ANNUAL REPORT 2015–2016

Torres and Cape Hospital and Health Service

Queensland Government

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Email: TCHHS-Board-Chair@health.qld.gov.au

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Letter of Compliance

7 September 2016

The Honourable Cameron Dick MP

Minister for Health and Minister for Ambulance Services
GPO Box 48
Brisbane Q 4001

Dear Minister

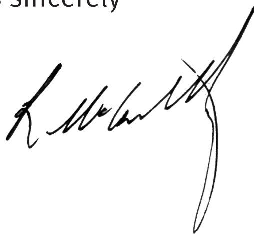
I am pleased to present the Annual Report 2015-2016 and financial statements for Torres and Cape Hospital and Health Service.

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 or can be accessed at www.health.qld.gov.au/torres-cape.

Yours sincerely



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

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1. 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
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
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
PNG	Papua New Guinea
PPH	Potentially Preventable Hospitalisations
PHCC	Primary Health Care Centre
TB	Tuberculosis
Service	Torres and Cape Hospital and Health Service

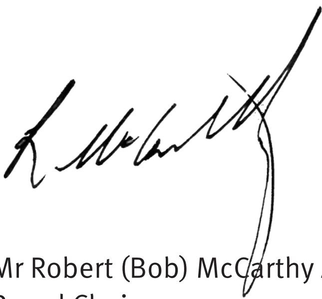
Welcome

2. INTRODUCTION

Welcome to Torres and Cape Hospital and Health Service's (HHS) Annual Report which provides a comprehensive record of the HHS's financial and non-financial performance for the period of July 2015 to June 2016.

Torres and Cape HHS covers an area of more than 130,000 square kilometres. The HHS is responsible for the health services of approximately 25,000 people widely spread across Cape York, the Northern Peninsula Area and the Torres Strait Islands. 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.

The HHS comprises of 31 primary health care centres, 2 hospitals (Thursday Island and Bamaga), a multi-purpose health service (Cooktown) and an integrated health service (Weipa). The service employs approximately 800 employees and 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.



Mr Robert (Bob) McCarthy AM
Board Chair

Mr Terry Mehan
Acting Health Service Chief Executive

3. ABOUT TORRES AND CAPE HOSPITAL AND HEALTH SERVICE

3.1 Role and main functions

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 HHS was established as a statutory body following the amalgamation of Torres Strait-Northern Peninsula HHS and Cape York HHS. These previous HHSs were established as statutory bodies on 1 July 2012 under the Act.

Torres and Cape HHS is overseen by a Hospital and Health Board (Board) reporting to the Minister for Health and Minister for Ambluance 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 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.

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

Torres and Cape HHS is:

- the principal provider of public sector health services in Torres and Cape
- accountable through the Hospital and Health Board Chair to the Minister for Health and Minister for Ambulance Services for local performance, delivering local priorities and meeting national standards
- subject to the *Financial Accountability Act 2009* and the S*tatutory 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.

About Torres and Cape Hospital and Health Service

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.

Hospitals

Cooktown Multi-Purpose Health Service (MPHS), Weipa Integrated Health Service (IHS), Thursday Island Hospital and Bamaga Hospital.

Cape York community primary health centres at:

Aurukun, Coen, Hope Vale, Laura, Lockhart River, Kowanyama, Mapoon, Napranum, Pormpuraaw and Wujal Wujal.

Northern Peninsula Area community primary health centres at:

Bamaga, New Mapoon, Umagico, Seisia and Injinoo. (Injinoo Primary Health Care Centre transitioned to a General Practice led service managed by the Northern Peninsula Area Family and Community Services Aboriginal and Torres Strait Islander Corporation in 2015.)

Torres Strait Island community primary health centres at:

Top western cluster:	Boigu (Talbot Island), Dauan (Mt Conwallis Island), Saibai
Near western cluster:	Badu (Mulgrave Island), Mabuiag (Jervis Island), St Pauls community on Moa (Banks Island) and Kubin community on Moa (Banks Island)
Eastern cluster:	Erub (Darnley Island), Mer (Murray Island), Ugar (Stephen Island)
Central cluster:	Iama (Yam Island), Masig (Yorke Island), Poruma (Coconut Island), Warraber (Sue Island), Ngurupai (Horn Island)
Inner cluster:	Waiben (Thursday Island)

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. Accreditation of residential aged care facilities is by the Australian Aged Care Quality Agency. General practices owned or managed 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.

Additionally, Torres and Cape HHS maintains a regional hub office in Cairns where business, finance, human resources, patient safety, quality, performance and planning services are based. Some Torres and Cape HHS clinical outreach services are also based in the Cairns hub office.

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.

3.2 Operating environment

3.2.1. Statutory obligations and progress

Torres and Cape HHS met its statutory obligations under sections 40 to 43 of the Act to develop and publish the following strategies:

- Consumer and Community Engagement Strategy – to promote consultation with health consumers and members of the community about the provision of health services by the HHS
- Clinician Engagement Strategy – to promote consultation with health professionals
- Maintains agreements and close working partnerships with local primary 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.

3.2.2. Nature and range of operations

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.

3.2.3. Strategic risks, opportunities and challenges

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

Environmental factors

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 is largely impossible during the three-month wet season. All the island populations are only accessible by air or sea. There are significant distances between communities and health services sites and to the major referral hospital in Cairns. Many of the areas that the HHS services are very remote with poor accessibility for goods, services and social interaction.

Demographics and socio-economic disadvantage

The population of Torres and Cape HHS region is estimated to be approximately 25,766 and projected to increase to 28,800 by 2026. Sixty four per cent of the population in the region identify as Aboriginal or Torres Strait Islander (Australian Census 2011), 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.

About Torres and Cape Hospital and Health Service

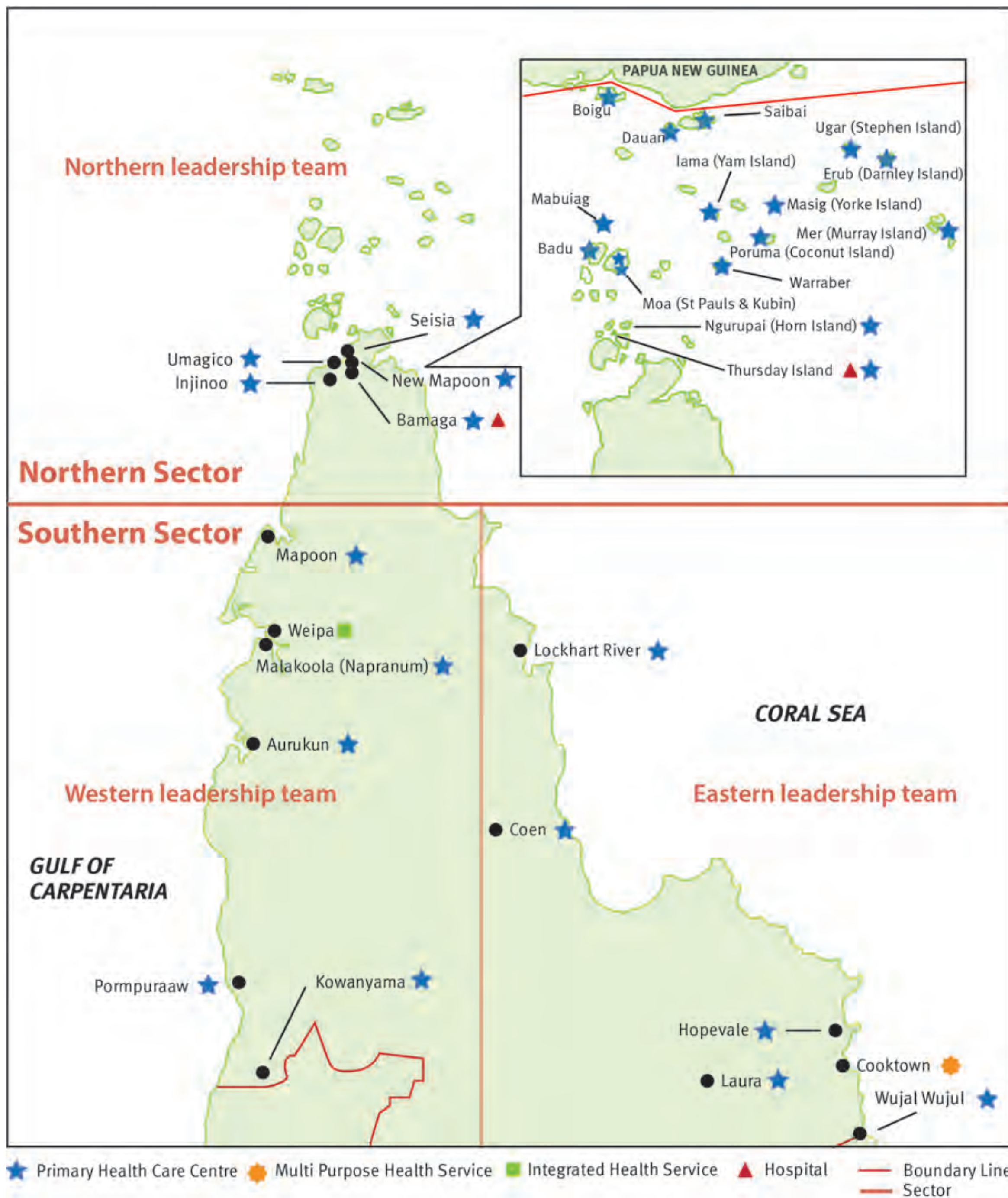


Figure 1: The catchment area serviced by Torres and Cape HHS

3.2.4. Significant initiatives

Local tuberculosis services established

Tuberculosis (TB) services for the Torres Strait and Cape York regions were transferred from Cairns and Hinterland HHS to Torres and Cape HHS from 1 January 2016. The TB Control Unit was established on Thursday Island and is well placed to take responsibility for the delivery of TB services on the ground. This gives Torres and Cape communities greater local control. The TB Control Unit liaises closely with with cross-border agencies, runs a comprehensive education project, and supports the delivery of arrangements that contribute to the safe and ethical transfer of Papua New Guinean (PNG) TB patients to the PNG health system.

Indigenous workforce advancements

Thursday Island Hospital made local Indigenous nursing history on 23 May 2016 with an entire shift on the general ward at Thursday Island Hospital staffed exclusively by Torres Strait Islander nurses for the first time. Furthermore, the Torres and Cape HHS has made a substantial commitment to the training and development of the Indigenous Health Workers with the commencement of a three year Primary Health Care Project - Workforce Development Program. Twenty-one Indigenous Health Workers started training towards the Certificate IV in Aboriginal and Torres Strait Islander (Practice) with a further 35 expected to commence in late 2016. Health Workers who complete the 18 month certificate will be eligible to register as health practitioners with the Australian Health Practitioner Regulation Agency (AHPRA).

Thursday Island nurses made history with an entire shift on the General Ward at Thursday Island Hospital staffed exclusively by Torres Strait Islander nurses for the first time on 23 May 2016.

Above: MacCauley (Max) Ghee (Registered Nurse), Shirley Kusu (Registered Nurse), May Seriat (Enrolled Nurse), Robyn Zitha (Advanced Enrolled Nurse) and Fred Tamu (first year Graduate Nurse).

Regional eHealth Project

A major Integrated Electronic Health Project (Regional eHealth Project) continued in 2015-16 in conjunction with Cairns and Hinterland HHS and eHealth Queensland. The project aims to improve patient outcomes by delivering eHealth infrastructure and systems that improve the quality and access to patient and clinical information for primary and community health care services across North Queensland. The solution will enhance local management and care planning capabilities and assist with collaborative service planning.

