHHS Nursing and Mental Health Services; whilst providing professional line management for Nurse Leaders (including DON 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

Note 28. Key management personnel disclosures (continued)

Position	Name	Contract classification and appointment authority	Initial appointment date

Executive Director Aboriginal and Torres Strait Islander Health - to provide a professional lead for Aboriginal and Torres Strait Islander Health workers and Health Practitioners, designing workforce strategies that will strengthen opportunities for Aboriginal and Torres Strait Islander peoples' career growth and help deliver the best possible health care to our region	Venessa Curnow	*DSO2* *Hospital and Health Boards Act 2011*	21 January 2019
Chief Information Officer - Provides leadership of the Information and Communication Technologies strategy; including information and communication technology management of enablers of systems for healthcare delivery	David Bullock	*DSO2* *Hospital and Health Boards Act 2011*	4 September 2018 to 28 May 2020
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	*DSO1* *Hospital and Health Boards Act 2011*	1 September 2019
Executive Director Workforce & Engagement - Responsible for providing strategic and operational leadership and governance of the human resources function including workforce planning, recruitment, industrial and employee relations, integrated learning centre and workforce health and safety	Erica Gallagher	*DSO1* *Hospital and Health Boards Act 2011*	15 July 2019

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.

Note 28. Key management personnel disclosures (continued)

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

Remuneration packages for Board members comprise the following components:

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

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

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

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

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

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

There were no performance bonuses paid in the 2019-20 financial year (2019: $nil).

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

Note 28. Key management personnel disclosures (continued)

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

2020 **Remuneration expenses**

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

Note 28. Key management personnel disclosures (continued)

2019 **Remuneration expenses**

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

Note 29. Related party transactions

Transactions with Queensland Government controlled entities
Material related party transactions for 2019-20 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 Department of Health and contracted to work for the TCHHS.

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

Note 29. Related party transactions (continued)

Department of Housing and Public Works
TCHHS pays rent to the Department of Housing and Public Works for office and staff accommodation. In addition, the Department of Housing and Public Works provides vehicle fleet management services (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 TAAHC. Members are incorporated in a unified company and governance structure to enhance health and health services research in the region, leveraging economies of scale and the proven opportunities of the Academic Health Centre concept for northern Queensland. TCHHS has paid its 2019-20 TAAHC membership contribution in 2020 which will be held in trust by James Cook University on behalf of TAAHC as the TAAHC company accounts have not been established yet. This transaction was endorsed by the TCHHS Board and is considered to be at arm's length considering this company has just been established.

TCHHS employees that are close family members of TCHHS key management personnel were recruited in accordance with the standard TCHHS recruitment policies and procedures. As Anthony Brown (KMP) is a close related family member to Board member Ruth Stewart, his total remuneration figures are disclosed in Note 29 and not included in the table below.

Note 29. Related party transactions (continued)

Related Party transaction values and outstanding balances

Related Party	Transaction Type	2020		2019	
		Transaction value Revenue/ (expense)	Receivables/ (payables)	Transaction value Revenue/ (expense)	Receivables/ (payables)
		$'000	**$'000**	**$'000**	**$'000**
Department of Health	Service Agreement *	216,999	(3)	201,784	389
Department of Health	Prescribed employee costs	(118,840)	(5,644)	(109,319)	(3,683)
Department of Health	Services support costs	(16,189)	(1,080)	(15,182)	(1,429)
Department of Health	Locally receipted programs **	(200)	-	(1,792)	-
Other Hospital and Health Services	Renal, interpretation and legal services, pharmacy supplies, office space, courier fees, contract labour, training costs, manuals and course fees	(779)	(110)	(611)	(953)
Department of Housing and Public Works	Building/fleet leases	(9,200)	-	(8,008)	-
NQPHN	Primary Health care support ***	(23)	(23)	(83)	(155)
TAAHC	Membership fee	(75)	(75)	(25)	-
Close family members	Aggregated salary and wages	(387)	-	(261)	-
T Mehan	Management consultancy services	-	-	(145)	-

