ANNUAL REPORT 2016–2017

Torres and Cape Hospital and Health Service

Queensland Government

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Attribution: Content from this annual report should be attributed as the Torres and Cape Hospital and Health Service annual report 2016-2017.

Letter of compliance

6 September 2017

The Honourable Cameron Dick MP
Minister for Health and Minister for Ambulance Services
GPO Box 48
Brisbane Q 4001

Dear Minister

I am pleased to present the Annual Report 2016-2017 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 2009, and
- the detailed requirements set out in the Annual Report requirements for Queensland Government agencies.

A checklist outlining the annual reporting requirements is included at the end of this report.

Yours sincerely

Mr Robert (Bob) McCarthy AM
Chair, Torres and Cape Hospital and Health Board

Acknowledgement

Acknowledgement to Traditional Owners and Custodians

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 and the Kulkalgal Nations.

The Torres and Cape HHS is committed to the Closing the Gap Initiative targets:

- to close the gap in life expectancy within a generation (by 2031); and
- to halve the gap in mortality rates for Aborginal and Torres Strait Islander children under five by 2018.

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Welcome

Introduction from the Board Chair

Bob McCarthy AM
Board Chair

Welcome to the Torres and Cape Hospital and Health Service (HHS) Annual Report which provides a comprehensive record of the HHS's financial and non-financial performance for the period of July 2016 to June 2017.

Our business directions and service delivery contributes to the achievement of the Queensland Government's objectives from *The Queensland Plan – Queenslanders' 30 year vision,* particularly in the areas of: delivering quality frontline services; building safe, caring and connected communities and creating jobs and a diverse economy.

We are also aligned with Queensland Health's 10 year strategy, *My health, Queensland's future: Advancing health 2026 (Advancing Health 2026)* with the vision that by 2026, Queenslanders will be among the healthiest people in the world. This vision is supported by five principles of sustainability, compassion, inclusion, excellence and empowerment. In line with this, our *Torres and Cape HHS Strategic Plan 2015-2019 (2016 update)* provides directions to achieve improvements in the health of people in the communities of Torres Strait, Northern Peninsula Area and Cape York through quality care, strengthening our workforce and a well governed organisation.

The steady increase in our operating budget since the formation of our health service in 2014 is a recognition by the State Government of the challenges of delivering health services in a remote and diverse region such as ours. I would like to thank the State Government and Health and Ambulance Services Minister Cameron Dick for his continued recognition and understanding of the unique circumstances of our health service.

This recognition extends to the need to maintain and progressively upgrade our health facilities so they remain fit for purpose in our harsh and demanding climate. With nearly one thousand full, part-time and casual employees, the Torres and Cape HHS is one of the largest single employers in the entire region, whether public or private. There are the flow-on effects resulting from our employment numbers and the expenditure of our health service budget.

The Board is committed to improving the way we engage with the community and our stakeholders. We are committed to meeting and engaging with stakeholders and staff in our communities and in 2016-17 the Board visited Thursday Island, Mer Island, Cooktown, Wujal Wujal, Laura, Coen, Kowanyama, Pormpuraaw, Weipa and Napranum.

We have had a very stable Board membership since 2014 and I am pleased that our most recent members, Dr Scott Davis and Cr Karen Price, were reappointed for a three year term. Thank you to our Board for their ongoing commitment to the region. They each bring a varied and in-depth knowledge of the communities we serve.

Thank you to all of our staff, our Executive and Chief Executive for the excellent work they do to improve the health of Torres and Cape communities.

Mr Robert (Bob) McCarthy AM
Chair, Torres and Cape Hospital and Health Board

Welcome

Chief Executive's Report

Michel Lok
Health Service Chief Executive

I am pleased to present my report of the Health Service's operations for 2016-17. The year builds on our continuing focus on patient-centred care, driving safety, building partnerships and improving the health of our communities.

During 2016-17 we delivered 221,062 health care occasions of service, which included 4,026 visiting specialists' consultations and 1,332 telehealth consultations. There were 23,634 presentations to our Accident and Emergency Departments, the frontline of our hospitals, of which 93 per cent were seen within the recommended timeframes; 748 surgical procedures were performed; 13,902 beds were occupied over the year; 143 babies were born within the health service and 11,682 oral health consultations were also provided.

As outlined elsewhere in this year's annual report, we have achieved strong improvements in health care performance and quality. Our health care staff have worked with patients to maintain high levels of childhood immunisation, reduce elective surgery and specialist outpatient waits and reduce potentially preventable hospitalisations.

The health service has continued to focus on quality and safety, successfully completing a standards review process in the northern sector in September 2016, made plans to accredit our general practices, and prepare the organisation for a full accreditation survey in September 2017.

I am grateful to our clinicians and support staff for their tireless efforts to maintain the highest standards of service to our communities. We employ almost a thousand staff and it was pleasing to have been able to achieve a full permanent medical workforce and increase health worker and nursing positions over the year.

Establishing our first five nurse navigators has already paid dividends with reductions in specialist wait lists, improved attendances at appointments and reductions in patient transport costs. Our navigators made sure Coen women received their biennial breast screens after the cancellation of service visits earlier in the year and are now working on plans for Pormpuraaw and Kowanyama women.

Another big achievement was the successful completion of all backlog maintenance works across the region, with more than $24 million being invested over the past four years to improve our facilities and staff accommodation.

Our Regional Health Partnership with Apunipima Cape York Health Council, the Northern Queensland Primary Health Network and the Royal Flying Doctor Service has continued to strengthen with increased collaboration to improve community health planning, enable sharing of patient records and undertake joint workforce orientation and training.

Our financial results for the year were solid. The health service spent $205.1 million leaving a small surplus from operations for reinvestment in infrastructure and trialling of new service models. Looking ahead, we have a modest increase in funding for 2017-18 which will enable us to create five more nurse navigators, expand renal and allied health services in the southern region and clear our endoscopy wait lists.

I wish to express my thanks to Mr Terry Mehan who acted as Chief Executive prior to my arrival in September 2016, and welcome the new members of my executive team - Executive General Managers Ms Beverley Hamerton and Ms Kim Veiwasenavanua and our new Principal Advisor Aboriginal and Torres Strait Islander Health Dr Sean Taylor.

Michel Lok
Health Service Chief Executive

Strategic direction

Vision, mission and purpose

Torres and Cape HHS's Strategic Plan 2015-2019 (2016 update) outlines our Board's vision and strategic objectives. The TCHHS objectives align with the Queensland Governments' objectives through the delivery of quality frontline services, supporting disadvantaged Queenslanders, strengthening safe systems of care, creating local employment and responding to our culturally diverse communities.

Our vision

Healthy people and communities in the Torres Strait, Northern Peninsula Area and across Cape York. To achieve our vision Torres and Cape HHS will:

- respect Aboriginal and Torres Strait Islander peoples and cultures
- work in partnership with communities and other organisations
- provide high quality, innovative and effective remote health services.

Our mission

To provide high quality, safe and culturally appropriate health care that delivers measurable improvements in the health of people and communities in Torres Strait, Northern Peninsula Area and across Cape York.

Our purpose

To improve the health and wellbeing of people in the Torres Strait, Northern Peninsula Area and Cape York areas by partnering with communities.

Our objectives

The service objectives defined within the strategic plan are:

Care is person centred:

Consistently deliver safe, patient centred, culturally appropriate, responsive and innovative health care in partnership with Torres Strait, Northern Peninsula Area and Cape York communities.

Care is supported through partnerships:

Grow partner relationships to enable integrated health service delivery.

An engaged, valued and competent workforce:

Maintain and develop a capable and competent workforce to meet current and future requirements.

A well governed organisation:

Deliver safe and accountable services through efficient, effective, responsible and innovative use of resources.

Progress towards achieving these objectives is managed using the principles of The Queensland Government Performance Management Framework. This includes developing strategic and operational plans, and publishing service results in the Service Delivery Statement and the Annual Report.

Underpinned by the legislative frameworks, the Torres and Cape HHS Service Agreement forms the primary vehicle through which the HHS performance is measured, reviewed and reported against defined performance indicators and targets to ensure outputs and outcomes are achieved.

Our values

Torres and Cape HHS promotes adherence to the Queensland Health Public Sector Values of

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

Key performance indicators

Key performance indicators are used to monitor the extent to which the HHS is delivering the objectives set out in the Service Agreement cover key aspects of HHS performance across four areas (domains) of health service delivery:

- Effectiveness – safety and quality
- Equity and effectiveness – access
- Efficiency – efficiency and financial performance
- Effectiveness – patient experience.

The HHS also has responsibilities under national and whole of government plans and contributes to national Key Performance Indicators.

Strategic direction

Strategic risks and challenges

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

Unacceptable health and life expectancy gap for Indigenous residents driving higher demand for health services

The population of Torres and Cape HHS region is estimated to be approximately 26,365 and projected to increase to 28,094 by 2026. Sixty four per cent of the population in the region identify as Aboriginal or Torres Strait Islander, with most Indigenous residents living within discrete Aboriginal communities throughout Torres and Cape HHS. The majority of residents reside in the most disadvantaged quintile highlighting the relative social disadvantage of the region. This is reflected in health disparities such as poor life expectancy and high levels of chronic disease.

Residents have a high level of disease burden with significant demand for primary and allied health services

Housing pressures, limited social services, a lack of training opportunities and fewer jobs in our communities means we need to engage better with communities and other partners to better address the economic and social determinants of health.

Operating in an isolated remote environment with extreme weather events requires significant planning and resources

Torres and Cape HHS delivers health services to a widely distributed population across 130,000 square kilometres including communities on 18 Torres Strait Islands. Access to, and delivery of, services is difficult and expensive, particularly as road access to some of the smaller communities is largely impossible during the three-month wet season. There are significant distances between communities and health services sites and to the major referral hospital in Cairns. Almost every area serviced by the HHS is classified as 'very remote' with poor accessibility for goods, services and social interaction.

Attracting, retaining and supporting a skilled and culturally-diverse workforce

Torres and Cape HHS recognises the challenge of attracting qualified local Indigenous staff. At present 16.37 per cent of our staff identify as Aboriginal and/or Torres Strait Islander.

Opportunities

Torres and Cape HHS is committed to making a difference to the health and wellbeing of people living in the region by:

- involving local communities in planning, designing and delivering health care.
- strengthening primary health care programs to eliminate preventable disease, promote healthy lifestyles and support self-management of chronic conditions.
- building cultural capability through the employment of local Indigenous people in our communities.

Role & functions

Role, main functions and operating environment

Torres and Cape HHS was established on 1 July 2014 as a statutory body, enacted under the Hospital and Health Boards Act 2011 (the Act) which sets out the functions and powers of the HHS and the relationship with the Department of Health.

The role of the Board

Torres and Cape HHS is the principal provider of health services in the region and is overseen by a Hospital and Health Board (the Board) reporting to the Minister for Health and Minister for Ambulance Services and accountable to the Torres and Cape community. The Board is responsible for providing strategic direction and leadership, and ensuring compliance with standards and legal requirements. Obligations are also imposed on the Board by the broader policy and administrative framework they operate within. The Board is accountable for local performance, delivering local priorities and meeting national standards.

Geographic profile

Torres and Cape HHS covers an area of more than 130,000 square kilometres. The HHS is responsible for the health services of 26,365 people widely spread across Cape York, the Northern Peninsula Area and the Torres Strait Islands.

Indigenous status of residents

Sixty four per cent of the population in the region identify as Aboriginal and/or Torres Strait Islander. The HHS is one of Australia's largest providers of health services to Aboriginal and Torres Strait Islander peoples.

Funding arrangements and service agreement

Torres and Cape HHS is a major provider of staff and infrastructure for health service delivery throughout Torres and Cape, and shares funding responsibility with the Queensland Department of Health, and with the Commonwealth Government which directly funds a range of initiatives. A Service Agreement between Torres and Cape HHS and the Department identifies the services to be provided, the funding arrangements for those services, and the defined performance indicators and targets to ensure the outputs and outcomes are achieved.

The role of the Health Service Chief Executive

The Torres and Cape Health Service Chief Executive (HSCE) is responsible for the operations of the HHS. The Executive Management Team, led by the HSCE, is accountable to the Board for making and implementing decisions about the HHS business within the strategic framework set by the Board.

Legal and statutory obligations

Torres and Cape HHS is:

- subject to the *Financial Accountability Act 2009* and the *Statutory Bodies Financial Arrangements Act 1982*
- a unit of public administration under the *Crime and Misconduct Act 2001*
- a body corporate representing the State and with the privileges and immunities of the State
- a legal entity that can sue and be sued in its corporate name.

Details of the HHS obligations are detailed within the:

- Service Agreement with the Department of Health
- Common Industrial Framework
- Directives issued by the Minister
- Health Service Directives issued by the Director-General
- Applicable whole of government policies.

The HSCE reports regularly to the Board and develops advice and recommendations on key strategic issues and risks for their consideration.

Facilities & services

Facilities

Health services across Queensland are provided under a tiered model as supported by the Clinical Service Capability Framework for Public and Licensed Private Health Facilities.

Thursday Island Hospital is a Level 4 facility providing moderate-risk inpatient and ambulatory care clinical services. Weipa Integrated Health Service (IHS) and Cooktown Multi-Purpose Health Service (MPHS) are Level 3 facilities providing low to moderate-risk inpatient and ambulatory care. Bamaga Hospital provides low risk inpatient and ambulatory clinical care services. Torres and Cape HHS residents access highly complex care at Townsville or Brisbane; while the majority of all but the most highly complex patients and procedures are managed at Cairns Hospital.

The HHS comprises 31 primary health care centres, two hospitals (Thursday Island and Bamaga), a multi-purpose health service (Cooktown) and an integrated health service (Weipa).

The regional office is located in Cairns hosting the health service'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 and Thursday Island.

Services

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

The HHS supports a wide range of healthcare providers including outreach teams and visiting specialist services from other health services and non-government providers such as Apunipima Cape York Health Council and the Royal Flying Doctor Service.

Partnerships

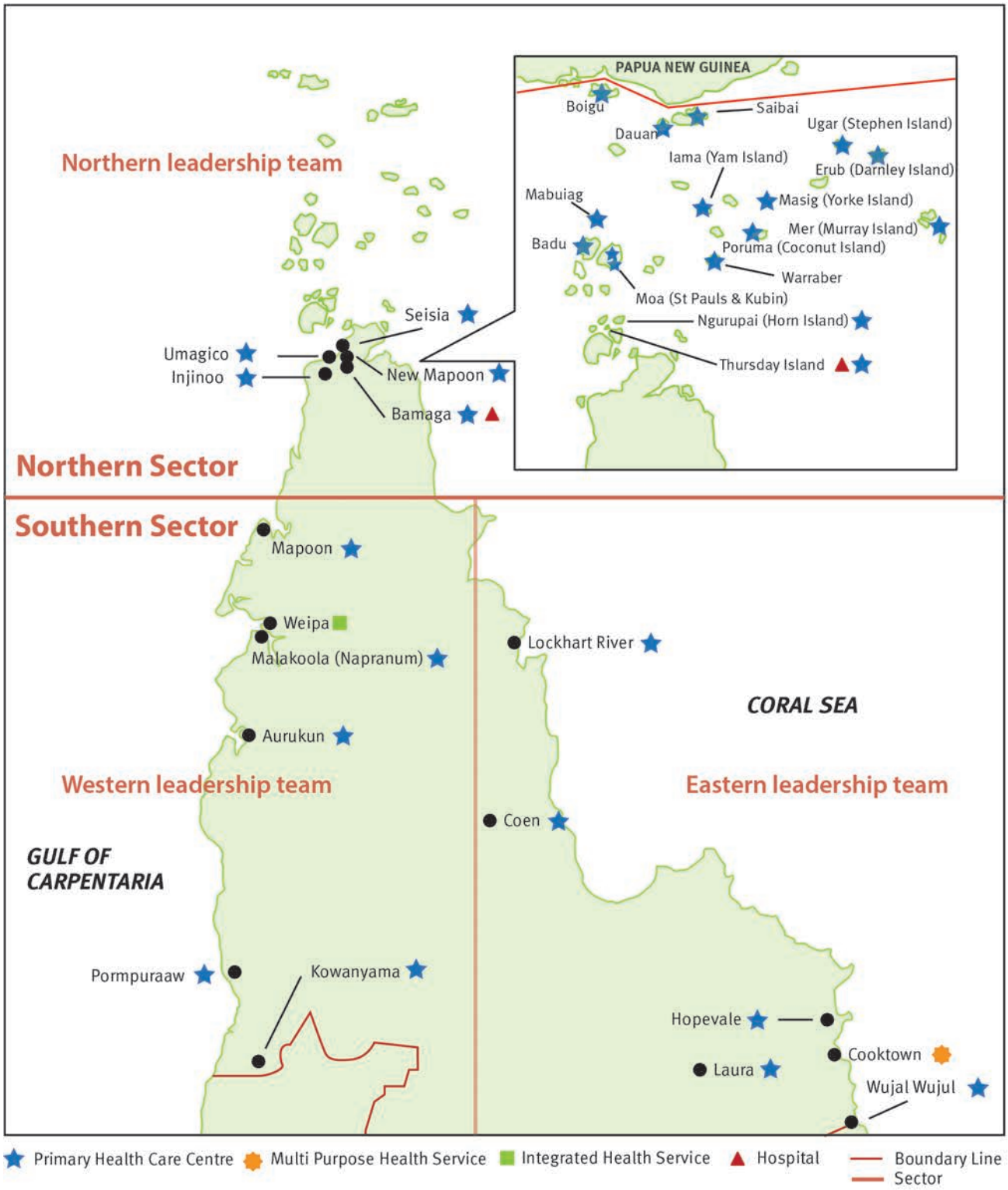
Torres and Cape HHS maintain agreements and close working partnerships with local health care organisations:

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

Integral to the success of Torres and Cape HHS initiatives is the health service partners' commitment to working together to improve health outcomes. As part of the standing service agreements, Torres and Cape HHS and its key partners agree to promote cooperation between providers in planning and delivery of health services to Torres and Cape communities to collaborate wherever possible and practical on matters of common concern and interest including joint clinician engagement.