Revitalised dental services in the Torres Strait Islands and Northern Peninsula Area

Following a review of dental services in the Torres Strait and Northern Peninsula Area in 2014, a Dental Blitz ran from March to December 2015 to provide immediate dental services to the outer islands while a long term sustainable model was developed. The Dental Blitz involved 488 adult and 802 child dental examinations, and a total of 592 follow up appointments at the Thursday Island Dental Clinic, with the HHS paying the travel costs. The Director of Oral Health position was created and commenced in September 2015. Several positions have also been permanently recruited to in 2015/16 including a Business and Operational Manager, Principal Dentist Thursday Island and Senior Oral Health Therapist. The Child Dental Benefit Scheme is being implemented in the School Dental program and has been extended until December 2016. A new dental model has been developed to provide dental services via portable equipment direct to the outer islands. This will commence in August 2016.

The Torres Strait Island and Northern Peninsula Area dental team.

Continuation of $36.3 Million Backlog Maintenance Remediation Program (BMRP)

This four year large-scale rectification and renewal project will inject $36.295 million into improving Queensland Health infrastructure across Torres Strait and Cape York. The BMRP is the single largest infrastructure project ever undertaken by the Torres and Cape HHS and will include up-skilling of HHS infrastructure staff.

$1.6 Million Thursday Island Asbestos Encapsulation Project

This Project involved the construction of a 300m ring road on the Thursday Island Hospital site in order to sufficiently contain asbestos fragments found in the soils. Works included drainage rectification, landscaping and a new road to assist emergency access and helipad access.

Five new nursing positions

The Torres and Cape HHS successfully secured recurrent funding of $692,000 per annum to employ four extra registered nurses, two at Saibai Island Primary Health Care Centre and two at Aurukun Primary Health Care Centre. Further funding of $274,000 was provided to employ an extra nurse and administration officer at Kowanyama PHCC. Additional staff will improve clinical services and support the training and education of administration officers across Cape York facilities.

About Torres and Cape Hospital and Health Service

Transfer of recruitment services from Cairns and Hinterland HHS to Torres and Cape HHS

In April 2016, Torres and Cape HHS successfully transitioned recruitment services from the Cairns and Hinterland HHS with the goal to improve processes. This transfer of services has given Torres and Cape HHS better leverage with its current staffing resources by establishing a more locally responsive service, while streamlining more effective recruitment practices. This has enabled Torres and Cape HHS to link attraction, recruitment and retention activities to the strategic direction of the organisation.

New nursing positions were secured for Kowanyama Primary Health Care Centre (PHCC) (pictured above), Aurukun PHCC and Saibai Island PHCC.

New mortuary on Thursday Island

This $997,000 mortuary was built in direct response to community concerns raised in 2013 about the original decision to locate the morgue in the new Community Wellness Centre. The new facility was constructed after extensive consultation with traditional owners, community advocates, the local funeral director and local councils; and it now meets cultural requirements and sensitivities.

Twenty-one Indigenous Health Workers started training towards the Certificate IV in Aboriginal and Torres Strait Islander (Practice).

3.2.5. 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 HHS has established significant, collaborative partnerships with the following key stakeholders:

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

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 on a sessional basis and typically travel from Cairns.

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.

3.2.6. Plans and priorities for 2016-17

Priorities to be undertaken in 2016-17 include:

- Expand renal services on Thursday Island from six to nine patients with an increase of $1.25 million funding per year by August 2016. This will include contracting a half time specialist renal physician from the Cairns and Hinterland HHS.
- Further improve functionality and condition of the dialysis space at Bamaga Hospital to enable a nurse led renal dialysis service.
- Finalise a needs assessment and capability assessment with a view to expand endoscopy services across the HHS.
- Enhance mental health services across the HHS including the transfer of child and youth mental health from Cairns and Hinterland to Torres and Cape HHS. Plan for a mental health crisis assessment and treatment team. Develop a Rural Generalist Mental Health position to support child and youth services, and co-morbid mental health and chronic disease. Progress a single care plan for mental health consumers with service partners. Provide suicide management and risk assessment training for front line primary health care nurses and Indigenous Health Workers in conjunction with the Northern Queensland Primary Healthcare Network.
- Return the management of Cooktown renal services from Cairns and Hinterland HHS to the Torres and Cape HHS to provide more community involvement in services.
- Improve oral health services in the Torres Strait region using a State Government grant allocation of $1.46 million as part of the Integrated Care Innovation Fund (ICIF). Employ a small team of health personnel over two years to deliver face-to-face workshops and online dental training to remote island primary health personnel. It will use existing tele-consulting technology and introduce the use of intra-oral cameras for primary health workers on the various islands to consult with dental staff at the main clinic on Thursday Island.
- Improve aged care service provision in the Northern Peninsula Area by implementing a MPHS model at Bamaga Hospital. Convert six beds at Bamaga Hospital to aged care and other living spaces services as designated within the national aged care standards.
- Implement a trial of coordinated diabetes care for Thursday Island with a newly created Practice Manager, Clinical Nurse (identified) and Project Manager and a Best Practice Information System Nurse.
- Work with partner groups, particularly Apunipima Cape York Health Council, to develop a primary health (including chronic disease) model for discrete Indigenous communities in Cape York. The model should consider the impacts of a probable introduction of "Health Care Homes" by the Commonwealth, and the possibility of an introduction of commissioning of primary health through the Northern Queensland Primary Healthcare Network.
- Continue work towards an improved career path for Indigenous Health Workers including supporting 56 staff to successfully complete the three year Primary Health Care Project - Workforce Development Program Certificate IV in Aboriginal and Torres Strait Islander (Practice).
- Commence a $11.3 million Priority Capital Funding program for infrastructure upgrades at Poruma (Coconut Island), Masig (Yorke Island), Ugar (Stephen Island), Dauan Island, St Paul's on Moa Island, the Thursday Island helipad and electrical upgrades at 14 sites.
- Commence $6.3 million upgrade of the Aurukun Primary Health Care Centre and $3.4 million for nurses' quarters at Kowanyama.

4. NON-FINANCIAL PERFORMANCE

4.1 Government objectives for the community

The Torres and Cape HHS's business directions and service delivery contributes to the achievement of the Queensland Government's objectives and priorities being:

1. Creating jobs and a diverse economy.
2. Delivering quality frontline services.
3. Protecting the environment.
4. Building safe, caring and connected communities.

My health, Queensland's future: Advancing health 2026 (Advancing Health 2026) has a 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 particular, the principle regarding sustainability requires us to ensure available resources are used efficiently and effectively for current and future generations.

In alignment with the directions of government, the *Torres and Cape Hospital and Health Service Strategic Plan 2015-2019 (2016 update)* provides service directions to achieve improvements in the health of people in the communities of Torres Strait and Cape York.

4.2 Other whole-of-government plans/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*.

Non-financial performance

4.3 Objectives and performance indicators

The *Torres and Cape HHS Strategic Plan 2015-2019* reflects the HHS vision to provide high quality health care delivering measurable improvements in the health of people in the communities of Torres Strait and Cape York.

The service objectives defined within the strategic plan are:

- To provide high quality health care, delivering measurable improvements in the health of people in the communities of Torres Strait and Cape York.
- Provide innovative and effective health care focusing specifically on the cultural, social and health needs of Torres Strait and Cape York communities.
- Build, strengthen and maintain relationships with key service partners to enable integrated service delivery throughout the local community
- Develop and empower our workforce to ensure staff are both capable and focused on meeting service and community needs.

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.

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 as indicated in section 4.4.1.

4.4 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.

Non-financial performance

The performance of the Torres and Cape HHS against the 2015/16 Budget documentation (Service Delivery Statement) is provided in Table 1.

Table 1: Performance Statement (Weighted Activity Units)

Torres and Cape HHS	Notes	2015-16 Target/ estimated	2015-16 Actuals	2016-17 Target/ estimated
Service standards				
Effectiveness measures				
Percentage of patients attending emergency departments seen within recommended timeframes:	1-3			
• Category 1 (within 2 minutes)		New measure	95%	100%
• Category 2 (within 10 minutes)		New measure	87%	80%
• Category 3 (within 30 minutes)		New measure	92%	75%
• Category 4 (within 60 minutes)		New measure	94%	70%
• Category 5 (within 120 minutes)		New measure	98%	70%
• All categories		New measure	95%	N/A
Median wait time for treatment in emergency departments (minutes)	1, 2	New measure	2	20
Percentage of elective surgery patients treated within clinically recommended times:	4			
• Category 1 (30 days)		New measure	74%	>98%
• Category 2 (90 days)		New measure	84%	>95%
• Category 3 (365 days)		New measure	99%	>95%
Median wait time for elective surgery (days)	4	New measure	15	25
Percentage of emergency department attendances who depart within 4 hours of their arrival in the department	1, 2	New measure	99%	>80%
Efficiency measures				
Other measures	5			
Total weighted activity units:				
• Acute Inpatient		4,020	4,215	4,761
• Outpatients		1,752	1,846	1,107
• Sub-acute		669	172	432
• Emergency Department		1,400	1,727	1,974
• Mental Health		115	537	87
• Interventions and Procedures		52	131	94
Ambulatory mental health service contact duration (hours)	6	>8,000	8,015	>8,116

Notes:

1. The 2015-16 actual figures are based on twelve months of actual performance from 1 July 2015 to 30 June 2016. From 2015-16, Queensland Health expanded the centrally collected dataset from 26 emergency departments to include an additional 32 emergency services in regional and rural areas around Queensland. This expansion to 58 facilities provides a broader representation of the patients who require emergency services.

2. This information is sourced from the Queensland Health Emergency Data Collection (EDC).
3. A target for percentage of emergency department patients seen within recommended timeframes is not included for the 'All categories' as there is no national benchmark. The included triage category targets 2015-16 are based on the Australasian Triage Scale (ATS).
4. The 2015-16 actual figures are based on twelve months of actual performance from 1 July 2015 to 30 June 2016. Torres and Cape Hospital and Health Service (Cooktown, Thursday Island & Weipa Hospitals) is now in scope for elective surgery reporting from 2015-16.
5. The Target/estimated weighted activity units reflect the finance and activity schedules of the 2016-17 Round 2 Service Agreements Contract Offers (v3.10).
6. 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. The target for this measure is determined using a standard formula based upon available clinical staffing, HHS rurality, and historical performance.

4.4.1. National Key Performance Indicators

In 2015-16 Torres and Cape HHS achieved above benchmark performance for some of its national Key Performance Indicators which monitor the major health issues affecting the regular client population of Indigenous-specific primary health care services, especially those of maternal health; early childhood; and the prevention, early detection and ongoing management of chronic diseases. Performance to December 2015 includes:

1. 51 per cent (13 per cent increase) of Indigenous clients (aged 50 yrs and over) were immunised against influenza in the last 12 months compared to 40 per cent nationally (Dec 2014).

2. 45 per cent (9 per cent increase) of Indigenous women received their first antenatal visit prior to 13 weeks compared to 36 per cent nationally (Dec 2014); with an additional 24 per cent (2 per cent increase) receiving their first visit before 20 weeks gestation.

4.4.2. State Key Performance Indicators

The HHS also achieved solid performance against State KPIs providing above expected service activity levels (1.2 per cent above target April 2016), whilst maintaining a balanced finance position. Other performance achievements in 2015-16 include:

- meeting the targets for 'Effectiveness - Safety and Quality' for the entire 12 month period. These targets were for in-hospital mortality rates, unplanned hospital readmission rates, and rates for healthcare associated infections.
- consistent above-target performance for the provision of non-admitted telehealth service events with 1297 events. The target was 763 events.