* *DoH Service Agreement receivables and payables (2020: $2.452m receivables and $2.455m payables) (2019: receivables $0.389m)*

** *DoH for locally receipted programs (2020: $1.761m revenue and $1.961m expenses) (2019: $3.707m revenue and $5.499m expenses)*

*** *NQPHN revenue and expenses (2020: $1.450m of revenue and $1.427m of expenses) (2019: $ 1.034m of revenue and $1.117m expenses). NQPHN receivables and payables (2020: $0.023m payables) (2019: $0.068m receivables and $0.223m 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

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

TCHHS has applied AASB 15 and AASB 1058 for the first time in 2019-20. AASB 15 replaces AASB 111 *Construction Contracts*, AASB 118 *Revenue*. AASB 1058 supersedes the majority of income recognition requirements relating to public sector not-for-profit entities.

Not-for-profits must first apply the principles of AASB 15 to revenue transactions in order to determine which revenue standard to apply. The core principles of AASB 15 are as follows:

- identify the obligations in contracts with customers
- ascertain the explicit and implicit promises in the contract to deliver goods and/or services to a customer
- determine the transaction price payable
- allocate the transaction price to the goods and/or services according to sufficiently specific performance obligations and
- recognise revenue based on when ‘control’ over the good or service transfers to the customer and the performance obligations are satisfied

AASB 1058 and AASB 1004 outline recognition principles for funding arrangements entered into by not-for-profit entities that fail to meet the criteria in AASB 15. The purpose of AASB 1058 is to align income transactions that are not contracts with customers, in accordance with their economic substance. AASB has also amended AASB 1004 *Contributions* as part of the release of new revenue standards.

Transition approach for AASB 15 and AASB 1058

TCHHS applied the modified retrospective transition method and has not restated comparative information for 2018-19, which continue to be reported under AASB 118 *Revenue*, AASB 111 *Construction Contracts*, AASB 1004 *Contributions* and related interpretations.

TCHHS elected to apply the standard retrospectively to all contracts, including completed contracts, at 1 July 2019. Completed contracts include contracts where TCHHS had recognised all of the revenue in prior periods under AASB 1004 *Contributions*.

TCHHS applied a practical expedient to reflect, on transition, the aggregate effect of all contract modifications that occurred before 1 July 2019.

The following table summarises the transitional adjustments on 1 July 2019 relating to the adoption of AASB 15 and AASB1058. Based on management’s review of its contracts with customers, there was no impact on opening accumulated surplus. The primary reason for this is TCHHSs contracts with customers contain refund liability (claw back) obligations and refundable amounts are raised as payables at the end of the financial year and would continue to do so under the new standards. Deferred revenue is expected to be minimal each year.

Note 30. Other information (continued)

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

The following table shows the impacts of adopting AASB 15 and AASB 1058 on TCHHS's 2019-20 financial statements (for only those items impacted). It compares the actual amounts reported to amounts that would have been reported if the previous revenue standards (AASB 1004, AASB 118, AASB 111 and related interpretations) had been applied in the current financial year.

	Note	As reported $'000	AASB 15 changes $'000	AASB 1058 changes $'000	Previous standards $'000
Operating result for 2019-20					
Income					
Funding for public health services	3	216,999	-	(2,259)	214,740
Total revenue		242,644	-	(2,259)	240,385
Expenses					
Other expenses	9	15,105	-	(2,259)	12,846
Total expenses		252,445	-	(2,259)	250,186
Total comprehensive income		943	-	-	943
Balances as at 30 June 2020					
Current assets					
Receivables	11	3,610	358	587	4,555
Other assets	13	1,252	(358)	(587)	307
Total current assets		32,061	-	-	32,061
Current liabilities					
Payables	15	18,823	-	(1,265)	17,558
Unearned revenue		-	-	1,265	1,265
Total current liabilities		23,200	-	-	23,200
Net assets		204,000	-	-	204,000

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

TCHHS applied AASB 16 *Leases* for the first time in 2019-20. TCHHS has applied the modified retrospective transition method and has not restated comparative information for 2018-19, which continue to be reported under AASB 117 *Leases* and related interpretations. The nature and effect of changes resulting from the adoption of AASB 16 are described below.