Torres and Cape HHS works in collaboration with other relevant agencies and service providers such as Mookai Rosie Bi-Bayan, a community controlled Indigenous family health centre, and visiting specialists including paediatricians, ophthalmologists, renal specialists and surgeons who use the HHS facilities and typically travel from Cairns.

Map of facilities



Torres and Cape Hospital and Health Service

Figure 1: Map of Torres and Cape Hospital and Health Service Facilities

Plans & priorities

Some of the Torres and Cape HHS plans and priorities for the 2017-2018 financial year are listed below.

Investment in our facilities

The Torres and Cape HHS has some $69 million of capital works programs approved or in progress to restore the condition of health facilities, expand clinical space and remediate compliance risks.

This investment includes $36 million for the redevelopment of the Thursday Island Hospital; $10 million to refurbish five clinics in the Torres Strait (Coconut, Masig, Duan, Stephen Islands and St Pauls on Moa Island); $6.6 million for clinic and staff housing upgrades in Aurukun; and $7 million for new and improved infrastructure with a new primary health care centre on Mer (Murray Island).

Boost allied health

The Health Service will boost physiotherapy and occupational health services to six Cape York communities with the creation of a new allied health position.

Making Tracks programs

Torres and Cape HHS will invest $1.8 million to deliver initiatives under the *Making Tracks towards closing the gap in health outcomes for Indigenous Queenslanders by 2033 – Investment Strategy 2015-18*.

Sexually Transmissible Infections activities

The Health Service will continue to implement the *North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan 2016-2021* with $1.57 million of funding.

Investment in renal services

In 2017-18 the Health Service will establish a new renal nurse position in Kowanyama to enhance care for patients with kidney disease and reduce or delay the need for dialysis treatment.

Following local consultation with Council, the health service will establish a community peritoneal dialysis chair in the Kowanyama clinic providing an alternative to Kowanyama patients who home dialyse to arrange their treatment and seek assistance from clinic staff if required. Modifications to the internal layout of the clinic are currently being scoped and works are planned to be commence in the latter half of 2017.

Aged Care

The Commonwealth Government has announced a total funding package of $708,882 for the provision of additional aged care places at Weipa and Bamaga. This will enable the Weipa services to expand and will allow a brand new aged care service for the Northern Peninsula Area (based in Bamaga).

Transition to community control

The Health Service will progress implementation of the Transition Action Plan with Apunipima Cape York Health Council to transition primary health care services to Aboriginal community control. Continue transition of primary health services to community control in up to four more communities and strengthen collaboration in other communities.

Nurse navigators

Torres and Cape HHS will engage a further five nurse navigators at a cost of $1.93 million to support the Government's commitment to rebuild the nursing workforce and improve patient care.

Integrated Care Innovation Fund Dental Telehealth Project

Work has commenced on a $1.43 million project to enhance the management of dental services in the outer islands of the Torres Strait. The project will empower the existing workforce in remote island facilities and use telehealth technology to assist the diagnosis, triage and management of patients. It will involve training and supporting staff in island primary health care centres (PHCCs) to help diagnose oral health issues via the use of an intra-oral camera. The technology will allow PHCC staff to liaise with oral health teams on Thursday Island via telehealth to effectively assess and provide a shared diagnosis. This will enable effective triage and case management planning.

The project plans to reduce the number of unnecessary hospitalisations due to oral health treatment delays. Training will be provided as part of the Indigenous Health Worker Certificate IV oral health care component. The project will also review referral process, consider PHCC workloads and involve training in the use of the technology. The project is funded by the Queensland Government Integrated Care Innovation Fund.

Plans & priorities

Whole of government plans, initiatives and accreditation

Other whole-of-government plans and specific initiatives

The Torres and Cape HHS has responsibilities under national and whole of government plans, including:

- the *National Health Reform Agreement (2011)*
- the *National Health Reform Agreement (2012)*
- the *National Indigenous Reform Agreement*.

Torres and Cape HHS also has responsibilities in accordance with the National Safety and Quality Health Service (NSQHS) Standards in alignment with the National Performance and Accountability Framework with national Key Performance Indicators. These are designed to measure local health system performance and to drive improved performance.

Other National and Statewide plans informing service directions include:

- the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*
- the *National Disability Strategy 2010-20*
- *Making Tracks Towards Closing the Gap in Health Outcomes for Indigenous Queenslanders by 2033*.

Service areas, service standards and other measures

During the reporting period the HHS measured its performance against its Closing the Gap targets and other health-related performance indicators and initiatives included in the following Council of Australian Governments (COAG) Agreements, signed by the Queensland Government:

- the *National Indigenous Reform Agreement*
- the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes*
- the *National Partnership Agreement for Indigenous Early Childhood Development*.

Queensland Government priorities

My health, Queensland's future: *Advancing health 2026 (Advancing health 2026)* articulates a 10-year vision and strategy for Queensland's health system. These principles and directions are reflected in the *Torres and Cape HHS Strategic Plan 2015-2019 (2016 update)*.

The principles

Five principles underpin the vision, directions and strategic agenda:

- Sustainability
- Compassion
- Inclusion
- Excellence
- Empowerment

The directions

- Promoting wellbeing
- Delivering healthcare
- Connecting healthcare
- Pursuing innovation

Accreditation

The HHS is accredited under the National Safety and Quality Health Service (NSQHS) Standards developed by the Australian Commission on Safety and Quality in Health Care.

General practices operated by the HHS are externally accredited in accordance with the current edition of the Royal Australian College of General Practitioners published accreditation standards (version 4). Mental health services maintain accreditation against the NSQHS Standards and the National Standards for Mental Health Services.

Medical imaging services are accredited by NATA against the Diagnostic Imaging Accreditation Scheme and the NSQHS.

Since July 2015 the Home and Community Care Program (HACC) program has been known as the Commonwealth Home Support Program (CHSP) and the Queensland Community Care Program (QCCP). Torres and Cape HHS Community Care Programs are accredited by the Australian Aged Care Quality Agency against the Home Care Common Standards V14.0.

Stakeholder engagement

Stakeholder engagement at the governance, executive and operational levels occurs in a wide range of forums and with a large number of organisations and people, including:

- Local Members of Federal and State Governments
- Local Government Councils
- Universities
- Industry groups
- Non-government service providers including Mookai Rosie Bi-Bayan and Wuchopperen Health Service
- Traditional owners
- Community Advisory Networks - Cooktown MPHS and Weipa IHS
- Health Action Teams
- Members of the public
- Torres and Cape HHS clinicians and workforce.

The *Torres and Cape HHS Communication and Engagement Strategies for Consumers and Community, and for Clinicians and the Workforce* deliver guiding principles for consultation and participation in decision making processes to ensure all stakeholders have the opportunity to participate and ensure their views and ideas are considered in relation to provision of health services. The development and publishing of these strategies are statutory obligations under sections 40 to 43 of the Act.

In April 2017 the Torres and Cape HHS Board endorsed a *Consumer and Community Engagement Strategy* with a focus on clarifying engagement responsibilities, nurturing the development of local engagement and establishing processes to provide two-way feedback about issues raised. Responsibility for developing the implementation plan and supporting capability development will be led by the Principal Advisor, Aboriginal and Torres Strait Health.

A baseline survey was completed in May 2017 to assess the baseline of local current engagement (community health groups, Councils, other agencies, consumers and information sharing). The baseline was undertaken to improve understanding of current action and enable improvements to be measured over time. The survey found that Health Action Teams and Health Action Groups operate irregularly in most communities and efforts will be made to re-establish these groups.

The survey found that Community Health Groups are active and effective in six of the region's communities. Two communities have regular group meetings but they are not effective and 10 communities have groups established that are not meeting. Fifteen communities have no Community Health Group.

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

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

These consultative groups allow the health service to report back to the community on ongoing infrastructure projects, health service provision and human resources, amongst other issues.

A number of recommendations to improve engagement will be implemented following the results of the baseline survey.

Year in review

Better access to specialist care

Aaliyah Gibson (9) and Anthea McGreen, Wujal Wujal. Aallyah received ENT surgery as part of an specialist care initiative.

Torres and Cape residents have improved access to specialist care as a result of initiatives taken by the health service.

ENT services

A collaboration with CheckUp has seen 34 children from the Cape receive ear surgery by surgeon Dr Suki Ahluwalia from Coral Sea Ear Nose and Throat (ENT) (16 in September, 11 in March and 7 in May), restoring hearing for these children and enabling them to develop their potential. In September 2016 and March 2017, the HHS fast-tracked ENT surgery for a total of 28 Cape York children in partnership with CheckUp and Dr Ahluwalia. Children came from Hope Vale, Wujal Wujal and Aurukun. Many of the children had been on waiting lists for more than a year; and children as young as three years benefited from the surgery.

Telehealth for cardiovascular health

A collaboration has been developed with Cairns and Hinterland HHS to establish a telehealth stress test program to improve cardiovascular health screening for our residents.

Endoscopy services on Thursday Island

The health service has employed a surgical rural generalist to undertake procedures and endoscopy services on Thursday Island.

Ophthalmological services

The health service continues to work with doctors to provide eye care to Cape York through regular visiting ophthalmological and optometry services.

All medical positions filled

In April 2017 all 35 medical positions were permanently filled for the first time in the HHS delivering more general practice services in the region. The successful recruitment to all medical positions was a significant achievement for a small, rural health service.

Pictured in Bamaga: Front row (from left) Gisela Dean (Clinical Nurse Consultant), Karyn Sam (Program Manager), NPA Regional Council Councillor Cassandra Adidi and Elizabeth Bond (Practice Manager). Back row: NPA Regional Council Deputy Mayor Michael Bond, Dr Zachary Connelly, Dr Mark Adsett, Dr Alan Furniss (Thursday Island Hospital Medial Superintendent) and Dr Peter Christensen.

Improved community-based care

- Reduced inpatient demand in regional hospitals through improved community based healthcare.
- Potentially preventable hospitalisation rates fell from 19.8 per cent to 17.5 per cent (and from 24.5 per cent to 21.3 per cent for Indigenous patients).
- Reductions in separations were reported for PPH dental and diabetes related conditions.

High immunisation rates

In October 2016, The Minister for Health and Ambulance Services commended Torres and Cape HHS for attaining the highest immunisation rates for Indigenous and non-Indigenous children under two years in Queensland with 96 per cent vaccinated.

In addition 97 per cent of Indigenous children aged under five years in the region are fully vaccinated.

This is a result of excellent collaborative efforts with Apunipima Cape York Health Council and Royal Flying Doctor Service.

Year in review

Nurse navigator successes

Nurse navigator client and partners on Thursday Island.

Nurse navigators coordinated breast screens for 17 Coen women.

The nurse navigators are supporting staff in remote communities and in our hospital hubs to increase patient attendance for travel and appointments, increase telehealth appointments, decrease wait lists, facilitate complex care and coordinate retrieval of patients.

Nurse navigators collaborated with BreastScreen Queensland to fly 17 women from the remote community of Coen to Cairns to receive their two yearly mammography scans. Similar arrangements are being planned for women in other Cape York communities. Five new nurse navigators commenced with the HHS in December 2016 and another five will be recruited in 2017. This program is supported by $1.9 million in funding.

Diabetes trial

The TCHHS Board allocated $500,000 towards a 12-month diabetes trial for Thursday Island funded from retained earnings. Thursday Island is the largest single group of diabetics in the HHS with 409 people with diabetes. Ten percent of the total HHS population have diabetes. The trial will include establishing a diabetes centre, expanding the diabetes clinic hours, and creating four new staffing positions with the aim to improve community-based diabetes management and education programs at Thursday Island initially with a view to further rolling them out across the HHS.

Renal dialysis

Thursday Island Hospital's renal dialysis unit expanded from six to nine chairs due to $1.25 million of funding from the State Government. The funding allowed for the purchase and installation of additional equipment, as well as an increase in staff.

The Thursday Island unit is now dialysing nine patients three times a week and has the capacity to offer short-term dialysis to patients from elsewhere who might be visiting Thursday Island for a short holiday or to visit family and friends.

The Regional eHealth Project

Regional eHealth staff and clinic staff at Napranum Primary Health Care Centre.

The Regional eHealth Project (ReHP) is a joint initiative between the Cairns and Hinterland HHS and Torres and Cape HHS.

The Regional eHealth Project has used Queensland Health's approved Co-Design Procurement Methodology and has commenced the Implementation Planning Study.

This solution will support patient focused, integrated care and comprehensive healthcare services delivered as close to the patient's home as possible.

The project aims to deliver an electronic health record system that is designed to meet the local needs of healthcare providers across the region.

The scope of the Regional eHealth Project currently covers 58 Queensland Health sites across Cairns and Hinterland HHS and Torres and Cape HHS (Cairns Hospital is out-of-scope).

It is intended that this information is shared with partnering healthcare providers from public, private and not-for-profit healthcare providers.

Year in review

Regional Health Partnership

The Regional Health Partnership meeting in Cairns.

Torres and Cape HHS is driving the Regional Health Partnership (RHP) with our partners Apunipima Cape York Health Council, Royal Flying Doctor Service and North Queensland Primary Healthcare Network. The RHP is an initiative to improve coordinated health service delivery in Cape York. In a significant milestone Apunipima clinicians can now access Torres and Cape HHS training programs at no cost. The RHP commenced a significant mapping exercise in 2017 to identify and outline the clinical services being provided in Cape York communities. This work will help inform better coordination of services between the partners.

Transition to community control

In December 2016 the health service and Apunipima Cape York Health Council concluded an action plan to transition primary health care responsibilities in Cape York to community control. This follows almost a decade of collaboration and planning to achieve transition.

The two health organisations have developed an integrated care model to create a single service that shares resources and focuses on the best possible care for the patient. The model will enable improved patient medical record sharing to overcome safety risks that arise when patient information is fragmented.

The first implementation site in Aurukun will commence transition in late 2017 following work with both local teams and the community to develop the integrated model.

Sexually transmissible infections plan

The health team at the Kowanyama community screen.

Torres and Cape HHS is hosting the Sexually Transmissible Infections Action Plan Project Officer for North Queensland. The Project Officer is supporting five HHSs to address the syphilis outbreak which is disproportionately affecting Indigenous people in north Queensland. The Action Plan is funded for $15.8 million.

Men's and women's health staff have been working closely with clinicians and our partners across the region to improve testing rates for sexually transmitted infections (STIs) and blood-borne viruses (BBV) in 15-29 year olds. Community screens are also done in collaboration with primary health care clinic staff; Tropical Public Health Service; the Men's, Women's and Sexual Health Program; Apunipima Cape York Health Council; My Pathway; community-based peer recruiters; and local councils.

Torres and Cape HHS teams held very successful community screens in Hope Vale, Kowanyama and Napranum in 2017. The model for the screens involves health promotion officers working with local peer recruiters who encouraged young people to attend and be screened. There is usually about three months of preparatory work. In early 2017, 70 per cent of people aged 15 to 29 years were screened in Hope Vale for STIs and BBV; in Kowanyama 75 per cent of the target age group were screened; and in Napranum 102 people of all ages were screened.

In addition, opportunistic testing has been very successful and in May 2017 Primary Health Care Centres in the Southern Sector tested 95 per cent of people with chlamydia and gonorrhoea for HIV and syphilis.

Closing the Gap

Closing the Gap refers to reducing the gap in health inequalities that exist between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander Australians. Under the National Indigenous Reform Agreement the Council of Australian Governments (COAG) committed to achieving six targets for closing the gap in health, education and employment outcomes.

The two health-specific targets are:

- to close the gap in Aboriginal and Torres Strait Islander life expectancy within a generation (by 2033); and
- to halve the gap in mortality rates for Aboriginal and Torres Strait Islander children under five within a decade (2018).

Reporting HHS performance against the National key performance indicators did not occur during 2016-17, due to changes made to reporting requirements nationally. Reporting will be completed during July 2017 to report activity for 2016-17.

In line with the Australian Government's COAG reform initiative starting with key areas of chronic disease and maternal and child health, Queensland Health has implemented Closing the Gap indicators to monitor HHS progress against the expected trajectories to achieve Closing the Gap targets with the most recent results for Torres and Cape HHS being developed.

The service performed well on the following Closing the Gap indicators:

Proportion of women who attended five or more antenatal visits

Our health service achieved the highest level of performance in Queensland (*Closing the Gap Performance Report 2016)* with 96 per cent of Torres and Cape Indigenous women attending five or more antenatal visits in 2015-2016.