4.4.3. Other indicators

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

- Reducing the number of potentially preventable hospitalisations through the provision of quality primary health care remains a focus for the HHS. In 2015-16, the HHS acheieved target performance for some quarters, but recognises that further improvement is still required specifically for Aboriginal and/or Torres Strait Islander residents.
- The number of women who smoked at any stage of pregnancy remains a significant challenge to resident health. Smoking during pregnancy is associated with poor health outcomes for the foetus including increased risk of perinatal mortality, low birth weight, and other health related issues.

5. GOVERNANCE - MANAGEMENT AND STRUCTURE

5.1 Organisational structure

The organisational structure of the Board, Health Service Chief Executive and Executive Leadership Team as at June 30 2016 is illustrated in Figure 2.

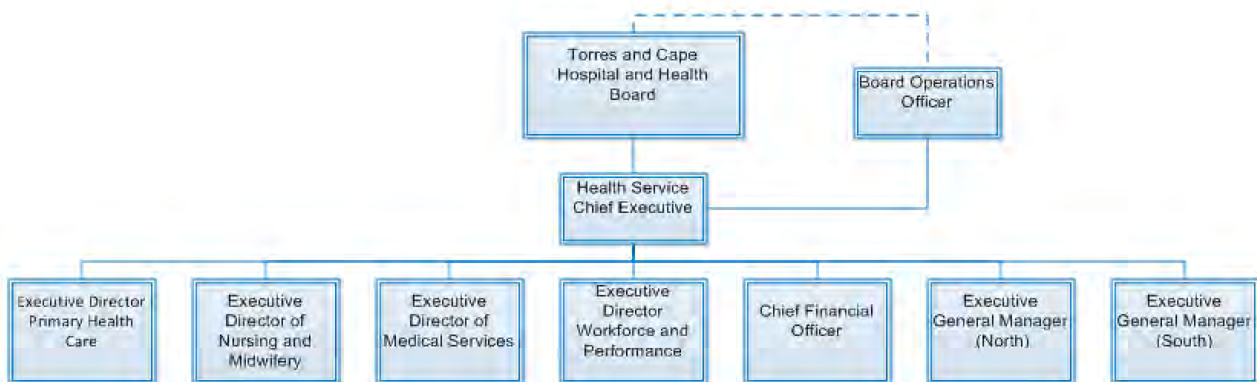


Figure 2: Torres and Cape HHS Managerial Structure as at 30 June 2016

5.2 Executive management

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 Workforce and Performance
- Executive General Manager (North)
- Executive General Manager (South)
- Executive Director Primary Heath Care

Governance - management and structure

The Executive Leadership Team meets fortnightly. Under its Terms of Reference the purpose and role of this group is to support the Health Service Chief Executive. This includes:

- Making recommendations on the strategic direction, priorities and objectives of the HHS and reviewing and endorsing operational and business plans and actions to achieve these objectives
- Monitoring and reviewing HHS performance against service agreements and Key Performance Indicators and making recommendations for corrective action or improvements
- Reviewing organisational risks and compliance with relevant regulatory requirements, standards, policies and procedures.

The executive management team as at 30 June 2016 is outlined in Table 2:

Table 2: Executive Management Team

Division and Title	Incumbent	Key responsibilities
Health Service Chief Executive	Dr Jill Newland	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 Torres and Cape population.
Executive Director of Medical Services	Dr Kate McConnon	Oversee clinical governance to maintain and improve clinical service safety and quality; accountable for delivery of HHS wide programmes for oral health, public health and research governance. Line management of medical staff and credentialing.
Executive Director of Nursing and Midwifery	Lyn Wardlaw	Provide strategic leadership and advice in the efficient and effective management of Torres and Cape HHS nursing and midwifery.
Executive Director Workforce and Performance	Allyson Cousens	Provide strategic leadership and advice in the efficient and effective management of Torres and Cape HHS human resources and promoting learning development, and workplace safety.
Chief Financial Officer	Danielle Hoins	Lead 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.
Executive General Manager (North)	Andrew Marshall	Provide strategic leadership, direction and day to day management of the northern sector (Torres Strait Island and Northern Peninsula Area facilities).
Executive General Manager (South)	Ian Pressley	Provide strategic leadership, direction and day to day management of the southern sector (Cape York facilities).
Executive Director Primary Health Care	Vonda Malone	Provide strategic advice on primary health initiatives, community engagement and community partnerships across both the Torres Strait and Cape York sectors of the health service.

5.3 Hospital and Health management committees

The Board, Board Committees, Health Service Chief Executive and Executive Leadership Team are supported by the work of three key management committees:

Table 3: Management Committees

Committee	Purpose and role	Frequency	Membership
Clinical Quality and Safety Committee	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 evidenced 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. -The committee provides overall strategic governance for safe, quality care in the areas of acute care, primary healthcare, health prevention and promotional activities.	Monthly	• Executive Director of Medical Services (Co-chair) • Executive Director of Nursing and Midwifery (Co-chair) • Executive Director Primary Health • Allied Health Clinical Lead • Director Mental Health Alcohol and Other Drugs Service • Director of Oral Health • Director of Quality, Safety & Risk • Royal Flying Doctor Service Representative • Apunipima Cape York Health Council, Medical Representative • Directors of Medical Services (3) • Directors of Nursing (2) • Clinical Nurse Consultants (2) • Rural and Remote Clinical Support Unit representative • Consumer Representative/s
People and Culture Governance Committee	Provides a strategic approach to ensuring a safe environment for staff, patients, other clients and visitors. Oversight of the TCHHS workforce strategy, workplace health and safety and learning and development.	Monthly	• Executive Director of Workforce and Performance (Chair) • Occupational Health and Safety Manager • Human Resources Manager • Learning and Development Coordinator • Director of Infrastructure • Director of Quality Safety & Risk • Representation from Northern Leadership Team (Northern Sector) • Representation from Eastern Leadership Team (Southern Sector) • Representation from Western Leadership Team (Southern Sector)

Table 3: Management Committees (cont)

Committee	Purpose and role	Frequency	Membership
Finance and Resource Management Committee	Review capital investment proposals & funding submissions. Assess & approve annual budgets. Establish and monitor internal scorecard. Advise Executive Management Committee on financial performance. Monitor & assess financial risks. Monitor progress against audit action plans. Monitor compliance against & effectiveness of financial policy. Strategic financial modelling.	Monthly	• Chief Financial Officer (Chair) or delegate • Principal Accountant • Management Accountant • Executive General Manager (North) • Executive General Manager (South) • Executive Director of Medical Services • Executive Director of Nursing and Midwifery • Executive Director of Workforce and Performance
Infrastructure Governance Committee	To make recommendations to EMT on its infrastructure and assets strategy and projects throughout the TCHHS. Ensure alignment of TCHHS strategic asset management planning to State-wide plans, DoH Service Agreement, the TCHHS Strategic Plan and the TCHHS Health Service Plan. Provide strategic advice to the Executive Management Team.	Monthly	• Executive General Manager – South (Chair) • Executive General Manager – North • Director of Infrastructure • Capital Works Manager • A/Capital Works Project Manager • Chief Finance Officer or delegate • Occupational Health and Safety Manager

5.4 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. The Board operates within its Board Charter to ensure statutory compliance. The following members were appointed for the terms shown in Table 4:

Table 4: Torres and Cape Hospital and Health Board

Name & appointment date	Current term of office	Biography
Mr Robert (Bob) McCarthy (1/7/2014)	**Chair** 1/07/2014 to 17/05/2018	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.
Ms Tracey Jia (1/7/2014)	26/06/2015 to 17/05/2018	Since 2012, Ms Jia has been a member of the Cape York HHS board. 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.
Associate Professor Ruth Stewart (1/7/2014)	26/06/2015 to 17/05/2018 **Deputy Chair since** 12/12/2014	Dr Stewart is Associate Professor of Rural Medicine and Director, Rural Clinical Training and Support at James Cook University. She also has been a member of the Cape York HHS board since 2012. Dr Stewart has chaired the Cape York HHS's Safety and Quality Committee and served on the Audit Committee and brings extensive management and clinical experience to the Board.
Mr Gregory Edwards (1/7/2014)	26/06/2015 to 17/05/2018	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.
Cr Ted (Fraser) Nai (1/7/2014)	26/06/2015 to 17/05/2018	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 Horace Baira (19/1/2015)	19/01/2016 to 17/05/2019	Mr Baira 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.
Mr Brian Woods (19/1/2015)	19/01/2016 to 17/05/2019	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.

Name & appointment date	Current term of office	Biography
Ms Karen Price (11/12/15)	11/12/2015 to 17/05/2017	Ms Price lives in Cooktown and has been involved in community and regional-based roles including management of regional projects in that town for the past 12 years. She is currently Director of the Cooktown District Community Centre and is a Councillor with Cook Shire Council with portfolios across community, arts and education. Ms Price previously worked for Cape York Hospital and Health Service as manager of the Learning and Development Unit.
Dr Scott Davis (18/5/2016)	18/05/2016 to 17/05/2017	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 FNQ&TS sector. He holds a doctorate from the University of Sydney in Indigenous Community Capacity (economic and social development).

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.

5.4.1. Board Performance

The Board meets monthly and is required to perform the work of the Board in determining strategy, monitoring performance and making decisions. During 2015-16 there were 12 Board meetings held using a mix of face to face, videoconferencing and teleconferencing, with an overall members' attendance rate of 85 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.

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.

Governance - management and structure

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.

5.4.2. 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 Table 5.

Table 5: Torres and Cape Hospital and Health Board Committees

Name	Frequency	No. Board Members	No. External Non-Board Members	Role in supporting the Board includes, for example:	No. meetings 2015-16
Executive Committee	As required	4		Monitoring Service's overall performance and working with Service's Chief Executive in responding to critical emergent issues requiring urgent decision making	5
Safety and Quality Committee	Monthly	6		Monitoring Service's governance relating to safety and quality of health services	8
Finance and Perfomance Committee	Monthly	4		Monitoring financial budgets and performance	10
Audit and Risk Committee	Monthly	5	1	Monitoring Service's internal controls, external audits and risk management	9

*Out of session meetings were held where required.

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 the 2015-2016 financial year was $863.13.

5.4.3. 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 Table 6 below:

Governance - management and structure

Table 6: Torres and Cape Hospital and Health Board Audit and Risk Committee Disclosure

Name	Period on Committee	Role on Audit and Risk Committee	Remuneration
Greg Edwards	01/07/2015 to 30/06/2016	Committee Chair	See Note 31 to Financial Statement
Assoc Prof Ruth Stewart	01/07/2015 to 30/06/2016	Committee member / Deputy Chair	See Note 31 to Financial Statement
Tracey Jia	01/07/2015 to 30/06/2016	Committee member	See Note 31 to Financial Statement
Brian Woods	01/07/2015 to 30/06/2016	Committee member	See Note 31 to Financial Statement
Ian Jessup	01/07/2015 to 30/06/2016	External non-Board member on Committee	Nil
Karen Price	11/12/2015 to 30/06/2016	Committee member	See Note 31 to Financial Statement

The Committee has observed the terms of its charter and had due regard to Queensland Treasury's *Audit Committee Guidelines*. 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 that there is a common understanding of the key risks to TCHHS. These risks will be clearly documented in TCHHS's risk register which will be 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

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 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 to it
- 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 to these
- 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.

During the year, issues addressed by the Audit and Risk Committee and reported to the Board included:

- regular review of the Service's risk management framework, policies and procedures and reporting, particularly the escalation of risks at all levels including to the Board
- monitoring the preparation of annual financial statements and external audit by Queensland Audit Office
- developing a comprehensive Committee work plan for approval by the Board
- monitoring the progress of implementation of the Finance System Replacement (FSR) project
- monitoring both internal and external audit activity and making relevant recommendations to the Board
- making representations to the Department on key strategic audit and risk matters
- reviewing the Service's compliance framework, policies and procedures and reporting, including fraud control
- reviewing and recommending to the Board the Torres and Cape HHS Finance Management Practice Manual.