Definition of a lease
AASB 16 introduced new guidance on the definition of a lease. For leases and lease-like arrangements existing at 30 June 2019, TCHHS elected to apply the practical expedient to grandfather the previous assessments made under AASB 117 and Interpretation 4 *Determining whether an Arrangement Contains a Lease* about whether those contracts contained leases. However, arrangements were reassessed under AASB 16 where no formal assessment had been done in the past or where lease agreements were modified on 1 July 2019.

Note 30. Other information (continued)

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

Amendments to former operating leases for office accommodation and employee housing
In 2018-19, TCHHS held operating leases under AASB 117 from the Department of Housing and Public Works (DHPW) for non-specialised commercial office accommodation through the Queensland Government Accommodation Office (QGAO) and residential accommodation through the GEH program.

Effective 1 July 2019, the framework agreements that govern QGAO and GEH were amended with the result that these arrangements would not meet the definition of a lease under AASB 16 and therefore are exempt from lease accounting.

From 2019-20 onward, the costs for these services are expensed as supplies and services expenses when incurred. The new accounting treatment is due to a change in the contractual arrangements rather than a change in accounting policy.

Changes to lessee accounting
Previously, TCHHS classified its leases as operating based on whether the lease transferred significantly all of the risks and rewards incidental to ownership of the asset to the lessee. This distinction between operating and finance leases no longer exist for lessee accounting under AASB 16. From 1 July 2019, all leases, other than short-term leases and leases of low value assets, are now recognised on the balance sheet as lease liabilities and right-of-use assets.

TCHHS has elected to recognise lease payments for short-term leases and leases of low value assets as expenses on a straight-line basis over the lease term, rather than accounting for them on balance sheet. This accounting treatment is similar to that used for operating leases under AASB 117.

Transitional impact
- New right-of-use assets were tested for impairment on transition and none were found to be impaired.

- On transition, TCHHS used practical expedients to:
  - not recognise right-of-use assets and lease liabilities for leases that had a total lease term of less than 12 months and leases of low value assets;
  - include initial direct costs from the measurement of right-of-use assets; and
  - use hindsight when determining the lease term.

The following table summarises the on-transition adjustments to asset and liability balances at 1 July 2019 in relation to former operating leases.

	$'000
Right-of-use assets – Land	1,930
Right-of-use assets – Buildings	5,870
Lease liabilities	(7,800)
Accumulated surplus	-

Reconciliation of operating lease commitments at 30 June 2019 to the lease liabilities at 1 July 2019

	$'000
Total undiscounted operating lease commitments at 30 June 2019*	17,888
- discounted using the incremental borrowing rate at 1 July 2019 (1.63%)	(1,132)
Present value of operating lease commitments	**16,756**
- less internal-to-government arrangements that are no longer leases	(7,619)
- less leases with remaining lease term of less than 12 months	(164)
- add/less adjustments due to reassessments of lease terms	(1,173)
Lease liabilities at 1 July 2019	**7,800**

Note 30. Other information (continued)

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

*** 2018-2019 disclosures under AASB 117**

	2019 $'000
Operating lease commitments at 30 June 2019	
Not later than 1 year	10,540
Later than 1 year but not later than 5 years	3,901
Later than 5 years	3,447
	17,888

(c) New accounting standards and interpretations not yet effective

Accounting standards early adopted

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

(d) Climate risk

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

(e) Other matters

On 1 August 2019, TCHHS implemented S4/Hana, a new State-wide enterprise resource planning (ERP) system, which replaced FAMMIS ERP. The system is used to prepare the general-purpose financial statements, and it interfaces with other software that manages revenue, payroll and certain expenditure systems. Its modules are used for inventory and accounts payable management.

IT and application controls were required to be redesigned and new workflows implemented.

Extensive reconciliations were completed on implementation to ensure the accuracy of the data migrated.