Proportion of low birthweight babies

Resident babies born during 2015-16 had a healthy weight range with only 5.5 per cent of babies being of low birthweight which is the second best HHS result in Queensland.

Immunisation

Immunisation is highly effective in reducing morbidity and mortality. In 2016-17 the health service achieved excellent levels of immunisation for Indigenous children and met or exceeded statewide targets with 97.9 per cent of the region's Aboriginal and Torres Strait Islander children under five years of age fully immunised.

The health service continues to experience challenges associated with the following Closing the Gap indicators:

Median age of death

The median age of death for Indigenous residents as reported in 2016 (*The health of Queenslanders 2016*) was 24 years less than the median age of death for Queenslanders as a whole.

Discharge against medical advice

In 2016-17 1.3 per cent of all our region's Aboriginal and Torres Strait Islander resident hospitalisations resulted in discharge against medical advice. This is an increase of 0.4% over the previous financial year.

Proportion of women who smoked in pregnancy

In 2015-16, 51.1 per cent of our region's Aboriginal and Torres Strait Islander mothers smoked compared to 11.6 per cent of non-Indigenous Queensland resident mothers.

Age standardised potentially preventable hospitalisations

In 2015-16 Indigenous residents were 2.8 times more likely than non-Indigenous residents to be hospitalised for a potentially preventable condition.

New programs funded for Aboriginal and Torres Strait Islander residents

In 2016-2017 Torres and Cape HHS was funded under the Making Tracks Investment Strategy 2015-2018 and the North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan 2016-2021 administered by the Aboriginal and Torres Strait Islander Health Branch.

Closing the Gap

Programs funded under the State Government's Making Tracks program and Commonwealth programs for 2016-2017 attracted $9,092,382 and are listed in the table below.

Table 1: Making Tracks and Commonwealth-funded programs

Project name	Funding 2016-2017
Torres Strait Hostel – Meriba Mudh	$226,375
Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010- 2033—Torres Strait	$110,000
Northern Peninsula Area Maternal and Infant Service	$207,754
Queensland Health Aboriginal and Torres Strait Sexual Health Men's Program	$112,851
Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010-2033—Cape York	$110,000
Improving Sexual Health - Supporting Syphilis Outbreaks in Remote Indigenous Communities	$864,685
Queensland Health Aboriginal and Torres Strait Islander Outreach Maternal Health Service	$429,922
Queensland Health Aboriginal and Torres Strait Islander Women's Health Program	$85,874
Project Support for regional oversight of the implementation of the North Queensland Aboriginal and Torres Strait Islander Sexually Transmissible Infections Action Plan 2016-2021	$87,670
Enhanced Sexual Health Services in Torres Strait and Northern Peninsula Area	$425,916
Child and Youth Mental Health Service Aurukun	$524,142
HIV/AIDS Outreach Program	$569,089
Population/Child Protection	$559,238
Making Tracks Multidisciplinary Team	$3,574,780
Women's Cancer Program	$34,452
Commonwealth Home Support Program	$734,989
Queensland Community Care Program	$204,269
District Palliative Care (Southern)	$45,542
Healthy Aging Loans Equipment	$35,453
Indigenous Health Services	$149,381
Total	**$9,092,382**

Clinical support unit

The Rural and Remote Clinical Support Unit (RRCSU) is hosted by Torres and Cape Hospital and Health Service on behalf of the four designated Rural and Remote Hospital and Health Services (RRHHSs); Torres and Cape, North West, Central West and South West Hospital and Health Services.

In partnership with the RRHHSs and other stakeholders, RRCSU delivers high quality evidence based products and services to support the rural and remote workforce to achieve the RRHHS's strategic objectives.

Launch of the Primary Clinical Care Manual 9th edition

The Primary Clinical Care Manual (PCCM) 9th edition was launched by Dr John Wakefield, Deputy Director General, Clinical Excellence Division, Queensland Health in March 2017.

The manual was developed in partnership with the Royal Flying Doctor Service (RFDS) and endorsed by State-wide Clinical Networks, for use by Queensland Health, RFDS, Queensland Ambulance Service (QAS), Australian Defence Force (ADF), Health Victoria, and other health jurisdictions within Australia.

The PCCM 9th edition has been well accessed with 1,900 manuals distributed and 5,800 new user hits recorded.

Distribution of the Chronic Conditions Manual (CCM) 1st Edition

The CCM 1st edition continues to be well accessed with 1,317 manuals distributed and 13,000 new user hits recorded.

Publication of the Rural and Remote Emergency Services Standardisation (RRESS) Guidelines

In June 2017, the initial RRESS guidelines, developed in partnership with RFDS, QAS, the Australasian College for Emergency Medicine, the Australian College of Rural and Remote Medicine and the Emergency Care Institute of New South Wales were launched. The guidelines are designed for use by clinicians working in rural and remote emergency care settings.

Launch of Primary Clinical Care Manual 9th edition in March 2017

Five new PARROT courses and increased learner numbers

During the year partnerships with the Rural and Remote Educators Network and Maternity and Neonatal Clinical Network saw the development and release of five new maternity care courses, updated PCCM course and the commencement of a medication safety course.

The new courses together with enhanced promotion resulted in a 52.5 per cent increase in learners completing Pathways to Access Rural and Remote Orientation and Training (PARROT) courses.

Credentialing, Medical Employment and Medical Advisory Services

During the year, RRCSU provided a range of services including:

- Processing of 903 scopes of clinical practice
- Development and publishing of Scope of Clinical Practice Supervision and Guidelines, Credentialing Committee Members Guidelines and Credentialing Book of Knowledge
- Collaboration on Queensland Health's Locum Medical Officers and recruiting medical officers through locum agencies Standing Offer Agreement
- Collaboration with Finance Branch to obtain a $94,572 reimbursement from the Long Service Leave Central Scheme to RRHHSs budgets.

Promotion of the unit

RRCSU staff attended three national and international rural health conferences. Outcomes included increased awareness and access of RRSCU's products and services; new partnerships and strong interest from Medical Officers on employment within the RRHHSs.

Financial summary

Torres and Cape Hospital and Health Service achieved a strong financial outcome for the year ending 30 June 2017 recording a $5.97 million surplus. This represents an 2.8 per cent variance against its revenue base of $211.1 million.

The end of year result consists of $4.9m in incentives received from the Department of Health for the successful completion of the Backlog Remediation Maintenance Program, $0.4 million of one-off gains from asset revaluation write-ons and $0.66 million of one-off gains in service delivery. Excluding these items, it shows that the underlying financial result for Torres and Cape HHS remains challenging in a constrained funding environment.

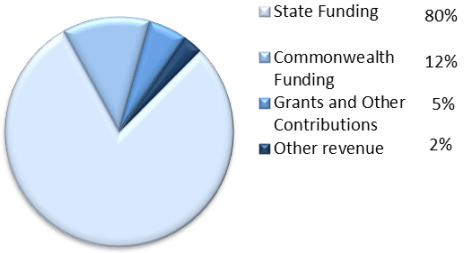
However, the result was positive given the additional investment in facility infrastructure, the improvement in own source revenue generation during the year and the re-investment of prior year surpluses in health worker education, enhancing chronic disease management and additional staff accommodation for Saibai Island.

During 2016-2017, the Health Service met its obligation to ensure all of its services are provided as cost effectively as possible. As a fixed non-activity based funded organisation it requires us to continually monitor performance, manage costs and actively explore own source revenue initiatives.

Where the funds came from

Torres and Cape HHS income from combined fund sources was $211.1 million. Funding was primarily derived from non-activity based funding from the Department of Health of $193.9 million. Other funding sources included other revenue $5.9 million, and grants and contributions $11.3 million primarily from Australian Government contributions for Indigenous health programs, rural and remote medical benefits scheme and Section 100 pharmaceutical scheme.

Figure 2: Income by funding source

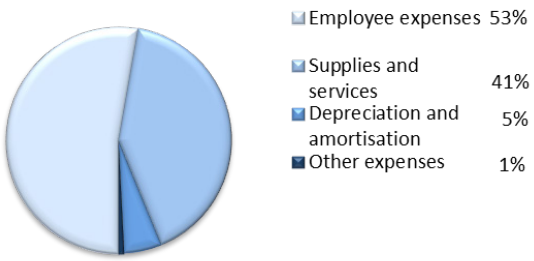


Where funding was spent

Total expenses for Torres and Cape HHS for 2016-2017 was $205.1 million, averaging a $0.56 million per day spend on serving the communities in our jurisdiction.

The largest expense was against labour costs that include clinicians and support staff was $108.2 million. Supplies and services represent the second highest expense at $84.2 million which includes maintenance expense of $14.8 million, patient and retrieval costs of $15.5 million, operating leases of $10.6 million, clinical supplies of $3.2 million and drug expense of $1.9 million.

Figure 3: Expenditure breakdown



Financial position

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

The net value of the HHSs assets increased during 2016-17 by $10.5 million.

Future outlook

The surplus generated for the Torres and Cape HHS in the current financial year will be reinvested for better health outcomes for the community. Generation of a surplus allows reinvestment into chronic disease initiatives, Thursday Island Hospital redevelopment, investments in staff housing, enhanced support for our front line staff in the regions, creation of regional traineeships and continued development of our health workers. This additional investment ensures Torres and Cape HHS is well placed to achieve its strategic objectives for the current year and outer years.

See Attachment 1 for Financial Statements 2016-17.

Performance indicators

State Key Performance Indicators

The HHS achieved solid performance against State KPIs providing above expected service activity levels (2.7 per cent above target at April 2017). Other performance achievements in 2016-17 include:

- 93 per cent of emergency patients seen within four hours against a target of greater than 80 per cent.
- Discharge against medical advice for non-Indigenous residents (0.6 per cent) was better than target performance (0.8 per cent), whilst for Indigenous residents (1.3 per cent); the result was slightly above target (1.0 per cent).
- Potentially preventable hospitalisations for Indigenous residents 17.5 per cent verses target of less than 20 per cent.

Other indicators

Torres and Cape HHS has identified other indicators requiring improvement including:

- Improving wait times for elective surgery for category type 1 and 2 patients
- Improving the rate of use of telehealth to achieve a growth of 20 per cent per annum
- Continuing to meet access to oral health services to meet the 100 per cent target for performance.

Achievements

Some of the key achievements from the Performance Statement table on the next page are:

- In 2016-17 all Torres and Cape residents waited less than two years for oral health services.
- Thursday Island Hospital increased the number of patients who received a surgical procedure in 2016-17 (544) by 13 per cent when compared with the prior year (479).
- Thursday Island Hospital recorded more births in 2016/17 (140) by 16 per cent when compared to prior year (121).
- Potentially preventable hospitalisations (PPH) 2016/17 Indigenous results 17.5 per cent verses target of <20 per cent, which demonstrated an improvement in 2015/16 of 20.4 per cent.

Performance statement

Weighted activity units

Table 2: Performance Statement (Weighted Activity Units)

Service Standards	2016-17 Target	2016-17 Actuals	2017-18 Target
Effectiveness measures			
Percentage of patients attending emergency departments seen within recommended timeframes[1]:			
· Category 1 (within 2 minutes)	100%	88%	100%
· Category 2 (within 10 minutes)	80%	89%	80%
· Category 3 (within 30 minutes)	75%	90%	75%
· Category 4 (within 60 minutes)	70%	91%	70%
· Category 5 (within 120 minutes)	70%	97%	70%
· All categories	n/a	93%	n/a
Median wait time for treatment in emergency departments (minutes)[2]	20	2	20
Percentage of elective surgery patients treated within clinically recommended times[3]:			
· Category 1 (30 days)	›98%	90%	›98%
· Category 2 (90 days)	›95%	86%	›95%
· Category 3 (365 days)	›95%	100%	›95%
Median wait time for elective surgery (days)[4]	25	15	25
Percentage of emergency department attendances who depart within 4 hours of their arrival in the department[5]	›80%	93%	›80%
Efficiency measures			
Other measures Number of elective surgery patients treated within clinically recommended times:			
· Category 1 (30 days)	New measure	46	31
· Category 2 (90 days)	New measure	49	40
· Category 3 (365 days)	New measure	153	169
Number of Telehealth outpatient occasions of service events[6]	New measure	1,332	1,380
Other measures			
Total weighted activity units[7,8]:			
Acute Inpatient	4,817	4,253	4,087
Outpatients	1,145	1,601	1,567
Sub-acute	432	467	463
Emergency Department	1,974	2,054	2,039
Mental Health	87	116	110
Prevention and Primary Care	677	894	867
Ambulatory mental health service contact duration (hours)[9]	›8,116	8,816	›8,116

Performance statement

Notes for Table 2 Performance Statement

1. The 2016-17 Estimated Actual figures are based on actual performance from 1 July 2016 to 30 June 2017.
2. This measure indicates the amount of time for which half of all people waited in the emergency department (for all categories), from the time of presentation to being seen by a nurse or doctor (whichever was first).
3. This is a measure of effectiveness that shows how hospitals perform in providing elective surgery services within the recommended timeframe for each urgency category.
4. This is a measure of effectiveness that reports on the number of days for which half of all patients wait before undergoing elective surgery.
5. This is a measure of access and timeliness of emergency department services.
6. This measure tracks the growth in occasions of service for Telehealth enabled outpatient services. These services support timely access to contemporary specialist services for patients from regional, rural and remote communities, supporting the reduction in wait times and costs associated with patient travel.
7. A WAU is a measure of activity and provides a common unit of comparison so that all activity can be measured consistently. Service agreements between the Department of Health and HHSs and other organisations specify the activity to be provided in WAUs by service type.
8. The 2016-17 Estimated Actual figures are based on 2016-17 Queensland WAU forecasts. 2017-18 Target/Estimate figures are based on the 2017-18 Final Round Service Agreements Contract Offers. All activity is reported in the same phase – Activity Based Funding (ABF) model Q19. 'Total WAUs– Interventions and procedures' has been reallocated to 'Total WAUs – Acute Inpatient Care' and 'Total WAUs – Outpatient Care' service standards. 'Total WAUs – Prevention and Primary Care' is comprised of BreastScreen and Dental WAUs. Total WAUS - Prevention and Primary Care' is a new measure for the Service Delivery Statement but it has been included in the HHS Service Agreements since 2016-17. Purchased Queensland WAUs in 2017-18 for Prevention and Primary Care are lower due to one off investments in Oral Health in 2016-17 and National Partnership Agreement funding not yet allocated. 2017-18 Target Queensland WAUs are lower than 2016-17 Estimated Actuals due to an over delivery in Non-ABF activity. Over delivery in Non-ABF activity has not been built into 2017-18 as these facilities are block-funded and activity levels vary year to year.
9. This measure counts the number of in-scope service contact hours attributable to each HHS, based on the national definition and calculation of service contacts and duration.

Governance

Torres and Cape Hospital and Health Board

Accountability for overall performance of the Service is vested in the Torres and Cape Hospital and Health Board comprising a Chair, Deputy Chair and seven other members. All members are appointed by the Governor in Council for specific terms and are accountable to Parliament through the local community and the Minister for Health and Minister for Ambulance Services. The Board operates within its Board Charter to ensure statutory compliance.

Mr Robert (Bob) McCarthy AM

Board Chair

(Appointed 1/7/2014) (Current term 1/7/2014 to 17/5/2018)

Mr McCarthy has more than 30 years' experience in high-level positions in the private sector, as well as Federal and Queensland governments. He has a wealth of experience as a member and chairman of a number of statutory boards and corporations. Mr McCarthy holds a Bachelor of Economics degree (honours) has been a Fellow of the Australian Institute of Management and a member of the Australian Institute of Company Directors.

Associate Professor Ruth Stewart

Deputy Chair since 12/12/2014

(Appointed 1/7/2014) (Current term 26/6/2015 to 17/5/2018)

Dr Stewart is Associate Professor of Rural Medicine and Director, Rural Clinical Training and Support at James Cook University. She was a previous member of the Cape York HHS board from 2012 to 2014. Dr Stewart has chaired the Cape York HHS's Safety and Quality Committee and served on the Audit and Risk Committee and brings extensive management and clinical experience to the Board.

Mr Gregory Edwards

Member

(Appointed 1/7/2014) (Current term 26/6/2015 to 17/5/2018)

Mr Edwards has established and developed a number of successful businesses - seafood processing, transport and marine engineering - in the Torres Strait Islands and Papua New Guinea since 1988. With a Company Director's qualification and career development courses at Harvard University, Mr Edwards brings extensive experience and highly developed business acumen to the role.

Ms Tracey Jia

Member

(Appointed 1/7/2014) (Current term 26/6/2015 to 17/5/2018)

Ms Jia is a previous member of the Cape York HHS Board from 2012 to 2014. She is well regarded for her work with the Department of Communities, Child Safety and Disability Services. In this role she has assisted people with a disability and their families in Weipa and the West Cape communities of Aurukun, Napranum and Mapoon.

Torres and Cape Hospital and Health Board (continued)

Cr Ted (Fraser) Nai
Member
(Appointed 1/7/2014) (Current term 26/6/2015 to 17/5/2018)

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

Mr Brian Woods
Member
(Appointed 19/1/2015) (Current term 19/1/2016 to 17/5/2019)

Mr Woods is a Cairns based accountant and auditor with long experience of working with business entities across the region. He provides consultancy services and advice to government departments including the Torres Strait Regional Authority and the Registrar of Indigenous Corporations as an examiner and special administrator. He brings extensive financial, business and management expertise to the Board.