Related entities

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

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 3 year audit plan.

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

- Financial Accountability 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 functionally directly to the Board's Audit and Risk Committee and administratively to the Health Service Chief Executive.

Governance - management and structure

5.5 *Public Sector Ethics Act 1994*

Torres and Cape HHS is a prescribed public service agency under sec. 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, whether on the Board, committees, management, clinicians, support staff, administrative staff or 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 provided 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 by the HHS 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. When breaches of the Code of Conduct were identified in 2014-15 appropriate performance management or other action was taken to ensure continuing compliance with the Code. Where the breaches involved suspected unlawful conduct, the matter was referred to the department's Ethical Standards Unit or other appropriate agency for any further action.

In the development of the HHS Strategic Plan 2013-2017, 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 have proper regard to the ethics principles and values, and the approved code of conduct.

6. GOVERNANCE - RISK MANAGEMENT AND ACCOUNTABILITY

6.1 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 who set the risk tolerance of the organisation. The Integrated Risk Management Framework is an important part of the Torres and Cape HHS Governance Framework and is central to decision making and prioritisation of actions by the TCHHS. All staff have access to report internal and external risks to the organisation.

The Board Audit and Risk Committee is comprised of five Board members and one external consultant (see Section 5.4.3)

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

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

The Integrated Risk Management Framework and Risk Management Procedure has been reviewed during audit by the Australian Council on Health Care Standards in 2015-2016, and is recognised as a significant improvement in the organisation's risk management.

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

- Helideck safety compliance (Thursday Island)
- Operating suite anaesthetic gas scavenging system (Cooktown)
- Primary Health Care Facility and accommodation upgrades
- Asbestos encapsulation (Thursday Island)
- Multi-drug resistant Tuberculosis management in Torres Strait
- Stabilisation of the Torres and NPA clinical information system

Current significant issues under management:

- Electrical switchboard maintenance in numerous Primary Health Care Centres
- Improving central sterilising department compliance with AS4187 (Thursday Island and Cooktown)
- Improving local clinical staffing at Dauan and Stephen Island
- Improving the Torres and Cape HHS clinical information management system and information sharing.

6.2 External scrutiny

For the 2015-16 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.

6.3 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. TCHHS has information and processes in place to assist patients to gain access to their medical records.

Torres and Cape Hospital and Health (TCHHS) create, receive and keep clinical and business records to support legal, community, and stakeholder requirements. Business and clinical records exist in physical and digital formats.

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

TCHHS 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.

Significant improvements are planned for the organisation including:

- Planning for a new digital clinical eHealth patient information system.
- An Information and Communication Technology (ICT) governance framework to manage ongoing investment and priorities in information management and technology solutions and assigning responsibilities for ICT management.
- A project to modernise business records management is underway in partnership with eHealth Queensland. This includes:
  - Corporate Information Management
  - Electronic forms, workflows and approvals to automate and streamline business processes
  - Business Intelligence and Reporting
  - Recordkeeping compliance with the Public Records Act 2002
  - Collaboration portals and enterprise search.

Patients and clients of the Torres and Cape HHS can obtain access to medical records by applying through the Queensland Department of Health Administrative Access application process, *Right to Information Act*. The Torres and Cape HHS did not disclose confidential informaiton in the public interest during 2015-16 in accordance with s.160 of the Hospital and Health Board Act 2011.

7. GOVERNANCE - HUMAN RESOURCES

7.1 Workforce planning and performance

As at 30 June 2016, Torres and Cape HHS has a total, occupied full-time equivalent (FTE) of 880.72 employees across all classification streams, an increase of 44.72 staff from 2014-2015. Of these, 44.67 per cent are clinical and 55.33 per cent are support staff. A breakdown of this total is outlined in the following table:

Table 7: Staff Full-time Equivalent (FTE) at 30 June 2016

	Medical	Nursing	Health practitioners	Management &Clerical	Operational	Trades	Total
Permanent	22.00	214.03	37.89	156.00	185.22	8.00	623.14
Temporary	7.70	88.16	12.30	68.14	35.05	0.00	211.35
Casual	0.39	10.96	0.00	6.02	28.86	0.00	43.23

The turnover rate for June 2016 was 1.08 per cent. The permanent separation rate for the 2015-2016 period was 1.11 per cent per month.

Additional profile information includes:

- 11.48 per cent of the Torres and Cape HHS workforce is 60 years or older
- 13.57 per cent of the workforce comes from a non-English speaking background.

The Torres and Cape HHS Workforce Plan articulates the challenges faced with regard to recruitment and retention of staff in a rural and remote environment and provides strategic approaches to overcoming these barriers. Workforce planning requires the supply of the right number of staff across all workstreams, recruitment, retention, education and development.

In April 2016, Torres and Cape HHS successfully transitioned full ownership of recruitment services from the Cairns and Hinterland HHS with the goal to improve the process. See Signficant Achievements in Section 3.3.4.

In an effort to attract the best people and to build sustainable talent pools for clinical positions the HHS is currently working in collaboration with our Nursing Workforce Team to create a recruitment marketing campaign that can be rolled out across all media platforms which will focus on rural and remote incentive packages and work life balance opportunities. This will be a key focus in 2016-2017.

In early 2016 the Service established a new 'Employee Opinion Survey' Review and Action Group to push forward on some of the recommendations of 2015 and 2016 Working for Queensland Surveys. The Action Group has 21 staff members from a range of facilities, and clinical and adminstrative sectors. Torres and Cape HHS is committed to ensuring that the results from these Employee Surveys are used to bring about positive change and improvements to the HHS.

Governance - human resources

The recruitment panel training that is being delivered throughout the TCHHS focuses on:

- increasing the availability of training in recruitment and selection
- challenging our traditional approaches to recruitment and selection - make our strategy robust
- candidate care – managing recruitment and selection processes in a timely and effective manner
- improving and supporting onboarding processes.

Torres and Cape HHS recognises that some staff may experience situations of domestic and family violence which can impact on their safety, wellbeing, attendance and performance at work. We are committed to providing a safe and supportive workplace for our employees by introducing a Domestic and Family Violence policy and guidelines. The Service is committed to protecting and improving the health and wellbeing of its employees and their immediate family by regularly promoting the Employee Assistance Program (EAP) for personal and work-related issues. The Service also runs a Fitness Passport program for Cairns-based staff offering reductions in gym and fitness facility membership.

Torres and Cape HHS has a flexible working arrangements policy which is particularly popular with staff returning to work from maternity leave. The HHS provides job sharing, nine-day fortnight rostered day-off and accrued day-off arrangements which enables staff to negotiate flexible work start and finish times and where appropriate, the HHS supports working from home and telecommuting arrangements.

A skilled, capable and professional workforce is required to adapt to the changing priorities and objectives to achieve the Torres and Cape HHS strategic direction. The Torres and Cape HHS has a Learning and Development Strategy and Operational Plan. Learning and Development activities in 2015-2016 included:

- research of funding opportunities from external training providers. In 2015/16 the HHS received a larger number of Administration and Operational Officer Incentive Fund places than allocated
- continuation of the orientation, induction, mandatory training and professional development programs
- maintenance of a one-stop Learning and Development intranet page to provide staff access to all relevant learning and development resources, links and learning calendars
- hosting of work experience positions and employment of school-based trainees to build a career pathway for young people in our local communities
- implementation of the Foundational Leadership Development Program to support the mature age staff in our HHS who have not had formal leadership training
- implementation of the 7 Habits of Highly Effective People Signature Edition 4.0 leadership training to develop and support the leaders in the HHS
- implementation of a Line Manager Program including face-to-face workshops, training modules and an intranet toolkit to build the capability of our line managers to perform their roles;
- implementation of an Allied Health Orientation Package, including resources and an intranet site to support new and existing Allied Health staff and managers and those utilising the services.

Torres and Cape HHS continues to encourage and maintain a strong consultative relationship with the workforce and the unions which represent the staff through the Health Service Consultative Forum which meets monthly. The meetings involve discussions on proposed organisational change. Consultative mechanisms are a crucial element in employee relations and the HHS encourages staff to engage with their respective bodies.

Governance - human resources

By continuing to improve People and Culture planning and governance frameworks, Torres and Cape HHS seeks to provide appropriate, effective and quality human resource services.

7.2 Early retirement, redundancy and retrenchment

No redundancy, early retirement, or retrenchment packages were paid during the 2015-2016 financial year.

7.3 Occupational Health and Safety

The geographical, environmental and cultural challenges that are encountered by the HHS workforce will always have an impact on business activities. This provides the HHS with the ability to be innovative in the solutions which are implemented when working towards becoming a safety driven organisation. The new Safety Management System was approved though an external AS4801 audit and when fully implemented will continue to improve the organisations ability to embed safety into the everyday business and truly achieve a safety culture across the entire organisation.

Since the amalgamation there has been a significant shift within the organisation to acknowledge responsibility in relation to Work Health and Safety obligations. The Occupational Health and safety performance this year:

- Legislative Compliance Checklist – zero non-conformances
- New Statutory Claims – 39 notifications, which is 6 cases below the industry average of 45. Two remained notifications only, 13 claims were denied and 24 accepted.
- Average Paid Days per accepted WorkCover Claim – 40.17
- Average days to first return to work – 33.5 which is 13.79 above the industry average
- Average Monthly Payments per accepted WorkCover claim - $4,031
- Common Law Conversion Rate - nil
- New Common Law claims – nil

The 2015-16 Financial Year saw a 46 per cent increase in the number of WorkCover Notifications on the previous financial year. This increase 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 paid days per accepted claim; average days to first return to work and average monthly payments per accepted claim. 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.

8. SUMMARY OF FINANCIAL PERFORMANCE

Torres and Cape HHS achieved a strong financial outcome for the year ending 30 June 2016 recording a $5.7 million surplus. This represents a 2.9 per cent variance against its revenue base of $198.6 million. The result contains one-off gains from the Backlog Maintenance Remediation Program incentive funding of $4.4 million and $1.3 million in one-off gains from unspent discrete programs.

The result was positive given the additional investment of $1.6 million in one-off projects funded by achievement of the efficiency targets and through the increase of own sourced revenue. These projects included investment in Indigenous Health Worker education and development, capital infrastructure works, the revitalisation of dental services in Torres Strait Islands and Northern Peninsula Area, and the completion the first Torres and Cape HHS Service Plan.

Excluding the one-off gains, from a normal operating perspective the organisation ended the year in a break-even position. This shows that the underlying financial result for Torres and Cape HHS remains challenging in a constrained funding environment. Torres and Cape HHS is a block funded organisation and this requires us to continually monitor performance, manage costs and actively explore own-source revenue initiatives. As a large and remote health service, Torres and Cape HHS faces challenges from short-term external medical and nursing costs and other costs associated with remoteness, including patient and staff travel and the cost of attracting skilled staff (including incentive payments and growing staff housing costs). The financial result was achieved while Torres and Cape HHS is facing a growing demand on its services. These demand pressures arise from an increasing burden of chronic diseases including diabetes, respiratory and cardiovascular disease.

8.1 Source of funds

Torres and Cape HHS income from combined funding sources was $198.6 million. Funding was primarily derived from the Department of Health at $183.1 million. Other funding sources included user charges at $1.5 million, other revenue at $2 million, and grants and contributions at $12 million.