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 $11.596m (5.64%) is mostly due to the COVID-19 extraordinary recovery amount of $3.925 funded by both the state ($1.717m) and commonwealth ($2.208m), EB funding allocation of $1.207m including the government wages policy one off payment, depreciation adjustment due to right-of-use assets $0.770m, 2018-19 end of year revenue received in advance $2.682m, Queensland government insurance fund adjustment $0.492m, Aboriginal and Torres Strait Islander health practitioner - practice preparation program $0.452m, acute post streptococcal glomerulonephritis outbreak funding $0.368m, Indigenous and use agreement funding $0.582m and other extraordinary window adjustment of $1.139m. This has been offset by the AASB 1058 Revenue clawbacks and land and buildings project deferrals $1.630m.
Grants and other contributions:	The increase of $4.839m (30.2%) is due primarily to higher than anticipated rural and remote medical benefits scheme $1.923m from northern renal services and additional doctors funded from practice preparation program revenue. Other increases include the reclassification of radiology service delivery from user fees and charges $0.875m, mental health after hours services funding $0.738m, services below fair value $0.159m and S100 drugs $0.370m together with minor increases in the Commonwealth Office of Aboriginal and Torres Strait Islander health (OATSIH) programs and CheckUp.
Other revenue:	The increase of $2.089m (187.5%) is due to contract staff recoveries for general medical training revenue, WorkCover plus recoveries from Queensland Ambulance Service and a private General Practitioner Practice costs which utilised TCHHS facilities.
Employee expenses:	The increase of $0.961m (5.62%) relates to a higher than anticipated number of Medical officers employed during the year.
Department of Health Contract staff:	The increase of $5.389m (4.75%) 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.
Supplies and services:	The increase overall of $4.678m (6.03%) relates to increases in eHealth levies of ($1.166m), travel costs for patients ($0.697m), consultancies ($0.917m), employment agency fees ($0.314m), repairs and maintenance ($0.389m), inter-entity communication services ($0.535m) and freight charges ($0.102m) due to implementation of S/4 HAHA the new finance system. Also included are COVID-19 response costs of $3.925m which are made up of freight charge from air charters due to pandemic travel restrictions, emergency management, quarantine accommodation costs and clinical supplies. These increases are offset by reductions in building lease costs ($4.254m) due to the changes relating to lease accounting under the new accounting standard AASB 16 which were not included in the original budget and electricity costs ($0.366m).
Depreciation expense:	The increase of $3.562m (24.5%) primarily relates to the depreciation expense from right-of-use assets of $3.119m that were not included in the budget, prior year's revaluation being higher than budget plus the timing of completed capital projects.
Other expenses:	The increase of $12.326m relates to the $10.000m payment to DoH as a contribution towards the Thursday Island hospital and primary health centre development and Treasury treatment of unspent grants under AASB 1058 of $2.259m.

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 $1.609m (80.4%) increase relates to the $2.452m Department of Health technical end of year adjustment which includes the Enterprise Bargaining (EB) adjustment and COVID recovery costs.
Other assets:	The increase of $1.106m (751.53%) relates to the change in recognition of revenue from contracts with customers recognised under the new accounting standard AASB 15 which have not been included in the budget.
Property, plant and equipment:	The increase of $10.198m (5.6%) primarily relates to assets comprehensively reassessed this year resulting in an increment of $8.646m. In addition, an indexation factor of 2.0% was applied to the remaining built assets whereas the budgeted increment was nil.
Right-of-use assets:	The increase of $6.404m directly relates to right of use assets being recognised for the first time this year with the introduction of the new AASB 16 *Leases* accounting standard, with nil budget set. All private leases with a term over 12 months that are not exempt or out of scope are now capitalised.
Payables:	The decrease of $3.056m (13.97%) relates to travel costs now being paid by credit card instead of via accounts payable, a reduction of external labour due to COVID-19 plus the reduction of vendor payments outstanding at the end of the financial year due to efficiencies in payment processing in the new S/4hana financial system.
Lease liabilities:	The increase directly relates to the change in accounting for leases and the underlying right-of-use assets. Right-of-use asset and lease liabilities have been recognised for the first time this year with the introduction of the new *AASB 16 Leases* accounting standard. All private leases with a term over 12 months that are not exempt or out of scope are now capitalised.
Accumulated surplus:	The main driver of the decrease by $10.207m is the $10.000m technical adjustment payment to the Department of Health as a contribution towards the Thursday Island hospital and primary health centre development.
Asset revaluation surplus:	The increase of $10.573m (57.9%) relates to the same factors outlined above under property, plant and equipment.