Mr Horace Baira
Member
(Appointed 19/1/2015) (Current term 19/1/2015 to 17/5/2019)

Mr Baira is a board member for 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.

Cr Karen Price
Member
(Appointed 11/12/2015) (Current term 18/5/2017 to 17/5/2020)

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

Dr Scott Davis
Member
(Appointed 18/5/2016) (Current term 18/5/2017 to 17/5/2020)

Dr Davis is based in Cairns and has a strong interest in regional development and Indigenous health, working on issues which impact on rural and remote Indigenous communities. He has more than 20 years' experience as a senior leader within the health, education and research sectors and more than 15 years of board experience. He is currently the Director of Greater Northern Australia Regional Training Network and is a committee member of the Regional Development Australia's Far North Queensland and Torres Strait sector. He holds a doctorate from the University of Sydney in Indigenous Community Capacity (economic and social development).

Governance

Torres and Cape Hospital and Health Board performance

Members of the Board contribute a solid mix of skills, knowledge and experience, including primary health care, health management, clinical expertise, legal expertise, financial management and business experience. All members reside in and/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.

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.

Board meeting in Cooktown in April 2017.

The Board meets monthly and determines strategy, monitors performance and makes strategic decisions. During 2016-17 there were 10 Board meetings held using a mix of face to face, videoconferencing and teleconferencing, with an overall members' attendance rate of 90 per cent. The Board is committed to community engagement and to conducting Board meetings in various communities throughout the Torres and Cape Hospital and Health Service area.

Board decision-making is supported by Board briefing papers and presentations by senior managers to inform the Board members of current and forthcoming strategic, operational and performance issues including service delivery, safety and quality, finances, human resources and risk management.

The Board is committed to community engagement and to conducting Board meetings in various communities throughout the region.

Between Board meetings, the Board has delegated authority to the Chair to act on behalf of the Board in appropriate circumstances. There is continuing and extensive contact between the Chair and the Health Service Chief Executive to discuss major policy and operational matters, especially when these have, or are likely to have, strategic implications for the Board.

As part of its commitment to achieving best practice corporate governance, the Board has implemented a formal and transparent process for assessing and evaluating the performance of the Board, including individual members.

Governance

Torres and Cape Hospital and Health Board committees

To enable the Board to concentrate on substantial strategy and performance management matters, other supplementary Board work has been divested to four Board committees under the *Hospital and Health Boards Act 2011*, as shown in the table below:

Table 3: Committees that support the Board

Name of committee	Number of Board members	Number of external members	Role in supporting the Board	Number of meetings held in 2016-2017
Executive Committee	4		Monitoring the Health Service's overall performance and working with Service's Chief Executive in responding to critical emergent issues requiring urgent decision making	4
Safety and Quality Committee	6		Monitoring governance relating to safety and quality of health services	7
Finance and Performance Committee	4		Monitoring financial budgets and performance	9
Audit and Risk Committee	5	1	Monitoring internal controls, external audits and risk management	8

The Board has approved each Committee's specific Terms of Reference and Business Rules. The total out of pocket expenses paid to the Board Members during 2016-2017 was $1,650.14.

Governance

Audit and Risk Committee's statutory disclosures

The Board's Audit and Risk Committee comes within the ambit of an 'audit committee' under the Financial and Performance Management Standard 2009 and the information required to be disclosed is in the table below:

Table 4: Audit and Risk Committee

Name	Duration on committee	Role
Greg Edwards	01/07/2016 to 30/06/2017	Committee Chair
Assoc Prof Ruth Stewart	01/07/2016 to 30/06/2017	Committee member / Deputy Chair
Tracey Jia	01/07/2016 to 30/06/2017	Committee member
Brian Woods	01/07/2016 to 30/06/2017	Committee member
Ian Jessup	01/07/2016 to 30/06/2017	External non-Board member
Karen Price	01/07/2016 to 30/06/2017	Committee member

The Committee has observed the terms of its charter and had due regard to Queensland Treasury's Audit Committee Guidelines. The remuneration for each member is listed in Note 24 of the Financial Statements. The Audit and Risk Committee's role, functions and responsibilities are:

Risk Management

- Oversee the risk management framework in line with international best practices, making recommendations for improvements when identified.
- Oversee the effectiveness of risk management and practices including those relating to compliance and legal risk.
- Oversee insurance arrangements relating to the risk management framework.
- Liaise with management to ensure there is a common understanding of the key risks to the HHS. These risks will be clearly documented in the HHS's risk register which is regularly reviewed to ensure that it remains up-to-date.
- Examine and advise the Board on strategic and major risk exposures and review risk tolerance settings.
- Review the effectiveness of the system for monitoring the agency's compliance with relevant laws, regulations and government policies.
- Review the findings of any examinations by regulatory agencies, and any audit observations.

Governance

Audit and Risk Committee's statutory disclosures

Financial statements

- Review the appropriateness of the accounting policies used.
- Review the appropriateness of significant assumptions made by management in preparing the financial statements.
- Review the financial statements for compliance with prescribed accounting and other requirements.
- Review, with management and internal and external auditors, the results of the internal and external audits and any significant issues identified.
- Ensure that assurance with respect to the accuracy and completeness of the financial statements is given by management.
- Review and recommend to the Board for endorsement the annual certified financials for the Annual Report.

Internal control

- Review the adequacy of the internal control structure and systems, including information technology security and control.
- Review whether relevant internal control policies and procedures are in place and are effective, and the adequacy of compliance, including delegations.
- Assess TCHHS's complex or unusual transactions or series of transactions or any material deviation from TCHHS's budget.
- Consult with the Queensland Audit Office regarding proposed audit strategies.

Internal audit

- Review the Internal Audit Plan, its scope and progress and any significant changes.
- Review the adequacy of the budget and resources for the internal audit function.
- Review the internal audit strategic and annual plans and recommend any variations.
- Receive internal audit reports and monitor action taken by management.
- Review the level of management cooperation with internal audit and co-ordination with the external auditor.

External audit

- Consult with external audit on the function's proposed audit strategy, audit plan and audit fees for the year.
- Monitor the findings and recommendations of external audit, the response to them by management, and monitor progress in implementing corrective action.
- Review the extent of reliance placed by the external auditor on internal audit work in relation to the overall audit plan.

Related entities

Torres and Cape HHS has not formed or acquired any related entities.

Governance

Management and structure

The organisational structure of the Board, Health Service Chief Executive and Executive Leadership Team as at 30 June 2017 is illustrated in Figure 4 below.

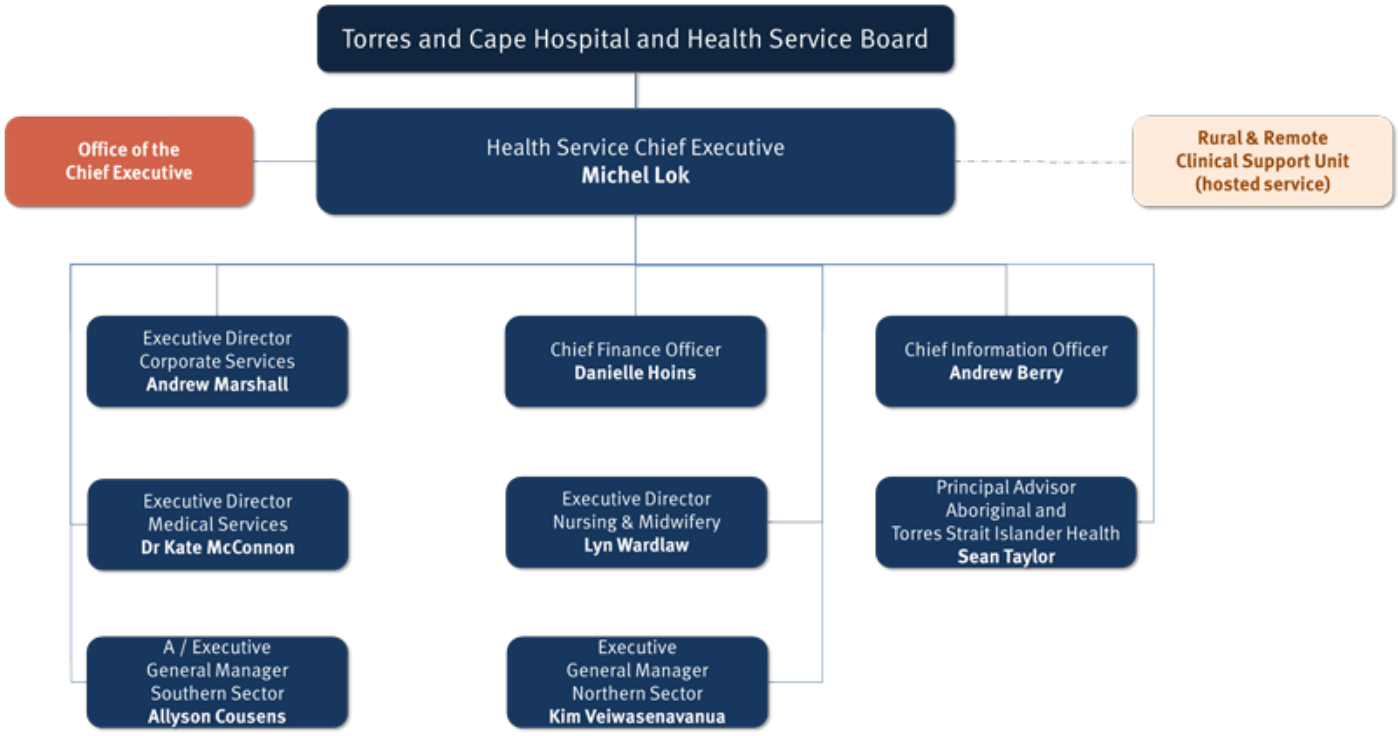


Figure 4: Torres and Cape HHS Managerial Structure as at 30 June 2017

Torres and Cape HHS's senior management group is the Executive Leadership Team comprising:

- Health Service Chief Executive (Chair)
- Chief Financial Officer
- Executive Director of Nursing and Midwifery
- Executive Director of Medical Services
- Executive Director of Corporate Services
- Executive General Manager (North)
- Executive General Manager (South)
- Principal Advisor Aboriginal and Torres Strait Islander Health

Governance

Executive Management Team and responsibilities

Michel Lok
Health Service
Chief Executive

The Chief Executive provides overall management of Torres and Cape HHS through major functional areas to ensure the delivery of key government objectives in improving the health and wellbeing of the Torres and Cape population.

Dr Kate McConnon
Executive Director
of Medical Services

The Executive Director of Medical Services oversees clinical governance to maintain and improve clinical service safety and quality. The role is accountable for delivery of HHS wide programs for oral health, public health and research governance. The role also provides professional leadership of medical staff and credentialing.

Lyn Wardlaw
Executive Director of
Nursing and Midwifery
Services

The Executive Director of Nursing and Midwifery Services provides strategic leadership and advice in the efficient and effective management of Torres and Cape HHS nursing and midwifery.

Andrew Marshall
Executive Director
Corporate Services

The Executive Director of Corporate Services provides strategic leadership and advice in the efficient and effective management of Torres and Cape HHS human resources and promoting learning development, and workplace safety.

Kim Veiwasenavanua
Executive General
Manager (North)

The Executive General Manager (North) provides strategic leadership, direction and day to day management of the northern sector (Torres Strait Island and Northern Peninsula Area facilities).

Allyson Cousens
Executive General
Manager (South)

The Executive General Manager (South) provides strategic leadership, direction and day to day management of the southern sector (Cape York facilities).

Danielle Hoins
Chief Finance
Officer

The Chief Finance Officer leads the finance function across the Torres and Cape HHS, formulating financial strategies, developing annual budgets, reporting HHS performance and designing policies to guide the efficient, effective and economic use of resources.

Governance

Executive Management Team and responsibilities (continued)

Andrew Berry
Chief Information Officer

The Chief Information Officer provides governance, guidance and support for information and communications technology investment, operation and usage at the Torres and Cape HHS.

Sean Taylor
Principal Advisor Aboriginal and Torres Strait Islander Health

The Principal Advisor role provides strategic advice on primary health initiatives, community engagement and community partnerships across both the Torres Strait and Cape York sectors of the health service.

Hospital and health management committees

The Board, Health Service Chief Executive and Executive Management Team are supported by the work of several management committees:

Clinical Quality and Safety Committee

This committee meets monthly and is co-chaired by the Executive Director of Medical Services and the Executive Director of Nursing and Midwifery Services. The membership comprises senior clinical staff and representatives from Apunipima Cape York Health Council and RFDS.

The Committee is responsible for the high level development, implementation, maintenance, review and ongoing improvement of patient safety and quality of care systems to ensure the effective, safe and efficient delivery of evidence based clinical services occurs by:

- identifying opportunities to achieve high quality clinical care, innovation and best practice in health outcomes
- identifying and minimising areas of preventable harm to patients
- providing overall strategic governance for safe, quality care in the areas of acute care, primary healthcare, health prevention and promotional activities.

People and Culture Governance Committee

This committee meets monthly, is chaired by the Executive Director of Corporate Services and membership is comprised of senior leaders from across Torres and Cape HHS disciplines.

The committee provides a strategic approach to ensuring a safe environment for staff, patients, other clients and visitors. Oversight of the workforce strategy, workplace health and safety and learning and development.

Finance and Resource Management Governance Committee

This committee meets monthly, is chaired by the Chief Financial Officer and members include the principal accountant and other executives. The purpose of this committee is to:

- review capital investment proposals and funding submissions
- assess and approve annual budgets
- advise Executive Management Team on financial performance
- monitor and assess financial risks
- monitor progress against audit action plans
- monitor compliance against, and effectiveness of, financial policy
- conduct strategic financial modelling.

Governance

Emergency Planning Committee

This committee meets monthly and is chaired by the Executive Director of Corporate Services. Membership is made up of representatives from Torres and Cape facilities across the region.

The Committee oversees the requirement for effective disaster and emergency incident management including regular review and assessment of plans, including mass gathering preparedness planning.

Infrastructure Governance Committee

This committee meets monthly and is chaired by the Executive General Manager (South) with members from senior infrastructure roles in the health service. The purpose of the committee is to:

- make recommendations to the Executive on its infrastructure and assets strategy and projects
- ensure alignment of the strategic asset management planning to State-wide plans, Department of Health Service Agreement, the Health Service's Strategic Plan and the Health Service Plan.

Executive Management Team

The Executive Management Team meets monthly and the chair is the Chief Executive. Members are the Executive Management Team. The purpose is to support the Board and the Chief Executive in meeting responsibilities outlined in the *Hospital and Health Boards Act 2011*, other relevant legislation and the Service Agreement. Other functions are to:

- support the Chief Executive to achieve the strategic direction, priorities, plans and objectives of Health Service
- develop, implement and embed robust governance, delegation, compliance, performance and risk management frameworks
- ensure systems and processes are in place to deliver the highest standards of safe, accessible, sustainable evidence based health care with a highly skilled and valued workforce that optimises the wellbeing of our community within the resources available.

Health Service Consultative Forum

These meetings occur each month and members are Executive Directors and representatives from the relevant unions. The purpose of the meetings are:

- to allow meaningful consultation and dialogue between the parties on an ongoing basis
- to ensure a better understanding of the key issues and developments within the organisation
- for members to work together to find solutions and resolve differences recognising that at times they may need to agree to disagree
- to coordinate and oversee the implementation of the certified agreements at a Health Service (or equivalent) level
- to consult on workplace reform and best practice activities within the Health Service.

Torres and Cape Hospital and Health Service Executive Management Team

Governance

Internal Audit function & Public Sector Ethics Act 1994

Internal Audit function

Torres and Cape HHS has engaged with an external consultant to undertake internal audit functions for the HHS.

Internal Audit's primary objective is to provide independent and objective assurance to the Torres and Cape HHS Board, via the Torres and Cape HHS 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 Health Service Chief Executive to accomplish their strategic and operational objectives by developing a systematic, disciplined approach to evaluate and improve the effectiveness of business risk management, control and governance processes. The approach taken to achieve these objectives are outlined in the three year audit plan.

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

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

Internal Audit reports are communicated directly to the Board's Audit and Risk Committee and administratively to the Health Service Chief Executive.

Public Sector Ethics Act 1994

Torres and Cape HHS is a prescribed public service agency under s.2 of the *Public Sector Ethics Regulation 2010*. Since its establishment on 1 July 2014, Torres and Cape HHS has been committed to implementing and maintaining the values and standards of conduct outlined in the 'Code of Conduct for the Queensland Public Service' under the *Public Sector Ethics Act 1994*.

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

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

In the development of the HHS *Strategic Plan 2015-2019 (2016 update)*, 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 HHS administrative procedures and management practices therefore have proper regard to the ethics principles and values, and the approved code of conduct.

Governance

Risk management and accountability

Risk management

The Torres and Cape HHS Integrated Risk Management Framework is structured to the AS/NZS ISO 31000:2009 Risk Management – Principles and Guidelines and is overseen by the Board Audit and Risk Committee. The Committee recognises that risks to health services are ever present and the task is to balance the level of risk the organisation is prepared to take to progress and improve the Health Service without compromising the safety and quality of patient services.