8.2 Spending

Total expenses for Torres and Cape HHS for 2015-2016 were $192.9 million, averaging a $0.527 million per day spend on servicing the communities in the region. The largest expense was labour costs of $100.8 million which includes clinicians and support staff. The second highest expense was supplies and services at $78.3 million. This included patient and retrieval costs of $17.7 million, $16.3m of consultancy and contracts expense (including $11 million for medical and nursing agency staff and $4.6 million for Non-Government Organisation's contracts), operating leases of $9.3 million, clinical supplies of $3.1 million and drug expenses of $2.3 million.

8.3 Financial outlook

The surplus generated for the Torres and Cape HHS in the current and prior financial year will be reinvested for better health outcomes for the community. The organisation will continue to reinvest in capital projects such as staff housing and staff development programs to ensure the HHS is well placed to meet the ongoing needs of our growing community and ensure the Torres and Cape HHS is well placed to achieve its strategic objectives into the future.

See Attachment 1 for Financial Statements 2015-16

9. Compliance checklist

Table 8: Compliance checklist

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister	ARRs – section 8	p.1
Accessibility	Table of contents Glossary	ARRs – section 10.1	p. 2-3
	Public availability	ARRs – section 10.2	p.i
	Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 10.3	p.i
	Copyright notice	*Copyright Act 1968* ARRs – section 10.4	p.i
	Information Licensing	*QGEA – Information Licensing* ARRs – section 10.5	p.i
General information	Introductory Information	ARRs – section 11.1	p.4
	Agency role and main functions	ARRs – section 11.2	p.5
	Operating environment	ARRs – section 11.3	p.7
Non-financial performance	Government's objectives for the community	ARRs – section 12.1	p.14
	Other whole-of-government plans/specific initiatives	ARRs – section 12.2	p.14
	Agency objectives and performance indicators	ARRs – section 12.3	p.15
	Agency service areas, and service standards	ARRs – section 12.4	p.15
Financial performance	Summary of financial performance	ARRs – section 13.1	p.34
Governance – management and structure	Organisational structure	ARRs – section 14.1	p.18
	Executive management	ARRs – section 14.2	p.18
	Government bodies (Statutory bodies and other entities)	ARRs – section 14.3	n/a
	Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* ARRs – section 14.4	p.28
	Queensland public service values	ARRs – section 14.5	p.28
Governance – risk management and accountability	Risk management	ARRs – section 15.1	p.29
	External scrutiny	ARRs – section 15.2	p.30
	Audit committee	ARRs – section 15.3	p.24
	Internal audit	ARRs – section 15.4	p.26
	Information systems and recordkeeping	ARRs – section 15.6	p.30
Governance – human resources	Workforce planning and performance	ARRs – section 16.1	p.31
	Early retirement, redundancy and retrenchment	Directive No.11/12 *Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	p.33

Compliance checklist

Table 8: Compliance checklist (cont)

Summary of requirement		Basis for requirement	Annual report reference
Open Data	Consultancies	ARRs – section 17 ARRs - section 34.1	p.i
	Overseas travel	ARRs – section 17 ARRs - section 34.2	p.i
	Queensland Language Services Policy	ARRs – section 17 ARRs - section 34.3	p.i
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 & 50 ARRs – section 18.1	Attach. 1
	Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	Attach. 1

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 2016

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

Torres and Cape Hospital and Health Service

Financial Statements – 30 June 2016

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Torres and Cape Hospital and Health Service
Statement of Comprehensive Income
For the year ended 30 June 2016

	Note	2016 $'000	2015 $'000
Income			
Health service funding	2	183,122	166,833
User charges and fees	3	1,449	1,609
Grants and other contributions	4	12,023	12,365
Other revenue	5	2,041	987
Interest		15	30
Total revenue		198,650	181,824
Expenses			
Employee expenses	6	10,185	8,971
Department of Health contract staff	7	90,682	81,318
Supplies and services	8	78,339	77,001
Depreciation	13	11,178	10,805
Impairment losses		(19)	16
Other expenses	9	2,531	1,560
Total expenses		192,896	179,671
Operating result for the year		5,754	2,153
Other comprehensive Income			
Items that will not be reclassified subsequently to operating result			
Increase(Decrease) in Asset Revaluation Surplus		(1,323)	1,323
Total other comprehensive income		(1,323)	1,323
Total comprehensive income		4,431	3,476

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

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Torres and Cape Hospital and Health Service
Statement of Financial Position
As at 30 June 2016

	Note	2016 $'000	2015 $'000
Current Assets			
Cash and cash equivalents	10	22,364	21,049
Trade and other receivables	11	7,173	2,016
Inventories	12	489	555
Other current assets		662	597
Total current assets		30,688	24,217
Non-current assets			
Property, plant and equipment	13	185,426	192,270
Total non-current assets		185,426	192,270
Total assets		216,114	216,487
Current liabilities			
Trade and other payables	14	12,994	12,107
Accrued employee benefits	15	705	622
Unearned revenue		1,180	1,425
Total current liabilities		14,879	14,154
Total liabilities		14,879	14,154
Net assets		201,235	202,333
Equity			
Contributed equity	16	193,329	198,857
Accumulated surplus		7,906	2,153
Asset revaluation surplus		-	1,323
Total equity		201,235	202,333

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

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Torres and Cape Hospital and Health Service
Statement of Changes in Equity
For the year ended 30 June 2016

	Contributed equity $'000	Accumulated surplus/ (deficit) $'000	Asset revaluation surplus $'000	Total equity $'000
Balance at 1 July 2014	-	-	-	-
Operating result for the year	-	2,153	-	2,153
Total other comprehensive income				
Increase in asset revaluation surplus	-	-	1,323	1,323
Total comprehensive income for the year	-	2,153	1,323	3,476
Transactions with owners:				
Transfer of net assets on 1 July 2014	223,946	-	-	223,946
Net assets transferred during year via machinery-of-Government change	(19,827)	-	-	(19,827)
Equity injections	5,545	-	-	5,545
Equity withdrawals	(10,807)	-	-	(10,807)
Balance as at 30 June 2015	**198,857**	**2,153**	**1,323**	**202,333**
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 with owners:				
Correction of prior year error - assets not previously recognised	1,445	-	-	1,445
Net assets transferred during year	1,540	-	-	1,540
Equity injections	2,664	-	-	2,664
Equity withdrawals	(11,178)	-	-	(11,178)
Balance as at 30 June 2016	**193,329**	**7,906**	**-**	**201,235**

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

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Torres and Cape Hospital and Health Service
Statement of Cash Flows
For the year ended 30 June 2016

	Note	2016 $'000	2015 $'000
Cash flows from operating activities			
Inflows:			
User charges and fees		2,217	1,808
Health service funding		165,947	155,808
Grants and other contributions		11,896	12,310
Interest received		15	30
GST collected from customers		1,357	370
GST input tax credits from ATO		5,203	4,775
Other		2,041	594
Outflows:			
Employee expenses		(10,103)	(8,371)
Department of Health contract staff		(93,642)	(81,229)
Supplies and services		(73,844)	(82,424)
Grants and subsidies		(1,351)	(1,376)
GST paid to suppliers		(5,558)	(4,779)
GST remitted to ATO		(1,411)	(324)
Other expenses		(1,229)	(1,217)
Net cash provided by/(used in) operating activities	24	**1,537**	**(4,025)**
Cash flows from/(used in) investing activities			
Payments for property, plant and equipment		(2,887)	(2,734)
Net cash from/(used in) investing activities		**(2,887)**	**(2,734)**
Cash flows from financing activities			
Proceeds from equity Injections		2,664	5,545
Net cash from/(used in) financing activities		**2,664**	**5,545**
Net increase/(decrease) in cash and cash equivalents		**1,315**	**(1,214)**
Cash and cash equivalents at the beginning of the financial year		21,049	22,263
Cash and cash equivalents at the end of the financial year	10	**22,364**	**21,049**

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

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Note 1. Objectives and principle 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 principle place of business of TCHHS is:

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

TCHHS serves a population of approximately 25,500 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 principle 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;
- 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 2016, 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 (NQPHNL)

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.

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

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Note 1. Objectives and principle activities of the Torres and Cape Hospital and Health Service (continued)
(c) Investment in North Queensland Primary Health Network Limited (NQPHNL) (continued)

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 Torres and Cape Hospital and Health Service 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 Torres and Cape Hospital and Health Service 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 the Company 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. Health service funding

	2016 $'000	2015 $'000
State Government block funding	61,474	55,358
System manager funding	121,648	111,475
Total health service funding	183,122	166,833

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.

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.

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. User charges and fees

	2016 $'000	2015 $'000
Hospital fees	367	469
Multi-purpose nursing fees received	446	418
Inter-hospital and health service recoveries	236	287
Pharmaceutical benefits scheme reimbursement	112	162
Training fees	36	41
Other	153	182
Rental income	99	50
	1,449	1,609

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Note 3. User charges and fee (continued)

User charges and fees controlled by TCHHS are recognised as revenues when the revenue has been earned and can be measured reliably with a sufficient degree of certainty; and where they can be deployed for the achievement of TCHHS's objectives.

Revenue recognition for user charges and fees is based on either invoicing for related goods, services and/or the recognition of accrued revenue.

Note 4. Grants and other contributions

	2016 $'000	2015 $'000
Australian Government – home and community care grants	926	1,097
Specific purpose – multipurpose centre	-	1,618
Rural and Remote Medical Benefits	2,669	1,975
Pharmaceutical Benefits Scheme Section 100 Arrangement	2,263	2,190
Rural Health Outreach Fund	949	961
Commonwealth Indigenous Health Programs	4,062	4,035
Queensland Government - home and community care grants	280	272
Other grants	747	162
Donations	127	55
	12,023	12,365

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 5. Other revenue

	2016 $'000	2015 $'000
Contract staff and recoveries	873	172
Inventory stock adjustments	-	133
Asset adjustments	-	260
Other	1,168	422
	2,041	987

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.

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Note 6. Employee expenses

	2016 $'000	2015 $'000
Wages and salaries	8,659	7,694
Annual leave levy	535	435
Employer superannuation contributions	615	515
Long service leave levy	178	152
Sick leave	67	29
Payroll tax	-	1
Other employee related expense	131	145
	10,185	8,971

The number of directly engaged full-time employees as at 30 June 2016 is 33 (2015: 33).

Note 7. Department of Health contract staff

TCHHS through service arrangements with DoH has engaged 830 (2015: 802) full time equivalent roles in a contracting capacity as at 30 June 2016. 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
The 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.

Payroll tax and workers' compensation insurance are a consequence of employing employees, but are not counted in an employee's total remuneration package. They are not employee benefits and are recognised separately as employee related expenses.

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Note 8. Supplies and services

	2016 $'000	2015 $'000
Building services	2,221	1,959
Catering and domestic supplies	1,034	813
Clinical supplies and services	3,122	2,660
Communications	1,744	2,011
Computer services	1,823	969
Consultants and contractors	16,315	16,861
Drugs	2,285	2,534
Electricity and other energy	2,879	2,723
Expenses relating to capital works	689	6,302
Freight	1,014	860
Motor vehicles	245	294
Operating lease rentals	9,379	8,638
Other supplies and services	952	1,299
Other travel	5,632	5,747
Pathology, blood and related equipment	4,471	4,007
Patient transport	4,052	3,660
Patient travel	13,731	10,480
Repairs and maintenance	6,751	5,184
	78,339	77,001

Services purchased from Non-Government Organisations (NGO)
During the year $4.655m (2015: $5.469m) was expensed in relation to the agreement with Apunipima Cape York Health Council (Apunipima) and Royal Flying Doctor Service (RFDS) for the provision of health services to public patients.

Services received free of charge or for a nominal value are recognised only if the services would have been purchased if they had not been donated and their fair value can be measured reliably. When this is the case, an equal amount is recognised as revenue and an expense.

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.