Note 31. Budget vs actual comparison (continued)

Statement of Cash Flows

User charges and fees:	The increase in cash inflows is lower than budgeted primarily due to asset movements between prior year and this year as a result of reclassification of revenue once the AASB 15 *Revenue from Contracts with Customers* accounting standard was introduced.
Funding for public health services:	The decrease in cash inflows is lower 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 same factors outlined in the major variances for the Statement of Comprehensive Income.
Employee expenses, Department of Health contract staff and supplies and services:	The increase in cash outflows is higher than budgeted primarily due to the same factors outlined in the major variances for the Statement of Comprehensive Income.
Payments for property, plant and equipment:	The increase in cash flows from investing activities is higher than the budgeted figure due to the same factors outlined in the major variances for the financial position.
Proceeds from equity injections:	The increase in cash flows from financing activities overall is higher than the budgeted figure due to the new *AASB 16 Leases* accounting standard, where all private leases with a term over 12 months that are not exempt or out of scope are now capitalised. Consequently, these leases reflected a reduction to operating revenue and an increase to equity equivalent to the annual reduction in lease liability.

Torres and Cape Hospital and Health Service
Management Certificate
For the year ended 30 June 2020

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 2020 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

21 / 8 / 2020

Ian Power
A/ Health Service
Chief Executive

21 / 8 / 20

Danielle Hoins - CPA
Executive Director Finance
Information and Digital
Services

21 / 8 / 20

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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 2020, 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 2020, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes to the financial statements including summaries of significant accounting policies and other explanatory information, and the management certificate.

Basis for opinion

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

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

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

Key audit matters

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

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Specialised buildings valuation ($165m)

Refer to Note 14 in the financial report.

Key audit matter	How my audit addressed the key audit matter
Buildings were material to Torres and Cape Hospital and Health Service at balance date and were measured at fair value using the current replacement cost method. Torres and Cape Hospital and Health Service performed a comprehensive revaluation of approximately 33.1% of its building assets this year with the balance being revalued using indexation. The current replacement cost method comprises: • Gross replacement cost, less • Accumulated depreciation. Torres and Cape Hospital and Health Service derived the gross replacement cost of its buildings at balance date using unit prices that required significant judgements for: • identifying the components of buildings with separately identifiable replacement costs; and • developing a unit rate for each of these components, including: o estimating the current cost for a modern substitute (including locality factors and oncosts), expressed as a rate per unit (e.g. $/square metre) o identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference. The measurement of accumulated depreciation involved significant judgements for forecasting the remaining useful lives of building components. The significant judgements required for gross replacement cost and useful lives are also significant for calculating annual depreciation expense.	My procedures included, but were not limited to: • Assessing the adequacy of management's review of the valuation process. • Assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices. • For unit rates associated with buildings that were comprehensively revalued this year: o Assessing the competence, capabilities and objectivity of the experts used to develop the models; o Reviewing the scope and instructions provided to the valuer, and obtaining an understanding of the methodology used and assessing its appropriateness with reference to common industry practices; and o On a sample basis, evaluating the relevance, completeness and accuracy of source data used to derive the unit rate of the: ▪ modern substitute (including locality factors and oncosts) ▪ adjustment for excess quality or obsolescence. • For unit rates associated with the remaining specialised buildings: o Evaluating the relevance and appropriateness of the indices used for changes in cost inputs by comparing to other relevant external indices; and o Recalculating the application of the indices to asset balances. • Evaluating useful life estimates for reasonableness by: o Reviewing management's annual assessment of useful lives; o Testing that no asset still in use has reached or exceeded its useful life; o Enquiring of management about their plans for assets that are nearing the end of their useful life; o Reviewing assets with an inconsistent relationship between condition and remaining useful life; and o Where changes in useful lives were identified, evaluating whether they were supported by appropriate evidence.