Over 2016-2017 Torres and Cape HHS became one of the first Health Services in Queensland to implement RiskMan, an improved risk management information system. The system was fully customised by Torres and Cape HHS to enable all staff to report issues that may present risks and to ensure senior staff is accountable for their management. The system was implemented on 18 April 2017 after an intensive period of staff training.

A single risk register captures the strategic and operational risks and is divided across the business functions:

- Clinical
- Workforce
- Infrastructure
- Information management
- Finance
- Planning and performance.

The Integrated Risk Management Framework and Risk Management Procedure has been subject to routine external financial and AS 4801 Occupational Health and Safety audits and found to be serving the organisation appropriately.

Significant risks that have been managed by the Board and Executive over the past year include:

- Improving the number of services and decreasing waiting times.
- Closure of the Lockhart River airport for one month. Patients continued to receive normal health services at Lockhart River Primary Health Care Centre and Cairns.
- Extended closure of the Cooktown operating theatre for repairs and maintenance- patients continued to receive surgical and birthing services.
- An HHS-wide review of the safety of medical gases installations following an incident in New South Wales. All systems tested and found to be in order.
- Water quality risk management and testing for legionella at each inpatient facility. Positive tests have been identified early and treated without patient or staff harm.
- Improving local clinical staffing at Dauan Island and Stephen Island.

Current significant issues under management:

- Addressing chronic disease and an ageing population.
- Clinical information management and information sharing– the HHS is moving toward a single electronic client record.
- Transition of primary health patient services at selected sites to Apunipima, a community controlled organisation.
- Improving central sterilising department AS4187 compliance at Thursday Island and Cooktown.
- Continued upgrades to facilities and accommodation.

Governance

Risk management and accountability

External scrutiny

For the 2016-17 financial year, Torres and Cape HHS was subject to the external audit by Queensland Audit Office. As the delegate of the Auditor-General of Queensland, Grant Thornton Australia Limited has issued an unqualified audit report for Torres and Cape HHS's financial statements for the 2015-16 year. There are no significant findings or issues identified by this external reviewer on the operations or performance of the HHS.

During 2016-2017 the Queensland Audit Office tabled a number of cross-service audits in Parliament relevant to the Torres and Cape HHS, including:

- Efficient and effective use of high value medical equipment
- Hospital and Health Services: 2015-16 results of financial audits
- Queensland public hospital operating theatre efficiency

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

Information systems and recordkeeping

Patients and clients of the Torres and Cape HHS can obtain access to records by applying under the Right to Information Act (Qld) 2009 and the Information Privacy Act (Qld) 2009. The HHS has information and processes in place to assist patients to gain access to their medical records.

Torres and Cape HHS creates, receives and keeps clinical and business records to support legal, community, and stakeholder requirements. Business and clinical records exist in physical and digital formats.

The HHS undertakes auditing of medical records to ensure compliance with recordkeeping standards and Health Sector (Clinical Records) Retention and Disposal Schedule, QDAN 683.

The HHS participates in a biannual record keeping self-assessment survey conducted by the Queensland State Archives. This includes an assessment of appropriate records storage, and security from unauthorised access, misuse and environmental threats.

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

- appointed a Chief Information Officer
- established an ICT governance committee
- established the Regional Health Partners group with information sharing identified as a key platform for improved health service delivery
- implemented a number of key information systems including:
  - the RiskMan application for governance and management of risks, incidents and feedback
  - electronic RTI processes
  - development of an information system to manage staff and patient travel
- selected a vendor for the Regional eHealth Project.

Further information technology improvements are planned for the organisation including:

- establishment of professional practice groups to ensure consistent policy and practice in the usage of information and information systems
- implementation of the Regional eHealth Project clinical information system
- implementation of Office365 and Sharepoint Online.

Through these initiatives the HHS aims to:

- improve access to information and collaboration across geographically remote facilities;
- improve corporate information management;
- streamline business through electronic forms, workflows and approvals;
- improve health outcomes and operational efficiency;
- ensure recordkeeping compliance with the *Public Records Act 2002*.

The Torres and Cape HHS did not disclose confidential information in the public interest during 2016-17 in accordance with s.160 of *the Hospital and Health Board Act 2011*.

Human resources

Workforce planning and performance

Torres and Cape HHS employs 909 full-time equivalent (FTE) employees and has a headcount of 996 staff across all classification streams to deliver its services across multiple sites. The number of full-time equivalent employees has increased by 46 FTE since 2015-2016 financial year.

In 2016-2017, the HHS had a retention rate of 71 per cent for permanent staff. These figures remain comparable with the previous two years.

A breakdown of this total is outlined in the following table:

Table 5: Staff Full-time Equivalent (FTE) at 30 June 2017

Type	Medical	Nursing	Health	Management & Clerical	Operational	Trades	Total
Permanent	26.8	218.5	46.7	175.6	195	7.0	669.3
Temporary	6.6	78.3	18.3	58.7	35.4	0	197.3
Casual	0	12.1	1.93	9.0	19.3	0	42.3

Torres and Cape HHS is committed 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 balance for all staff. Additional profile information includes:

- 11 per cent of the Torres and Cape HHS workforce is 60 years or older
- 16 per cent of the workforce identifies as Aboriginal and Torres Strait Islander
- 13 per cent of the workforce comes from a non-English speaking background.
- 13 per cent of the workforce is part time.

Recruitment initiatives

Recruiting and retaining highly qualified staff to meet current and future requirements in rural and regional areas is an ongoing challenge. In 2016-17 the recruitment team successfully delivered recruitment and selection training to 83 hiring managers. The team has been focused on:

- challenging the traditional approach to recruitment and selection
- increasing the availability of training including system support
- greater emphasis on the value of referee reports
- the importance of good candidate care
- improving and supporting onboarding processes.

Recruitment and Nursing Workforce Services have promoted nursing recruitment using the slogan ‘Not Just Nursing – Use all your Skills and More’ and attended the National Rural Health Conference to increase awareness of professional opportunities in the region, meet with non-traditional candidates and network with other organisations.

Employee Opinion Survey Action Group

An Employee Opinion Survey Action Group was formed in 2016 which helped achieve a 52 per cent response rate for the Working for Queensland Survey 2016. This was 29 per cent higher than that achieved in 2015. This strong response shows our workforce is keen to be engaged and involved in making ongoing improvements to their workplace.

There was an increase in the level of staff positivity surrounding the three strategic priorities between the 2015 and 2016 Working for Queensland survey results:

Human resources

- Agency engagement (pride and attachment to the organisation) – 14 per cent positive change since 2015
- Organisational leadership – 7 per cent positive change since 2015
- Innovation – 2 per cent positive change since 2015.

The results for the key drivers across the strategic priorities were:

Table 6: Torres and Cape HHS Working for Queensland Survey results comparing 2015 to 2016

Agency engagement (14 per cent increase in positive responses)	2016 per cent positive	2015 per cent positive	Organisational leadership (7per cent increase in positive responses)	2016 per cent positive	2015 per cent positive	Innovation (2 per cent increase in positive responses)	2016 per cent positive	2015 per cent positive
Organisational leadership	39 per cent	32per cent	Organisational fairness *	39 per cent	-	Learning and development	53 per cent	44 per cent
Organisational fairness*	39 per cent	-	Learning and development	53 per cent	44 per cent	My manager	62 per cent	57 per cent
Anti-discrimination	70 per cent	62per cent	Anti-discrimination	70 per cent	62 per cent	Organisational fairness *	39 per cent	-

* this factor has been altered between 2015 and 2016. It is therefore not trended over time.

It was also identified that employees had a strong understanding of what was expected in their role and how they contributed to the organisation's objectives. The proportion of employees who had noticed actions had been taken since the 2015 survey remained low at 13 per cent. This indicates the need for Torres and Cape HHS to ensure that action was taken from the 2016 survey results.

Areas requiring monitoring for future surveys were:

- Building opportunities for growth within all job roles.
- Ensuring continued work/life balance for staff through access to flexible working arrangements.

Areas to focus on and improve for future surveys were:

- Organisational fairness – ensuring there are fair, transparent and defensible processes.
- Inspiring, motivating, developing and empowering managers to build their capability and improve their engagement in the organisation.

From the survey results, the Employee Opinion Survey Action Group developed an Action Plan outlining the strategies to address the results.

Learning and Development

The Health Service invested strongly in capability development to maintain and develop our existing workforce to meet service delivery requirements. The Learning and Development team delivered the following activities in 2016-2017:

- Redesigned the orientation program to provide mandatory training requirements to new staff.
- Acquired permanent funding for a senior staffing position to continue to deliver the line manager training program.
- Piloted the public service commission leaders capability assessment and development (lcad) program for 11 staff as a precursor to a talent identification program.
- Developed a succession management intranet page and planning tool.
- Continued the Line Manager Training Program including delivery of:
  - 7 Habits of Highly Effective People leadership program to 43 staff
  - TCHHS Line Manager Workshop to 85 staff (51 per cent of line managers)
  - recruitment and selection training to 83 staff

Human resources

- Delivered several professional development programs such as:
  - Process Improvement training for clinical and non-clinical staff (13 staff)
  - Resilience training (20 staff)
  - Effective Feedback training (27 staff)
  - Communication training (23 staff)
  - Change Management training (24 staff)
  - Team Building training (38 staff)
- Facilitated several operational and strategic planning days.
- Assisted senior primary health care staff and the Health Worker Educator to support 53 staff and local residents enrolled in the Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care and Certificate IV in Aboriginal and Torres Strait Islander (Practice) in partnership with TAFE Queensland.
- Redeployed the training manager database from the Cairns and Hinterland HHS to the Torres and Cape HHS eHealth server.

Early retirement, redundancy and retrenchment

No redundancy, early retirement, or retrenchment packages were paid during the 2016-2017 financial year.

Occupational Health and Safety

The strategies for Occupational Health and Safety focus on enhancing health and safety capability across the organisation. The geographical, environmental and cultural challenges that are encountered by the HHS workforce will always have an impact on occupational health and safety activities. As a result the HHS must be innovative in the solutions which are implemented when working towards becoming a safety driven organisation.

The HHS Safety Management System is aligned with AS4801 and the organisation continues to work towards enhancing the implementation to improve the organisation's ability to embed safety into the everyday business and truly achieve a safety culture across the entire organisation.

The Occupational Health and Safety performance data up to 31 March 2017 is:

- Legislative Compliance Checklist – zero non-conformances.
- Three Provisional Improvement Notices received from Workplace Health and Safety Queensland.
- New Statutory Claims – 23 new claims, which is 22 claims below the industry average of 45. There were no notifications only, 10 claims were denied and 13 accepted.
- Average Paid Days per accepted WorkCover Claim – 54.00
- Average days to first return to work – 53.86 which is 36.88 above the industry average
- Average Monthly Payments per accepted WorkCover claim - $1,175
- Common Law Conversion Rate – 1.67 per cent
- New Common Law claims – 1

The 2016-17 Financial Year: 41 per cent decrease in the number of WorkCover Notifications on the previous financial year. This decrease is reflective of staff education and organisational growth, as we head towards the establishment of effective and efficient safety systems.

Torres and Cape HHS is above industry average in average days to first return to work and new common law claims. Analysis shows that contributing factors to this trend include: a change in WorkCover case manager during the financial year, reduced access to Allied Health Services for Torres and Cape HHS personnel, the requirement to wait for specialist appointments and low manager engagement in actively supporting return to work and injury management. These items are being addressed in the new financial year through:

- faster response to diagnosis and treatment by direct referral to private health services
- increased training and awareness programs focused on line management
- proactive engagement with the worker by both WorkCover and line management.

Abbreviations

Act	Hospital and Health Boards Act 2011
ARRs	Annual report requirements for Queensland Government agencies
ATODS	Alcohol, Tobacco and Other Drugs Service
BMRP	Backlog Maintenance Remediation Program
Board	Torres and Cape Hospital and Health Board
Cape	Cape York
COAG	Council of Australian Governments
Department	Department of Health
FAA	Financial Accountability Act 2009
FPMS	Financial and Performance Management Standard 2009
FTE	Full-time equivalent
Health Service	Torres and Cape Hospital and Health Service
HH	Hospital and Health
HHS	Hospital and Health Service
HSCE	Health Service Chief Executive
IHS	Integrated Health Service
KPI	Key Performance Indicator
MPHS	Multi-Purpose Health Service
NPA	Northern Peninsula Area
PPH	Potentially preventable hospitalisations
PHCC	Primary Health Care Centre
Service	Torres and Cape Hospital and Health Service
Torres	Region including the Torres Strait Islands and Northern Peninsula Area

Compliance checklist

Table 7: Compliance checklist

Summary of requirement		Basis for requirement	Annual report
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister	ARRs – section 7	p.2
Accessibility	Table of contents Glossary	ARRs – section 9.1	p.4,41
	Public availability	ARRs – section 9.2	p.1
	Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 9.4	p.1
	Copyright notice	*Copyright Act 1968* ARRs – section 9.4	p.1
	Information Licensing	*QGEA – Information Licensing* ARRs – section 9.5	p.1
General information	Introductory Information	ARRs – section 10.1	p.5,6
	Agency role and main functions	ARRs – section 10.2	p.9
	Operating environment	ARRs – section 10.3	p.10, 11
Non-financial performance	Government's objectives for the community	ARRs – section 11.1	p.5, 12
	Other whole-of-government plans/specific initiatives	ARRs – section 11.2	p.18-19
	Agency objectives and performance indicators	ARRs – section 11.3	p.7
	Agency service areas, and service standards	ARRs – section 11.4	p.22-24
Financial performance	Summary of financial performance	ARRs – section 12.1	p.21
Governance – management and structure	Organisational structure	ARRs – section 13.1	p.31
	Executive management	ARRs – section 13.2	p.31
	Government bodies (Statutory bodies and other entities)	ARRs – section 13.3	n/a
	Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* ARRs – section 13.4	p.35
	Queensland public service values	ARRs – section 13.5	p.7
Governance – risk management and accountability	Risk management	ARRs – section 14.1	p.36
	Audit committee	ARRs – section 14.2	p.29
	Internal audit	ARRs – section 14.3	p.35
	External scrutiny	ARRs – section 14.4	p.37
	Information systems and recordkeeping	ARRs – section 14.5	p.37
Governance – human resources	Workforce planning and performance	ARRs – section 15.1	p.38
	Early retirement, redundancy and retrenchment	Directive No.11/12 *Early Retirement, Redundancy and Retrenchment* ARRs – section 15.2	p.40

Compliance checklist

Table 7: Compliance checklist (continued)

Summary of requirement		Basis for requirement	Annual report
	Statement advising publication of information	ARRs – section 16	p.1
Open Data	Consultancies	ARRs – section 33.1	p.1
	Overseas travel	ARRs – section 33.2	p.1
	Queensland Language Services Policy	ARRs – section 33.3	p.1
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 & 50 ARRs – section 17.1	Attach. 1 (p.35)
	Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 17.2	Attach. 1 (p.36-39)

FAA *Financial Accountability Act 2009*
FPMS *Financial and Performance Management Standard 2009*
ARRs *Annual report requirements for Queensland Government agencies*

ATTACHMENT 1

Financial statements 30 June 2017

Torres and Cape Hospital and Health Service
ABN 99 754 543 771

Torres and Cape Hospital and Health Service

30 June 2017

Contents

Torres and Cape Hospital and Health Service
Statement of Comprehensive Income
For the year ended 30 June 2017

	Note	2017 Actual	2017 Original Budget	*Budget Variance	2016 Actual
Income		**$'000**	**$'000**	**$'000**	**$'000**
User charges and fees	2	196,845	189,304	7,541	185,313
Grants and other contributions	3	11,304	11,136	168	12,023
Other revenue	4	2,961	689	2,272	1,299
Interest		2	24	(22)	15
Total revenue		**211,112**	**201,153**	**9,959**	**198,650**
Expenses					
Employee expenses	5	14,206	9,200	5,006	10,185
Department of Health contract staff	6	94,061	108,952	(14,891)	90,682
Supplies and services	7	84,230	71,170	13,060	78,339
Depreciation	12	11,091	11,326	(235)	11,178
Impairment losses		(15)	3	(18)	(19)
Other expenses	8	1,572	502	1,070	2,531
Total expenses		**205,145**	**201,153**	**3,992**	**192,896**
Operating result for the year		**5,967**	**-**	**5,967**	**5,754**
Other comprehensive income					
Items that will not be reclassified subsequently to operating result					
Increase(decrease) in asset revaluation surplus		11,193			(1,323)
Total other comprehensive income		11,193			(1,323)
Total comprehensive income		**17,160**			**4,431**

**An explanation of major variances is included at Note 27*

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

Torres and Cape Hospital and Health Service
Statement of Financial Position
As at 30 June 2017