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Note 9. Other expenses

	2016 $'000	2015 $'000
Advertising	145	92
Audit fees - internal and external	367	269
Insurance	501	608
Losses from the disposal of non-current assets	80	77
Special payments - ex gratia	14	6
Other legal costs	118	195
Asset revaluation decrement	376	-
Inventory stock adjustments	86	-
Other	844	313
	2,531	1,560

Remuneration of auditors

	2016 $'000	2015 $'000
Audit of the Financial Statements - Queensland Audit Office	160	165

Insurance

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 2015-16 policy year, the premium was allocated to each HHS according to the underlying risk of an individual insured party.

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.

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 an ex gratia payment of $0.014m (2015: $0.005m) was made to a patient for out of pocket medical expenses.

Note 10. Cash and cash equivalents

	2016 $'000	2015 $'000
Cash on hand	1	1
Cash at bank	22,287	20,202
QTC cash funds	76	846
	22,364	21,049

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. 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.

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Note 10. Cash and cash equivalents (continued)

A deposit is held with the Queensland Treasury Corporation (QTC) reflecting the value of the Torres and Cape Hospital and Health Service General Trust Funds. The value of this deposit as at 30 June 2016 was $0.076m (2015: $0.845m) and the annual effective interest rate was 2.85% (2015 2.84%)

Note 11. Trade and other receivables

	2016 $'000	2015 $'000
Trade receivables	763	748
Less: Allowance for impairment of receivables	(346)	(563)
	417	185
GST input tax credits receivable	630	453
GST payable	(40)	(67)
	590	386
Health service funding in arrears	6,162	1,415
Other	4	31
	6,166	1,446
	7,173	2,016

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 while other receivables may take longer than twelve months.

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.

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 60 days. The allowance for impairment reflects the assessment of the credit risk associated with receivables balances.

Movements in the provision for impairment of receivables are as follows:	2016 $'000	2015 $'000
Balance at the start of the year	563	549
Receivables written off during the year as uncollectable	(198)	(2)
Increase/(decrease) in provision recognised	(19)	16
Balance at the end of the year	346	563

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Note 11. Trade and other receivables (continued)

Ageing of trade receivables 2015

	Not overdue	*Less than 30 days*	*31 - 60 days*	*61 - 90 days*	*More than 90 days*	*Total*
	$'000	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*
Receivables	36	23	31	31	627	748
Allowance for impairment	-	-	-	(11)	(552)	(563)
Carrying amount	36	23	31	20	75	185

Ageing of trade receivables 2016

	Not overdue	*Less than 30 days*	*31 - 60 days*	*61 - 90 days*	*More than 90 days*	*Total*
	$'000	*$'000*	*$'000*	*$'000*	*$'000*	*$'000*
Receivables	-	302	11	13	437	763
Allowance for impairment	-	-	-	-	(346)	(346)
Carrying amount	-	302	11	13	91	417

Note 12. Inventories

Inventories consist mainly of pharmaceutical and medical supplies held for distribution in hospitals and are provided to patients at a subsidised rate. 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.

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Note 13. Property, plant and equipment

Note 13 a. Balances and reconciliation of carrying amounts

	Land $'000	Buildings $'000	Plant and equipment $'000	Capital works in progress $'000	Total $'000
Net assets received on 1 July 2014	19,193	189,876	8,722	684	218,475
Additions	-	434	1,393	906	2,733
Disposals	-	-	(81)	-	(81)
Revaluation increments	-	1,323	-	-	1,323
Asset adjustments	-	260	-	-	260
Transfers between classes	-	(200)	739	(539)	-
Transfers in	-	5,274	5	-	5,279
Transfers out	(9,697)	(15,217)	-	-	(24,914)
Depreciation expense	-	(9,088)	(1,717)	-	(10,805)
Carrying amount at 30 June 2015	9,496	172,662	9,061	1,051	192,270
At 30 June 2015					
At cost/fair value	9,496	270,197	19,063	1,051	299,807
Accumulated depreciation	-	(97,535)	(10,002)	-	(107,537)
Carrying amount at 30 June 2015	9,496	172,662	9,061	1,051	192,270
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 adjustments	-	396	1,049	-	1,445
Transfers between classes	-	2,304	616	(2,920)	-
Transfers in *	-	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
At 30 June 2016					
At cost/fair 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

* Transfers in during the current period included $0.126m of donated dental assets and DoH contributed assets at completion of construction $1.786m.

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Note 13 b. Accounting policies

Recognition thresholds for property, plant and equipment
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 of assets
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 of property, plant and equipment
Land and Buildings are measured at fair value and in accordance with AASB 116 Property, Plant and Equipment, AASB 13 Fair Value 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 for 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 (CWIP) are not depreciated until ready for use, when they are reclassified to the relevant classes within property, plant and equipment.

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.

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Note 13 b. Accounting policies (continued)

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

Class	Depreciation rates used	Useful lives
Buildings	1.2% – 4%	25 – 79 years
Plant and equipment	4% – 20%	5 – 23 years

Key estimate: 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 lives, or technically obsolete or non-strategic assets that have been abandoned or sold will be written off or written down.

Impairment of non-current assets
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 depreciated 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 of property, plant and equipment at fair value
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.

Approximately 30% of buildings were revalued at fair value using depreciated replacement cost methodology. Indexation assessment was completed for the remaining land and building assets for the year ending 2016. No adjustment was made to the carrying value of the indexed assets (2015: Nil) due to the accumulative percentage increase being less than 5% in accordance with the QLD Treasury and Trade Non-Current Asset Policy (NCAP3).

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.

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

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Note 13 c. Valuation

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 Policy the independent revaluations occur at least once every five years. In the off cycle year's 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.

Buildings
An independent valuation of the building portfolio was performed during 2015-16 by independent quantity surveyors AECOM Cost Consulting Pty Ltd (AECOM). Reflecting the specialised nature of health service buildings and on hospital-site residential facilities, fair value is determined by applying depreciated replacement cost methodology or an index which approximates movement in market prices for construction labour and other key resource inputs, as well as changes in design standards as at reporting date. Both methodologies are executed on behalf of TCHHS by AECOM.

AECOM physically inspected each asset to be revalued using depreciated replacement cost methodology. The observed Condition Assessment Rating was then applied to the asset in order to estimate 'Cost to Bring the Asset to Current Standards'. The 'Depreciated Replacement Cost' is the result of the 'Replacement Cost' less the 'Cost to Bring the Asset to Current Standards'

Key judgement and estimate: Depreciated replacement cost is determined as the replacement cost less the cost to bring an asset to current standards. In determining the depreciated replacement cost the independent quantity surveyors consider a number of factors such as age, gross floor area, number of floors, number of lifts and staircases, functionality, location and physical condition.

The 'cost to bring to current standards' is the estimated cost of refurbishing the asset to bring it to current standards and a new condition. This estimated cost is linked to the condition factor of the building determined by the quantity surveyor. The condition of the building is based on visual inspection, asset condition data, guidance from asset managers and previous reports. In assessing the condition of a building the following ratings are applied by the quantity surveyors.

Category	Condition	Description
1	Very good condition	Only normal maintenance required
2	Minor defects only	Minor maintenance required (up to 5% of capital replacement cost)
3	Maintenance required to return to acceptable level of service	Significant maintenance required (up to 50 per cent of capital replacement cost)
4	Requires renewal	Complete renewal of internal fit-out and services (up to 70 per cent of capital replacement cost)
5	Asset unserviceable	Complete asset replacement required

Note 13 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

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Note 13 d. Fair value measurement (continued)

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.

2015	Level 1 $'000	Level 2 $'000	Level 3 $'000	Total $'000
Assets				
Land	-	9,496	-	9,496
Buildings (health service sites)	-	-	172,662	172,662
Total assets	-	9,496	172,662	182,158

2016	Level 1 $'000	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

There were no transfers between levels during the financial year.

Note 14. Trade and other payables

	2016 $'000	2015 $'000
Trade and other payables	2,321	4,534
Department of Health contract staff	2,600	1,830
Accrued expenses	8,073	5,743
	12,994	12,107

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 15. Accrued employee benefits

TCHHS directly engaged employees
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.

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Note 15. Accrued employee benefits (continued)

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 – directly engaged employees
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 16. Contributed equity

	2016 $'000	2015 $'000
Opening balance at beginning of year	198,857	-
Prior year correction		
Correction of prior year error - assets not previously recognised	1,445	-
Non-appropriated equity injections		
Minor capital funding	2,664	5,545
Non-appropriated equity withdrawals		
Non-cash depreciation funding returned to DoH as a contribution towards the DoH capital works program	(11,178)	(10,807)
Non-appropriated equity asset transfers		
Transfer of net asset on 1 July 2014	-	223,946
Buildings	1,540	(19,827)
Balance at the end of the financial year	193,328	198,857

Equity transfer value total at 30 June 2016
Non-reciprocal transfers of assets and liabilities between wholly-owned Queensland State Public Sector entities as a result of machinery-of-government changes 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.

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Note 16. Contributed equity (continued)

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 $11.178m (2015: $10.805m) were offset by non-cash adjustments through equity withdrawals. Refer to Note 13 Property Plant and Equipment.

Note 17. 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. Apart from cash and cash equivalents, TCHHS holds no financial assets classified at fair value through profit or loss.

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

	2016 $'000	2015 $'000
Financial assets		
Cash and cash equivalents	22,364	21,049
Trade and other receivables	7,173	2,016
Total financial assets	29,537	23,065
Financial liabilities		
Trade and other payables	12,994	12,106

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.

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Note 17. Financial instruments (continued)

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 (CBA) and Queensland Treasury Corporation (QTC).

(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 from Queensland Treasury Corporation 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.

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Note 18. Key management personnel disclosures

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:

Position	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	Bob 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

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Note 18. Key management personnel disclosures (continued)

Position	Name	Contract classification/appointment authority	Initial appointment date
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	S24/S70 / *Hospital and Health Boards Act 2011*	1 July 2014
Chief Finance Officer (CFO) - Responsible for financial management, contract management, and statutory reporting obligations of TCHHS.	Danielle Hoins Cherie Campbell (Acting)	DSO 1 / *Hospital and Health Boards Act 2011*	17 April 2015 17 August 2015 to 4 September 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 (Acting)	HES 2 / *Hospital and Health Boards Act 2011*	5 January 2015 14 December 2015 to 3 January 2016
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 Presley	HES 2 / *Hospital and Health Boards Act 2011*	1 July 2014
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.	Katheryn McConnon Winton Barnes (Acting)	MMO 11 / *Hospital and Health Boards Act 2011*	7 December 2015 29 June 2015 to 15 January 2016

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Note 18. Key management personnel disclosures (continued)

Position	Name	Contract classification/appointment authority	Initial appointment date
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 - Workforce Performance - Responsible for providing leadership of organisational strategy to continuously develop and implement the people and performance strategies to enable the organisation to achieve its strategic priorities. Working directly with the HSCE, the outputs of this role are pivotal to the delivery of the objectives of the TCHHS including information and communications technology management and health information management.	Allyson Cousens Helen Reed (Acting)	DSO 1 / *Hospital and Health Boards Act 2011*	1 July 2014 5 June 2015 to 17 June 2015, 31 August 2015 to 18 September 2015, 30 November 2015 to 18 December 2015
Board Operations Manager - Responsible for providing strategic advice and governance support to the Hospital and Health Board, its Committees and the HSCE of TCHHS to fulfil their functions under the Hospitals and Health Boards Act 2011.	Andrea Brophy	AO6 / *Hospital and Health Boards Act 2011*	23 May 2015

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Note 18. Key management personnel disclosures (continued)

Position	Name	Contract classification/appointment authority	Initial appointment date
Executive Director, Rural & Remote Clinical Support - Responsible for leadership, management and expert advice within RRSCU on issues of clinical quality, safety, and service improvement including professional registration, credentialing and scope of clinical practice, standards and protocols, services capability, risk management, audit, quality performance measures, evidence based health care, service coordination and any other clinical support functions that address common issues for the RRHHSs.	Peter McCormack	DSO 1 / *Hospital and Health Boards Act 2011*	1 July 2014
Executive Director Primary Health Care provides strategic and profession leadership in the implementation, coordination and management of Primary Health Care programs within the Torres and Cape Hospital and Health Service. 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 Rhonda Shibasaki (Acting)	AO8/ *Hospital and Health Boards Act 2011*	1 July 2015 16 May 2016 to 30 June 2016

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 management personnel comprise the following components:

- Short term employee base benefits which includes 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 include amounts expensed in respect of long service leave.
- Post-employment benefits which include amounts expensed in respect of employer superannuation obligations.