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Shared Services

Refer to Note 30(e)

Key audit matter	How my audit addressed the key audit matter

The Department of Health (the Department) is the shared service provider to Torres and Cape Hospital and Health Service for the management of the financial management information system, and processing of accounts payable transactions in the system.
 	
The Department replaced its primary financial management information system on 1 August 2019.
 	
The financial management system is used to prepare the general purpose financial statements. It is also the general ledger and it interfaces with other software that manages revenue, payroll and certain expenditure streams. Its modules are used for inventory and accounts payable management.
 	
The replacement of the financial management system increased the risk of fraud and error in the control environment of the Department and Torres and Cape Hospital and Health Service.
 	
The implementation of the financial management system was a significant business and IT project for the Department and Torres and Cape Hospital and Health Service. It included:
• designing and implementing IT general controls and application controls
• cleansing and migrating of vendor and open purchase order master data
• ensuring accuracy and completeness of closing balances transferred from the old system to the new system
• establishing system interfaces with other key software programs
• establishing and implementing new workflow processes.
	I have reported issues relating to internal control weaknesses identified during the course of my audit to those charged with governance.
	
	My procedures included, but were not limited to:
	• assessing the appropriateness of the IT general and application level controls including system configuration of the financial management system by:
	  ○ reviewing the access profiles of users with system wide access
	  ○ reviewing the delegations and segregation of duties
	  ○ reviewing the design, implementation and effectiveness of the key general information technology controls.
	• validating account balances from the old system to the new system to verify the accuracy and completeness of data migrated
	• documenting and understanding the change in process and controls for how material transactions are processed, and balances are recorded
	• assessing and reviewing controls temporarily put in place due to changing system and procedural updates
	• Undertaking significant volume of sample testing to obtain sufficient appropriate audit evidence, including:
	  ○ verifying the validity of journals processed pre and post go-live
	  ○ verifying the accuracy and occurrence of changes to bank account details
	  ○ comparing vendor and payroll bank account details
	  ○ verifying the completeness and accuracy of vendor payments, including testing for potential duplicate payments
	• Assessing the reasonableness of:
	  ○ the inventory stocktakes for completeness and accuracy
	  ○ the mapping of the general ledger to the financial statement line item

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Responsibilities of the Board for the financial report

The Board is responsible for the preparation of the financial report that gives a true and fair view in accordance with the *Financial Accountability Act 2009*, the *Financial and Performance Management Standard 2019* and Australian Accounting Standards, and 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 control 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.
- 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.

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- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

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

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

Report on other legal and regulatory requirements

Statement

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2020:

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.

24 August 2020

C G Strickland
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

GLOSSARY

Aboriginal and Torres Strait Islander health worker	An Aboriginal and/or Torres Strait Islander person who holds the specified qualification and works within a primary healthcare framework to improve health outcomes for Aboriginal and Torres Strait Islander people.
Acute	Having a short and relatively severe course of care in which the clinical intent or treatment goal is to: manage labour (obstetric) cure illness or provide definitive treatment of injury perform surgery relieve symptoms of illness or injury (excluding palliative care) reduce severity of an illness or injury protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function perform diagnostic or therapeutic procedures
Admission	A patient who undergoes a hospital's formal admission process as an overnight-stay patient or a same-day patient.
Allied health staff	Professional staff who meet mandatory qualifications and regulatory requirements in the following areas: audiology; clinical measurement sciences; dietetics and nutrition; exercise physiology; leisure therapy; medical imaging; music therapy; nuclear medicine technology; occupational therapy; orthopaedics; pharmacy; physiotherapy; podiatry; prosthetics and orthotics; psychology; radiation therapy; sonography; speech pathology and social work
CAC	Community Advisory Committee
Clinical governance	A framework by which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Clinical practice	Professional activity undertaken by health professionals to investigate patient symptoms and prevent and/or manage illness, together with associated professional activities for patient care.
Clinical workforce or staff	Employees who are or who support health professionals working in clinical practice, have healthcare specific knowledge/experience, and provide clinical services to health consumers, either directly and/or indirectly, through services that have a direct impact on clinical outcomes.
Coronavirus	See COVID-19
COVID-19	The COVID-19 novel coronavirus is a new 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).
Full-time Equivalent (FTE)	Full-time Equivalent is calculated by the number of hours worked in a period divided by the award full-time hours prescribed by the award/industrial instrument for the person's position.
Hospital	Healthcare facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day-procedure unit and authorised to provide treatment and/or care to patients.
Hospital and Health Boards	The Hospital and Health Boards are made up of a mix of members with expert skills and knowledge relevant to governing a complex healthcare organisation.
Hospital and Health Service	Hospital and Health Services are separate legal entities established by Queensland Government to deliver public hospital services. Hospital and Health Services commenced in Queensland on 1 July 2012, replacing existing health service districts.
Hospital-in-the-home	Provision of care to hospital-admitted patients in their place of residence, as a substitute for hospital accommodation.