	Note	2017 Actual $'000	2017 Original Budget $'000	*Budget Variance $'000	2016 Actual $'000
Current assets					
Cash and cash equivalents	9	35,812	16,423	19,389	22,364
Trade and other receivables	10	6,108	2,897	3,211	7,173
Inventories	11	503	568	(65)	489
Other current assets		913	96	817	662
Total current assets		**43,336**	**19,984**	**23,352**	**30,688**
Non-current assets					
Property, plant and equipment	12	189,770	212,278	(22,508)	185,426
Total non-current assets		**189,770**	**212,278**	**(22,508)**	**185,426**
Total assets		**233,106**	**232,262**	**844**	**216,114**
Current liabilities					
Trade and other payables	13	18,818	9,204	9,614	12,994
Accrued employee benefits	14	978	1,804	(826)	705
Unearned revenue		1,553	1,426	127	1,180
Total current liabilities		**21,349**	**12,434**	**8,915**	**14,879**
Total liabilities		**21,349**	**12,434**	**8,915**	**14,879**
Net assets		**211,757**	**219,828**	**(8,071)**	**201,235**
Equity					
Contributed equity	15	186,690	184,090	2,600	193,328
Accumulated surplus		13,874	2,152	11,722	7,907
Asset revaluation surplus		11,193	33,586	(22,393)	-
Total equity		**211,757**	**219,828**	**(8,071)**	**201,235**

**An explanation of major variances is included at Note 27*

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

Torres and Cape Hospital and Health Service
Statement of Changes in Equity
For the year ended 30 June 2017

	Contributed equity $'000	Accumulated surplus $'000	Asset revaluation surplus $'000	Total equity $'000
Balance at 1 July 2015	**198,857**	**2,153**	**1,323**	**202,333**
Operating result for the year	-	5,754	-	5,754
Total other comprehensive income				
Increase/(decrease) in asset revaluation surplus	-	-	(1,323)	(1,323)
Total comprehensive income for the year	-	5,754	(1,323)	4,431
Transactions as owners				
Correction of prior year error - assets not previously recognised	1,445	-	-	1,445
Equity asset transfers during the year	1;540	-	-	1,540
Equity injections	2,664	-	-	2,664
Equity withdrawals	(11,178)	-	-	(11,178)
Balance as at 30 June 2016	**193,328**	**7,907**	**-**	**201,235**
Balance at 1 July 2016	193,328	7,907	-	201,235
Operating result for the year	-	5,967	-	5,967
Total other comprehensive income				
Increase in asset revaluation surplus	-	-	11,193	11,193
Total comprehensive income for the year	-	5,967	11,193	17,160
Transactions as owners				
Equity asset transfers during the year	286	-	-	286
Equity injections	4,167	-	-	4,167
Equity withdrawals	(11,091)	-	-	(11,091)
Balance as at 30 June 2017	**186,690**	**13,874**	**11,193**	**211,757**

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

Torres and Cape Hospital and Health Service
Statement of Cash Flows
For the year ended 30 June 2017

	Note	2017 Actual $'000	2017 Original Budget $'000	*Budget Variance $'000	2016 Actual $'000
Cash flows from operating activities					
Inflows:					
User charges and fees		186,792	189,140	(2,348)	168,905
Grants and other contributions		11,278	11,136	142	11,896
Interest received		2	24	(22)	15
GST collected from customers		2,337	3,903	(1,566)	1,357
GST input tax credits from ATO		4,718	-	4,718	5,203
Other		2,427	689	1,738	1,299
Outflows:					
Employee expenses		(12,324)	(8,604)	(3,720)	(10,103)
Department of Health contract staff		(95,147)	(108,643)	13,496	(93,642)
Supplies and services		(79,158)	(71,170)	(7,988)	(73,844)
Grants and subsidies		(201)	-	(201)	(1,351)
GST paid to suppliers		(5,356)	(3,905)	(1,451)	(5,558)
GST remitted to ATO		(2,190)	-	(2,190)	(1,411)
Other expenses		(1,205)	(500)	(705)	(1,229)
Net cash provided by/(used in) operating activities	22	**11,973**	**12,070**	**(97)**	**1,537**
Cash flows from/(used in) investing activities					
Payments for property, plant and equipment		(2,692)	(1,969)	(723)	(2,886)
Net cash from/(used in) investing activities		**(2,692)**	**(1,969)**	**(723)**	**(2,886)**
Cash flows from financing activities					
Proceeds from equity Injections		4,167	(9,357)	13,524	2,664
Net cash from/(used in) financing activities		**4,167**	**(9,357)**	**13,524**	**2,664**
Net increase/(decrease) in cash and cash equivalents		13,448	744	12,704	1,315
Cash and cash equivalents at the beginning of the financial year		22,364	15,679	6,685	21,049
Cash and cash equivalents at the end of the financial year	9	**35,812**	**16,423**	**19,389**	**22,364**

**An explanation of major variances is included at Note 27*

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

Note 1. Objectives and principal activities of the 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 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:

Level 6
William McCormack Building
5B Sheridan Street
Cairns QLD 4870

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.

(a) Statement of compliance

The financial statements:

- have been prepared in compliance with section 62(1) of the Financial Accountability Act 2009 and section 43 of the Financial and Performance Management Standard 2009;
- are general purpose financial statements prepared on a historical cost basis, except where stated otherwise;
- are presented in Australian dollars;
- have been rounded to the nearest $1,000 or, where the amount is $500 or less, to zero unless the disclosure of the full amount is specifically required;
- 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.
- present reclassified comparative information where required for consistency with the current year's presentation; and
- 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 2017, and other authoritative pronouncements.

(b) Issuance of financial statements

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

(c) Investment in North Queensland Primary Health Network Limited

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

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

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

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 sixth of the voting power of the NQPHNL and may be presumed to have significant influence (in accordance with AASB 128 *Investments in Associates and Joint Ventures*), the fact that each other member also has one sixth 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 NQPNHL 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.

Note 2. User charges and fees

	2017 $'000	2016 $'000
State Government block funding	67,520	61,474
System manager funding	126,376	121,648
Hospital fees	780	367
Multi-purpose nursing fees received	431	446
Inter-hospital and health service recoveries	349	236
Pharmaceutical benefits scheme reimbursement	84	112
Training fees	91	36
Other	1,104	895
Rental income	110	99
	196,845	185,313

TCHHS receives health service funding from DoH for specific public health services delivery by TCHHS as per a service agreement between DoH and TCHHS. The service agreement is reviewed periodically and updated for changes in activities and prices.

TCHHS is dependent upon the ongoing receipt of federal and state government funding to ensure the on-going continuity of its programs and delivery of specialised health services.

The funding from DoH is received fortnightly in advance. At the end of the financial year, an adjustment may be required where the level of services provided is above or below the agreed level.

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

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

Note 3. Grants and other contributions

	2017 $'000	2016 $'000
Australian Government – home and community care grants	821	926
Rural and remote medical benefits	3,182	2,669
Pharmaceutical benefits scheme section 100 arrangement	2,084	2,263
Rural health outreach fund	974	949
Commonwealth indigenous health programs	3,650	4,062
Queensland Government - home and community care grants	-	280
Other grants	567	747
Donations	26	127
	11,304	12,023

Grants, contributions, donations and gifts that are non-reciprocal in nature are recognised as revenue in the year in which TCHHS obtains control over them. Contributed assets are recognised at their fair value. Contributions of services are recognised only when a fair value can be determined reliably and the services would be purchased if they had not been donated. Where this is the case, an equal amount of revenue and expense is recognised.

Note 4. Other revenue

	2017 $'000	2016 $'000
Contract staff and recoveries	2,116	873
Asset revaluation increment	376	-
Asset adjustments (changes of inventory)	125	-
Other	344	426
	2,961	1,299

Contract staff recoveries
There are arrangements where TCHHS staff are placed with external organisations, for which fees are charged by TCHHS to recover staffing and other costs related to the arrangements. Revenue recognition for other revenue is based on either invoicing for related goods, services and/or the recognition of accrued revenue based on estimated volumes of goods or services delivered.

Note 5. Employee expenses

	2017 $'000	2016 $'000
Wages and salaries	11,193	8,659
Annual leave levy	724	535
Employer superannuation contributions	859	615
Long service leave levy	251	178
Sick leave	105	67
Other employee related expenses	1,074	131
	14,206	10,185

Note 5. Employee expenses (continued)

The number of directly engaged full-time employees as at 30 June 2017 is 35 (2016: 33).

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 remumeration disclosures are declared in Note 24.

TCHHS pays premiums to Workcover Queensland in respect of its obligations for employee compensation. These costs are reimbursed on an annual basis by DoH to TCHHS.

Note 6. Department of Health contract staff

TCHHS through service arrangements with DoH has engaged 874 (2016: 830) full time equivalent roles in a contracting capacity as at 30 June 2017. These personnel remain employees of DoH.

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.

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

Note 7. Supplies and services

	2017 $'000	2016 $'000
Building services	2,235	2,221
Catering and domestic supplies	730	1,034
Clinical supplies and services	3,217	3,122
Communications	1,728	1,744
Computer services	1,671	1,823
Consultants and contractors	16,304	16,315
Drugs	1,912	2,285
Electricity and other energy	3,394	2,879
Expenses relating to minor works	5,020	689
Freight	801	1,014
Motor vehicles	268	245
Operating lease rentals	10,343	9,379
Other supplies and services	1,425	952
Other travel	5,536	5,632
Pathology, blood and related equipment	4,372	4,471
Patient transport	3,833	4,052
Patient travel	11,623	13,731
Repairs and maintenance	9,818	6,751
	84,230	78,339

Services purchased from Non-Government Organisations (NGO)
During the year $4.750m (2016: $4.655m) was expensed in relation to the agreement with Apunipima Cape York Health Council and Royal Flying Doctor Service for the provision of health services to public patients.

Note 7. Supplies and services (continued)

TCHHS receives outsourced services under specific contractual arrangements. TCHHS also receives corporate services support from DoH for no cost. Corporate services received include payroll services, finance transactional services (including accounts payable), banking services, administrative services and taxation services. As the fair value of these services is unable to be estimated reliably, no associated revenue and expense is recognised in the Statement of Comprehensive Income.

Operating leases are entered into as a means of acquiring access to office accommodation facilities, staff accommodation and motor vehicles. Lease terms range between 1 to 5 years. TCHHS has no option to purchase the leased item at the conclusion of the lease although the lease provides for a right of renewal at which time the lease terms are renegotiated. Operating lease rental expenses comprises the minimum lease payments payable under operating lease contracts.

Note 8. Other expenses

	2017 $'000	2016 $'000
Advertising	151	145
Audit fees - internal and external	304	367
Insurances other	62	56
Insurance premiums QGIF	532	445
Losses from the disposal of non-current assets	141	80
Special payments - ex gratia	4	14
Other legal costs	103	118
Asset revaluation decrement	-	376
Inventory stock adjustments	(94)	86
Other	369	844
	1,572	2,531

Remuneration of auditors
Total audit fees quoted by the Queensland Audit Office relating to the 2016-17 financial statements are $0.157m (2016: $0.160m).

Insurance
TCHHS insure with QGIF which is a Queensland Treasury self-insurance fund covering the State's insurable liabilities.

The Insurance Arrangements for Public Health Entities Health Service Directive (Directive number QH-HSD-011:2012) enables hospital and health services to be named insured parties under DoH's policy. For the 2016-17 policy year, the premium was allocated to each HHS according to the underlying risk of an individual insured party.

Property and general losses above a $10,000 threshold are insured through the Queensland Government Insurance Fund (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
Special payments include ex gratia expenditure and other expenditure that TCHHS is not contractually or legally obligated to make to other parties. In compliance with the Financial and Performance Management Standard 2009, TCHHS maintains a register setting out details of all special payments exceeding $5,000

During the year there were no ex gratia payments that exceeded $5,000.

Note 9. Cash and cash equivalents

	2017 $'000	2016 $'000
Cash on hand	1	1
Cash at bank	35,733	22,287
QTC cash funds	78	76
	35,812	22,364

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 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 2017 was $0.078m (2016: $0.076m) and the annual effective interest rate was 2.49% (2016: 2.85%).

Note 10. Trade and other receivables

	2017 $'000	2016 $'000
Trade receivables	705	763
Less: Allowance for impairment of receivables	(182)	(346)
	523	417
GST input tax credits receivable	634	630
GST payable	(93)	(40)
	541	590
Health service funding in arrears	5,044	6,162
Other	-	4
	5,044	6,166
	6,108	7,173

Trade receivables are recognised at their carrying value less any impairment. The recoverability of trade receivables is reviewed on an ongoing basis at an operating unit level.

Trade receivables are generally settled within 90 days.

Aged care and dental billing makes up the majority of aged receivables. Aged care billing has a 30 day turnaround for payment. Dental billing has a longer turnaround due to implementation of payment plans for clients with financial difficulties.

Impairment of receivables
At the end of each reporting period TCHHS assesses whether there is objective evidence that a financial asset is impaired. Objective evidence includes financial difficulties of the debtor, the class of debtor, changes in debtor credit ratings and current outstanding accounts over 90 days. The allowance for impairment reflects the assessment of the credit risk associated with receivables balances.

Any allowance for impairment is based on loss events. All known bad debts were written off when identified, and approved by the Health Service Chief Executive.

Note. 10 Trade and other receivables (continued)

Movements in the provision for impairment of receivables are as follows:	2017 $'000	2016 $'000
Balance at the start of the year	346	563
Receivables written off during the year as uncollectable	(243)	(198)
Increase/(decrease) in provision recognised	79	(19)
Balance at the end of the year	182	346

	Not overdue $'000	Less than 30 days $'000	31 - 60 days $'000	61 - 90 days $'000	More than 90 days $'000	Total $'000
Ageing of trade receivables 2016						
Receivables	-	302	11	13	437	763
Allowance for impairment	-	-	-	-	(346)	(346)
Carrying amount	-	302	11	13	91	417
Ageing of trade receivables 2017						
Receivables	-	543	8	5	149	705
Allowance for impairment	-	(44)	(5)	(3)	(130)	(182)
Carrying amount	-	499	3	2	19	523

Note 11. Inventories

Inventories consist mainly of pharmaceutical and medical supplies held for distribution in hospitals and are provided to patients at a subsidised rate. Inventories are measured at weighted average cost, adjusted for any loss in service potential.

Unless material (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 12. Propery, plant and equipment

Note 12a. Balances and reconciliation of carrying amounts

	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Carrying amount at 1 July 2015	9,496	172,662	9,061	1,051	192,270
Additions	-	-	708	2,248	2,956
Disposals	-	(44)	(35)	-	(79)
Revaluation decrements	-	(1,323)	-	-	(1,323)
Asset revaluation decrement	-	(376)	-	-	(376)
Asset not previously recognised	-	396	1,049	-	1,445
Transfers between classes	-	2,304	616	(2,920)	-
Transfers in/(out) from other Queensland Government	-	1,437	478	-	1,915
Transfers out	(110)	-	(86)	(8)	(204)
Depreciation expense	-	(9,328)	(1,850)	-	(11,178)
Carrying amount at 30 June 2016	**9,386**	**165,728**	**9,941**	**371**	**185,426**
As at 30 June 2016					
Gross value	9,386	281,352	21,738	371	312,847
Accumulated depreciation	-	(115,624)	(11,797)	-	(127,421)
Carrying amount at 30 June 2016	**9,386**	**165,728**	**9,941**	**371**	**185,426**
Carrying amount at 1 July 2016	9,386	165,728	9,941	371	185,426
Additions	-	1,126	1,492	979	3,597
Disposals	-	-	(115)	-	(115)
Asset revaluation increment	-	376	-	-	376
Revaluation increments	-	11,193	-	-	11,193
Asset not previously recognised		51	48	-	99
Transfers between classes	-	(2,544)	2,544	-	-
Transfers in/(out) from other Queensland Government	-	286	-	-	286
Depreciation expense	-	(8,914)	(2,177)	-	(11,091)
Carrying amount at 30 June 2017	**9,386**	**167,302**	**11,732**	**1,350**	**189,770**
At 30 June 2017					
Gross value	9,386	344,286	24,162	1,350	379,184
Accumulated depreciation	-	(176,984)	(12,430)	-	(189,414)
Carrying amount at 30 June 2017	**9,386**	**167,302**	**11,732**	**1,350**	**189,770**

Note 12 b. Accounting policies

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

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

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

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

For assets acquired at no cost or for nominal consideration from another Queensland Government entity (whether as a result of a machinery-of-Government change or other involuntary transfer), the acquisition cost is recognised as the gross carrying amount in the books of the transferor immediately prior to the transfer together with any accumulated depreciation. These assets are recognised at their fair value at the date of acquisition in accordance with AASB 116 *Property, Plant and Equipment.*

Assets under construction are recorded at cost until they are ready for use.

Subsequent measurement
Land and Buildings are measured at fair value and in accordance with AASB 116 *Property, Plant and Equipment*, AASB 13 *Fair Value Measurement* and Queensland Treasury's Non-Current Asset Policies for the Queensland Public Sector. In respect of these asset classes, the costs of items acquired during the financial year have been judged by management to be materially reflective of their fair value at the end of the reporting period.

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

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

Land parcels which are located in reserve areas and which cannot be bought or sold are recorded in the land assets for a nominal 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 as the Hospital and Health Service does not control the land element of these properties. The land element is recorded in the Government Land Register as improvements only.

Depreciation
Key judgement: The following depreciation methodologies are employed for each class of depreciable assets:

- Property, plant and equipment is depreciated on a straight-line basis over its estimated useful life to TCHHS.
- Land is not depreciated as it has an unlimited useful life.
- Capital works in progress are not depreciated until ready for use, when they are reclassified to the relevant classes within property, plant and equipment.