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.

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Note 18. Key management personnel disclosures (continued)

Key management personnel – Board

TCHHS is independently and locally controlled by the Hospital and Health Board (The Board). The Board appoints the health service chief executive and exercises significant responsibilities at a local level, including controlling the financial management of TCHHS and the management of TCHHS land and buildings (Section 7 Hospital and Health Boards Act 2011).

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

2016	Short-term benefits					
Name and position	Base $'000	Non-monetary $'000	Post-employment benefits $'000	Long-term benefits $'000	Termination benefits $'000	Total $'000
Executive						
Board Operations Manager						
– Andrea Brophy	88	9	2	12	-	111
Chief Executive						
– Jill Newland	340	6	8	41	-	395
Chief Finance Officer						
– Danielle Hoins	128	9	3	18	-	158
– Cherie Campbell	5	9	0	1	-	15
Director, rural & Remote Clinical support						
– Peter McCormack	138	9	3	17	-	168
Executive Director, Workforce Performance						
– Allyson Cousens	142	10	3	18	-	173
– Helen Reed	8	9	0	1	-	18
Executive Director, Nursing & Midwifery						
– Lyn Wardlow	135	41	3	17	-	195
Executive General Manager, Northern Sector						
– Andrew Marshall	165	10	4	19	-	197
– Kim Veiwasenavanua	11	7	0	1	-	20
Executive General Manager, Southern Sector						
– Ian Pressley	172	-	4	19	-	195
Executive Director, Medical Services						
– Katheryn McConnon	81	4	3	11	-	99
– Winton Barnes	29	0	4	15	-	49
Executive Director, Primary Health Care						
– Vonda Moar-Malone	92	-	2	13	-	107
– Rhonda Shibasaki	18	-	0	2	-	20
Board						
Chairperson						
– Bob McCarthy	70	-	8	-	-	78
Deputy Chairperson						
– Ruth Stewart	38	-	-	-	-	38
Board Members						
– Brian Woods	38	-	4	-	-	42
– Fraser (Ted) Nai	38	-	4	-	-	42
– Greg Edwards	38	-	4	-	-	42
– Horace Baira	38	-	4	-	-	42
– Tracey Jia	38	-	4	-	-	42
– Kaz Price	20	-	2	-	-	22
– Scott Davis	3	-	-	-	-	3

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Note 18. Key management personnel disclosures (continued)

2015	Short-term benefits					
Name and position	Base $'000	Non-monetary $'000	Post-employment benefits $'000	Long-term benefits $'000	Termination benefits $'000	Total $'000
Executive						
Board Secretary						
– Christopher Black	100	-	10	2	-	112
Board Operations Manager (Secretary)						
– Andrea Brophy	14	-	1	-	-	15
Chief Executive						
– Jill Newland	385	7	38	7	-	437
Chief Finance Officer						
– Cherie Campbell	16	-	-	-	-	16
– Danielle Hoins	30	-	3	1	-	34
– David Hepper	106	-	11	2	6	125
Director, Rural & Remote Clinical Support						
– Peter McCormack	138	-	16	3	-	157
Executive Director, Nursing & Midwifery						
– Lyn Wardlow	129	2	15	2	-	148
Executive Director, People & Culture						
– Allyson Paull	149	-	15	3	-	167
Executive General Manager, Northern Sector						
– Andrew Marshall	87	-	9	2	-	98
– Benjamin Jesser	21	5	1	-	-	27
– Kerrie Freeman	41	11	4	1	-	57
Executive General Manager, Southern Sector						
– Ian Pressley	160	-	15	3	-	178
Board						
Chairperson						
– Bob McCarthy	73	-	7	-	-	80
Deputy Chairperson						
– Ruth Stewart	44	-	4	-	-	48
Board Members						
– Brian Woods	18	-	1	-	-	19
– Fraser (Ted) Nai	39	-	4	-	-	43
– Greg Edwards	40	-	4	-	-	44
– Horace Baira	17	-	1	-	-	18
– Kevin Quirk	40	-	4	-	-	44

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Note 19. Contingent liabilities

Litigation in progress
As at 30 June 2016 there were no cases filed in the courts naming the State of Queensland acting through the TCHHS as defendant.

As of 30 June 2016 there were 2 claims managed by QGIF (13498 and 14452), which may never be litigated or result in payments of a claim. Tribunals, commissions and board figures represent the matters that have been referred to QGIF for management. The maximum exposure to TCHHS under this policy is $20,000 for each insurable event.

There are currently eight 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 Northern Peninsula Area and one in the Torres Strait). These reserves are held in the name of DoH as trustee and recorded at fair value in TCHHS's Statement of Financial Position. Fair value of these reserves is a nominal value ($1).

Registered trustee leases and ILUAs have been negotiated for eight facilities previously located on DOGIT land, while an additional three trustee leases and ILUAs are either still being negotiated or are awaiting registration. In the case of the remaining nine sites on which facilities have been constructed on DOGIT land, tenure and ILUA negotiations will progress with the Torres Strait Island Regional Council and the native title holders respectively, subject to funding availability. Seven of the trustee leases are registered in the name of TCHHS and the lease commitment (generally for a period of 30 years).

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Note 20. Commitments

	2016 $'000	2015 $'000
Commitments - capital expenditure		
Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	275	18,365
One to five years	-	9,074
Commitments - operating lease expenditure		
Committed at the reporting date but not recognised as liabilities, payable:		
Within one year	5,216	1,025
One to five years	2,752	869
	8,243	29,333

Leases

Most operating leases are entered into by DoH, with DoH being the legal lessee. Accordingly, most lease commitments relating to TCHHS premises and operations are disclosed within the accounts of DoH.

TCHHS is not party to any finance leases.

Note 21. Patient trust transactions and balances

	$'000	$'000
Receipts		
Opening balance	4	6
Amounts receipted on behalf of patients	14	6
Total receipts	18	12
Payments		
Amounts paid to or on behalf of patients	8	8
Total payments	8	8
Trust assets and liabilities		
Assets		
Cash held and bank deposits	10	4
Total assets	10	4

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 22. Events after the reporting period

There are no matters or circumstances that have arisen since 30 June 2016 that have significantly affected, or may significantly affect TCHH's operations, the results of those operations, or the HHS's state of affairs in future financial years.

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Note 23. Right of Private Practice arrangement

	2016 $'000	2015 $'000
Receipts		
Private practice receipts*	3,644	2,205
Total receipts	3,644	2,205
Payments		
Payments to employees	2,111	1,222
Payments to external providers	249	1
Total payments	2,360	1,223

* Hospital and Health Services now hold the prerogative to grant clinician limited rights to conduct private practice on the terms and conditions of the private practice schedule within the employment contract (granted private practice). These new arrangements introduced two new contract options replacing Options A and B. 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 Private Practice Trust Fund.

Note 24. Reconciliation of operating result to net cash from operating activities

	Note	2016 $'000	2015 $'000
Operating result for the year		5,754	2,153
Non-cash movements:			
Depreciation and amortisation	13	11,178	10,805
Depreciation offset from Department of Health	16	(11,178)	(10,807)
Loss on disposal		80	(183)
Donated assets		(127)	(55)
Impairment on inventory		86	(133)
Reversal of impairment loss receivables	11	(19)	16
Change in operating assets and liabilities			
Increase trade and other receivables		(4,814)	(762)
Increase in GST receivables		(177)	(5)
Decrease in inventories		66	(169)
Increase prepayments		(9)	(53)
Increase in trade and other payables		3,843	(6,306)
Increase accrued employee benefits		83	597
Decrease accrued contract labour		(2,957)	85
Decrease in GST payable		(27)	47
Decrease unearned revenue		(245)	746
Net cash from operating activities		1,537	(4,025)

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Note 25. 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.

	2016 $'000	2015 $'000
Opening balance	856	935
Revenue received during the year	19	62
Expenditure during the year	(1)	(141)
Transfer prior year placement fees	(783)	-
Balance of General Trust	91	856

The closing cash balance of the General Trust at 30 June 2016 is $0.091m (2015: $0.856m). This is held on deposit with the Queensland Treasury Corporation $0.076m (2015: $0.846m) and the Commonwealth Bank $0.015m (2015: $0.010m).

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.

(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 2015-16.

Accounting standards early adopted for 2015-16

Two Australian Accounting Standards have been early adopted for the 2015-16 year as required by Queensland Treasury. These are:

AASB 2015-2 Amendments to Australian Accounting Standards – Disclosure Initiative: Amendments to AASB 101 [AASB 7, AASB 101, AASB 134 & AASB 1049]

The amendments arising from this standard seek to improve financial reporting by providing flexibility as to the ordering of notes, the identification and location of significant accounting policies and the presentation of sub-totals, and provide clarity on aggregating line items. It also emphasizes only including material disclosures in the notes. The HHS has applied this flexibility in preparing the 2015-16 financial statements, including co-locating significant accounting policies with the related breakdowns of financial figures in the notes.

AASB 2015-7 Amendments to Australian Accounting Standards – Fair Value Disclosures of Not-for-Profit Public Sector Entities [AASB 13]

This standard amends AASB 13 Fair Value Measurement and provides relief to not-for-profit public sector entities from certain disclosures about property, plant and equipment that is primarily held for its current service potential rather than to

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Note 26. Other information (continued)
(b) First Year Application of New Standards or change in Policy (continued)

generate future net cash inflows. The relief applies to assets under AASB 116 Property, Plant and Equipment which are measured at fair value and categorised within Level 3 of the fair value hierarchy.

As a result, the following disclosures are no longer required for those assets. In early adopting the amendments, the following disclosures have been removed from the 2015-16 financial statements:

- disaggregation of certain gains/losses on assets reflected in the operating result;
- quantitative information about the significant unobservable inputs used in the fair value measurement ; and
- a description of the sensitivity of the fair value measurement to changes in the unobservable inputs.

Accounting Standards Applied for the First Time in 2015-16
No new Australian Accounting Standards effective for the first time in 2015-16 had any material impact on this financial report.

(c) New Accounting Standards and interpretations not yet effective
Other than AASB 2015-2 and AASB 2015-7 referred to above, Australian Accounting Standards and Interpretations that are not yet mandatory were not early adopted by TCHHS during 2015-16. TCHHS is not permitted to early adopt accounting standards unless approved by Queensland Treasury.

AASB 124 Related Party Disclosures will become effective from reporting periods beginning on or after 1 July 2016. This accounting standard requires a range of disclosures about the remuneration of key management personnel, transactions with related parties/entities, and relationships between parent and controlled entities. TCHHS already discloses information about the remuneration expenses for key management personnel (refer Note 18. Key management personnel disclosures) in compliance with requirements from Queensland Treasury. Therefore, the most significant implications of AASB 124 for TCHHS's financial statements will be the disclosures to be made about transactions with related parties, including transactions with key management personnel or close members of their families.