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

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

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
	• **Public availability**	ARRs – section 9.2	2
	• **Interpreter service statement**	*Queensland Government Language Services Policy* ARRs – section 9.3	2
	• **Copyright notice**	*Copyright Act 1968* ARRs – section 9.4	2
	• **Information Licensing**	*QGEA – Information Licensing* ARRs – section 9.5	2
General information	• **Introductory Information**	ARRs – section 10.1	7-8
	• **Machinery of Government changes**	ARRs – section 10.2, 31 and 32	not applicable
	• **Agency role and main functions**	ARRs – section 10.2	9-12
	• **Operating environment**	ARRs – section 10.3	13-15
Non-financial performance	• **Government's objectives for the community**	ARRs – section 11.1	6
	• **Other whole-of-government plans / specific initiatives**	ARRs – section 11.2	6
	• **Agency objectives and performance indicators**	ARRs – section 11.3	6-12, 14-15, 28, 34-35
	• **Agency service areas and service standards**	ARRs – section 11.4	35-36
Financial performance	• **Summary of financial performance**	ARRs – section 12.1	37-38
Governance – management and structure	• **Organisational structure**	ARRs – section 13.1	25-28
	• **Executive management**	ARRs – section 13.2	16-24
	• **Government bodies (statutory bodies and other entities)**	ARRs – section 13.3	20-21
	• **Public Sector Ethics**	*Public Sector Ethics Act 1994* ARRs – section 13.4	32
	• **Human Rights**	*Human Rights Act 2019* ARRs – section 13.5	33-34
	• **Queensland public service values**	ARRs – section 13.6	10
Governance – risk management and accountability	• **Risk management**	ARRs – section 14.1	29-31
	• **Audit committee**	ARRs – section 14.2	21
	• **Internal audit**	ARRs – section 14.3	29
	• **External scrutiny**	ARRs – section 14.4	30-31
	• **Information systems and recordkeeping**	ARRs – section 14.5	30-31
Governance – human resources	• **Strategic workforce planning and performance**	ARRs – section 15.1	27-28
	• **Early retirement, redundancy and retrenchment**	Directive No.04/18 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	28

Summary of requirement		Basis for requirement	Annual report reference
Open Data	• **Statement advising publication of information**	ARRs – section 16	2**Consultancies**
	2**Consultancies**	ARRs – section 33.1	https://data.qld.gov.au
	• **Overseas travel**	ARRs – section 33.2	https://data.qld.gov.au
	• **Queensland Language Services Policy**	ARRs – section 33.3	https://data.qld.gov.au
Financial statements	• **Certification of financial statements**	FAA – section 62 FPMS – sections 38, 39 and 46 ARRs – section 17.1	84
	• **Independent Auditor's Report**	FAA – section 62 FPMS – section 46 ARRs – section 17.2	85-89

FAA *Financial Accountability Act 2009*

FPMS *Financial and Performance Management Standard 2019*

ARRs *Annual report requirements for Queensland Government agencies*