Note 12 b. Accounting policies (continued)
Any expenditure that increases the capacity or service potential of an asset; and major components purchased specifically for particular assets are capitalised and depreciated over the remaining useful life of the asset to which they relate.

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

Class	Depreciation rates used	Useful lives
Buildings	1.2% – 4%	25 – 83 years
Plant and equipment	4% – 20%	5 – 25 years

The useful lives could change significantly as a result of technical innovations or some other event. The depreciation charge will increase where the useful lives are less than previously estimated. Technically obsolete or non-strategic assets that have been abandoned or sold will be written off or written down.

Impairment
Key judgement and estimate: All non-current physical assets are assessed for indicators of impairment on an annual basis. If an indicator of possible impairment exists, TCHHS determines the asset's recoverable amount. Any amount by which the asset's carrying amount exceeds the recoverable amount is recorded as an impairment loss.

The asset's recoverable amount is determined as the higher of the asset's fair value less costs to sell and current replacement cost.

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

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

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

Revaluations using an independent professional valuer are undertaken in a rolling cycle 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 appraisal.

Assets not specifically appraised in the reporting period, are materially kept up-to-date via the application of relevant indices to previous valuations.

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.

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.

Note 12 b. Accounting policies (continued)

Assets under construction are not revalued until they are ready for use.

Note 12 c. Valuation methodology

Land
Land is measured at fair value using asset specific independent revaluations or indexation by the State Valuation Service within the Department of Natural Resources and Mines.

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 occur at least once every five years. In the off cycle years indexation is applied where there is no evidence of significant market fluctuations in land prices.

Land indices are based on actual market movements for the relevant locations and asset category and are applied to the fair value of land assets on hand. Indexation method on land was applied, however, due to immateriality, no change to the value of land occurred.

Buildings
In 2016-17 TCHHS engaged independent experts AECOM to undertake building revaluations in accordance with the fair value methodology.

For the year ended 2017, approximately 25% of buildings were revalued at fair value using current replacement cost methodology. A desktop valuation was performed for the remaining building assets to align the fair value assessment to the 2016-17 methodology. The effective date of the valuation was 30 June 2017.

Key judgement and estimate: 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 and staircases.

This method makes an adjustment to the replacement cost of the modern day equivalent building for any utility embodied in the modern substitute that is not present in the existing asset to give a gross replacement cost that is of comparable utility (the modern equivalent asset). The methodology makes further adjustment to total estimated life taking into consideration physical obsolescence impacting on the remaining useful life to arrive at the current replacement cost via straight line depreciation.

This method addresses each form of obsolescence referred to by AASB 13 as follows:

Physical deterioration – Where the condition of a building has declined significantly over the course of a year, the impact is on the estimate of total useful life and future maintenance costs rather than the benefits provided by the building during the year. If a component's current condition is better (or worse) than previously anticipated, its estimated total useful life is extended (reduced), resulting in a higher (lower) fair value.

Functional (technological) obsolescence – This form of obsolescence is captured either via the gross replacement cost (because the modern equivalent asset of comparable utility by definition excludes functional obsolescence) or through a decrease in the component's total useful life (if the component will be replaced early because it is functionally obsolete).

Economic (external) obsolescence – This method measures any permanent surplus capacity by basing the modern equivalent asset of comparable utility on the required service capacity rather than the service capacity of the existing asset. If an entity will replace a component earlier than anticipated because of economic obsolescence, it captures the resulting reduction in fair value by decreasing the component's estimated total useful life.

The building valuation for 2016-17 resulted in a net increment of $11.569 million to the carrying amount of buildings. The independent valuation resulted in a net increment of $3.757 million and the desktop valuation resulted in a net increment of $7.812 million.

Note 12 d. Fair value measurement

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, and include, but are not limited to, published sales data for land.

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.

The following tables detail TCHHS assets, measured or disclosed at fair value, using a three level hierarchy, based on the lowest level of input that is significant to the entire fair value measurement, being:

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

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

Level 3: Unobservable inputs for the assets.

2016	**Level 2 $'000**	**Level 3 $'000**	**Total $'000**
Assets			
Land	9,386	-	9,386
Buildings (health service sites)	-	165,728	165,728
Total assets	9,386	165,728	175,114
2017			
Assets			
Land	9,386	-	9,386
Buildings (health service sites)	-	167,302	167,302
Total assets	9,386	167,302	176,688

There were no transfers between levels during the financial year.

Note 13. Trade and other payables

	2017 $'000	**2016 $'000**
Trade and other payables - other	2,922	2,321
Department of Health contract staff	3,123	2,600
Accrued expenses - other	11,405	6,967
Department of Health payables and accrued expenses	1,368	1,106
	18,818	12,994

Note 13. Trade and other payables (continued)

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.

Note 14. Accrued employee benefits

The following relates to TCHHS directly engaged employees.

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

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

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

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

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

Superannuation
Employer superannuation contributions are paid to QSuper, the superannuation scheme for Queensland Government employees, 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 to QSuper.

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.

Note 15. Contributed equity

	2017 $'000	2016 $'000
Opening balance at beginning of year	193,328	198,857
Prior year correction		
Correction of prior year error - assets not previously recognised	-	1,445
Non-appropriated equity injections		
Minor capital funding	4,167	2,664
Non-appropriated equity withdrawals		
Non-cash depreciation funding returned to DoH as a contribution towards the DoH capital works program	(11,091)	(11,178)
Non-appropriated equity asset transfers		
Buildings	286	1,540
Balance at the end of the financial year	186,690	193,328

Equity transfer value total at 30 June 2017

Non-reciprocal transfers of assets and liabilities between wholly-owned Queensland State Public Sector entities are adjusted to contributed equity in accordance with Interpretation 1038 *Contributions by Owners Made to Wholly-Owned Public Sector Entities*. Appropriations for equity adjustments are similarly designated.

TCHHS receives funding from DoH to cover depreciation costs. However, as depreciation is a non-cash expenditure item, the Minister of Health has approved a withdrawal of equity by the State for the same amount, resulting in non-cash revenue and non-cash equity withdrawal. Depreciation expenses to the value of $11.091m (2016: $11.178m) were offset by non-cash adjustments through equity withdrawals. Refer to Note 12 *Property Plant and Equipment.*

Note 16. Financial instruments

A financial instrument is any contract that gives rise to both a financial asset of one entity and a financial liability or equity instrument of another entity. TCHHS holds financial instruments in the form of cash, receivables and payables.

Recognition
Financial assets and financial liabilities are recognised in the Statement of Financial Position when TCHHS becomes party to the contractual provisions of the financial instrument.

Classification
Financial instruments are classified and measured as follows;
- Cash and cash equivalents - held at fair value through profit or loss
- Receivables - held at amortised cost
- Payables - held at amortised cost

TCHHS does not enter into transactions for speculative purposes, nor for hedging.
TCHHS has the following categories of financial assets and financial liabilities:

	2017 $'000	2016 $'000
Financial assets		
Cash and cash equivalents	35,812	22,364
Trade and other receivables	6,108	7,173
Total financial assets	41,920	29,537
Financial liabilities		
Trade and other payables	18,818	12,994

Note 16. 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.

The allowance for impairment reflects the occurrence of loss events. If no loss events have arisen in respect of a particular debtor, or group of debtors, no allowance for impairment is made in respect of that debtor / group of debtors. If TCHHS determines that an amount owing by such a debtor does become uncollectable (after deploying appropriate debt recovery actions), that amount is recognised as a bad debt expense and written-off directly against receivables.

The carrying amount of trade receivables represents the maximum exposure to credit risk. 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.

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

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

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

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

Note 17. Contingent liabilities

Litigation in progress
As at 30 June 2017 there were no cases filed in the courts naming the State of Queensland acting through TCHHS as defendant.

As of 30 June 2017 there were four open 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 17. Contingent liabilities (continued)

There are currently five (5) claims underway with Workcover. 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 Queensland Government Native Title Work Procedures were designed to ensure that native title issues are considered in all of TCHHS's land and natural resource management activities. All dealings pertaining to land held by or on behalf of TCHHS must take native title into account before proceeding. These dealings include disposal, acquisition, development, redevelopment, clearing, fencing and the granting of leases, licences or permits and so on. Dealings may proceed on TCHHS's owned land where native title continues to exist, provided native title holders or claimants receive the necessary procedural rights.

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 Deed of Grant in Trust land 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 Deed of Grant in Trust (DOGIT) land, which is Aboriginal or Torres Strait Islander community land 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).

Native title has been cleared over ten sites on Thursday Island and two sites on Horn Island, with DoH holding the land in freehold tenure. In addition, DoH, as trustee, holds tenure over eight reserves on Thursday Island and one reserve on Prince of Wales Island in the Torres Strait. The land and reserves are recorded at fair value in TCHHS's Statement of Financial Position.

Also, TCHHS administers eight reserves located within DOGIT land (seven reserves in the Northern Peninsula Area and one in the Torres Strait). These reserves are held in the name of DoH as trustee and recorded in TCHHS's Statement of Financial Position at a nominal value ($1).

Registered trustee leases and ILUAs have been negotiated for eleven facilities previously located on DOGIT land which have terms for generally 30 years.

Note 18. Commitments

	2017 $'000	2016 $'000
Commitments - capital expenditure		
Committed at the reporting date but not recognised as liabilities, payable:		
Not later than 1 year	560	275
Later than 1 year but not later than 5 years	551	-
Commitments - operating expenditure		
Committed at the reporting date but not recognised as liabilities, payable:		
Not later than 1 year	12,452	11,030
Later than 1 year but not later than 5 years	2,281	2,752
Later than 5 years	1,476	2,811
	17,320	16,868

Leases

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

Operating commitments also includes service contracts between Apunipima, Royal Flying Doctor Service and with Cairns Hinterland and Hospital and Health Services that TCHHS are currently obligated to pay. TCHHS is not party to any finance leases.

Note 19. Patient trust transactions and balances

Patient trust receipts and payments	2017 $'000	2016 $'000
Receipts		
Opening balance	10	4
Amounts receipted on behalf of patients	11	14
Total receipts	21	18
Payments		
Amounts paid to or on behalf of patients	16	8
Total payments	16	8

Trust assets and liabilities

Assets		
Cash held and bank deposits	5	10
Total assets	5	10

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

Note 20. Events after the reporting period

There are no matters or circumstances that have arisen since 30 June 2017 that have significantly affected, or may significantly affect TCHHS's operations, the results of those operations, or the HHS's state of affairs in future financial years.

Note 21. Grant of private practice arrangement

	2017 $'000	2016 $'000
Receipts		
Private practice receipts - Revenue Assignment*	4,552	3,644
Total receipts	4,552	3,644
Payments		
Payments to employees	2,427	2,111
Payments to external providers	266	249
Total payments	2,693	2,360

* Hospital and health services now hold the prerogative to grant clinicians limited rights to conduct private practice on the terms and conditions of the private practice schedule within the employment contract (granted private practice). Private practice during employed time is integrated into the employment contract as a schedule and will no longer be a separate contract. The contract options are:

1. Revenue Assignment; where all revenue is assigned to the HHS.
2. Revenue Retention; where a clinician engaging in private practice during employed time can retain private practice revenue after paying service fees and GST to the HHS. Amounts over a ceiling cap are split 1/3 to the doctor and 2/3 to the HHS which at the discretion of the HHS will be transferred to the Private Practice Trust Fund. TCHHS had no grant of private practice revenue retention arrangements in 2017.

Note 22. Reconciliation of operating result to net cash from operating activities

	Note	2017 $'000	2016 $'000
Operating result for the year		5,967	5,754
Non-cash movements:			
Depreciation	12	11,091	11,178
Depreciation offset from Department of Health	15	(11,091)	(11,178)
Loss on disposal		140	80
Donated assets		26	(127)
Impairment on inventory		(94)	86
Movements in impairment loss receivables	10	79	(19)
Change in operating assets and liabilities			
Increase in trade and other receivables		(654)	(4,814)
Decrease in GST receivables		(4)	(177)
Increase in inventories		14	66
Increase in prepayments		(29)	(9)
Increase in trade and other payables		5,300	3,843
Increase in accrued employee benefits		272	83
Increase/(decrease) in accrued contract labour		530	(2,957)
Increase/(decrease) in GST payable		53	(27)
Increase/(decrease) in unearned revenue		373	(245)
Net cash from operating activities		11,973	1,537

Note 23. 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.

	2017 $'000	2016 $'000
Opening balance	91	856
Revenue received during the year	2	19
Expenditure during the year	-	(1)
Transfer prior year placement fees	-	(783)
Balance of general trust	93	91

The closing cash balance of the general trust at 30 June 2017 is $0.093m (2016: $0.091m). This is held on deposit with the Queensland Treasury Corporation $0.078m (2016: $0.076m) and the Commonwealth Bank of Australia $0.016m (2016: $0.015m).

Note 24. Key management personnel disclosures

As from 2016-17, TCHHS's responsible Minister is identified as part of its key management personnel, consistent with additional guidance included in the revised version of AASB 124 Related Party Disclosures. That Minister is Cameron Dick MP, Minister for Health and Minister of 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. The following persons were considered key management personnel of TCHHS during the current financial year:

	Name	Contract classification/appointment authority	Initial appointment date
Non-executive Board Chairperson - Provides strategic leadership and guidance and effective oversight of management, operations and financial performance.	Robert McCarthy	*S25 Hospital and Health Board Act 2011 by Governor in Council*	1 July 2014
Non-executive Deputy Chairperson - Provides strategic leadership and guidance and effective oversight of management, operations and financial performance.	Ruth Stewart	*S25 Hospital and Health Board Act 2011 by Governor in Council*	1 July 2014
Non-executive Board member - Provides strategic guidance and effective oversight of management, operations and financial performance.	Horace Baira Greg Edwards Tracey Jia Fraser (Ted) Nai Brian Woods Kaz Price Scott Davis	*S23 Hospital and Health Board Act 2011*	19 January 2015 1 July 2014 1 July 2014 1 July 2014 19 January 2015 11 December 2015 18 May 2016
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.	Jill Newland Terry Mehan (Acting) Michel Lok	S24/S70 / *Hospital and Health Boards Act 2011*	1 July 2014 to 8 July 2016 4 July 2016 to 16 September 2016 12 September 2016
Chief Finance Officer (CFO) - Responsible for financial management, contract management, and statutory reporting obligations of TCHHS.	Danielle Hoins	DSO 1 / *Hospital and Health Boards Act 2011*	17 April 2015
Executive General Manager - Northern Sector - Responsible for providing strategic leadership, direction and day to day management to the Torres Strait and Northern Peninsula area within the TCHHS.	Andrew Marshall Kim Veiwasenavanua	HES 2 / *Hospital and Health Boards Act 2011*	1 January 2015 to 4 January 2017 10 February 2017
Executive General Manager - Southern Sector - Responsible for providing strategic leadership, direction and day to day management to the Cape York area within the TCHHS. The EGMS is also responsible for the infrastructure and assets management for TCHHS.	Ian Pressley Allyson Cousens (Acting)	HES 2 / *Hospital and Health Boards Act 2011*	1 July 2014 to 9 December 2016 5 December 2017

Note 24. Key management personnel disclosures (continued)

	Name	Contract classification/appointment authority	Initial appointment date
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.	Allyson Cousens (Acting) Andrew Marshal (Acting) Andrew Marshal	*HES2 1 / Hospital and Health Boards Act 2011*	16 May 2016 to 4 December 2016 9 January 2017 to 26 February 2017 27 February 2017
Executive Director - Medical Services - Responsible for leading, directing, implementing, planning and evaluating the delivery of medical (including mental health), dental and allied health services across all departments and facilities within the TCHHS.	Katherine McConnon	MMO 11 / *Hospital and Health Boards Act 2011*	7 December 2015
Executive Director - Nursing and Midwifery Services - Responsible for providing nursing leadership and governance to TCHHS Nursing 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.	Lyn Wardlaw	NRG 11 / *Hospital and Health Boards Act 2011*	16 August 2014
Executive Director Primary Health Care - Provides strategic and professional leadership in the implementation, coordination and management of Primary Health Care programs within the TCHHS. The role works with the community and other service providers to promote and build healthy partnerships and oversee the operational management, planning and administration of community and primary health care programs.	Vonda Moar-Malone	*A08/ Hospital and Health Boards Act 2011*	1 July 2015 to 21 April 2017
Principal Advisor Aboriginal and Torres Strait Islander Health - New role responsibility providing strategic advice on primary health initiatives, community engagement and community partnerships across both the Torres Strait and Cape York sectors.	Sean Taylor	A08/ Hospital and Health Boards Act 2011	22 May 2017
Chief Information Officer - New role responsible for providing leadership of the Information and Communication Technologies strategy; including information and communication technology management of enablers of systems for healthcare delivery.	Andrew Berry	DSO 2 / *Hospital and Health Boards Act 2011*	1 February 2017

Note 24. Key management personnel disclosures (continued)

Key management personnel – Minister for Health and Minister for Ambulance Services
The Legislative Assembly of Queensland's Members' Remuneration Handbook outlines the ministerial remuneration entitlements. TCHHS does not incur any remuneration costs for the Minister of Health and 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. From 1 July 2016 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 from 2016-17, which are published as part of the Queensland Treasury Report on State finances.

Key management personnel – Board
TCHHS appoints and controls the Board. 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 comprise the following components:

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

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

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

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

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

There were no performance bonuses paid in the 2016-17 financial year (2016: $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 24. Key management personnel disclosures (continued)
The value of renumeration received by Board Members in their capacity as Board Members and the Executive Management Team is disclosed in the following sections.

2017 **Short-term benefits**

Name and position	Monetary	Non-monetary	Post-employment benefits	Long-term benefits	Termination benefits	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Board						
Chairperson – Robert McCarthy	73	-	7	-	-	80
Deputy Chairperson – Ruth Stewart	41	-	2	-	-	43
Board Members – Horace Baira	39	-	4	-	-	43
– Greg Edwards	40	-	4	-	-	44
– Tracey Jia	39	-	4	-	-	43
– Fraser (Ted) Nai	39	-	4	-	-	43
– Brian Woods	39	-	4	-	-	43
– Kaz Price	39	-	4	-	-	43
– Scott Davis	39	9	4	-	-	52
Executive						
Chief Executive – Jill Newland	1	2	-	-	-	3
– Terry Mehan	80	-	8	1	-	89
– Michel Lok	229	9	22	4	-	264
Chief Finance Officer – Danielle Hoins	157	9	21	3	-	190
Executive Director, Corporate Services – Andrew Marshall	185	9	18	4	-	216
Executive Director, Nursing and Midwifery – Lyn Wardlaw	154	15	17	3	-	189
Executive General Manager, Northern Sector – Kim Veiwasenavanua	68	10	6	1	-	85
Executive General Manager, Southern Sector – Ian Pressley	84	9	7	1	1	102
– Allyson Cousens	191	8	18	4	-	221
Executive Director, Medical Services – Katheryn McConnon	329	9	25	6	-	369
Executive Director, Primary Health Care – Vonda Moar-Malone	50	-	3	1	1	55
Principal Advisor Aboriginal and Torres Strait Islander Health – Sean Taylor	16	-	-	1	-	17
Chief Information Officer – Andrew Berry	61	9	7	1	-	78

Note 24. Key management personnel disclosures (continued)

2016 **Short-term benefits**

Name and position	Monetary	Non-monetary	Post-employment benefits	Long-term benefits	Termination benefits	Total
	$'000	$'000	$'000	$'000	$'000	$'000
Board						
Chairperson – Robert McCarthy	70	-	8	-	-	78
Deputy Chairperson – Ruth Stewart	38	-	-	-	-	38
Board Members – Horace Baira	38	-	4	-	-	42
– Greg Edwards	38	-	4	-	-	42
– Tracey Jia	38	-	4	-	-	42
– Fraser (Ted) Nai	38	-	4	-	-	42
– Brian Woods	38	-	4	-	-	42
– Kaz Price	20	-	2	-	-	22
– Scott Davis	3	-	-	-	-	3
Executive						
Board Operations Manager – Andrea Brophy	88	9	12	2	-	111
Chief Executive – Jill Newland	340	6	41	8	-	395
Chief Finance Officer – Danielle Hoins	128	9	18	3	-	158
– Cherie Campbell	5	9	1	-	-	15
Director, Rural and Remote Clinical Support – Peter McCormack	138	9	17	3	-	168
Executive Director, Workforce Performance – Allyson Cousens	142	10	18	3	-	173
– Helen Reed	8	9	1	-	-	18
Executive Director, Nursing and Midwifery – Lyn Wardlaw	135	41	17	3	-	195
Executive General Manager, Northern Sector – Andrew Marshall	165	10	19	4	-	197
– Kim Veiwasenavanua	11	7	1	-	-	20
Executive General Manager, Southern Sector – Ian Pressley	172	-	19	4	-	195
Executive Director, Medical Services – Katheryn McConnon	81	4	11	3	-	99
– Winton Barnes	29	-	15	4	-	49
Executive Director, Primary Health Care – Vonda Moar-Malone	92	-	13	2	-	107
– Rhonda Shibasaki	18	-	2	-	-	20

Note 25. Related party transactions

Transactions with Queensland Government controlled entities

AASB 124 *Related Party Disclosures* takes effect from 1 July 2016. Material related party transactions for 2016-17 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.

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 initatives delivered by TCHHS.

The TCHHS signed Service Agreement is published on the Queensland Government website and is publically available. The 2016-17 Service Agreement was for $201.1 million at the commencement of the year.

In addition, DoH provides a number of services including procurement, payroll, information technology infrastructure and support as well as accounts payable services. Any expenses paid by DoH on behalf of TCHHS for these services are recouped by DoH. During the 2016-17 year, the total of recouped expenditure was $117.4m.

Queensland Treasury Corporation
TCHHS has accounts with the Queensland Treasury Corporation for general trust monies.

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

Inter HHS
Payments to and receipts from other hospital and health services occur to facilitate the transfer of pharmacy, pathology, telecommunications, computer, aeromedical, insurance and other incidentals.

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 entity 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 arms length and are in accordance with the entity's constitution. TCHHS receives funding from two funding sources; Primary Health Network Health Pathways and Medicare Locals totalling $144, 436 during this financial year.

Mr Greg Edwards jointly owns Torres Strait Tours Pty Ltd. This company provides boat and bus transfer services to TCHHS. The transactions with this company were at arms length and these services were no different to those applying to unrelated parties. Net transactions year to date totalled $162,575. All transactions during the financial year are included as supplies and services in the Statement of Comprehensive Income.

TCHHS employees that are close family members of TCHHS key management personnel were recruited in accordance with the standard TCHHS recruitment policies and procedures. The total aggregate amount of employee expenses for these close family members for the year ended 30 June 2017 totalled $806,357.

Note 26. Other information

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

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

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

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

Note 26. Other information(continued)

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

Changes in accounting policy
The HHS did not voluntarily change any of its accounting policies during 2016-17.

Accounting standards applied for the first time in 2016-17
The only Australian Accounting Standard that became effective for the first time in 2016-17, and materially impacted on this financial report, is AASB 124 *Related Party Disclosures*. This standard requires note disclosures about key management personnel (KMP) remuneration expenses and other related party transactions, and does not impact on financial statement line items. As Queensland Treasury already requires disclosure of KMP remuneration expenses, there was minimal impact for TCHHS disclosures compared to 2015-16 (refer to Note 24). Material related party transactions for 2016-17 are disclosed in Note 25. No comparative information is required in respect of 2015-16.

(c) New Accounting Standards and interpretations not yet effective

Australian Accounting Standards and Interpretations that are not yet mandatory were not early adopted by TCHHS in 2016-17. TCHHS is not permitted to early adopt accounting standards unless approved by Queensland Treasury.
At the date of authorisation of the financial report, the expected impacts of new or amended Australian Accounting Standards issued but with future effective dates are set out below.

AASB 9 *Financial Instruments* and AASB 2014-7 *Amendments to Australian Accounting Standards* arising from AASB 9 (December 2014) will become effective for reporting periods beginning on or after 1 January 2018. The main impacts of these standards on TCHHS are that they will change the requirements for the classification, measurement, impairment and disclosures associated with TCHHS's financial assets. AASB 9 will introduce different criteria for whether financial assets can be measured at amortised cost or fair value. TCHHS will be required to reassess the way its financial assets are classified. However, the impact from these standards has not been assessed at this time.

AASB 15 *Revenue from Contracts with Customers* will become effective for not-for-profit entities for reporting periods beginning on or after 1 January 2019. This standard contains detailed requirements for the accounting for certain types of revenue from customers. Depending on the specific contractual terms, the new requirements may potentially result in a change to the timing of revenue from sales of TCHHS's goods and services, such that some revenue may need to be deferred to a later reporting period to the extent that TCHHS has received cash, but has not met its associated obligations (such amounts would be reported as a liability (unearned revenue) in the meantime). TCHHS is yet to complete its analysis of current arrangements for sale of its goods and services, but at this stage does not expect a significant impact on its present accounting practices. AASB 1058 *Income from Not-for-profit Entities* will become effective from reporting periods beginning on or after 1 January 2019. This standard establishes principles for not-for-profit entities that apply to transactions where the consideration to acquire an asset is significantly less than fair value principally to enable a not-for-profit entity to further its objectives and the receipt of volunteer services. TCHHS is yet to complete its analysis of revenue relating to this standard.

AASB 16 *Leases* will become effective for reporting periods beginning on or after 1 January 2019. This standard introduces a single lease accounting model for lessees. Lessees will be required to recognise a right-of-use asset and a liability for all leases with a term of more than 12 months, unless the underlying assets are of low value. When AASB 16 comes into effect, the majority of operating leases (as defined by the current AASB 117) will be reported in the Statement of Financial Position. TCHHS is yet to complete its analysis of current operating leases, but at this stage does not expect a significant impact on its present accounting practices.

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

Note 27. Budget vs actual comparison

Explanations of major variances

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

Major variances have been identified and explained:

Statement of Comprehensive Income

User charges and fees:

The increase in user charges of $7.541m (4%) relates to an increase to general user charges and fees ($0.795m) and an increase in State funding ($6.746m): through window adjustments during the year for new State and Commonwealth program initiatives: including sexual health ($0.513m), mental health ($0.524m), Cape York transition to community control ($0.150m) and community engagement ($0.130m), indigenous health programs ($0.301), renal expansion ($1.2m), Kowanyama nursing support ($0.274m), oral health ($0.887m), recruitment services ($0.109m), and blood borne viruses - Saibai ($1.120m). There was also growth due to the changes to the enterprise bargaining agreement which was funded ($0.568m), multipurpose health service funding ($0.349m), activity purchasing incentives ($0.103m) and backlog maintenance remediation program incentives payments ($4.894m). The increase was offset by program deferrals into 2017-18 ($4.032m) and a reduction in depreciation revenue ($0.235m).

Employee expenses:

The increase in employee expenses of $5.006m (54%) relates to permanent recruitment of 100% senior medical officers in Thursday Island Hospital that were reported as Department of Health contract staff in the original Service Delivery Statements (SDS).

Department of Health contract staff:

The decrease in DoH contract staff of $14.891m (14%) is a result of: the inclusion in employee expenses of $5.006m relating to the permanent recruitment of senior medical officers at Thursday Island; The inclusion of agency staff costs of $5.467m in supplies and services; and a reduction in internal labour costs of $3.585m below that budgeted.

Supplies and services:

The increase in supplies and services of $13.060m (18%) relates to changes in expenditure allocations after the original budget was built. Material increases from the original budget include: additional medical and nursing agency staff ($5.467m), consultancies ($0.833), increases in travel ($1.894m), residential, vehicle lease costs ($5.747m) and electricity costs ($1.421m). The increases are offset by a reduction in other expenditure due to the late commencement of new programs ($0.944m) and reduction in outsourced service delivery contracts ($1.358m).

Note 27. Budget vs actual comparison (continued)

Statement of Financial Position

Cash and cash equivalents:	The increase in cash and cash equivalents of $19.389m (118%) is due to: the original SDS budget not including 2015-16 and 2016-17 surplus results ($11.721m) and the non-cash expenditure included in this surplus amount ($1.608m). Outstanding current liabilities increased ($8.915m) due to final contract payments from the completed Back-log Maintenance Remediation Project (BMRP) program in June, and slow uptake on minor capital ($1.040m) have increased cash reserves held. The increase was offset by a rise in all other current assets ($3.895m) primarily relating to the recognition of the BMRP incentive payments.
Trade and other receivables:	The increase in trade and other receivables of $3.211m (111%) is made up of accrued revenue from DoH payments agreed during the end of financial year service agreement adjustments ($2.969m) and the clearance of old receivable impairment after completion of the debt collection process ($0.242m).
Property, plant and equipment:	Property, plant and equipment decreased against the original budget by $22.508m (11%) due to the original SDS budget including an estimated valuation increments attributable to the BMRP ($22.413m) which was later deferred (Thursday Island redevelopment project).
Trade and other payables:	The increase in trade and other payables of $9.614m (104%) relates to end of year payroll accrual ($3.122m), accrued expenditure ($4.345m) made up of DoH fee for services invoices, final BMRP expense payments and general expenditure from normal operation. In addition, there were external labour accruals for outstanding locum agency accounts and outsourced labour contracts ($2.711m) that remained unpaid but not in the original SDS budget. The increase was offset by a decrease in grants payable for Commonwealth programs ($0.564m).
Asset revaluation surplus:	The decrease in the asset revaluation surplus of $22.393m (65%) was due to the original SDS budget including estimated valuation increments attributable to the BMRP which was later deferred (Thursday Island redevelopment project).
Contributed equity:	The increase in contributed equity of $2.6m (1%) was due to an equity swap for BMRP capitals items ($1.876m) and lower than budgeted depreciation in 2015-16 and 2016-17 financial years ($0.724m).
Accumulated surplus:	The increase in the accumulated surplus of $11.722m (541%) was due to the original SDS budget including a balanced position for the 2015-16 ($5.754m) and 2016-17 ($5.967m) financial years. The 2015-16 result contains one-off gains from the BMRP funding ($4.415m) and the one-off surplus of ($4.570m) due to vacancies in State base and discrete programs. This is offset by planned use of prior years' accumulated surplus on retained earnings projects ($3.231m). The 2016-17 result contains one-off gains from the BMRP funding ($4.895m) and the one-off surplus of ($4.443m) due to vacancies in state base and discrete programs. This is offset by planned use of prior years' accumulated surplus on retained earnings projects ($3.371m) such as Saibai accommodation, health worker training and the diabetes trial.

Note 27. Budget vs actual comparison (continued)

Statement of Cash Flows

Employee expenses:	Refer to commentary in the Statement of Comprehensive Income – employee expenses above. The overall cash flow increase in employee expenses against original budget was $3.720m.
Department of Health contract staff and supplies and services:	Refer to the commentary in the Statement of Comprehensive Income – Department of Health contract staff and supplies and services. The variance between the Department of Health contract staff and supplies and services is $5.508m (3%). When this variance is offset against employee expenses it is not deemed material.
Payments for property, plant and equipment:	The increase in payments for non-financial assets of $0.723m relates to BMRP capital spend ($1.581m) not included in the original SDS budget offset by a lower than planned spend of minor capital ($0.858m).
Proceeds from equity injections:	The equity withdrawals relating to depreciation reported in the original budget are classified as a cash item in SDS budget ($11.326m). The actual equity withdrawals in the Statement of Cash Flows are non-cash items and therefore are not reported through the cashflow statement. The remaining increase is made up of BMRP equity swap $1.876m and minor reimbursements from the Priority Capital Program and Health Technology Equipment Replacement Programs.

Torres and Cape Hospital and Health Service
Management Certificate
For the year ended 30 June 2017

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

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

b) the financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Torres and Cape Hospital and Health Service for the financial year ended 30 June 2017 and of the financial position of the Torres and Cape Hospital and Health Service at the end of that year; and

c) these assertions are based on an appropriate system of internal controls and risk management processes being effective, in all material respects, with respect to financial reporting throughout the reporting period.

Robert McCarthy
Board Chair

22 / 8 / 17

Michel Lok
Health Service
Chief Executive

22 / 8 / 17

Danielle Hoins - CPA
Chief Finance Officer

22 / 8 / 17

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. The financial report comprises the statement of financial position as at 30 June 2017, 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.

In my opinion, the financial report:

a) gives a true and fair view of the entity's financial position as at 30 June 2017, and its financial performance and cash flows for the year then ended

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

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.

Buildings valuation ($167.3M)

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 25% of its building assets this year with the balance being revalued using a desktop valuation. The current replacement cost method comprises: • Gross replacement cost, less • Accumulated depreciation Torres and Cape Hospital and Health Service derived the gross replacement cost of its buildings at balance date using unit prices that required significant judgements for: • identifying the components of buildings with separately identifiable replacement costs • developing a unit rate for each of these components, including: o estimating the current cost for a modern substitute (including locality factors and oncosts), expressed as a rate per unit (e.g. $/square metre) o identifying whether the existing building contains obsolescence or less utility compared to the modern substitute, and if so estimating the adjustment to the unit rate required to reflect this difference. The measurement of accumulated depreciation involved significant judgements for forecasting the remaining useful lives of building components. The significant judgements required for gross replacement cost and useful lives are also significant for calculating annual depreciation expense.	My procedures included, but were not limited to: • Assessing the adequacy of management's review of the valuation process. • Assessing the appropriateness of the components of buildings used for measuring gross replacement cost with reference to common industry practices. • 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. 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. • 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. • Where changes in useful lives were identified, evaluating whether they were supported by appropriate evidence.

Refer to Note 12 in the financial report.

Other information

Other information comprises the information included in the entity's annual report for the year ended 30 June 2017, but does not include the financial report and my auditor's report thereon.

The Board is responsible for the other information.

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

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

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Responsibilities of the entity for the financial report

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

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

Auditor's responsibilities for the audit of the financial report

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

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

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

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

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

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

Report on other legal and regulatory requirements

In accordance with s.40 of the *Auditor-General Act 2009*, for the year ended 30 June 2017:

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

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

QUEENSLAND
25 AUG 2017
AUDIT OFFICE

D J OLIVE
as delegate of the Auditor-General

Queensland Audit Office
Brisbane

Torres and Cape Hospital and Health Service
2016 – 2017 Annual Report
www.health.qld.gov.au/torres-cape