AASB 15 Revenue from Contracts with Customers will become effective from reporting periods beginning on or after 1 January 2018. 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 9 Financial Instruments and AASB 2014-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2014) will become effective from 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 16 Leases will become effective from 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 AASB16 comes into effect, the majority of operating leases (as defined by the current AASB 117) will be reported on 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.

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Note 27. Budget vs actual comparison

A budget vs actual comparison, and explanations of major variances, has not been included for the Statement of Changes in Equity, as major variances relating to that statement have been addressed in explanations of major variances for other statements.

Statement of Comprehensive Income	Note	Original Budget 2016 $'000	Actual 2016 $'000	Variance $'000	Variance % of budget
Income					
Health service funding	a	-	183,122	183,122	100%
User charges and fees	a	170,496	1,449	(169,047)	(99%)
Grants and other contributions		8,048	12,023	3,975	49%
Other revenue		923	2,041	1,118	121%
Interest		38	15	(23)	(61%)
Total income		179,505	198,650	19,145	
Expenses					
Employee expenses	b	8,086	10,185	2,099	26%
Department of Health contract staff		89,226	90,682	1,456	2%
Supplies and services	c	70,432	78,339	7,907	11%
Depreciation		11,230	11,178	(52)	-
Impairment losses		5	(19)	(24)	(480%)
Other expenses		526	2,531	2,005	381%
Total expenses		179,505	192,896	13,391	
Operating result		-	5,754	5,754	
Other comprehensive income					
Items that will not be reclassified subsequently to operating result					
Increase(Decrease) in Asset Revaluation Surplus		-	(1,323)	(1,323)	(100%)
Total other comprehensive income for the year		-	(1,323)	(1,323)	
Total comprehensive income		-	4,431	4,431	

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Note 27. Budget vs actual comparison (continued)

Statement of Financial Position	Note	Original Budget 2016 $'000	Actual 2016 $'000	Variance $'000	Variance % of budget
Assets					
Current assets					
Cash and cash equivalents	d	13,928	22,364	8,436	61%
Trade and other receivables	e	(4,430)	7,173	11,603	(262%)
Inventories		400	489	89	22%
Other		43	662	619	1440%
Total current assets		9,941	30,688	20,747	
Non-current assets					
Property, plant and equipment	f	211,994	185,426	(26,568)	(13%)
Total non-current assets		211,994	185,426	(26,568)	
Total assets		221,935	216,114	(5,821)	
Liabilities					
Current liabilities					
Trade and other payables	g	11,369	12,994	1,625	14%
Accrued employee benefits		18	705	687	3817%
Unearned revenue		-	1,180	1,180	100%
Other current liabilities		680	-	(680)	(100%)
Total current liabilities		12,067	14,879	2,812	
Total liabilities		12,067	14,879	2,812	
Net assets		209,868	201,235	(8,633)	
Equity					
Contributed equity		209,868	193,329	(16,539)	(8%)
Accumulated surplus		-	7,906	7,906	100%
Asset revaluation surplus		-	-	-	
Total equity		209,868	201,235	(8,633)	

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Note 27. Budget vs actual comparison (continued)

Statement of Cash Flows	Note	Original Budget 2016 $'000	Actual 2016 $'000	Variance $'000	Variance % of budget
Cash flows from operating activities					
Inflows:					
User charges and fees	h	170,351	2,217	(168,134)	(99%)
Health service funding	h	-	165,947	165,947	100%
Grants and other contributions		8,048	11,896	3,848	48%
Interest received		38	15	(23)	(61%)
GST collected from customers		-	1,357	1,357	100%
GST input tax credits from ATO		-	5,203	5,203	100%
Other		4,826	2,041	(2,785)	(58%)
Outflows:					
Employee expenses	i	(8,096)	(10,103)	(2,007)	25%
Department of Health contract staff	j	-	(93,642)	(93,642)	(100%)
Supplies and services	j	(166,865)	(73,844)	93,021	(56%)
Grants and subsidies		-	(1,351)	(1,351)	(100%)
GST paid to suppliers		-	(5,558)	(5,558)	(100%)
GST remitted to ATO		-	(1,411)	(1,411)	(100%)
Other expenses		(526)	(1,229)	(703)	134%
Net cash provided by/(used in) operating activities		**7,776**	**1,537**	**(6,239)**	
Cash flows from investing activities					
Payments for property, plant and equipment	k	(2,351)	(2,887)	(536)	23%
Net cash provided by/(used in) investing activities		**(2,351)**	**(2,887)**	**(536)**	
Cash flows from financing activities					
Equity withdrawals	l	(11,230)	-	11,230	(100%)
Proceeds from equity injections		2,351	2,664	313	13%
Net cash from/(used in) financing activities		**(8,879)**	**2,664**	**11,543**	
Net increase/(decrease) in cash and cash equivalents		(3,454)	1,315	4,769	(138%)
Cash and cash equivalents at the beginning of the financial year		17,382	21,049	3,667	21%
Cash and cash equivalents at the end of the financial year		**13,928**	**22,364**	**8,436**	

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Note 27. Budget vs actual comparison (continued)

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

a) In the original budget reported in the Service Delivery Statement (SDS) user charges and health service funding were combined ($170.496m), whereas the actual revenue amounts have been disaggregated. The overall increase to funding ($14.075m) relates to a decrease in user charges and fees ($-0.874m) and increased State funding ($14.949m) through window adjustments during the year for new State and Commonwealth program initiatives including; Indigenous Health Outcomes ($1.015m), oral health ($0.243m), Saibai Island health clinic ($0.500m),Nurse Graduate and Navigator program ($0.299m), Ice Initiative ($0.348m), targeted sexual health programs ($0.865m), mental health ($0.290m), and new service positions ($0.467). Part way through the year the Tuberculosis Control Unit was transferred from Cairns and Hinterland HHS ($0.575m) and the Primary Health Care Information System and Support Unit was transferred from DoH ($1.570m). There was also growth due to the enterprise bargaining agreement ($1.828m), Multipurpose Health Service funding ($1.644m), activity incentive payments for quality improvement ($0.309m), other general program funding ($0.605m), programs deferred from 2013-14 and 2014-15 ($1.729m), and Backlog Maintenance Remediation Program funding (BMRP) ($2.662m).

b) The increase in employee expenses of $2.099m (26%) relates to the recruitment of additional senior medical officers ($1.1m) and an increase of two Board members and two Health Executive Service (HES) officers since the calculation of the original budget. Enterprise Bargaining (EB) agreements (3%) are also driving the increase in actuals.

c) The increase in supplies and services of $7.907m (11%) relates to additional expenditure consumed due to new program funding received after the original budget was built detailed above in note a). Specific increases from the original budget include; patient transport and retrieval costs ($3.100m), employee housing lease costs ($0.400m), clinical supplies ($0.225m), electricity costs ($0.111m), drugs expense (0.410m) and expenditure associated with the BMRP ($3.661m).

Statement of Financial Position

d) The increase in cash and cash equivalents of $8.436m (61%) relates predominantly to incentive payments received for BMRP ($8.407m) program performance, which was not included in the original budget.

e) The original budget for trade receivables (-$4.430m) contained revenue in advance ($4.800m) that should have been classified in trade and other payables in the original budget work-up. The original budget should have reported planned receivables of $0.918m. The actuals ($7.173m) is mostly made up of accrued revenue from DoH of $6.158m related to window 3 funding.

f) Property, plant and equipment decreased against the original budget by $26.568m (13%). The decrease relates to the transfer of non-operational employee housing to Department of Housing and Public Works ($24.914m) which was not accounted for in the original budget. The decrease was also due to a reduction in the valuation of property, plant and equipment at the end of the year ($1.7m).

g) The increase in trade and other payables of $1.625m (14%) relates to an increase in accrued payables associated with the increase in employee labour.

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Note 27. Budget vs actual comparison (continued)

Statement of Cash Flows

h) Refer to the commentary in Note a) above. The overall decrease in user charges and fees and health service funding against the original budget was $0.816m.

i) Refer to the commentary in Note b) above.

j) Department Health contract staff and supplies and services are combined in the original budget. The variance between the two is not material.

k) The increase in cash movement for property, plant and equipment ($0.536m) relates to an underspend in allowances for health technology equipment replacement (-$0.245m), minor capital allowance (-$0.067m) and includes BMRP spend of ($0.848m) previously recognised as a movement in supplies and services.

l) The equity withdraws reported in the original budget are classified as a cash item in the SDS. The actual equity withdrawals in the Statement of Cash Flows are non-cash items and therefore are not reported through the actuals in the Statement of Cash Flows.

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Torres and Cape Hospital and Health Service
Management Certificate
30 June 2016

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

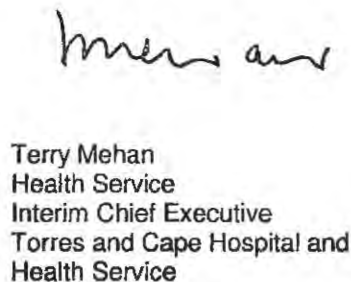
b) the financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of Torres and Cape Hospital and Health Service for the financial year ended 30 June 2016 and of the financial position of the Torres and Cape Hospital 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

Torres and Cape Hospital and Health Board

23/8/16



Terry Mehan
Health Service
Interim Chief Executive
Torres and Cape Hospital and Health Service

23/8/16

Danielle Hoins
Chief Finance Officer

Torres and Cape Hospital and Health Service

23 / 08 / 2016

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INDEPENDENT AUDITOR'S REPORT

To the Board of Torres and Cape Hospital and Health Service

Report on the Financial Report

I have audited the accompanying financial report of Torres and Cape Hospital and Health Service, which comprises the statement of financial position as at 30 June 2016, 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 significant accounting policies and other explanatory information, and certificates given by the Board Chair, Health Service Interim Chief Executive and the Chief Finance Officer.

The Board's Responsibility 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 prescribed accounting requirements identified in the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2009*, including compliance with Australian Accounting Standards. The Board's responsibility also includes such internal control as the Board determines is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on the audit. The audit was conducted in accordance with the *Auditor-General of Queensland Auditing Standards*, which incorporate the Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit is planned and performed to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation of the financial report that gives a true and fair view in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control, other than in expressing an opinion on compliance with prescribed requirements. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Board, as well as evaluating the overall presentation of the financial report including any mandatory financial reporting requirements approved by the Treasurer for application in Queensland.

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

Independence

The *Auditor-General Act 2009* promotes the independence of the Auditor-General and all authorised auditors. The Auditor-General is the auditor of all Queensland public sector entities and can be removed only by Parliament.

The Auditor-General may conduct an audit in any way considered appropriate and is not subject to direction by any person about the way in which audit powers are to be exercised. The Auditor-General has for the purposes of conducting an audit, access to all documents and property and can report to Parliament matters which in the Auditor-General's opinion are significant.

Opinion

In accordance with s.40 of the *Auditor-General Act 2009* –

(a) I have received all the information and explanations which I have required; and

(b) in my opinion –

  (i) the prescribed requirements in relation to the establishment and keeping of accounts have been complied with in all material respects; and

  (ii) the financial report presents a true and fair view, in accordance with the prescribed accounting standards, of the transactions of the Torres and Cape Hospital and Health Service for the financial year 1 July 2015 to 30 June 2016 and of the financial position as at the end of that year.

Other Matters - Electronic Presentation of the Audited Financial Report

Those viewing an electronic presentation of these financial statements should note that audit does not provide assurance on the integrity of the information presented electronically and does not provide an opinion on any information which may be hyperlinked to or from the financial statements. If users of the financial statements are concerned with the inherent risks arising from electronic presentation of information, they are advised to refer to the printed copy of the audited financial statements to confirm the accuracy of this electronically presented information.

D.J OLIVE FCPA
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane